ies Report

Institute for Employment Studies

Evaluation of Mind's mental health and resilience training for new recruits to the Blue Light sector

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Institute for Employment Studies

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Contents

Executive Summary

Background

The report presents the findings of an evaluation of the 'Mental Health and New Recruits' training interventions undertaken by the Institute for Employment Studies (IES). The training constitutes Strand 2 of the third phase of Mind's Blue Light programme of work for emergency services personnel in England and Wales. Separate evaluations were undertaken by other research partners for the other strands of work. The analysis and conclusions presented in this report were developed independently of these other research partners.

New recruits into the emergency services face significant pressures as they transition into their roles. Previous research with trainee paramedics showed that early intervention has potential to significantly reduce the likelihood of an individual experiencing mental health problems later in their career. As part of the Phase 3 programme, a series of training courses were delivered between January and June 2018 to new recruits within the Blue Light sector. The 'Mental health and New recruits' training programme, which comprised two half-day courses, aimed to introduce new recruits across the emergency services to a range of psychological coping skills and encourage help-seeking behaviour.

The Institute for Employment Studies' evaluation for 'Strand 2: New Recruits' was designed to contribute to the robust evidence base required as part of this project. The main areas of enquiry as specified by Mind centred on:

1. Determining the extent to which the training course could be made most relevant and engaging to new recruits and their employers;
2. Understanding whether the course had led to any change in new recruits' mental health knowledge, help-seeking behaviour and use of coping skills; and
3. Where changes had occurred, identifying how long these were sustained.

Approach

A mixed methods approach to the evaluation was adopted comprising three waves of survey, in-depth qualitative interviews, training observations and post Part 1 training focus groups. The broad aim was to capture actual and potential impacts of the training for recruits across the Blue Light sector and gain an understanding of issues that need to be considered in any potential wider rollout.

IES administered surveys over the course of the evaluation to explore immediate as well as longer lasting outcomes:

- 'baseline' survey: participants completed this prior to Part 1 of the training

- 'post Part 1 training' survey: participants completed this immediately after attending Part 1.
- 'follow-up' survey: participants completed this prior to Part 2 of the training; this was normally 8 -12 weeks after attending Part 1.

Different qualitative approaches were applied strategically to understand the training objectives, content and delivery; to evaluate how recruits engaged with the training; and to identify learning outcomes and any changes in behaviour.

Main Findings

Approval ratings for the training were high; 94 per cent of new recruits attending Part 1 agreed it was useful. The training materials were felt to be relevant and of high quality. Experienced local Mind trainers were successful in engaging participants and facilitating open group discussion, and they were able to respond flexibly to the interests and needs of the different Blue Light services. Recruits who attended the second part said that it had helped cement their learning and increased the likelihood of them implementing useful changes in the longer term.

Although fewer participants attended Part 2 than Part 1 there was no evidence that 'no-shows' at Part 2 stemmed from lack of satisfaction of Part 1 or rejection of the material**. It seems likely that many participants simply had competing priorities and/or felt free to drop out of training that was not compulsory**. Anecdotal evidence from recruits who were interviewed indicated that some organisations had made Part 1 a compulsory requirement, but had not mandated participants to attend Part 2. This is likely to account for some level of drop-out between the two sessions, although this could not be verified as once people had dropped out of the course they also dropped out of the evaluation (despite efforts to contact them).

When the populations who attended Part 1 of the training voluntarily and mandatorily were compared there were marked gender differences. Among those who attended Part 1 on a voluntary basis the majority were female (72 per cent). In contrast, women made up only a minority (40 per cent) of those mandated to attend. One major implication therefore of making training optional is that smaller numbers of men attend.

Recruits whose attendance was voluntary were more likely to have experience of poor mental health (either their own or that of someone around them) than those for whom attendance was compulsory. This suggests that those with lived experience of mental health problems may have been especially motivated to attend the training. The above findings suggest that the basis upon which the training is offered has a direct impact upon the composition of training groups.

Recruits demonstrated relatively good levels of knowledge and understanding of mental health prior to Part 1 training. Where baseline levels of knowledge were high, there was limited potential for scores to improve further. **The biggest impact of the training was found on self-reported understanding of ways to build resilience.** The percentage of

survey respondents saying they understood this rose from 48 per cent before Part 1 of the training, to 93 per cent afterwards. This decreased to 71 per cent after the follow up period (ie just prior to Part 2), evidencing the difficulty of retaining new knowledge after several weeks and the potential benefits of a two-stage training model.

At the follow up stage, 32 per cent had applied a coping technique that they had learned in Part 1 and a further 20 per cent intended to try. The most popular responses[1] were 'mindfulness', 'meditation' and 'sharing experiences with colleagues'. There was increased understanding of the support needs of people with mental health problems but also a recognition of the boundaries of a role in the emergency services.

The training was also **successful in raising awareness of and engagement with Mind's Blue Light resources**. One notable finding was that the proportion of recruits who had accessed Blue Light booklets increased from 9 per cent of new recruits at baseline to 20 per cent by the end of the evaluation period.

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

Learning points and recommendations

The course as it stands appears to be sufficiently relevant and engaging without any major review or change of approach. IES's research has shown that Mind's current training package increases understanding and knowledge around resilience building and help-seeking behaviours. **The findings demonstrate potential for the training to make a positive impact on the wellbeing of Blue Light New Recruits and we strongly recommend wider roll out.**

Achieving long-term impact is a challenge for any training provider but the two-session model appears to enhance the potential for meaningful change. Our findings show that the two-session training package is an effective one. However, any future roll out should be accompanied by a requirement to attend both sessions as there was substantial drop-out between Part 1 and Part 2 of the piloted training.

Evidence suggests that making training compulsory may help achieve a more representative balance of genders: in the population studied, men were less likely to attend the training when it was not compulsory. This could also help address potential self-selection biases among those who attend voluntarily; our findings suggest recruits with less personal familiarity with mental health and its impacts were under-represented among groups attending voluntarily. Ideally, senior management within services should endorse and emphasise the importance of the training.

[1] This was an open text survey question so respondents used their own words.

Mind could consider shifting the emphasis of the course to where there is most potential for new learning, ie psychological coping and resilience. An additional suggestion would be to emphasise the coping skills content more strongly when promoting the course to recruits and services. A change in title could overcome resistance from those who feel they know about mental health already. Language used to publicise the training could highlight the relevance of the training to future work scenarios.

We strongly recommend that Mind make printed or electronic content available to enhance learning outcomes. Some recruits felt they would have liked to have received course materials that they could refer to afterwards and thus help cater to diverse learning styles.

Changes in course duration should be introduced with caution. Condensing training can result in valuable time spent in open discussion being lost. Potential to change attitudes and increase empathy can be compromised. Evidence suggests that recruits particularly valued the opportunity for open and honest group discussion offered by the course; particularly as some recruits noted that they had little opportunity to talk with colleagues during shifts.

1 Introduction

This report presents the findings of an evaluation of the 'Mental Health and New Recruits' training interventions undertaken by the Institute for Employment Studies (IES). The training constitutes Strand 2 of the third phase of Mind's Blue Light programme of work for emergency services personnel in England and Wales. Separate evaluations were undertaken by other research partners for the other strands of work. The analysis and conclusions presented in this report were developed independently of these other research partners.

1.1 Evaluation context

Between March 2015 and March 2016, Mind delivered the first year of their Blue Light programme which aimed to improve the mental health of emergency services staff and volunteers in England. To support this work, Mind commissioned research partners to assess the impact of the programme and identify process learning. As part of this initial phase, the Institute for Employment Studies undertook an evaluation of Mind's 'Workplace Wellbeing' intervention for emergency services personnel in England[2]. A second phase then involved a small number of continued legacy activities. In November 2016, the government provided further funding to Mind to support a third phase of the Blue Light Programme (Phase 3). Mind have used this additional support to continue delivering various aspects of the programme in England, extend the programme to Wales, and begin working with additional 'at risk' groups such as new recruits and Accident and Emergency staff.

Scoping research undertaken by Mind and Research Ability[3] found that new recruits into the emergency services faced significant pressures as they transitioned into their roles. Pressures and stressors identified in the scoping research included lifestyle transitions such as shift working. Recruits reported experiencing challenges around maintaining social relationships and dealing with external stressors, such as probation periods and exams. Also, despite the wide range of training programmes that new recruits undertake, they felt underprepared to deal with some aspects of their role. Feeling unprepared was particularly prevalent in 'distressing situations' or 'critical incidents'.

[2] Wilson S, Sinclair A, Huxley C, Spiegelhalter K (2016), *Evaluation of Mind's Blue Light Programme, Strand 2: Workplace wellbeing*, Mind

[3] Mind, Research Ability (unpublished), *Blue Light Programme – Phase Three New Audience Scoping: New Recruits Final Report*, Mind.

Previous research[4] with trainee paramedics showed that early intervention has potential to significantly reduce the likelihood of an individual experiencing mental health problems later in their career. As part of the Phase 3 programme, a series of training courses were delivered between January and June 2018 to new recruits within the Blue Light sector. The 'Mental health and New recruits' training programme, which comprised two half-day courses, aimed to introduce new recruits across the emergency services to a range of psychological coping skills and encourage help-seeking behaviour.

The evaluation for 'Strand 2: New Recruits' was designed to contribute to the robust evidence base required as part of this project, and the main research questions as specified by Mind centred on :

1. Determining the extent to which the training course could be made most relevant and engaging to new recruits and their employers;
2. Understanding whether the course had led to any change in new recruits' mental health knowledge, help-seeking behaviour and use of coping skills; and
3. Where changes had occurred, identifying how long these were sustained.

In addition to the primary research questions, the evaluation sought to compare the process, effectiveness and outcomes of the training across the four emergency services to identify any similarities or differences. A further objective was to assess the practical implications of the evaluation findings to make recommendations for the possible wider roll-out of the training.

1.2 Overview of the training

Mind's face-to-face training for new recruits was rolled out from late January 2018 as part of a pilot phase. The training focused on a number of aspects of mental health and building resilience in the workplace. The training aimed to introduce new recruits to a range of psychological coping skills and encourage help-seeking behaviour.

The training took the format of a PowerPoint presentation with exercises and discussion activities delivered by a trainer to a group of between eight and twenty individuals, over the course of two half days delivered at different points during recruits' training. In order to fit with local services' schedules over the evaluation period, one of the Blue Light networks delivered a shorter version of the training. This covered the same content as the full half-day training but in a condensed format.

It was aimed at new recruits (defined as having up to three years' service within an emergency services organisation). On occasion, a manager or Blue Light programme representative from the Blue Light employer was also present at the training.

[4] Wild J, Smith K V, Thompson E, Béar F, Lommen M J J, Ehlers A (2016), 'A prospective study of pre-trauma risk factors for post-traumatic stress disorder and depression', *Psychological medicine*, Vol. 46, No.(12)

The training took place in two parts: Part 1 covered awareness and understanding of mental health and resilience, tools and techniques for building resilience, and support available for new recruits including Mind's Blue Light programme. Part 2 focused on refreshing participants' understanding of mental health awareness and of techniques for managing wellbeing and building resilience, as well as giving an opportunity for reflection on the impact of their experiences since the first part of the training, and how they have or plan to put their learning into practice. It was envisaged that Part 2 would be delivered approximately three months after Part 1. In practice, Part 2 was delivered between two and four months after Part 1 of the training.

There were 16 training sessions delivered by four Blue Light Networks in England, including seven sessions delivered in the condensed format. These were attended by 241 new recruits to the emergency services. The number of people who received training was more than double Mind's original target. Attendance numbers at Part 2 were more modest[5]; but still achieved impressive reach.

1.3 Structure of the report

The report brings together findings obtained using a mix of methodologies and provides a synthesis of qualitative as well as quantitative data. In order to help navigate the findings, key 'take home points' are summarised at the top of sections or subsections within the chapters.

- Chapter 2 sets out the evaluation methodology.
- Chapter 3 provides a summary of who attended the training and changes in attendance between Part 1 and Part 2, as well as motivations for and barriers to attending the training.
- Chapter 4 focuses on how the face-to-face training for new recruits was received and views on its content and format.
- Chapter 5 provides an overview of the outcomes of the training for new recruits in terms of participants' knowledge and beliefs about mental health and coping.
- Chapter 6 addresses behaviour changes occurring after the training and application of new skills and knowledge.
- Chapter 7 draws out main conclusions and suggests some learning points for the future.

[5] 123 new recruits

2 Methodology

A mixed-methods approach to the evaluation was adopted comprising three waves of survey, in-depth qualitative interviews, training observations and post-training focus groups. The broad aim was to capture actual and potential impacts of the training for recruits across the Blue Light sector and gain an understanding of issues that need to be considered in any potential wider rollout.

2.1 Evaluation rationale

2.1.1 Evaluating training programmes

Training impacts can be hard to detect and the design of training evaluations requires an understanding that the impacts of training can occur at various different levels. Kirkpatrick's model (which is the most widely adopted model of training evaluation) sets out four levels as follows:

1. Reaction: what participants thought and felt about the training and the way it was delivered (satisfaction, 'happy sheets').
2. Learning: resultant increase in knowledge and/or skills and/or change in attitudes.
3. Behaviour: transfer of knowledge, skills, and/or attitudes from classroom to the job (e.g. change in job behaviour due to training programme)
4. Results: the final results that occurred because of attendance and participation in the training programme (e.g. job attendance, performance, productivity).

Kirkpatrick notes that useful evaluation at Level 3 and above should occur three to six months post-training. Some Level 4 impacts may take longer periods to observe and this is out of scope for most short to medium term evaluations.

2.1.2 Design of this evaluation

IES's surveys were designed to capture 'Level 1' and 'Level 2' impacts, and also to gather as much data as possible to indicate Level 3 impacts, ie planned or actual behavioural changes. Table 2.1 sets out this rationale.

Mini focus groups and in-depth interviews were designed to elicit data showing Level 3 and 4 impacts or indicating impacts that might take place subsequent to the evaluation period. These also provided nuanced data not easily captured via survey. The perspective of the trainers was obtained via two further interviews; these provided unique insights into the training delivery process.

Table 2.1 Evaluation design

Blue Light Phase 3, Strand 2: New recruits							
Type of outcome	Training Observation	Interviews with trainers	Qual research with new recruits		Surveys completed by new recruits		
			Mini focus groups (immediately after Part 1)	Interviews (15-24 weeks after Part 1)	Baseline (prior to Part 1)	Post-training (after Part 1)	Follow up survey (prior to Part 2, 2-4 months after Part 1)
Reaction/delivery	●	●	●	●		●	●
Learning impacts	●		●	●	●	●	●
Behaviours			●	●	●	●	●

●High potential to inform on this level

●Moderate potential to inform on this level

Source IES, 2017

2.2 Quantitative research elements

IES administered the following surveys over the course of the evaluation to explore immediate as well as longer-lasting outcomes:

- 'baseline' survey: participants completed this prior to receiving Part 1 of the training
- 'post Part 1 training' survey: participants completed this immediately after having participated in Part 1 of the training.
- 'follow-up' survey: participants completed this prior to receiving Part 2 of the training.

2.2.1 Survey development

A high degree of consistency in format and wording was used across all of the surveys to allow comparison of outcomes across time points. Sets of questions exploring awareness and understanding of, as well as behaviours relating to mental health and resilience in the workplace were developed in line with the objectives of the training. Questions were also added to elicit feedback on the delivery and content of training materials/facilitation, as well as views on when the training should be delivered to be most effective and useful. All were developed in consultation with Mind, whose guidance helped to ensure that measures and language were appropriate, and that the survey length and format was managed in order to encourage participation.

2.2.2 Surveys to evaluate new recruits training

In total three surveys were administered to individuals who had participated in the new recruits training delivered by local Minds.

- **A 'baseline' survey** to collect basic demographic information, and explore previous experience and awareness of and attitudes to mental health, resilience and wellbeing in the workplace and beyond. All participants that attended Part 1 of the training were asked to complete a paper copy of the survey prior to beginning the training.
- **A 'post-training' survey** to capture immediate impressions of the training and its usefulness. This was delivered to all those that completed Part 1 of the training immediately after the training had concluded.
- **A 'follow-up' survey** to explore training-related changes in participants' knowledge and behaviour relating to mental health and resilience. The survey was administered approximately two to four months after the delivery of Part 1 of the training and immediately before Part 2 to evaluate the effectiveness of learning from Part 1 over time.

2.2.3 Processing of survey data

In order to survey training participants on the day of training, a paper-based format was required. The trainers oversaw initial survey distribution, completion and collection of surveys before a secure handover to local Mind staff who were responsible for data entry via the Snap survey website. Data was then downloaded securely by IES for subsequent analysis. Each local Mind was given instructions for storing and disposing of paper data securely.

2.2.4 Survey analysis

All survey data was exported into SPSS file format. The dataset was cleaned to remove duplicates, test data and responses with no data. The final datasets were analysed using SPSS statistical software. These were analysed to obtain descriptives including counts, and percentages. For variables of interest cross-tabulations were analysed using chi-square tests to test for statistical significance. To detect change over time in attitudes, understanding and behaviour, datasets were combined and changes in scores were tested for statistical significance using repeated measure ANOVAs/Friedman's ANOVAs. Paired sample t-tests were used to isolate main effects and mixed-design ANOVAs were applied to understand group differences.

2.3 Qualitative research elements

Different qualitative approaches were applied strategically to understand the training objectives, content and delivery; to evaluate how recruits engaged with the training, and to identify learning outcomes and any changes in behaviour. These approaches included:

training observations, interviews and mini focus groups with learners, interviews with trainers from local Minds, and discussions with members of the Blue Light programme team at national Mind.

2.3.1 Engagement with Mind Blue Light programme teams

In order to inform understanding of the training context, objectives and delivery, IES observed elements of the set-up and training development process, and participated in discussions with members of the Blue Light programme team at national Mind. These elements included shadowing a teleconference with national Mind and local Minds regarding set-up and feedback on the training, receiving versions of the training in development, and discussing implementation and development of the training with members of the Blue Light programme team at national Mind throughout the development and delivery period.

2.3.2 Training observations

Independent observation of one Part 1 and one Part 2 training session with different trainers was undertaken to provide early formative feedback on the training with practical suggestions for improving course content and delivery. These observations gave insight into a delivery session's facilitation, knowledge and learning, and other behaviours, such as non-verbal communication. A data capture tool was employed to record behaviours (e.g. trainer interaction with trainees, trainee attentiveness, time allocation to specific elements) that could affect learning and pinpoint any areas where there was more/less engagement and interest allowing exploration of the delivery, the response of participants, the quality of the debate, and the atmosphere of the sessions.

2.3.3 Mini focus groups

Following the training observations, two mini focus groups were conducted to capture immediate feedback on the training. Six participants participated in the Part 1 focus group and four participants in the Part 2. Bespoke topic guides were developed to allow reflection on elements specific to one part of the training as well as elements common to both sessions. They explored participants' experiences of the course with respect to format, content, and quality of delivery. Thematic analysis was used to identify emerging themes and examples of personal engagement with the training. These focus groups supplemented the data collected from the training observations to provide early formative feedback on the training while delivery was ongoing.

2.3.4 Interviews with new recruits

Twelve in-depth telephone interviews with trainees from differing locations, Blue Light services and other demographical factors were undertaken up to two months after they had attended the training. These allowed IES to explore the experiences and views of course participants and the extent to which they were able to apply their learning as well as how well the learning has been sustained.

An 'opt-in' process via paper-based surveys provided a primary means of interview recruitment. Respondents were asked to provide their contact details if they were agreeable in principle to discussing their views and experiences further. In consultation with Mind, a sampling frame was developed to help ensure interview sample included representation with respect to Blue Light service and other demographic characteristics. These included participants who reported having relevant lived experience (some individuals self-identified as having this lived experience in their survey responses). Standardised procedures for informed consent and assurance of confidentiality were developed, also in consultation with Mind.

Topic guides were developed to ensure consistency of approach across interviews. These covered issues such as:

- Acceptability of the training format, content and style of presentation and perceived usefulness and relevance, especially with regards to Part 2 of the training as this information was not captured in the surveys which all took place before Part 2 training had been received.
- Learning outcomes with respect to understanding and confidence to deal with/manage mental health issues at work as well as resilience building.
- Implementation in the workplace/in personal life and reflection on how recruits plan to use resilience tools and techniques in their future career and training.
- Views from the perspective of lived experience of mental health problems (where disclosed).

The data was analysed by coding it onto a two-dimensional template using Excel software. The approach allowed researchers to sort and code quotations and notes thematically. It also enabled thematic analysis to proceed on a partly bottom-up (data driven) as well as top-down (research-question driven) basis. This ensured that emerging, non-anticipated issues and themes were captured, as well as those defined from the outset. The final, populated frameworks were used to structure the report and the contents of the cells (quotes as well as summary notes) were synthesised with the quantitative findings to provide its narrative.

2.3.5 Interviews with trainers

In addition to interviews with trainees, IES carried out in-depth interviews with two course trainers to gain their professional insights in relation to the strengths and weaknesses of the content of the training programme and its delivery to participants. The sample included one trainer who had delivered training in the shorter two hour format and one who had delivered the full half-day training. Thematic analysis was used to identify key themes and examples of learner engagement with the training. Feedback and comments gathered from trainers during observation of Part 1 and 2 training were also incorporated into this data analysis.

2.4 Achieved samples

2.4.1 Survey overview

The three surveys administered to individuals who had participated in the new recruits training delivered by local Minds included:

- **'baseline' survey**: participants completed this prior to receiving Part 1 of the training
- **'post Part 1 training' survey**: participants completed this immediately after having participated in Part 1 of the training.
- **'follow-up' survey**: participants completed this prior to receiving Part 2 of the training.

2.4.2 Survey response rates

The response rates for each of the surveys as a percentage of the recorded attendance for Part 1 training, ie the baseline sample, are shown in Table 2.2 below.

Table 2.2 Survey response rates

	Responses	Response rate as % of original baseline sample
Baseline	223	92.5
Post-training	221	91.7
Follow-up	124	51.5

Source: IES, 2018

2.4.3 Achieved interviews and focus groups samples

As shown in Table 2.3, 12 individual in-depth interviews with learners were conducted and two mini focus groups were undertaken. A purposive sampling approach was used to recruit participants to depth interviews. This ensured, as far as possible, that the sample reflected the various Blue Light services. Despite targeted approaches (and the offer of incentives to all interview participants) no Search and Rescue participants came forward for interview.

Table 2.3 Interviews and focus groups with learners (number of participants)

	Police	Fire	Ambulance	Search & Rescue	Total
Learner interviews	5	3	4	0	12
Part 1 mini focus group (at police service session)	6	-	-	-	6
Part 2 mini focus group (at ambulance service session)	-	-	4	-	4

Source: IES, 2018

2.5 Structure of the report

The sequence of presentation in the subsequent chapters follows the logic of the Kirkpatrick model presented earlier. Chapter 4 presents feedback on the content and format of the training (Level 1 in the Kirkpatrick model) while Chapter 5 discusses learning outcomes (Level 2). Chapter 6 considers early behavioural impacts (Level 2) and Chapter 7 draws together final conclusions and recommendations for Mind.

3 Reaching new recruits

This chapter examines the demographic characteristics of training participants, whether the training reached its intended audience and whether the profile of those attending each part of the training differed in any systematic way.

Qualitative data is presented to explore recruits' motivations for attending the training and any reported barriers. Thoughts about the need for the training, and whether the training reached its intended audience are also presented.

The 'Mental health and New Recruits' course was delivered in two parts with the first part introducing the topics of mental health and resilience as well as providing information about resilience techniques and support available for Blue Light staff. The second part refreshed learning around mental health and resilience, and provided opportunities for recruits to share experiences and discuss the application of new coping techniques in their work.

The first part of the training was delivered between late January and the end of March 2018 and information about attendance was captured in the baseline survey. The second part was delivered between late April and early June (usually 4-6 weeks later) and attendance information was captured in the follow-up survey.

3.1 Basis of attendance and motivations to attend

- Services varied widely with regards to whether they made the training compulsory. Fewer than half of the recruits from the fire service reported that attendance was compulsory.
- One in five recruits reported personal interest as a reason why they attended Mind's training.
- Only around one in twenty recruits had been encouraged to attend the training by a manager or HR professional.

This section explores reasons why new recruits attended the training and barriers to attending.

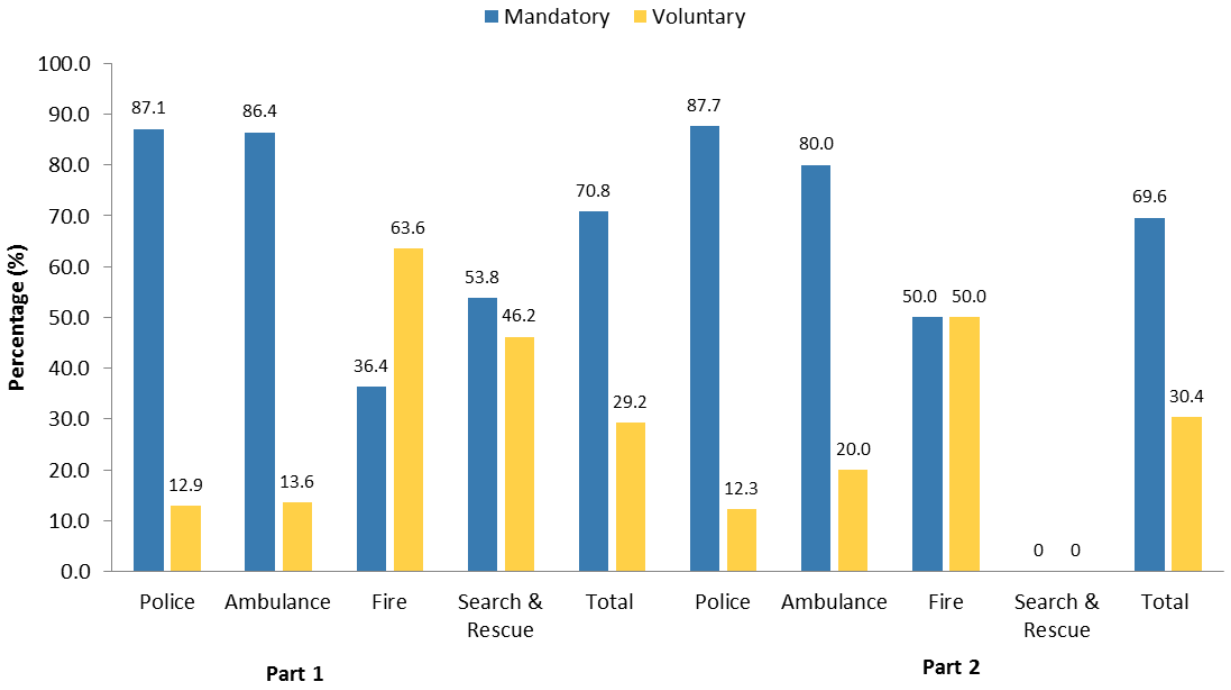
3.1.1 Motivations for and barriers to attending

Reasons for attending the training and how these differed across Part 1 and Part 2 are discussed below. However, it should be noted that attendance figures were much lower for the Part 2 training so, in some cases, percentages reported in Part 2 are likely to be disproportionately influenced by a few individuals.

Compulsory attendance

For both Part 1 and Part 2 training, the majority of recruits reported that one of their reasons for attending the training was because it was promoted as mandatory training or they were explicitly told to attend (see Figure 3.1).

Figure 3.1 Whether attendance was mandatory or voluntary by Blue Light service (%)



Note: respondents were able to select multiple options for this question. This table displays data for one of those options.

Source: Baseline survey, Follow-up survey, IES 2018

The predominance of mandatory attendance varied widely by service (Figure 3.1). The majority of recruits in the police and ambulance services reported that they attended the training on this basis. The smallest proportion of recruits who reported that attendance was mandatory was among the fire service: around a third of recruits from the fire service who attended Part 1 reported this, however at Part 2 this had increased to half of all fire recruits present.

Across the services, there are likely to have been a number of reasons underlying attendance numbers for Part 2, not all of them related to whether new recruits were instructed to (or expected to) attend. As explained at the beginning of this section, five Part 2 sessions did not take place within the evaluation period. Moreover an important limitation of the evaluation is that researchers were not able to reach those who did not

attend Part 2 to explore their reasons[6]. There is therefore no way of ascertaining, for example, how many new recruits intended to undertake Part 2 but were called away to attend an emergency.

The majority of new recruits interviewed for the evaluation (all interviewees had completed both parts) thought that mental health training should be mandatory but some felt that recruits should be able to 'opt out' if they already had good knowledge around mental health from a previous role or from prior training.

> *"I think it should be offered and I can't see why everyone shouldn't be made aware of it and be advised to attend but, whether they should or not, it's entirely up to them."*
>
> Vulnerable Persons Advocate. Fire service

Other interviewees felt that Mind's training should be compulsory for all new recruits as the inconvenience to some outweighed the risk of others missing out on important messages. There was also a feeling that many people assuming they had a good knowledge of mental health already would find the training more beneficial than they expected.

Several recruits who participated in interviews or focus groups suggested that it would be useful for line managers and senior staff to receive the training as well, and that this would help embed a more widespread organisational culture which was supportive of mental health and wellbeing.

> *"It should be a mandatory course for all managers and anyone going into management should have this kind of training behind them so that if someone did feel like they needed to go and have a conversation then the manager didn't send them on again and it didn't feel like you're being passed around."*
>
> Student Paramedic, Ambulance Service

Personal interest

Just under a fifth of recruits who attended either Part 1 or Part 2 stated that they attended the training because of they had a personal interest in the topic (see Table 3.1).

[6] With Mind's permission IES sent short questionnaires to those whose contact details were available, providing an opportunity for those not present at Part 2 to (anonymously) disclose any barriers to attending. However the small volume of responses prevented meaningful conclusions from being drawn.

Table 3.1 Had a personal interest in attending the training by Blue Light service (%)

	Police		Fire		Ambulance		Search & Rescue		All services	
	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2
Personal interest	15.7	17.3	36.4	50.0	15.9	40.0	61.5	-	19.2	18.2
Total (No.)	**140**	**81**	**22**	**10**	**44**	**10**	**13**	**0**	**223**	**124**

Note: respondents were able to select multiple options for this question. This table displays data for one of those options.

Source: Baseline survey, Follow-up survey, IES 2018

The proportion of recruits who reported that personal interest was a motivating factor for attending the training varied by service (see Table 3.1); levels were highest among those services which had the lowest levels of mandatory attendance. The majority of search and rescue recruits who attended Part 1 cited personal interest as a reason for attending, although this group was very small (13 individuals). Over a third of recruits from the fire service reported personal interest as a motivation at Part 1 and this increased to half of those who attended Part 2 training; however, this group was also quite small (22 individuals). The proportion of recruits from the ambulance service who reported this doubled between Parts 1 and 2; however, cautions should be taken interpreting this result as the Part 2 group was very small (10 individuals).

While Part 2 groups were quite small in some cases, the evidence does seem to suggest that recruits with a personal interest may be more likely to attend Part 2 training – the proportion reporting this increases between Part 1 and 2 for all services. This finding highlights the role that making training compulsory can play in ensuring that all recruits obtain the full benefits of the two-part training model, and not only those who self-select with an interest in mental health and wellbeing.

Several recruits interviewed cited personal interest as a reason for attending. Some were interested in learning more about looking after their own mental health and that of colleagues, either in recognition of the demands of the job and the distressing scenes that they can encounter or in response to lived experienced of poor mental health, whereas some were hoping to use the training in their personal lives outside of work, eg helping them support a family member with poor mental health.

> *"It can seem in the emergency services like nothing affects us… we need to counter the image that this job shouldn't affect you because it's what we do, but there's no way that you can't be affected by what you've seen or dealt with."*
>
> Community Support Officer, Police service

However, several interviewees reported that they had received mental health training previously and had viewed the additional Mind training as unnecessary, although some acknowledged that they had found it useful to refresh and reinforce their previous

learning. Previous experience of mental health training varied widely among interviewees: student paramedics reported taking a study module about mental health, some police recruits described mental health training which focused on legal aspects of dealing with vulnerable members of the public, and one fire service recruit had attended a course delivered by Mind at a previous employer.

Encouragement to attend

Very few recruits who attended Part 1 or Part 2 training reported that they were encouraged to attend by managers or HR (see Table 3.2). However, the training was compulsory for the majority of recruits who attended so managers may have felt that further encouragement was unnecessary. Interestingly, reported levels of encouragement were highest among recruits from the fire and search and rescue services, ie those services where formal obligation to attend was lowest. Among recruits from the ambulance service, the proportion reporting that they were encouraged to attend the training increased between Parts 1 and 2. It seems likely that recruits who received encouragement from managers or HR were more motivated to attend both parts of the training; **however, the group that attended Part 2 training was very small (10 individuals) so these results must be treated with caution.**

Table 3.2 Encouraged by managers or HR to attend training by Blue Light service (%)

	Police		Fire		Ambulance		Search & Rescue		All services	
	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2
Encouraged by managers/HR	2.9	6.2	13.6	10.0	2.3	10.0	7.7	-	4.0	5.6
Total (No.)	**140**	**81**	**22**	**10**	**44**	**10**	**13**	**0**	**223**	**124**

Note: respondents were able to select multiple options for this question. This table displays data for one of those options.

Source: Baseline survey, Follow-up survey, IES 2018

Interviews with recruits evidenced a mix of messages coming from organisations about Mind's training. For some recruits, the training was expected to fit around their scheduled shifts, and others reported that the Part 1 training had been mandatory but attendance for Part 2 was voluntary.

> *"[Training] was encouraged if you were free/shift patterns fitted in."*
>
> Constable, Police service

3.2 Training attendance

This section describes who participated in the training with regard to work and personal characteristics, as well as their personal experience of mental health.

In the initial aims for the project, Mind set out to deliver the 'Mental Health and New Recruits' training to 100 recruits. Over twice as many recruits received the training during the evaluation period. A total of 223 recruits completed the baseline survey at the start of the Part 1 training session. However just under half of this number attended Part 2 of the training: (124 follow-up survey responses). Course information provided by Mind showed that five planned Part 2 sessions did not take place during the evaluation period; this was predominantly due to logistical difficulties around scheduling the training. Overall, this could have impacted on the attendance of as many as 60 participants (assuming an average of 12 per session). Therefore, some participants who were able and willing to attend Part 2 were not able to benefit from the entire course at this time (or provide a full set of data to the evaluation).

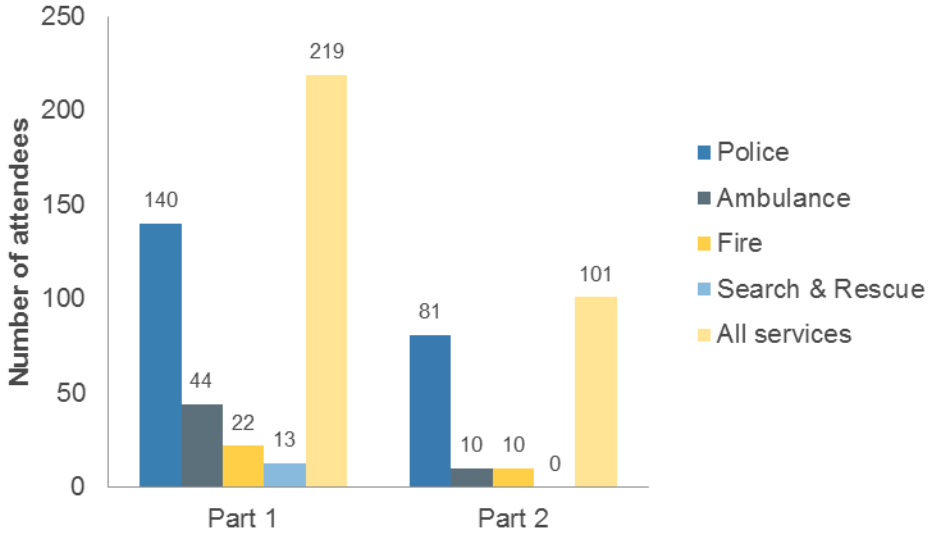
3.2.1 Work and service profile

- Through the first training session, Mind was able to reach 140 recruits from the police service, 44 from the ambulance service, 22 from the fire service and 13 from Search and Rescue.
- Changes in the balance of services attending Part 2 show that drop out was a bigger issue for some of the services than others.
- The biggest fall in numbers was seen in the ambulance service; only 23 per cent of those attending Part 1 completed the second half of the training.
- Nearly all those attending met Mind's expectation that participants would have been in training for three years or less. The majority of recruits attending had been in training for three months or less.

Blue Light service

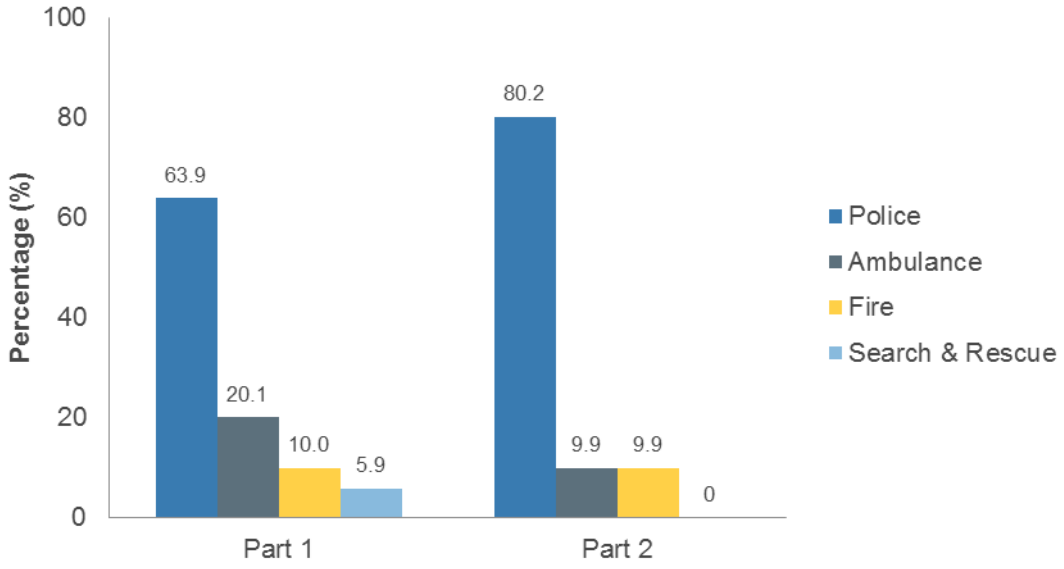
Of those attending Part 1, nearly two-thirds of recruits originated within the police service, a fifth were from the ambulance service, a further tenth were from the fire service, with only six per cent from search and rescue (see Figure 3.3).

Figure 3.2 Blue Light Service (attendance numbers)



Source: Baseline survey, Follow-up survey, IES 2018

Figure 3.3 Blue Light Service (%)



Source: Baseline survey, Follow-up survey, IES 2018

Figure 3.2 shows how attendance halved between Part 1 and Part 2 (from 219 to 101: these figures refer to those who disclosed which service they belonged to). While attendance numbers fell for all services between the training sessions, drop out was a bigger issue for some of the services than others. Among recruits from the ambulance service, attendance at Part 2 falls to a quarter of that at Part 1 (from 44 to 10 recruits) and

the number of fire service recruits halved between Part 1 and Part 2 (from 22 to 10). None of the recruits from search and rescue who attended Part 1 completed Part 2 during the evaluation period (there was only one training group of 13 search and rescue recruits in the evaluation).

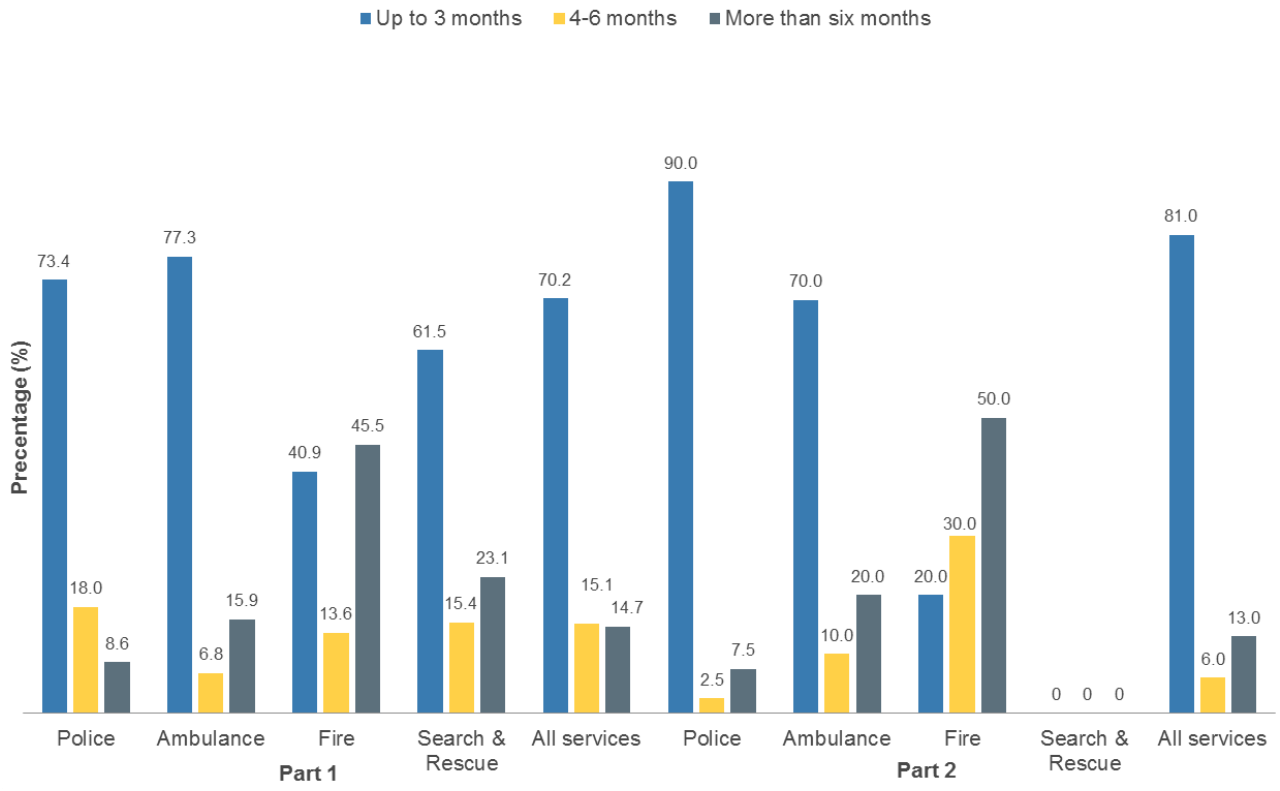
Figure 3.3 shows changes in the balance of services attending Parts 1 and 2 as a result of the fall in numbers attending. The proportion of recruits from the ambulance service halved (from 20 per cent to 10 per cent) between Part 1 and Part 2, and, as highlighted above, no search and rescue recruits attended Part 2 training.

Time in training

Nearly all those attending met Mind's expectation that participants would have been in training for three years or less. Most received their training within the first few months of transitioning into their role: the majority of recruits attending Part 1 had been in training for three months or less, and 15 per cent had been in training for four to six months (see Figure 3.4).

While there was lower attendance across all levels of experience at Part 2, attendance rates were proportionately lower among recruits with more experience. The proportion of recruits decreased slightly for those with more than six months experience (from 15 per cent to 13 per cent) and more markedly for those with four to six months experience (from 15 per cent to 6 per cent).

Figure 3.4 Time in training by Blue Light service (%)



Source: Baseline survey, Follow-up survey, IES 2018

However, this overall pattern of decreased attendance among more experienced recruits was not the case across all services, The proportion of recruits who had been in training for three months or less at the start of the training decreased among those from the ambulance service (from 77 per cent to 70 per cent) and from the fire service (from 41 per cent to 20 per cent). This suggests that this finding is mostly attributable to police service recruits, who comprised the majority of training participants.

It is unclear why recruits' level of experience affected Part 2 training drop-out differently for individual services (although note that collectively fewer than 20 individuals from the fire and ambulance services participated in Part 2). One possible factor influencing attendance could be that recruits with more experience are more in demand for attending incidents. Some recruits may be receiving a lot of training in addition to Mind's mental health course and as a result they may be experiencing training fatigue.

3.2.2 Personal characteristics

- Overall, there was an even balance of men and women attending the training. However, as the majority of staff in these Blue Light sectors are male, we might expect to see a higher proportion of men attending. This could be a reflection of actual numbers of women recruited at the time of the evaluation or a 'macho' culture resulting in resistance to attending.
- Among recruits who attended Part 1 voluntarily, nearly three quarters were female. In contrast when attendance was mandatory, only 40 per cent were female. Despite the majority of staff in the ambulance, fire and police services being male, only just over a tenth of men (11 per cent) attended the training voluntarily compared with just under a third of women (32 per cent). This suggests that making the training compulsory may achieve a better balance of genders.

Gender

Overall, there was relatively little change in the gender balance of recruits attending training across the sessions: around half of recruits attending Part 1 and 2 were male (see Table 3.3). However, as the majority of staff in the ambulance, fire and police services are male, we would expect the majority of recruits attending the training to be men. It is also possible that the gender balance may in some cases reflect current recruiting practice.

Among recruits who attended Part 1 voluntarily, 72 per cent were women, whereas among those whose attendance was mandatory only 40 per cent were female. Again, we would expect the majority of recruits to be male for both voluntary and mandatory training. However, only just over a tenth of men (11 per cent) attended the training voluntarily compared with just under a third of women (32 per cent). This suggests that making the training compulsory may achieve a better balance of genders.

Table 3.3 Gender by Blue Light service (%)

	Police		Fire		Ambulance		Search & Rescue		All services	
	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2
Male	55.4	55.0	40.9	30.0	55.8	33.3	61.5	-	54.4	50.5
Female	43.9	45.0	59.1	70.0	44.2	66.7	38.5	-	45.2	49.5
Prefer not to say	0.7	0.0	0.0	0.0	0.0	0.0	0.0	-	50.0	0.0
Total (%)	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**-**	**100**	**100**
Total (No.)	**139**	**80**	**22**	**10**	**43**	**9**	**13**	**0**	**217**	**99**

Source: Baseline survey, Follow-up survey, IES 2018

Table 3.3 shows that the ambulance and fire services experienced particularly large drops in attendance by men between Part 1 and Part 2 of the training. The proportion of men attending Part 2 from the ambulance service decreased from 56 per cent to 33 per cent, and for the fire service this statistic also decreased (41 per cent to 30 per cent).

Age

The modal age range of participants was 25 to 35 years and overall the majority of recruits attending the training were relatively young. The age profile of recruits attending the course remained relatively consistent between Part 1 and Part 2: over three-quarters of recruits were aged under 35 years, and a little under a third were aged 25 years or younger (see Table 3.4). It is worth highlighting that around a fifth of recruits had considerable life or career experience before transitioning to their current role in the Blue Light services.

Table 3.4 Age by Blue Light service (%)

	Police		Fire		Ambulance		Search & Rescue		All services	
	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2
Up to 24 years	32.1	28.4	22.7	30.0	27.3	40.0	15.4	-	29.2	29.7
25-35 years	54.3	59.3	27.3	0.0	52.3	50.0	15.4	-	48.9	52.5
35 years and over	13.6	12.3	50.0	70.0	20.5	10.0	69.2	-	21.9	17.8
Total (%)	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**-**	**100**	**100**
Total (No.)	**140**	**81**	**22**	**10**	**44**	**10**	**13**	**0**	**219**	**101**

Source: Baseline survey, Follow-up survey, IES 2018

Table 3.4 shows the variation in age profile by service. Recruits from the fire and search and rescue services tended to be older. Among fire service recruits, half of those

attending Part 1 were aged 35 or over and this increased to the majority of attendees at Part 2. Similarly, 69 per cent of search and rescue recruits who attended Part 1 were aged 35 or older; no search and rescue recruits attended Part 1. Among recruits from the ambulance service, the proportion of those aged 35 years or older halved between Part 1 and 2 (from 21 per cent to 10 per cent).

Some of the variation in age by service may be influenced by the training pathways for certain roles, e.g. paramedics who were studying at university and detective constables recruited via the direct entry pathway. It is unclear why older recruits were less likely to attend Part 2 training. Some older recruits may have felt their existing coping skills were sufficient or they may simply have had more demands upon their time.

Ethnicity

Table 3.5 provides an overview of ethnicity among recruits who attended the training. The majority of recruits who attended the training identified as white, around one tenth identified as black and minority ethnic. As some groups include small numbers of individuals, further detail and commentary have not been included for service or additional ethnicity groups. Data presented here should be treated with caution as some groups are very small (10 individuals).

Table 3.5 Ethnicity by Blue Light service (%)

	Police		Fire		Ambulance		Search & Rescue		All services	
	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2
White	90.0	87.7	100.0	100.0	83.3	70.0	100.0	-	90.3	87.1
BME	9.3	12.3	0.0	0.0	16.7	30.0	0.0	-	9.2	12.9
Prefer not to say	0.7	0.0	0.0	0.0	0.0	0.0	0.0	-	0.5	0.0
Total (%)	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**-**	**100**	**100**
Total (No.)	**140**	**81**	**22**	**10**	**42**	**10**	**13**	**0**	**217**	**101**

Source: Baseline survey, Follow-up survey, IES 2018

Other personal characteristics

The surveys collected information about other personal characteristics such as disability, sexuality, and religion or belief. Information has not been provided for these characteristics at the level of Blue Light service as some groups comprise a very small number of responses and would therefore not be suitable for further analysis. Key points are as follows:

- The majority of recruits (95 per cent) attending either Part 1 or Part 2 did not consider themselves to be disabled. Among recruits who attended Part 1 training, a higher proportion of recruits for whom training was voluntary (nine per cent) identified as disabled, compared with those for whom training was mandatory (two per cent).

- Similar proportions of recruits in Part 1 and Part 2 identified as heterosexual (85 per cent and 86 per cent respectively), gay, lesbian or bisexual (11 per cent each); or preferred not to say (4 per cent and 3 per cent respectively).
- Just over half of recruits attending Part 1 identified as having no religion (52 per cent), 40 per cent identified as Christian, one per cent as Muslim, one per cent comprised either Buddhist or Hindu, and four per cent preferred not to say. In Part 2, the largest proportion identified as Christian (46 per cent), 44 per cent as having no religion, three per cent as Muslim, one per cent as Buddhist, two per cent as any other religion and four per cent preferred not to say.

3.2.3 Personal mental health and wellbeing

- When training attendance was voluntary, recruits attending were more likely to have had personal experience of mental health or to have used mental health services than those for who attendance was compulsory.
- This evidence suggests that those with experience of mental health may be self-selecting to attend. More generally the basis upon which the training was offered appears to have affected the composition of training groups.

This section presents findings for all recruits from both Part 1 and Part 2, but service level information is provided for Part 1 only. Service level findings from Part 2 are not reported as the Part 2 groups for ambulance and fire are quite small (10 individuals each) and there is a risk of disclosing sensitive information about individuals. Similarly, findings for search and rescue recruits have not been reported as this group comprised 13 individuals only.

Personal experience of mental health problems

Around a third of recruits who attended Part 1 and Part 2 training reported having personal experience of mental health problems (see Table 3.6).

However, among recruits who attended Part 1, a higher proportion of recruits for whom training was voluntary (56 per cent) reported having personal experience of mental health problems compared with those for whom training was mandatory (29 per cent). This suggests that for some recruits learning to manage their own mental health (or indeed struggling to do so) may have influenced their decision to attend the training. This draws attention to the partially self-selected nature of the sample and the requirements of different groups; arguably those less familiar with mental health problems would stand to benefit from their awareness being raised. However the resilience/coping skills elements and space for reflection may be needed more by those who already have experience of mental health problems and may be seeking out new ways of coping.

Table 3.6 Personal experience of mental health problems by Blue Light service (%)

	Police	Fire	Ambulance	All services	
	Part 1	Part 1	Part 1	Part 1	Part 2
Yes	28.3	31.8	37.2	32.9	31.0
No	63.8	54.5	58.1	59.3	63.0
Not sure	2.9	9.1	4.7	4.2	2.0
Prefer to not say	5.1	4.5	0.0	3.7	4.0
Total (%)	**100**	**100**	**100**	**100**	**100**
Total (No.)	**138**	**22**	**43**	**216**	**100**

Source: Baseline survey, Follow-up survey, IES 2018

Table 3.6 shows that levels of personal experience of mental health problems were similar across the police, ambulance and fire services with around a third of recruits reporting this.

Use of mental health services

Around a fifth of recruits who attended either Part 1 or Part 2 training had used or were currently using mental health services (see Table 3.7).

Among recruits who attended Part 1 training, over twice as many recruits for whom training was voluntary (37 per cent) reported having used mental health services compared with those for whom training was mandatory (17 per cent). This suggests that those who have already used mental health services may be more willing to engage with further sources of support such as Mind's training. Again, there is a risk that some recruits may self-select out of the training if they feel less able or willing to access support. This could be due to stigma or feeling that the training is for others with greater needs than their own. It is important that those with less experience of using mental health services do not miss out on the training.

Table 3.7 Used mental health services by Blue Light service (%)

	Police	Fire	Ambulance	All services	
	Part 1	Part 1	Part 1	Part 1	Part 2
Yes	13.0	27.3	29.5	20.3	16.8
No	82.6	72.7	68.2	76.5	80.2
Not sure	2.2	0.0	2.3	1.8	2.0
Prefer to not say	2.2	0.0	0.0	1.4	1.0
Total (%)	**100**	**100**	**100**	**100**	**100**
Total (No.)	**138**	**22**	**44**	**217**	**101**

Source: Baseline survey, Follow-up survey, IES 2018

Reported levels of use of mental health services were lowest among recruits from the police service: around one in ten of those who attended Part 1 reported using mental

health services at some point (see Table 3.7). This is especially interesting considering that levels of personal experience of mental health were similar across the ambulance, fire and police services (around a third). This suggests that police recruits attending the training were less likely to seek help. Mind's training may be particularly helpful for some recruits with regards to help-seeking behaviours.

Current mental health

The vast majority of recruits who attended Part 1 and Part 2 of the training felt their current mental health was good or very good (88 per cent each) A very small number (ie one per cent) felt that their current mental health was poor (see Table 3.8).

Table 3.8 Current mental health by Blue Light service (%)

	Police	Fire	Ambulance	Total	
	Part 1	Part 1	Part 1	Part 1	Part 2
Very good	30.7	50	31.8	32	28.7
Good	56.4	45.5	54.5	55.7	59.4
Moderate	9.3	4.5	9.1	8.7	8.9
Poor	0.7	0	4.5	1.4	1
Don't know	0.7	0	0	0.5	0
Prefer not to say	2.1	0	0	1.8	2
Total (%)	**100**	**100**	**100**	**100**	**100**
Total (No.)	**140**	**22**	**44**	**219**	**101**

Source: Baseline survey, Follow-up survey, IES 2018

Encouragingly, most recruits across the services who attended Part 1 training reported that their current mental health was good or very good (see Table 3.8). Recruits from the fire service were most likely to describe their current mental health this way (96 per cent), followed by recruits from the police service (87 per cent) and the ambulance service (86 per cent). Recruits from the ambulance service were most likely to describe their current mental health as 'poor': one in twenty ambulance service recruits reported this.

3.2.4 Mental health and wellbeing at work

- The majority of recruits attending the training had experienced stress, low mood or poor mental health at either their current or a previous workplace or place of study. This was quite high for a relatively young group, ie mostly aged under 35 years.
- A higher proportion of recruits who attended voluntarily had experienced poor mental health in the workplace or taken time off because of poor mental health than those for whom training was mandatory. This highlights a risk of self-selection biases for previous experience of poor mental health in the workplace among those who choose to attend the training.

- Ambulance service recruits were most likely to report having taken time off work for mental health reasons: over a third of recruits from ambulance service reported having taken time off for this reason.

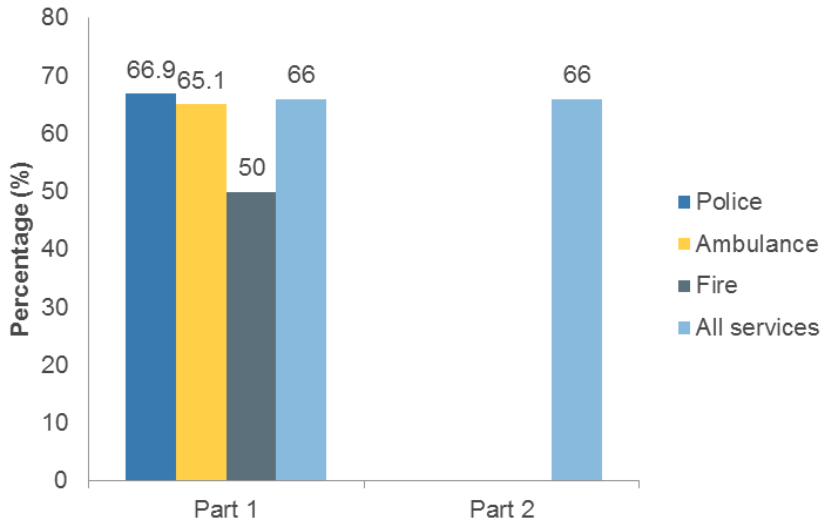
This section presents findings for all recruits from both Part 1 and Part 2, but service level information is provided for Part 1 only. Service level findings from Part 2 are not reported as the Part 2 groups for ambulance and fire are quite small (10 individuals each) and there is a risk of disclosing sensitive information about individuals. Similarly, findings for search and rescue recruits have not been reported as this group comprised 13 individuals only.

Stress, low mood or poor mental health in the workplace

The majority of recruits attending Part 1 or Part 2 training (66 per cent each) had experienced stress, low mood or poor mental health at either their current or a previous workplace or place of study (see Figure 3.5). This is quite high considering that this was a relatively young group; most recruits were under 35 years. Similarly, the majority of recruits at Part 1 had been in training for up to six months, however, a quarter (25 per cent) had already experienced stress or poor mental health in their current workplace or place of study.

Among recruits who attended Part 1 training, a higher proportion of recruits for whom training was voluntary (89 per cent) had experienced stress, low mood or poor mental health at either their current or a previous workplace compared with recruits whose training was mandatory (66 per cent). This suggests that those who have already experienced poor mental health in their role may be more motivated to attend. While it is good that recruits are seeking the support they need in their role, it is also important that those who have not yet experienced poor mental health at work engage with the training to reduce risk of future poor mental health.

Figure 3.5 Personal experience of stress, low mood or poor mental health in the workplace by Blue Light service (%)



Source: Baseline survey, Follow-up survey, IES 2018

Experience of poor mental health in the workplace varied by service (see Figure 3.5). Among those who attended Part 1, the highest proportions of recruits who reported having experienced stress, low mood or poor mental health in either their current or a previous role were among the police and ambulance services (67 per cent and 65 per cent respectively).

Time off work

Just under a fifth of recruits who attended Part 1 had taken time off from work, training or study as a result of stress, low mood or poor mental health, and over a tenth of those who attended Part 2 reported having taken time off for these reasons (see Table 3.9).

Among recruits who attended Part 1 training, twice as many recruits for whom training was voluntary (30 per cent) had taken time off from work, training or study as a result of stress, low mood or poor mental health compared with recruits whose training was mandatory (15 per cent). Again, this suggests that those who have experienced poor mental health at work may be more motivated to attend the training compared with those who have not experienced this. While it is encouraging that those for whom the training is most directly relevant are more likely to attend, it is key that the training reaches all recruits who would benefit, whether or not they have previously experienced poor mental health in the workplace.

Table 3.9 Taken time off work, training or study as a result of stress, low mood or poor mental health by Blue Light service (%)

	Police	Fire	Ambulance	All services	
	Part 1	Part 1	Part 1	Part 1	Part 2
Yes	8.7	18.2	38.6	17.5	11.9
No	90.6	81.8	59.1	80.2	87.1
Not sure	0.0	0.0	0.0	0.9	0.0
Prefer to not say	0.7	0.0	2.3	1.4	1.0
Total (%)	100	100	100	100	100
Total (No.)	138	22	44	217	101

Source: Baseline survey, Follow-up survey, IES 2018

The proportion of recruits at Part 1 training who reported having taken time off work, training or study because of poor mental health varied considerably by service (see Table 3.9). Over a third of recruits from ambulance service reported having taken time off for this reason, whereas just under a tenth of police recruits reported having done this.

3.2.5 Experience of mental health among family, friends and colleagues

- Similarly to previous findings, when training attendance was voluntary, recruits attending were more likely to have experience of a family member, colleague or person they live with

having mental problems. This suggests that some recruits may have been motivated to attend so that they could learn to support others.

- However, recruits may not be aware if colleagues are experiencing poor mental health; which underlines the potential benefits of compulsory training in preparing all recruits to support their colleagues when they are experiencing problems.
- Recruits from the ambulance service were most likely to report working or studying alongside someone with a mental health problem: around one in five ambulance recruits who attended Part 1 reported this. However, this group included paramedics in their third year of study who may have felt more able to disclose as they have known each other longer than recruits who have only met recently.

As with the previous section we present findings for all recruits from both Part 1 and Part 2, but service level information is provided for Part 1 only. Again this is due to the small numbers of Part 2 attendees in some categories and concerns around anonymity.

Family and friends

More than half of the recruits who attended either Part 1 (53 per cent) or Part 2 training (52 per cent) had a family member who had experienced mental health problems. Among recruits who attended Part 1 training, a higher proportion of those for whom training was voluntary (72 per cent) had a family member who had experienced mental health problems compared with recruits whose training was compulsory (49 per cent). This suggests that for some recruits, learning to support or understand a family member's mental health may have contributed to their decision to attend the training.

Just under a third of recruits who attended either Part 1 (29 per cent) or Part 2 (32 per cent) of the training were currently living with someone experiencing a mental health problem or had previously done so. Among recruits who attended Part 1 training, a higher proportion of recruits for whom training was voluntary (46 per cent) were currently living with or had lived with someone with a mental health problem compared with recruits whose training was mandatory (25 per cent). Similar to the above finding, this suggests that some recruits may have been motivated to attend the training because they wanted to better support or understand someone with a mental health condition.

Colleagues

Fewer than one tenth of recruits who attended Part 1 training and Part 2 reported that they were currently working or training alongside someone with a mental health problem (see Table 3.10). However, around half of the recruits who attended Part 1 (47 per cent) or Part 2 (54 per cent) reported that they had worked or trained alongside someone with a mental health condition at some point.

Among recruits who attended Part 1 training, over a fifth of recruits for whom training was voluntary (22 per cent) were currently working or training alongside someone with a mental health problem, compared with only four per cent of recruits for whom the training was mandatory. Possibly, for some recruits, learning to support a colleague's mental health may have influenced their decision to attend the training.

Table 3.10 Currently working or training alongside someone with a mental health problem by Blue Light service (%)

	Police	Fire	Ambulance	All services	
	Part 1	Part 1	Part 1	Part 1	Part 2
Yes	2.9	4.5	20.5	7.9	7.0
No	33.6	59.1	4.9	38.0	35.0
Not sure	62.8	36.4	38.6	53.7	57.0
Prefer to not say	0.7	0.0	0.0	0.5	1.0
Total (%)	100	100	100	100	100
Total (No.)	137	22	44	216	100

Source: Baseline survey, Follow-up survey, IES 2018

The proportion of recruits at Part 1 training who reported working alongside someone with a mental health problem varied considerably by service (see Table 3.10). The highest proportion of recruits who reported working or studying alongside someone with a mental health problem was among the ambulance service: around one in five ambulance recruits who attended Part 1 reported that this was the case, compared with around one in twenty police or fire service recruits. It is worth noting that recruits who have been in training for a longer period would be more likely to know whether fellow recruits were experiencing mental health problems. Recruits from the ambulance service included paramedics in their third year of study who may be working with others they studied alongside.

3.3 Conclusions

The reach of the training changed substantially between Parts 1 and 2. More than 200 new recruits completed the evaluation baseline survey (on arrival at Part 1), compared with just over 120 who were present at Part 2 to complete the follow-up survey. An important issue to address in the evaluation therefore was basis of attendance, ie whether employers had mandated their new recruits to attend or offered it as an option.

Services varied widely with regards to whether they made the training compulsory. While the majority of recruits in the police and ambulance services reported that training was mandatory (around 80 per cent), fewer than half of those in the fire service reported that attendance was compulsory. Across all services, only around one in twenty recruits had been encouraged to attend the training by a manager or HR professional.

In general the training reached the populations for which it was intended. Nearly all those attending fitted with Mind's expectation that the audience had been in training for three years or less. Similarly, the majority were aged 35 years or under which fits well with Mind's aim of offering training to individuals early in their career to help prevent poor mental health throughout their Blue Light career. Overall, there was an even balance of men and women attending the training. However Part 1 attendance figures show that women were more likely to attend on a voluntary basis than men.

Data from the evaluation confirms that both first and second-hand experience of poor mental health in the workplace is high among Blue Light recruits. Two thirds of recruits attending the training had experienced stress, low mood or poor mental health at either their current or a previous workplace or place of study, and a quarter had already experienced this in their current role. This is quite a high level considering that this was a relatively young group (most recruits were under 35 years) and that the majority at Part 1 had been in training for up to six months. It is likely, however, that the training audience may not be entirely representative of the population of new recruits as a whole. Encouraging services to make the training compulsory could help counter self-selection biases and ensure that the training reaches all who would benefit from it.

Findings show that personal experience of mental health was a key motivation to attend for some recruits. One in five recruits reported that personal interest was a reason why they attended the training. When training attendance was voluntary, those attending were more likely to have had lived experience of poor mental health (either their own or someone else's), compared with those for whom attendance was compulsory. This suggests that some recruits were motivated to attend by circumstances in their own lives or those of people they knew.

The impacts reported in subsequent chapters should be interpreted in this context of the findings reported above; ie arguably they may not reflect the impacts that could have been achieved if new recruits who were less interested or knowledgeable about mental health had been mandated to attend.

4 Views on the training

This chapter focuses on impressions of the training format and content to identify 'Level 1'[7] training impacts; including whether a suitable context for learning was provided and the appropriateness of the material for its intended audience.

Table 4.1 presents an overview of the surveys that provided the data presented in this chapter and when they occurred in the evaluation timeline.

Table 4.1 Overview of surveys

Survey	Timing
Baseline survey (Wave 1)	Completed prior to receiving Part 1 of the training
Post-training survey (Wave 2)	Completed immediately after having participated in Part 1 of the training
Follow-up survey (Wave 3)	Completed prior to receiving Part 2 of the training

Source: IES, 2018

The analysis explores whether specific groups responded to the training differently. Throughout the chapter, it is highlighted where statistically significant differences have been found with respect to:

- **Blue Light Service**: ie whether individual services responded differently
- **Training requirement**: ie whether attendance was mandatory or voluntary
- **Training format**: since some training was delivered in a 'condensed' two hour format instead of the 'full' half-day format, data for recruits in the 'full' and 'condensed' conditions was compared.

4.1 General views about the training

- The vast majority of recruits across the Blue Light services found the training useful and would recommend it to others.
- Recruits who had attended the training on a voluntary basis were more likely to recommend the training than those for whom the training was compulsory.
- In line with Mind's aims, there was agreement that the training was particularly suited to recruits who were new to the Blue Light services or hadn't previously received mental health training.

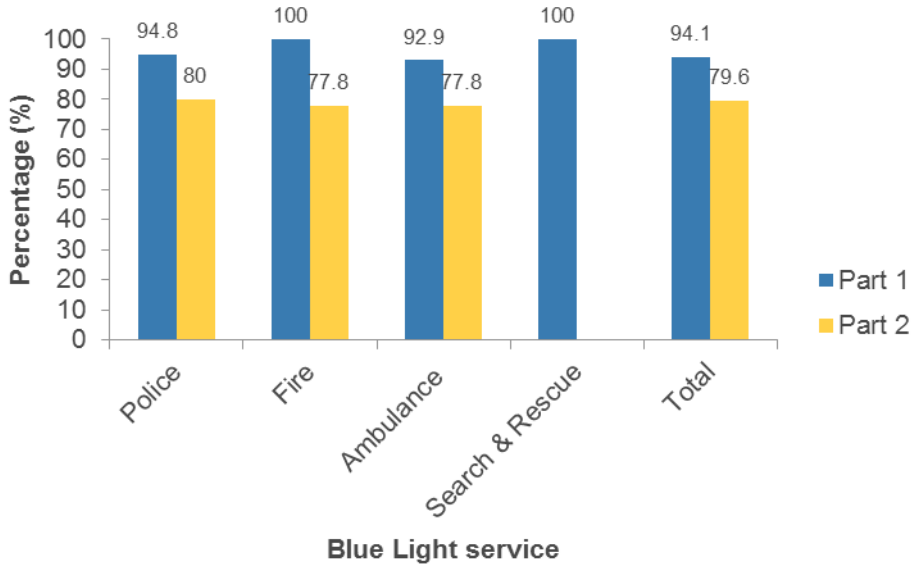
[7] According to Kirkpatrick's (2010) model presented in Chapter 2.

- The format of the training received (full or condensed versions) did not affect approval ratings in a significant way.

All but one of the recruits who attended Part 1 agreed or strongly agreed that the information given was clear and easy to understand; the same number agreed or strongly agreed that the information was presented at a pace that they could follow.

Nearly all recruits who completed Part 1 of the training said they found it useful (see Figure 4.1) and the majority of respondents (92 per cent) said they would recommend the training to others. Levels of agreement for these questions were similar across the Blue Light services (see Figure 4.1), regardless of whether attendance had been mandatory or not or whether recruits attended the full or condensed training formats (see Figure 4.2).

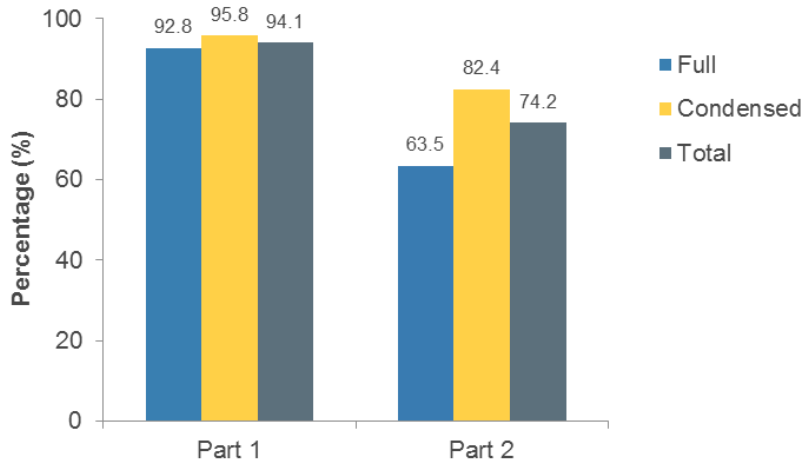
Figure 4.1 Found Part 1 training useful by Blue Light service (percentage)



Source: Post-training survey, Follow-up survey, IES 2018

Recruits who attended Part 2 were asked to reflect on Part 1 a second time. With hindsight, just under three-quarters of respondents felt the training had been useful (see Figure 4.1). Surprisingly, a higher proportion (82 per cent) of respondents who had received the condensed training felt the training had been useful compared with 64 per cent of respondents who had received the full half-day training (see Figure 4.2). Views on this question were similar across the Blue Light services (see Figure 4.1), and did not differ according to whether attendance had been mandatory or not.

Figure 4.2 Found Part 1 training useful by Training format (percentage %)



Source: Post-training survey, Follow-up survey, IES 2018

Just over three-quarters (76 per cent) of respondents who attended Part 2 said they would recommend the training to others. Between-group comparisons showed that all respondents who had attended Part 2 on a voluntary basis said that they would recommend the training, while among those who were mandated to attend, only 81 per cent said they would recommend it (this difference was statistically significant)[8]. Views on this did not differ across the Blue Light services.

The evaluation interviews yielded similar findings. The training was felt to be especially useful among recruits who had not previously worked in similar roles and/or hadn't received any previous mental health training. Others felt it mainly served to update and consolidate existing knowledge.

> *"There is a lot of information in there that we wouldn't have otherwise have got and I think whichever role you tend to go into, it is vital information to look after each other and notice the signs when people are struggling."*
>
> Student Paramedic, Ambulance service

> *"Yes definitely I think that there were things that I hadn't learnt even after being on the mental health awareness course beforehand and it was interesting to have the refresher as well."*
>
> Forensic Examiner, Police service

[8] Fisher's Exact test, $p < .05$.

A small minority of those interviewed said they would not recommend the training. Reasons for this included, the view that the expectation to talk openly in a group environment would not suit everyone. Some interviewees also expressed concerns about confidentiality within their organisation if they were to seek help at work, and therefore had reservations around the advice regarding help-seeking. A view was also put forward that some colleagues might find the content repetitive or 'basic'.

4.2 Views about training format

- Almost all of recruits who participated in the evaluation felt that the information was clear and easy to understand.
- Most recruits felt that the balance between presentations and interactive elements was good and appreciated having opportunities to talk about issues the slides had raised.
- Most recruits were happy with the length of the training regardless of whether they had attended the full-length training or the condensed version.

This section explores thoughts on the format of the training including the balance of interactive and presentation elements, and the length of the training.

4.2.1 Balance of information and activities

The majority of Part 1 attendees (92 per cent) felt that the amount of information provided in the training was "about right". The majority of respondents (92 per cent) felt that the balance between presentations and interactive elements was about right: most of those who disagreed wanted more interactive content. Respondents who had received the full (half-day) training were more likely (11 per cent) to report that there was too much time spent listening to presentations; none of those who received the condensed two-hour training had this complaint[9]. However, observation of the condensed training suggested that there may be less time available for discussion in this format.

Recruits who were interviewed were generally positive about the balance on elements in the training sessions. Several interviewees had liked the way the slides had been used as the basis for discussions with the group. Some particularly valued the opportunities for recruits to share their experiences and, in some cases, when the trainer shared relevant examples from their own life. However, one police recruit felt that participants had been 'less talkative' in Part 2 of the training because several groups had been combined. He felt that his original Part 1 group had bonded well and were quite open, whereas people were less comfortable speaking about mental health with people they didn't know in the group. Several recruits reported that the activities helped them keep engaged and paying attention.

"It kept you engaged throughout so it wasn't death by PowerPoint."

Student Paramedic, London Ambulance

[9] $\chi 2(1)=10.46$, $p < .01$.

Some of interviewees from the police service felt that there were too many slides or too much information in the Part 1 training,

> *"It was really interactive and engaging, but there was just too much content in Part 1 in the short space of time."*
>
> Community Support Officer, Police

However, one police recruit thought that it had worked well to 'frontload' statistics at the beginning of the first presentation. One potential benefit of two-part training is that there are two opportunities for knowledge to be absorbed and become embedded (see section 4.6 Views on Part 2).

4.2.2 Duration of training sessions

Around one in ten respondents (13 per cent) felt that the training was too long. In particular, respondents for whom the training was mandatory were more likely to feel this way (17 per cent) than those who attended on a voluntary basis (3 per cent).

Table 4.2 Views on length of training by training format attended

	Full training	Condensed training
Too long	17.7	7.4
About right	74.2	90.4
Too short	4.8	2.1
Not sure	3.2	0.0
Total (%)	**100**	**100**
Total (No.)	**124**	**94**

Source: Post-training survey, IES 2018

Just under a fifth of those who received the full half-day training felt it was too long, compared with less than a tenth of those who received the condensed two-hour training[10]. Interestingly, very few respondents who received the condensed training felt that the training was too short. Among those who received the lengthier version, five per cent felt that the training was too short. Overall, the majority of respondents felt that the length was "about right". Views on the duration of the training were similar across the Blue Light services.

Generally, recruits who participated in interviews felt that the training they had received was about the right length and that there was sufficient time to cover all the information and provide opportunities for discussion. Feedback was mostly positive regardless of training format.

[10] $\chi 2(1)=5.75$, $p < .05$.

"I think a full day [for Part 1 and 2] is good but anything longer would not add anything new to this because its difficult with any training as people get bored and don't take it seriously enough."

Constable, Police service

"I think the length of the training was nice as we had a small group and the sessions went on for about two hours each which was a nice length of time."

Paramedic, Ambulance service

However, one ambulance recruit reported that some of his colleagues had felt frustrated because they had travelled in for a two-hour training session during their day off. A police recruit who had attended the full half-day training felt that there had been a lot of content to fit into Part 1 and that they would have liked a printed hand-out that they could refer back to in their own time at a later point.

4.3 Views about training delivery

- Recruits were generally positive about how the facilitator delivered their training, especially their role in facilitating open and honest group discussion.
- The delivery approach did not always work for everyone; some recruits found the tone too prescriptive in how individuals should manage their stress.

All but one of the recruits who attended Part 1 agreed or strongly agreed that the information given was clear and easy to understand; the same number agreed or strongly agreed that the information was presented at a pace that they could follow.

Recruits who participated in interviews or focus groups provided largely positive feedback. The opportunity the training provided for open discussion about mental wellbeing was particularly appreciated. Several interviewees commented on how well the trainer engaged with the group and created a comfortable environment for conversations touching on personal experiences, and this opinion was echoed across the services. One recruit from the ambulance service observed that it could be difficult for some people to 'open-up' in a group environment, while another highlighted that discussions with large groups could be challenging.

"[They] really did try to get us to discuss strategies for looking after our own MH, and offered for the group to stay longer to keep the discussions going, but it's just difficult to do when you're with a large group."

Constable, Police service

Interview data indicated that Mind's trainers were able to tailor their approach to the needs and interests of the training group. They were seen as knowledgeable about the topic of mental health as well as the work of the Blue Light services. One recruit from the ambulance service described their trainer as 'fantastic' and willing to answer all their questions and a police service recruit felt the trainer was very 'responsive' to the needs of the group. Another interviewee appreciated how the trainer was able to give real-life examples and ad lib around the slides.

> *"[They described] really good scenarios and used videos that came to [their] mind bouncing off the group's interest that was not a formal part of the training content."*
>
> Constable, Police service

However, some focus group participants felt that sometimes when the trainer had diverged from the presentation it had not always been relevant and meant that other aspects of the training had felt slightly rushed. Both of the trainers who were interviewed stressed the value of being able to provide relevant examples from the Blue Light sectors, and had found it useful to draw upon their experience of delivering other training in the Mind Blue Light programme. One trainer felt that they might have struggled if they had not had this experience and suggested that it could be helpful to include some examples of relevant scenarios or individual case studies from the different sectors in the presentation materials.

The delivery style did not always work for everyone attending. This is not entirely unexpected for training where attendance was compulsory for the majority of attendees. Some interviewees from the police and ambulance services felt that at some points the training was a bit 'cheesy' or 'wishy-washy'. One recruit from the police service observed that a handful of attendees were not taking the training seriously and one recruit from the ambulance service felt that some attendees on their course were 'not interested'. A few interviewees highlighted the importance of not being too prescriptive when introducing techniques and recognising that different individuals find different techniques and approaches useful.

> *"She came across a bit 'hippyish' and a bit too, you know, like 'I need you to sit and listen to this music now and what you should hear is this, that and the other', and that kind of thing doesn't work for everybody."*
>
> Clinical Care Assistant, Ambulance service

One of the trainers observed that some elements of the training felt a bit 'fluffy' for the police and fire services as they were very 'practical' and 'focused' populations. They found that some training participants were 'less accepting' of talking about mental health and understood that the way the training was delivered could be seen by some as (in the trainer's words) 'mental health charity-ish'.

Both trainers thought that a level of discomfort with mental health as a topic was inevitable for some individuals. However, they felt it was important to push boundaries to get some points across and ensure that the training challenged misperceptions.

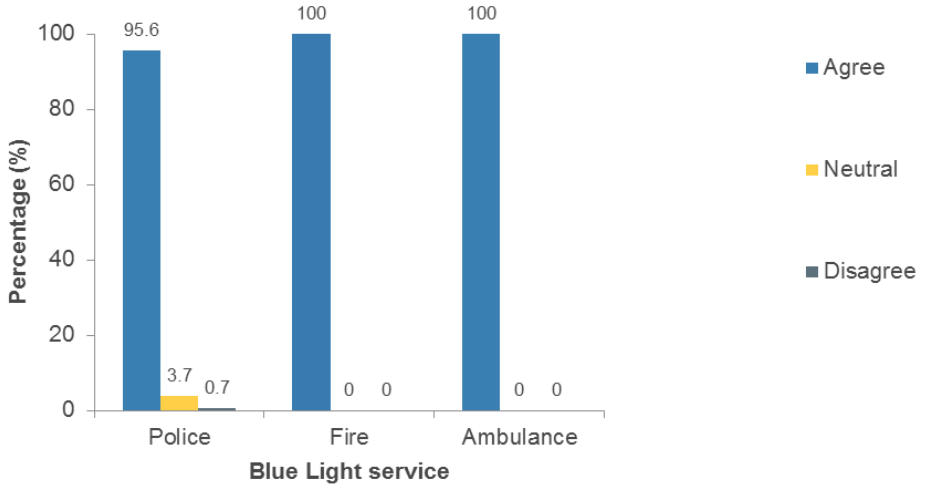
4.4 Views on training content

- Most recruits felt the information provided in the training was relevant and useful to their work and personal lives.
- Some recruits felt it was important for the training to prepare recruits for potentially distressing experiences in their role.

- There were mixed responses to the content about abstract and concrete thinking, however, this does not necessarily mean that there is not value in covering this topic in the training.

The vast majority of those who attended the Part 1 training (91 per cent) agreed or strongly agreed that the information provided was relevant to their workplace. Nearly all (95 per cent) felt that it would be useful in their work and the majority (93 per cent) felt that the information would be useful in their personal lives. Levels of agreement for these questions were similar across the Blue Light services (see Figure 4.3), as well as by whether attendance had been mandatory or not and whether recruits attended the full or condensed training.

Figure 4.3 Views of whether information provided will be useful in my work by Blue Light service



Source: Post-training survey, IES 2018

Most interviewees agreed that the training content was relevant to their career stage. However some interviewees felt like they were already familiar with some of the information and ideas presented. For this reason one recruit from the fire service felt that it was not relevant to her personally but may have been more relevant for others. Several interviewees stressed the applicability of the training to preparing new recruits for encountering traumatic or distressing situations. One recruit from the ambulance service felt it was important to normalise these issues and encourage new recruits to talk about them.

"[The] problem is that you don't really realise the significance and importance of the training until you get out there."

Constable, Police service

"I think it's a useful thing to have when you're joining the service because it gives you the important things to think about and how to look after yourself… I think if you

> *get people that have been in the service for twenty years or so then it is quite easy to get their attitude of 'don't talk about it, it's fine... just soldier on'... it's new people that are more aware that what we see every day is not normal."*
>
> Paramedic, Ambulance service

A recruit from the Ambulance service felt it would be helpful for the course content to cover emergency situations they would be dealing with involving mental health. One police recruit felt that the training had been too general and would have liked it to have been more tailored to his service.

> *"I think it would have been good to have given it some context at the time because we don't know when you start what might make you vulnerable. You might say, you know, you're going to obviously have a lot of confrontation, quite a lot of institutional negativity because people have been worn down, you might get a physical injury that causes you mental health problems because it changed your life or you might be exposed to stuff or suffering that it is hard to cope with and that's why resilience is important and here are potential ways that you might want to start thinking about building those into your life, and just kind of say it like that rather than a rather general 'look after yourself' approach because everyone knows that."*
>
> Trainee Detective Constable, Police

4.4.1 Feedback on specific elements of the training

Multiple participants reported that they had found the 'Black Dog' video and exercise particularly helpful. The video (which comprised a ten minute story of an individual overcoming 'the black dog of depression') was followed by a brief discussion of what 'came to mind' for participants while watching the video. One recruit from the police service also found the Black Dog exercise to be triggering due to her father experiencing severe depression but felt that the exercise had been valuable in helping her to understand his experience.

Some interviewees indicated that they had found elements of the training which explored personal experiences of poor mental health, such as the 'Black Dog' video, to be particularly useful in helping them understand others' behaviour and thinking. As a consequence they felt more able to relate and provide advice to someone in distress. One recruit from the police service commented: 'it helps you understand why people behave in a certain way'. Some felt that this had improved their interactions with members of the public.

There were mixed views from interview and focus group participants regarding some interactive aspects. Both Parts 1 and 2 included role-play exercises to demonstrate 'concrete' (ie practical and solution-focused) and 'abstract' thinking, (eg 'why has this happened and could I have done anything to prevent it ?)'. Some recruits struggled to engage with the phenomenon of abstract thinking as they felt it was counter to how they were trained to react in situations. On the other hand, some recruits found it helpful and were able to identify instances of this in their personal or professional lives. One recruit from the ambulance service who was a call handler explained that when a call '*goes*

wrong', (such as when someone dies after a caller has provided insufficient or inaccurate information) this could lead to them 'questioning themselves' (as one participant put it) about what happened. Trainers acknowledged that there can be a tendency for some Blue Light staff to assume they are already concrete thinkers. Nevertheless, they felt that it was valuable for recruits to understand these concepts early on in their career, while they are learning about the role and developing their approach to handling adverse situations.

4.5 Views about timing of training delivery

- Most recruits felt that it would be most useful to receive Mind's training in their first year as a new recruit, ideally before they came face-to-face with potentially distressing scenes.
- It was felt that Part 2 training was best delivered several weeks into undertaking their role in the field to optimise application of the training to their own practical experience.

Thoughts about the timing of the training was mixed. Although the majority (57 per cent) of recruits who attended Part 2 training felt that the training was offered to them at the right stage, more than a quarter (29 per cent) disagreed and 15 per cent were unsure. There were no consistent trends across the services with regard to these views.

Among individuals interviewed for the evaluation there was more consensus. All who had been in their role between one and three years felt that the training would have been more useful if they had received it earlier. In contrast, those with less than one year's experience thought that the timing was 'about right'. Several interviewees suggested that the first part should be delivered before recruits went out into the field and witnessed distressing scenes. One police recruit, reflecting on her time in another police force, said she had not received any training on mental health prior to attending scenes. As a result of this she had become traumatised and reported experiencing flashbacks. Similar sentiments were expressed across other services.

> *"I think it should be a much higher focus for not just the emergency services to run it but also in the universities and the training schools for these emergency services before they go on their first placement."*
>
> Paramedic, Ambulance service

Interviewees who had been in their role for less than six months felt that Part 2 would have been more beneficial after they had acquired practical experience of working in their role, or 'in the field' as some expressed it. Some preferences were specific to particular services. For example, one ambulance service recruit thought that Part 2 of the training should be delivered after a month 'out on the road'; a police service recruit suggested that it be delivered after a three week work placement.

One trainer reported struggling to deliver Part 2 of the training in circumstances where participants had very little operational experience and had found this 'awkward'. Similar views were expressed about a Part 1 session that had been delivered to new recruits on the fifth day of their training; it was felt this had been much too soon.

4.6 Views on Part 2: opportunities for reflection and refreshing learning

- Where recruits had acquired relevant practical experience, Part 2 was felt to offer valuable opportunities to discuss and reflect on experiences and techniques.
- However, some recruits felt that Part 2 was repetitive and offered little additional benefit.
- The majority of recruits (59 per cent) did feel that it would be helpful to attend training in future to refresh knowledge from the Blue Light training.

Part 2 of the training aimed to refresh recruits' understanding of mental health awareness and techniques for wellbeing and resilience. It also provided an opportunity to reflect on experiences since Part 1, how they had applied any learning and/or how they could use the learning to look after themselves in future.

This section explores recruits' views on how useful they found Part 2 training as an opportunity to refresh learning from Part 1 and reflect on experiences and how they had used learning since participating in Part 1, as well as whether they felt it would be useful to revisit this training again in the future.

4.6.1 Refreshing learning in Part 2

Most recruits interviewed felt that Part 2 had offered them a valuable opportunity to refresh their learning. Several interviewees said they had found it helpful in reinforcing learning from Part 1 and reminding them of elements they had forgotten. Some interviewees highlighted the group discussions as useful in helping them reflect on (i) their experiences and (ii) how they had incorporated learning from Part 1.

> *"It gave me a chance to reflect on the models and academic theories that they gave you and recognise them in yourself and out on the job. It's probably made me a better person having the reflection on the second day."*
>
> Constable, Police service

For some, the training had provided much needed space to discuss the impact of their job on their wellbeing. It was felt that there was rarely the opportunity to talk at work as they were constantly being interrupted and 'didn't really talk' during breaks. Most Part 2 attendees had found it easy to re-engage with the training and re-connect with the topic.

A minority of interviewees felt Part 2 was unnecessary. One recruit from the fire service felt that 'it was a bit dry going over the content covered already', and another thought that Part 2 could have been replaced with a booklet or other materials given out at the Part 1 training.

Some recruits described external factors which had contributed to feeling less engaged with Part 2. One recruit from the police service felt that Part 2 had been less helpful as several groups from Part 1 had been combined together and that had made it harder for recruits to share experiences. Another recruit from the ambulance service admitted to

feeling somewhat 'blasé' about the training as they had had to come into work on their day off to attend the training. While they felt that the training was valuable, they were less engaged with the training because attending it had intruded into their time off.

4.6.2 Refreshing learning in future

In addition to reflecting on Part 2 learning, recruits who attended Part 2 training were asked whether they felt it would be helpful to attend more training in future to refresh the knowledge from the Blue Light training. The majority (59 per cent) felt it would be useful, while just over a fifth (21 per cent) felt it would not be useful. Levels of agreement for this question were similar across the Blue Light services.

Among recruits who attended Part 2 training, all of those for whom course attendance was voluntary felt it would be useful to refresh their knowledge; while the majority of those for whom the training was mandatory (72 per cent) felt that this would be useful[11].

Among those who were interested in further training, the majority (67 per cent) wanted to refresh their knowledge after one year. One recruit from the police service felt that one lesson or course wouldn't be sufficiently 'life-changing' and suggested that a longer course was needed. She suggested that the first session could be mandatory and cover 'mental health and your service', and then further sessions could be voluntary. This would allow recruits to implement coping techniques and reflect over a longer period. This was a minority view however, and findings presented in the previous chapter suggest that voluntary attendance is not the best way forward.

4.7 Conclusions

Overall, impressions of the training were very positive. Nearly all recruits across the Blue Light services found the training useful (95 per cent) and would recommend it to others (92 per cent). It was felt that the training was particularly suited to recruits who were new to the Blue Light services or hadn't previously received mental health training which fits well with Mind's aims for the training. As may be expected, recruits who attended voluntarily were more likely to recommend the training than those for whom training was mandatory. It was interesting to note that approval ratings were not affected by the format of the training received, ie full or condensed versions.

The overall training format was also well-received. Almost all recruits who participated in the evaluation felt that the information was clear and easy to understand. Most recruits felt that the training struck a good balance between presentations and interactive elements. In particular, many recruits appreciated having opportunities to discuss issues and themes that the slides had raised. Finally, the majority of recruits were happy with the length of the training including both those who attended the full-length or condensed training.

[11] Fisher's Exact test, $p < .01$.

Overall, recruits were positive about how the facilitator delivered their training. In particular, they highlighted the facilitator's role in facilitating open and honest discussion among the group. As may be expected, the delivery approach did not always work for everyone. Some recruits found the tone too prescriptive and emphasised that different individuals cope with stress or poor mental health in different ways.

The training was successful in engaging with the needs of new recruits. Nearly all recruits felt the information provided in the training was relevant and useful to both their work and personal lives. Some recruits felt it was especially important for the training to prepare recruits for potentially distressing experiences in their role. However, not all training exercises were universally well-received. In particular, responses to content about abstract and concrete thinking were mixed. This does not necessarily mean that there is no value in covering this topic, and may just signal that this is an area of learning that can be hard to digest. Indeed, some trainers felt that some level of discomfort with open discussion of mental health could be expected, and that it can be important to push boundaries sometimes to challenge misperceptions and communicate new ideas. Trainers' experience of mental health training in the Blue Light sector meant that they were particularly well-positioned to do this.

Recruits' views on the timing of training aligned with Mind's aim of engaging with new recruits early in their career in order to reduce prevalence of mental health problems going forward. The majority of recruits felt that it would be most useful to receive the training within their first year in the services. More specifically, they suggested that the training should take place before they first encounter potentially distressing incidents. In contrast, it was felt that Part 2 training was best delivered several weeks' into undertaking their role in the field. This timing would allow recruits an opportunity to apply Part 1 learning in the field beforehand and to relate the training to their own practical experience.

Views on Part 2 training were more nuanced, although still generally positive. Where recruits had acquired relevant practical experience, Part 2 was felt to offer valuable opportunities to discuss and reflect on experiences and techniques. However, recruits with less or no practical experience of their role felt that they were less able to benefit from these activities. In some cases, recruits felt that Part 2 was repetitive and offered little additional benefit. This does not, however, reflect the view of the majority. Most recruits felt that it would be helpful to attend training in future to refresh knowledge and some felt that having an information booklet or hand-out from the training that they could refer back to would be useful.

In conclusion, recruits found the training engaging and relevant to their needs and were happy with the format. Opportunities for open and honest group discussion were particularly well-received. It was generally felt that the training would be especially beneficial to those new to the Blue Light services or mental health training, which aligns with Mind's aims for this as an early career intervention. The evaluation findings indicate that Part 2 allowed reflection on previous learning and experience, but those who had not yet acquired practical experience in their role found this less valuable.

5 Training outcomes: understanding mental health and resilience

This chapter presents findings in relation to knowledge changes brought about by the training, essentially covering 'Level 2' training impacts. These include changes to self-reported and actual understanding of issues covered by the training and beliefs about mental health. Due to the way elements of the evaluation were designed (ie different methods to address different questions) this chapter presents quantitative data only.

A comprehensive set of survey questions were developed to detect learning outcomes. These included exam-style questions designed to detect objective changes in knowledge. These required accurate recall of course content. These were scored according to a written protocol. Self-report items were also included to assess subjective perceptions of knowledge. These were worded more generically and in effect detected changes in confidence.

The analysis compared recruits scores throughout the evaluation to measure changes in knowledge and behaviour[12]. In order to identify immediate and short-term outcomes, questions about knowledge, behaviours and beliefs were asked at three timepoints throughout the evaluation. The surveys varied slightly in content to reflect the evaluation context so not all questions were asked at all time points. Also, responses are lower for the final time point as attendance of Part 2 of the training was lower. Table 5.1 provides an overview of the survey waves, timing and type of outcome observed.

Table 5.1 Overview of outcomes analysis

Survey	Timing	Outcome
Wave 1: baseline survey	Immediately prior to Part 1 training	Measures 'baseline' knowledge, behaviour and beliefs prior to receiving Part 1 training
Wave 2: post-training survey	Immediately after Part 1 training	Measures immediate changes in knowledge and beliefs after Part 1 training
Wave 3: follow-up survey	Immediately before Part 2 training	Measures short-term changes in knowledge, behaviour and beliefs after receiving Part 1 training and before Part 2 training

Source: IES, 2018

[12] Analysis of Variance (ANOVA) was used to compare changes across three time points, and matched pairs analysis was used to compare changes between two time points. Because of the requirements of the test, ANOVA analysis included only data from recruits who participated in both parts of the training.

The analysis also included comparisons of differences between key groups[13]. These included differences by:

- Blue Light service: ambulance, fire, police and search and rescue.
- Time in training: how long recruits had been in training at the time of Part 1.
- Training format: whether recruits had received the two-hour condensed training or the full half-day training format.

In order to help navigate the findings, key 'take home points' are summarised at the top of each sub-section.

5.1 Self-reported knowledge about mental health

- The training brought about significant positive changes in self-reported knowledge and understanding of facts about mental health
- Notably, the observed improvements after the training all occurred in the context of relatively high baseline scores (more than three quarters of respondents thought they had a good understanding of mental health issues before the training).

Table 5.2 Indivdiual items for self reported knowledge about mental health (percentages %)

Self-reported knowledge	% 'agreeing' or 'strongly agreeing'		
	W1 (N=222)	W2 (N=220	W3 (N=124)
I have a good understanding of the difference between good and poor mental health[14]	77.9	96.8	91.9
I have a good understanding of some common signs of poor mental health[15]	82.4	96.8	92.7
I know/understand what factors can have a negative effect on mental health[16]	79.3	97.3	91.9

Source: Baseline survey, Post-training survey, Follow-up survey, IES, 2018

[13] Mixed factorial ANOVA were used to compare differences between groups over several points in time. Because of the requirements of the test, mixed factorial ANOVA analysis included only data from recruits who participated in both parts of the training.

[14] Friedman's chi^2 = 35.6, $p < .001$; W1 vs W2: $Z = -7.33$, $p < .001$; W2 vs W3: $Z = -2.97$, $p < .01$; W2 vs W3: $Z = -2.97$, $p < .01$.

[15] Friedman's chi^2 =41.1, $p < .001$; W1 vs W2: $Z = -7.27$, $p < .001$; W2 vs W3: $Z = -2.86$, $p < .01$; W1 vs W3: $Z = -3.66$, $p < .001$.

[16] Friedman's chi^2 =47.0, $p < .001$; W1 vs W2: $Z = -8.59$, $p < .001$; W2 vs W3: $Z = -2.64$, $p < .01$; W1 vs W3: $Z = -4.22$, $p < .001$.

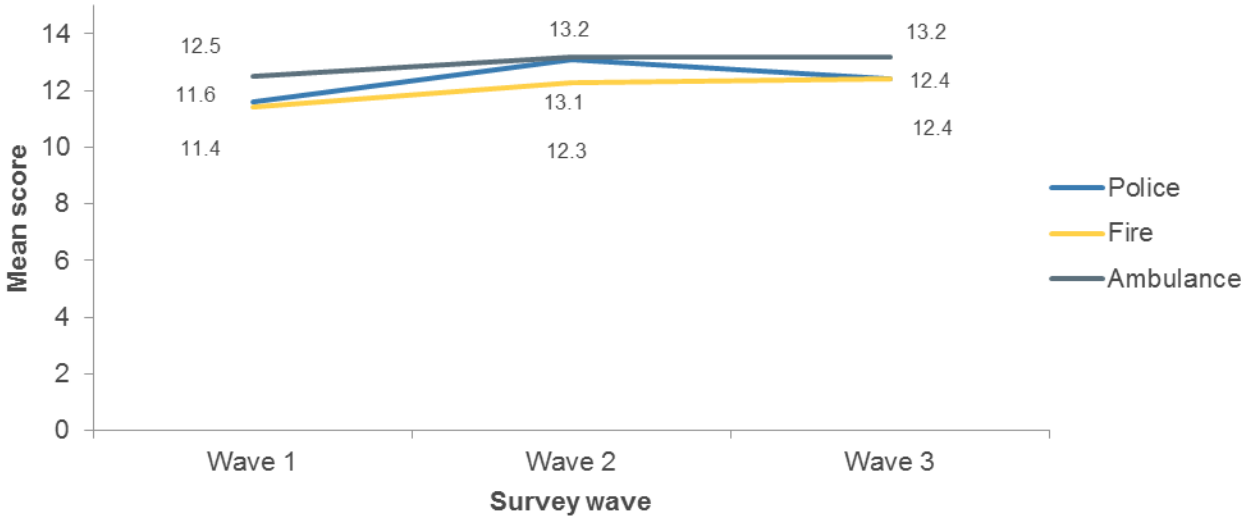
Self-reported understanding of the difference between good and poor mental health changed across the evaluation period[17]; most importantly there was a statistically significant improvement following Part 1 of the training. Scores fell significantly between Part 1 and Part 2 training delivery but remained (again significantly so) above baseline.

The same pattern was true for the other two questions in this category, with significant variation across training stages. Notably, the observed improvements after the training all occurred in the context of relatively high baseline scores; more than 75 per cent thought they had a good understanding of mental health issues before the training.

5.1.1 Between-group comparisons

The above items about mental health knowledge were combined into one score so groups could be compared more easily.

Figure 5.1: Change in self-reported knowledge about mental health by Blue Light Service



Source: Baseline survey, Post-training survey, Follow-up survey, IES, 2018[18]

A mixed design, repeated measures ANOVA (three survey waves x four Blue Light services) showed no overall differences between scores obtained across the Blue Light services. Figure 5.1 shows a trend towards higher scores at baseline and follow-up stages in the ambulance service relative to the other services, but these small between-group differences were not statistically significant.

[17] Friedman's chi^2 = 35.6, p < .001; W1 vs W2: Z = -7.33, p < .001; W2 vs W3: Z = -2.97, p < .01; W2 vs W3: Z = -2.97, p < .01.

[18] Note that there was no data provided by the search and rescue service for this item.

Further between-group tests showed no systematic effects of either duration already spent in a Blue Light Service as a recruit[19] or training format (half-day vs. two-hour version).

5.2 Self-reported knowledge about resilience and managing stress

- The training brought about significant positive changes in self-reported knowledge and understanding about resilience and managing stress
- There was a notable improvement in self-reported knowledge of 'ways to build resilience' after the first training session, highlighting the value of the training in this area.
- The large improvements observed in self-reported knowledge on this topic were observed in a consistent way across the Blue Light services.

5.2.1 Scores for individual items

Table 5.3 Individual items for self-reported knowledge about resilience and managing stress

Self-reported knowledge	% 'agreeing' or 'strongly agreeing'		
	W1 (N=~220)	W2 (N=~220)	W3 (N=~120)
I have a good understanding of what resilience is[20].	68.0	97.3	83.9
I know ways to build resilience[21].	47.7	93.2	70.7
I know ways to manage stress or difficult emotions at work[22].	69.5	95.4	83.1

Source: Baseline survey, Post-training survey, Follow-up survey, IES, 2018

Self-reported understanding and knowledge for all of the above items changed in a consistent way across survey waves[23]. Scores for each question showed a statistically significant improvement after Part 1 of the training compared with baseline. As with the items in the previous section, scores reduced significantly between Part 1 and Part 2 training delivery but stayed significantly above baseline. It is notable that relatively low numbers of recruits agreed with the statement "I know ways to build resilience" before the

[19] There were three levels for this dependent variable: <3 months, 3 - 6months, > 6 months)

[20] Friedman's $chi^2 = 55.2$, $p < .001$; W1 vs W2: $Z = -8.73$, $p < .001$; W2 vs W3: $Z = -4.23$, $p < .001$; W1 vs W3: $Z = -3.58$, p , >001.

[21] Friedman's $chi^2 = 71.1$, $p < .001$; W1 vs W2: $Z = -10.00$, $p < .001$; W2 vs W3: $Z = -4.41$, $p < .001$; W1 vs W3: $Z = -4.70$, $p < .001$

[22] Friedman's $chi^2 = 46.2$, $p < .001$; W1 vs W2: $Z = -7.90$; $p < .001$; W2 vs W3: Z = -3.66, $p < .001$; W1 vs W3: $Z = -3.08$, $p < .01$.

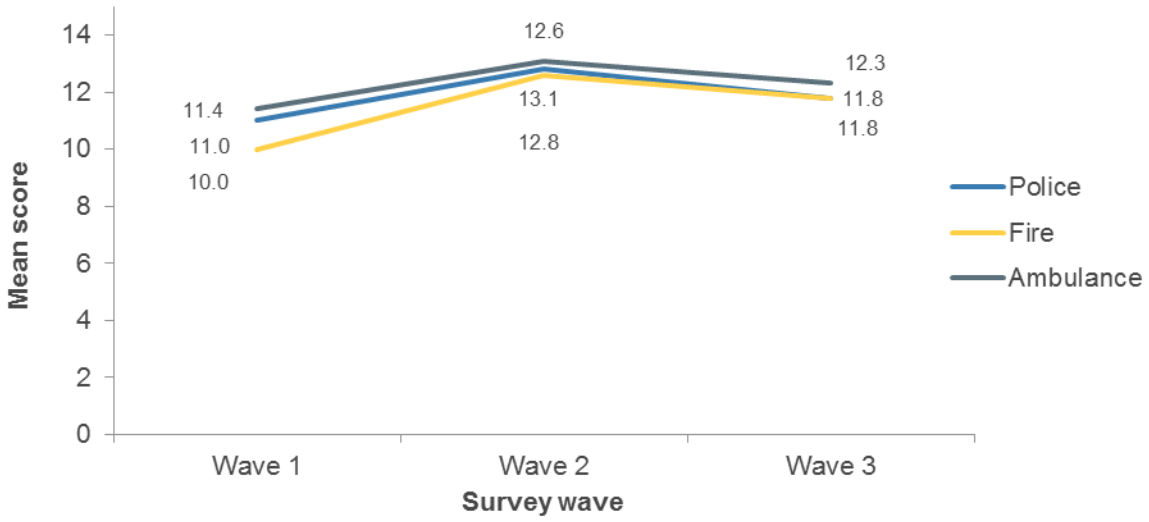
[23] Results of significant ANOVA and paired comparisons for these items are given for each item in the table in the corresponding footnote.

training. The jump to almost full agreement is very marked and arguably where the training was most impactful in terms of building knowledge and confidence.

5.2.2 Between-group comparisons

To simplify comparison between different groups of participants, aggregate scores were calculated which combined scores on the three questions above. A series of mixed-design ANOVAs were applied to these scores; however, these showed no systematic effect of Blue Light service, duration as a new recruit or training format. The consistency across services can be seen clearly in Figure 5.2.

Figure 5.2 Change in self-reported knowledge about resilience and managing stress by Blue Light Service



Source Baseline survey, Post-training survey, Follow-up survey, IES, 2018

5.3 Self-reported knowledge about obtaining support

- The training resulted in significant positive changes in self-reported knowledge about where to seek help.
- The improvements observed in self-reported knowledge on this topic were observed in a consistent way across the Blue Light services.

Table 5.4 Individual items for self-reported knowledge about obtaining support

Self-reported knowledge	% 'agreeing' or 'strongly agreeing'		
	W1 (N=~220)	W2 (N=~220)	W3 (N=~120)
I know where to find information about mental health[24]	78.0	97.3	91.9
I know where I can access support or advice regarding my own mental health[25]	75.7	97.3	87.1
I know where I could go for help with a mental health problem	78.3	98.6	89. 4

Source: Baseline survey, Post-training survey, Follow-up survey, IES, 2018

In regard to knowing where to go for help there was pronounced change across survey waves, which reached statistical significance[26]. Scores improved immediately after Part 1, this represented a statistically significant increase. Scores remained above baseline in the follow-up, again significantly so.

5.3.1 Between-group comparisons

To look at between-group comparisons, again, an aggregate score was calculated combining each of the above items. Mixed-design ANOVAs showed no systematic effect of service on the aggregate score. However, those who had been a new recruit for more than six months started and finished with a higher score than those who had been in the various services for a shorter time[27]. There was no reliable effect of training format on this measure.

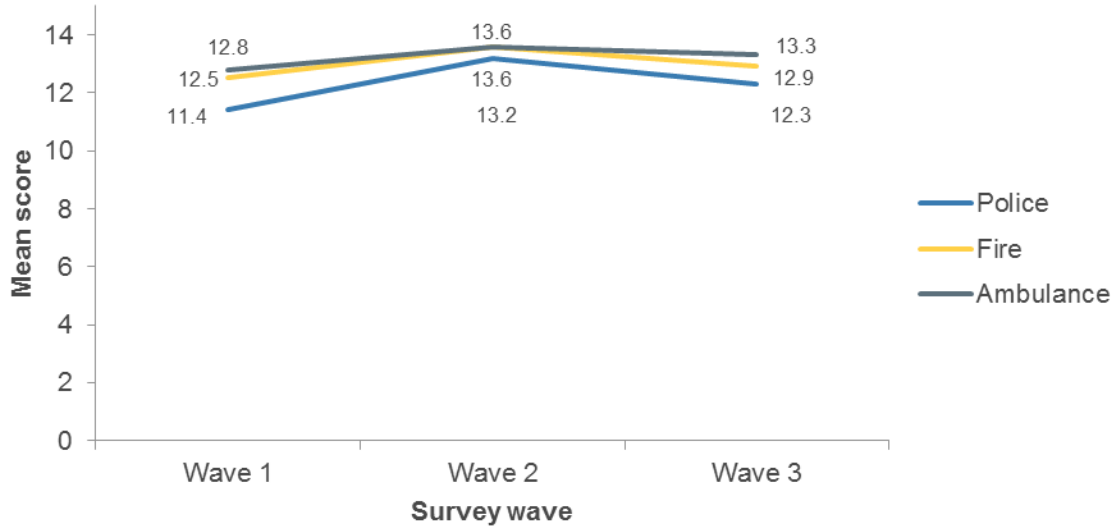
[24] Friedman's chi2 =33.1, p < .001; W1 vs W2: Z = -7.56, p < .001; W2 vs W3: Z = -3.08, p < .01; W1 vs W3: Z = -3.08, p < .01.

[25] Friedman's chi2 =46.8, p < .001; W1 vs W2: Z = -7.91, p < .001; W2 vs W3: Z = -3.97, p < .001; W1 vs W3: Z = -3.18, p < .01.

[26] Friedman's chi^2 = 51.5, p < 0.001; W1 vs W2: Z = -8.43, p < .001; W2 vs W3: Z = -4.81, p < .001; W1 vs W3: Z = -3.33, p < .01.

[27] F (1,2) = 4.04, p<0.05

Figure 5.3 Change in self-reported knowledge about obtaining support by Blue Light Service



Source: Baseline survey, Post-training survey, Follow-up survey, IES, 2018

5.4 Knowledge recall about mental health

5.4.1 Scores on individual items

- Surprisingly, knowledge scores about mental health did not change after the training; many participants had good general knowledge about the topic at the outset.
- There was a trend towards the fire service scoring less well; this could reflect the differences in the nature of their job or the training they receive.

Table 5.5 Individual items for knowledge recall about mental health

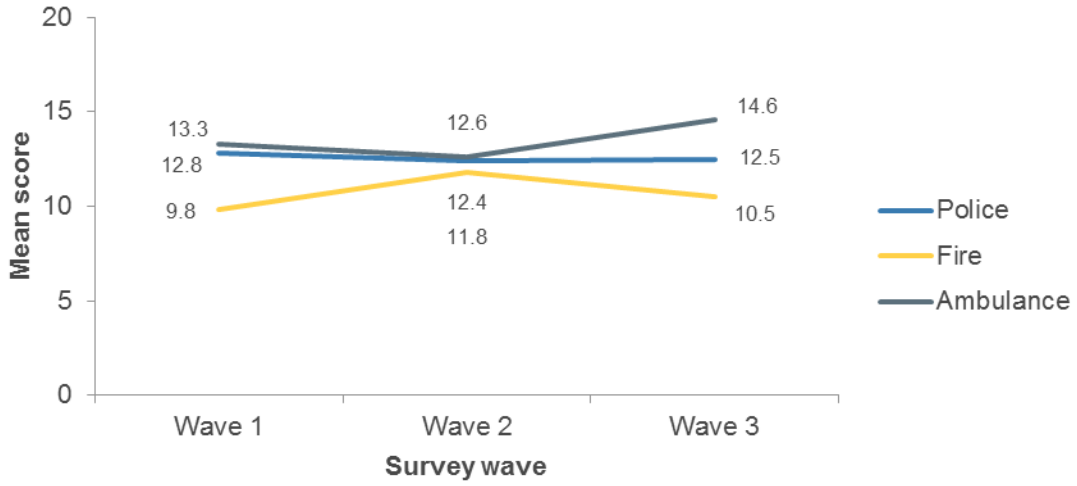
Knowledge recall	Average score		
	W1 (N~200)	W2 (N~200)	W3 (N~100)
What do you understand by the term 'mental health'? (max score = 2)	1.09	1.19	1.09
What life events and experiences can cause poor mental health? (max score = 10)	6.45	6.19	6.01
Can you provide some examples of common symptoms of poor mental wellbeing (max score = 8)	4.94	5.00	4.95

Source: Baseline survey, Post-training survey, Follow-up survey, IES, 2018

The average scores shown in Table 5.5 show an overall trend for scores to improve immediately after Part 1. Scores subsequently fell at follow-up at stage, but remained similar to baseline. None of these changes, however, were statistically significant.

5.4.2 Between-group comparisons

Figure 5.4 Change in knowledge recall about mental health by Blue Light Service



Source Baseline survey, Post-training survey, Follow-up survey, IES, 2018

A series of mixed-design ANOVAs showed no systematic differences by service on these measures, and no significant effects of duration as a recruit or training format. There was a tendency for lower scores among fire service new recruits (particularly at baseline) but these differences were not statistically significant. It is only possible to be speculative about the reasons for (small) differences in trends across the services; they could reflect the differences in career background or the training they receive.

5.5 Knowledge recall about resilience

- The training resulted in some small but significant changes in knowledge about resilience.
- The largest training-related improvement was seen in self-reported knowledge of techniques to build resilience' after the first training session, highlighting the value of the training in this area.

5.5.1 Scores for individual items

Table 5.6 Individual items for knowledge recall about resilience

Knowledge recall	Average score		
	W1 (N=223)	W2 (N=221)	W3 (N=125)
What do you understand by the term 'resilience'?[28] (max score = 2)	0.87	1.00	0.96
Please list some tools and techniques that can be helpful for building resilience.[29] (max score = 10)	3.60	4.95	3.89

Source: Baseline survey, Post-training survey, Follow-up survey, IES, 2018

In contrast with the findings described in the previous section, above Table 5.6 shows a tendency for scores to improve between baseline and Part 1. For both questions this improvement was statistically significant[30]. At follow-up, average scores were lower, and for the second question this represented a significant deterioration in performance between training Parts 1 and 2[31].

5.5.2 Between-group comparisons

An aggregate score for each of these three items was calculated to look at between-group comparisons. Knowledge scores on this topic across the various services are shown in Figure 5.5. This shows a trend towards lower scores among the fire service, both before and after the training[32]. However, a three-way mixed ANOVA showed the differences noticed by service were not quite statistically significant[33]. There was also no systematic effect of duration as a new recruit on resilience recall. There was, however, a small effect of training format, but counter intuitively those attending the shorter model obtained significantly higher scores[34].

[28] Friedman's chi^2 = 7.00, $p < .05$; W1 vs W2: $Z = -2.48$, $p < .05$; W2 vs W3: not statistically significant; W1 vs W3: not statistically significant.

[29] Friedman's chi^2 =18.68, $p < .001$; W1 vs W2: $Z = -4.39$, $p < .001$; W2 vs W3: $Z = -3.40$, $p < .001$; W1 vs W3: not statistically significant.

[30] W1 vs W2 resilience: $Z = -2.48$, $p< 0.05$; W1 vs W2 tools and techniqies: $Z= 4.39$, $p<0.01$

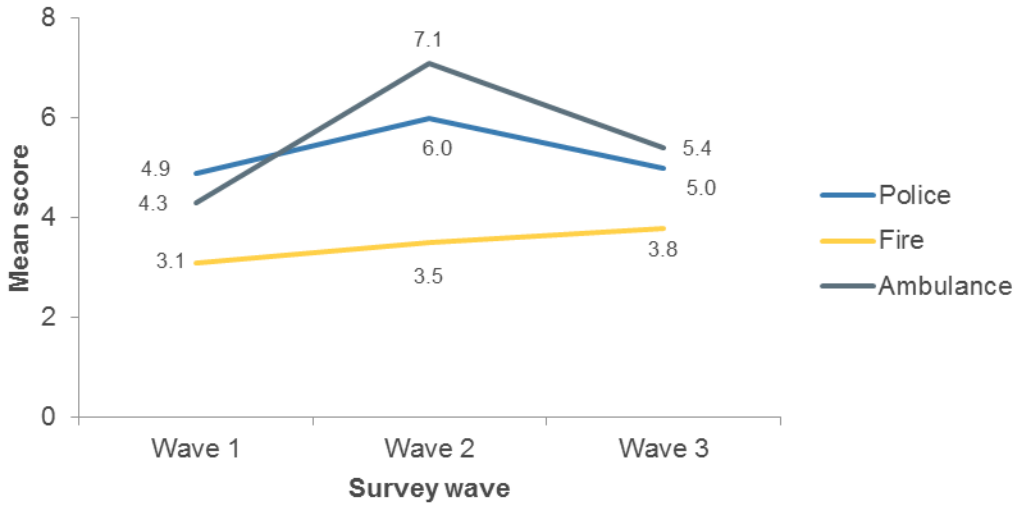
[31] W2 vs W3: $Z = -3.60$, $p<0.01$

[32] Post-hoc comparisons using the Games-Howell test indicated that fire service mean scores were significantly lower than police service scores: Mean difference = -1.83, SE = .64, $p < .05$.

[33] $F(1,2) = 3.85$, $p < 0.05$

[34] $F(1,1) = 4.39$, $p<0.05$

Figure 5.5 Change in knowledge recall about resilience by Blue Light Service



Source Baseline survey, Post-training survey, Follow-up survey, IES, 2018

5.6 Beliefs about mental health

5.6.1 Scores for individual items

Five items altogether were used to assess perceptions about mental health. These included items from the Mental Health Knowledge Schedule (MAKs) as well as a question to test beliefs about prevalence of mental health problems in people working for the emergency services.

- Positive shifts in belief about mental health were seen after the training, although baseline measures suggested that many new recruits were relatively well-informed at the outset.
- Relative to the other services, ambulance recruits demonstrated more informed beliefs at all stages of the evaluation.

Table 5.7 Individual items for beliefs around mental health

Beliefs about mental health	% 'agreeing' or 'strongly agreeing'		
	W1 (N=~220)	W2 (N=~220)	W3 (N=~120)
I know where I could go for help with a mental health problem[35]	76	99	89
Medication can be an effective treatment for people with mental health problems[36].	62	81	71
Psychotherapy (eg talking therapy or counselling) can be an effective treatment for people with mental health problems[37].	89	97	87
It's not always possible to identify the cause of someone's mental health problem[38].	79	85	82
Do you think people working in the emergency services are more or less likely to experience a mental health problem than the general population?[39]	90	93	92

Source: Baseline survey, Post-training survey, Follow-up survey, IES, 2018

Table 5.7 shows the change in responses over time. Agreement with the statements (signifying more informed approach) increased markedly between baseline and immediately after the first part of the training but these fell back towards baseline at follow up.

In regard to knowing where to go for help there was pronounced change across survey waves which showed statistical significance[40]. This was also the case for the questions about medication, psychotherapy and identifying the cause of mental health problems[41]. For the first four items there was a trend towards increasing agreement immediately after Part 1 of the training and dropping towards baseline at follow up.

As one might expect, the slight changes in agreement for the item about mental health among emergency services staff were not statistically significant.

[35] Friedman's chi2 =51.5, $p < .001$; W1 vs W2: $Z = -8.4$, $p < .001$; W2 vs W3: -4.81, $p < .001$; W1 vs W3: $Z = -3.33$ $p < .01$.

[36] Friedman's chi2 =23.0, $p < .001$; $Z = -5.5$, $p < .001$; W2 vs W3: $Z = -3.01$, $p < .01$; W1 vs W3: not statistically significant.

[37] Friedman's chi2 =27.4, $p < .001$; $Z = -6.5$, $p < .001$; W2 vs W3: $Z = -3.56$, $p < .001$; W1 vs W3: not statistically significant.

[38] Friedman's $chi^2 = 9.3$, $p < 0.01$; $Z = -2.2$, $p < .05$; W2 vs W3: $Z = -2.38$, $p < .05$; W1 vs W3: not statistically significant

[39] No significant effect when comparing raw scores

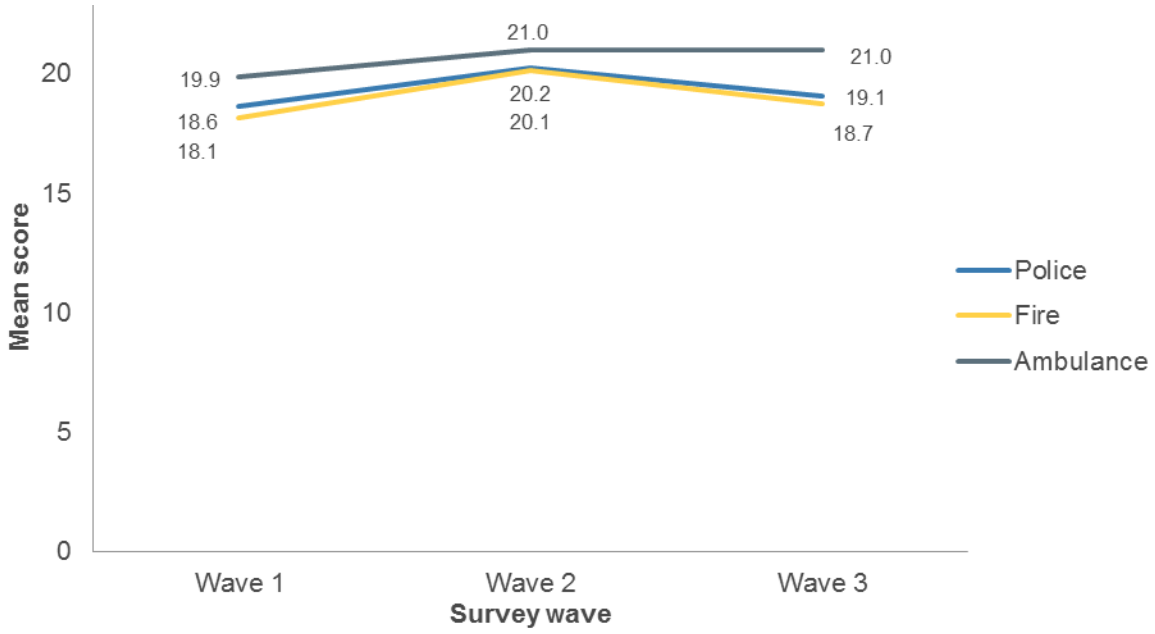
[40] Please refer to item in Table 5.7 and corresponding footnote listing significant results.

[41] Respectively: Friedman's $chi^2 = 23.0$, $p < 0.01$, Friedman's $chi^2 = 27.4$, $p < 0.01$, Friedman's $chi^2 = 9.3$, $p < 0.01$.

5.6.2 Between-group comparisons

To facilitate comparison between different groups of training participants, a single aggregate score was calculated for these items. There was no systematic effect of service on these scores or duration as a recruit, or of training format.

Figure 5.6 Changes in beliefs about mental health by Blue Light Service



Source Baseline survey, Post-training survey, Follow-up survey, IES, 2018

5.7 Concluding comments

For most of the measures reported in this chapter there is a general pattern of scores improving immediately after Part 1 of the training and then dropping to a lower level a few weeks afterwards. This arguably supports the usefulness of Part 2 in helping consolidate earlier learning.

The stand out finding from this chapter is the large improvement observed in self-reported understanding about resilience and coping with stress. Improved scores were sustained between Parts 1 and 2 of the training.

The findings in this chapter are important but principally centre on acquisition of theoretical knowledge and confidence about that knowledge. A key aim of the two part programme was to help embed practical learning; more applied aspects of learning are addressed in the next chapter.

6 Training Outcomes: seeking support and coping

This chapter focuses on practical outcomes of training, ie recruits applying their learning to managing the pressures of their job and maintaining wellbeing. Interview data is presented alongside survey data; qualitative data was important in understanding small, short-term changes that could manifest in long-term benefits to individuals.

Because behaviour changes would only be expected to occur some time after training (ie not immediately), this chapter concentrates on changes between baseline and follow-up. The effects reported here therefore refer to the period between parts 1 and 2 of the training, and focus on data obtained from participants who completed the whole course. Please see Chapter 5 for an overview of the outcomes analysis approach and evaluation context.

6.1 Paying attention to health and wellbeing

- The proportion of new recruits paying attention to health and wellbeing (of self and others) at work were high at baseline, ie prior to receiving any training on the topic.
- This may reflect the partially self-selected nature of the training sample but could also signify that new recruits across all the Blue Light services have an interest in and are concerned about these issues.
- Some participants reported taking more breaks and focussing on self-care. There were also anecdotal examples of participants successfully identifying when their own thinking style was not conducive to good mental wellbeing.

The evaluation surveys asked three questions which centred on thinking about one's own and colleague's mental health while at work.

6.1.1 Scores on individual survey items

Table 6.1 Paying attention to mental health

Paying attention to mental health	% saying yes	
	W1 (N=221)	W3 (N=124)
I pay attention to my mental health and wellbeing at work.	76.5	77.4
I take steps to manage stress and look after my health and wellbeing at work.	70.1	72.6
I pay attention to the mental health and wellbeing of my colleagues at work.	81.0	82.3

Source:,Baseline survey, Follow-up survey, IES 2018

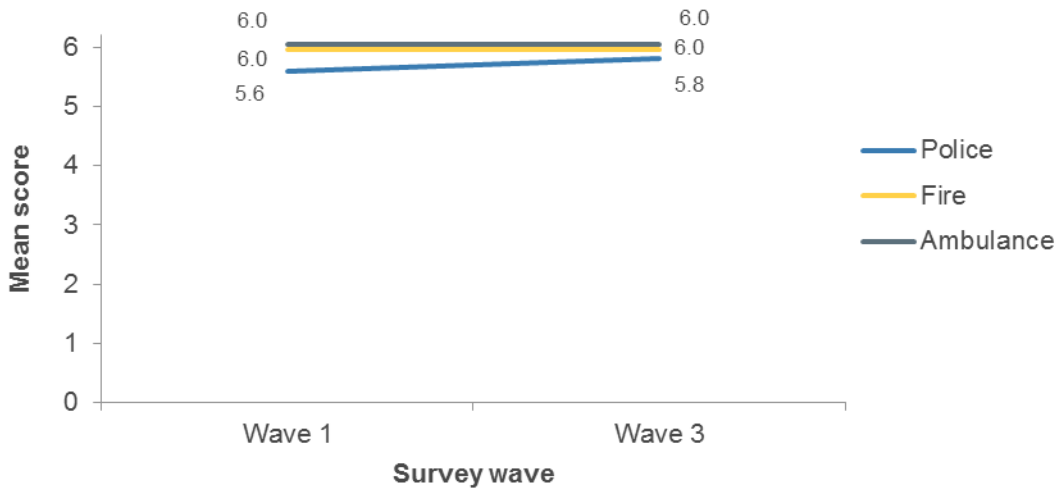
Interestingly the proportion of new recruits paying attention to their own health and wellbeing at work were high prior to the training and only small, non-statistically significant changes were reported over time for each of the items shown in Table 6.1. This may indicate that those who attended the training were already concerned about their own mental wellbeing and that of colleagues prior to the training.

It is worth noting that these questions required a 'yes/no' response and therefore could not capture qualitative changes in relation to these behaviours or application of new strategies. Participant interviews (reported on below) were able to shed light on more nuanced changes, such as an increased tendency to question their thinking style. Note that one approach for paying attention to mental health is mindfulness: specific techniques like this are discussed later in the chapter (see Section 6.4 which addresses coping techniques).

6.1.2 Between-group comparisons

To facilitate comparison between different groups of training participants, a single aggregated score was calculated from responses to all three items. Interestingly, a series of mixed-design ANOVAs did not show any systematic between-group effects: Figure 6.1 shows the relative homogeneity of responses across the services as well as the small amount of change between baseline and training follow-up.

Figure 6.1 Changes in behaviours (self management) by Blue Light Service



Source IES, 2018

6.1.3 Insights from interviews

Lifestyle changes

It was usual for interviewees to single out one or two small changes they had made as a result of lessons from the training. Some participants had reflected on their wellbeing in a broad sense, and questioned whether they were doing all they could to stay physically as well as mentally well. It was noted that there can be a tendency among those in first response roles to neglect one's own wellbeing.

> *"In this role you tend to put other people above yourself and forget that you need a good night's sleep and a proper meal."*
>
> PCO, Police Service

There were several examples of interviewees taking more notice of what worked for them as an individual. In particular there was renewed awareness of the health benefits of breaks and some reports of altered behaviour.

> *"I have noticed that if I am having a particularly stressful day then I need to take five minutes to grab a coffee and carry on rather than plough through like I would normally do."*
>
> Paramedic, Ambulance Service

> *"I realise now that a biscuit and a chat can be a real way to manage your mental health, whereas before I just thought that it was just tea and biscuits".*
>
> Constable, Police Service

The importance of having a life outside work was a message that hit home with some recruits. A police forensic examiner who had been struggling with negative thoughts reported that as a consequence of the training she had been trying to keep more active and took up a new hobby (needlework) outside of work to help maintain good mental health. Several participants however, especially those with families at home, felt that their working hours prevented them from finding the time they needed for self-care. For example, a problem identified by ambulance call handlers was the incompatibility of their shifts with gym or swimming pool opening hours. In the police it was reported that it could be difficult to access healthy food during shifts; obtaining fast-food was often the most practical option.

Changed style of thinking

For some participants the main point they had taken away was to exercise more self-compassion on a daily basis. Those with a 'driven' personality who thrived on the challenge of their role admitted the flip side of this was that they could be hard on themselves. For some the training course was the first time they had considered this.

> *"I've realised that 'it's ok to take time for me to do something that I want to do, if I don't want to wash the pots right this minute, nothing's going to happen."*
>
> CSO, Police Service

There were other important ways participants had learned to challenge their own thinking style. As identified earlier in the report a key aim of the training was to build resilience and a central component of this was recognising how abstract thinking (eg analysing why something is happening, its implications, and asking 'what if' questions with no obvious answer) could lead to low mood.

Some participants were able to see how they habitually lapsed into abstract thinking and recognised the value of the distinction between this and more concrete thinking.

> *"We're all guilty in the police force of thinking in a one-track mind of "what if", and "if I'd only".*
>
> Community Support Officer, Police Service

6.2 Awareness of Blue Light services

- Awareness of Blue Light resources was very low among new recruits before they received the training.
- This raises the possibility that new recruits outside the training pilot areas may miss out altogether on hearing about the information and support provided by Mind.
- More broadly the training was successful in promoting available support and raising awareness of local Blue Light activities.

6.2.1 Scores on individual survey items

Table 6.2 Awareness of Blue Light services

Awareness of Blue Light services	% responding yes	
	W1 (N=~220)	W3 (N=~120)
I have heard about the Blue Light Infoline	42.7	90.3
I have accessed the Blue Light Infoline (phone/text/email) for myself/ for a friend'	1.9	2.9
I have accessed/used Mind Blue Light information booklets.	8.7	20.4
I have attended mental health awareness training (provided either by Mind or another organisation) when working in a previous role	31.4	42.7
My organisation has signed up to the Blue Light pledge.	49.0	85.4
My organisation has one or more Blue Light Champions	42.7	86.3

Source: Baseline survey, Follow-up survey, IES, 2018

Across the services the percentage who had heard of the Blue Light Infoline rose from 43 per cent at baseline to 90 per cent at the time of attending Part 2 of the training. Numbers accessing Blue Light booklets rose from 9 to 20 per cent. Interestingly those reporting their organisation had signed up to the Blue Light Pledge rose from 49 to 85 per cent; this

presumably reflected better awareness of their organisation's activities rather than actual change. Similarly the proportion reporting their organisation had one or more Blue Light Champions rose from 43 to 86 per cent.

Awareness of the various initiatives launched under Mind's Blue Light programme was relatively low before the training. Given the early career stage of most of the target group this low level of awareness might be expected. Nevertheless these findings suggest that a briefing on Mind's Blue Light programme is not a standard part of induction for most new recruits, so those in other parts of the UK, ie those outside pilot areas, may miss out on important sources of information and support.

6.2.2 Insights from interviews

Not surprisingly interviews confirmed that there was less potential for the training to make an impact on Blue Light awareness among participants whose services already prominently displayed posters and signposting information. For those who already had basic knowledge the training was able to provide additional detail about the campaign such as the criteria to become a Champion. Interestingly there a mix of views about approaching BL Champions: one trainee expressed a preference to talk to 'someone who knew what s/he was going through', perhaps reflecting a view that the role of a trainee can only be understood properly by a peer.

There was no notable change in numbers accessing the Blue Light Infoline (a change from 2 to 3 per cent) but, given the relatively short timeframe of the evaluation that would be expected. Some interviewees mentioned that it was something they would consider now they were aware of it.

Because of the short timeframe of the evaluation the potential for participants to apply what they had learned to support colleagues was limited. However some interviewees reported they would be more likely to encourage a peer to seek help (and/or speak to a Blue Light Champion); this included a fire service worker who said she might still feel reticent about seeking help herself.

6.3 Approaching others for help and supporting colleagues

- There was no evidence that preferred sources of support had changed as a result of the training.
- However, new recruits pointed out that [people in] their organisation would need to change for them to reconsider who they approached for help.

Respondents were asked who they would be likely to approach for support. Table 6.3 shows responses at baseline and follow-up. No significant changes were seen between baseline and follow up. Between-groups analysis showed no reliable trends in regard to these responses.

6.3.1 Scores on individual survey items

Table 6.3 Seeking support

Seeking support	W1 (N~200)	W3 (N~100)
Another new recruit	24.2	24.0
Other person I work or train alongside	44.7	54.9
Person who supervises my work/training	66.2	61.0
Person who delivers my workplace/induction training	39.2	32.5
HR	36.3	38.7
Occupational Health	71.4	63.7
Chaplain	27.0	12.1

Source: Baseline survey, Follow-up survey, IES 2018

6.3.2 Insights from interviews

The interviews provided some level of explanation for the survey findings, ie the apparent lack of change in this area. Several new recruits felt that the culture within their organisation would need to change for them to reconsider who they approached for help. There was a view (as mentioned in Chapter 4) that providing training to line managers (and senior staff more generally) would help achieve the changes that many participants wanted to see.

Nonetheless the training served as a useful reminder of existing support for some participants: one reported placing a list of useful numbers and organisations in her work locker and at home in case she ever needed help. Perhaps more importantly the training was valuable in reinforcing the message that it is acceptable to ask for help when struggling, and that support is not there solely for people who have become seriously unwell. There were indications that the messages about the importance of early intervention had been taken on board.

> *"Everyone goes through 'ups' and 'downs' but when you can't get out of the down…[and] if I am having these thoughts for more than a couple of weeks then it is time to seek help."*
>
> Forensic Examiner, Police Service

> *"I learned that it's ok to need some support, and that you're not going to be judged or penalised. We all go through things in life that ultimately build up… and then mental wellbeing is not as it should be."*
>
> Community Support Officer, Police Service

A student paramedic felt he could now make a distinction between the circumstances of when he would use work based support (via a Blue Light Champion or other designated peer supporter) and those in which he would go to his GP. He felt that his initial step would be to approach someone within his workplace and that seeing a GP would only be necessary if there was 'a bigger issue'. After the training he realised that the ambulance service were more understanding about the need to talk than he had previously thought. This realisation was informed both by the approachability of his peers in the training group, and their willingness to share their own experiences of the need to talk.

One of the trainers felt that it was important to increase the social acceptability of speaking out within the emergency services and thought that discussion among peers in the training session had more potential to influence mindsets than she did.

> *"It's messy and hard to change cultures, and it takes somebody in the room to say "yes I contacted them [BL] and it was really good" to challenge thinking, and I can't replicate this as a trainer."*

Blue Light trainer, Mind

As might be expected there were beneficial knock-on effects to some new recruits' home lives and some reported improved coping with relatives with poor mental health. Learning the difference between abstract and concrete thinking had proved useful in approaching different scenarios at home.

> *"It's helped me to stop asking 'why is [my dad] like this?' 'Why isn't therapy working?' 'How long will this go on?' and instead try to focus on dealing with the existing situation."*

Forensic Examiner, Police Service

Participants who had benefited in this way felt there were consequences for their mental wellbeing more generally. Some interviewees thought the difference the training had made to their coping skills outside work was more impactful than any changes they were able to report in their working lives.

6.4 Putting new techniques into practice

- Around a third of survey respondents had applied coping techniques they had learned in Part 1, often more than one. A further fifth said they intended to try new techniques.
- The most popular techniques to try had been mindfulness, meditation and sharing experiences with colleagues.
- This indicates a willingness to try new things among the new recruit population and indicates Part 2 was likely to have been useful in embedding new habits.

6.4.1 Scores on individual survey items

Table 6.4 Have you used any techniques from Part 1 of the training to manage your mental health or wellbeing?

Have you used any techniques from Part 1 of the training to manage your mental health or wellbeing?	Number responding yes	Number responding 'no but intend to'
Police	24	16
Fire	1	4
Ambulance	7	1
All services	32	21

Source: Baseline survey, Follow-up survey, IES 2018

The largest number of participants who have used techniques from the training were recruits from the police service. Furthermore, across the three services 21 recruits reported that they intended to use techniques in the future.Thirty two per cent of survey respondents had tried to put techniques in practice that the first training session had covered. The majority of those (49 per cent) had opted to try mindfulness. Other techniques that were common included speaking with friends, family and colleagues about issues that are impacting on wellbeing (28 per cent) and general lifestyle choices to support general and mental wellbeing such as sleeping well (21 per cent). However it was common for participants to take many suggestions on board and some open text responses in the survey comprised lists.

> *"Looking after my general wellbeing: eating properly, sleeping, relaxation technique, enjoying open spaces and music, spending quality time with family and talking, sharing more with others."*
>
> Anonymous survey respondent, Ambulance Service

> *"I have tried mindfulness although it was not for me. I have tried increasing my social life and taking more time to relax."*
>
> Anonymous survey respondent, Ambulance Service

Interestingly, possibly because of the way questions were asked (ie in an open style), interviewees tended to describe how they were changing their everyday habits rather than name specific techniques. For example (as detailed in Section 6.1), several participants spontaneously mentioned their efforts to switch from abstract to concrete thinking but did not refer to it in those terms, instead using phrases like 'dwelling on things less'.

6.5 Coping with everyday working life and beyond

- Although the follow-up period for the evaluation was relatively short more than a third of survey respondents thought the training made a difference to how they performed their role

- There was increased understanding of the support needs of people with mental health problems but, with that, appreciation of the boundaries of their role, ie that it lay beyond them as individuals to 'fix everything'.
- Among a cohort whose working life is focused on rescuing, this was arguably one of the most important learning points of the training.

6.5.1 Scores on individual survey items

Table 6.5 Training impacts on carrying out work by Blue Light service

Has the training made a difference to...	% responding yes				
	Fire	Police	Amb	S&R	Total
How you perform your role	60.2	34.2	50.0	-	36.1
How you interact with people you work or train alongside	60.0	41.3	50.0	-	43.1
How you interact with members of the public	60.0	37.5	60.0	-	41.0
Total	10	~80	10	0	~100

Source: Follow-up survey, IES, 2018

When asked whether they felt the training had made a difference to how they performed their role, 36 per cent of all respondents said they thought it had. Forty-three per cent thought they interacted with people they worked or trained alongside differently as a result of the training. Forty-one per cent of respondents said they interacted differently with members of the public after their training.

The interviews shed more light on the different ways participants from the various services had benefited. In contrast to the ambulance services, individuals from the police and fire services did not have a background of medical training, so generally there was more new, factual information for them to take on board about mental health. In some cases, that had been particularly helpful when dealing with members of the public and communicating sympathetically yet also with the right amount of professional distance.

> *"It's helped me to take a step back and look outside the box and choose your words differently like not saying "I understand", when you don't fully understand."*
>
> Community Support Officer, Police Service

A female firefighter thought that she had a tendency to get 'too bogged down' by other people's situations. The training had helped her realise the need to be supportive but also to accept that she could not 'resolve everyone's issues' personally. After the training she said she was able to appreciate more fully that some individuals with acute support needs were best handled by specialised mental health services. There were several other comments that indicated participants had become more self-aware about the language they used. There was also greater acceptance among several interviewees of their professional limitations, ie they couldn't offer solutions all the time and that when dealing with someone in a crisis it was more appropriate to provide guidance focusing on the present rather than identify what they needed to do to change their situation in the longer

term. Among a cohort whose working life is focused on rescuing, this was arguably one of the most important learning points of the training.

6.6 Concluding comments

This chapter showed several important outcomes of the training which signal its potential to bring about behavioural change and improved coping styles among Blue Light new recruits.

An interesting finding is that, among those responding to the baseline survey, the proportion of new recruits paying attention to health and wellbeing (of themselves and others) was relatively high before receiving any training on the topic. Nevertheless the training had a discernible impact on self-care and participants reported taking more breaks than before and questioning thinking styles that were not helpful, especially when outcomes of incidents were distressing.

Awareness of Blue Light services was lower than one might presume considering all pilot groups belonged to services who had made the Blue Light Pledge. Although the training was successful in alerting participants to sources of support, responses at follow-up indicated that attitudes towards approaching various other in-house sources of support had not changed. Those interviewed felt that wider organisational change was needed to alter this; one suggestion was that Mind should offer training to new recruits' managers.

Around a third of survey respondents had applied coping techniques they had learned in Part 1, with many more intending to and there appeared to be a general openness to try new things. Although the follow up period was short it was notable that a sizable proportion of participants felt the training had brought about positive changes in their working lives and also equipped them with more knowledge and confidence when dealing with the public. Some felt that they applied professional boundaries more effectively and saw where mental health support needs lay outside their own expertise and training.

7 Conclusions and learning points

This chapter starts by addressing the research questions specified by Mind. We have also made some additional observations and recommendations, since plans to roll out the training more widely are under consideration. These are intended to inform future decision-making regarding this.

7.1 Research Questions

7.1.1 How can the course be made most relevant and engaging to new recruits and their employers?

Approval ratings for the course were high; 94 per cent of new recruits attending Part 1 agreed it was useful. The training materials were felt to be relevant as well as of high quality. Mind's experienced trainers were successful in engaging participants and feedback was particularly positive regarding their ability to facilitate open and honest group discussion, as well as responding to the groups' interests and needs.

In line with Mind's aims the training was felt to be particularly beneficial for recruits who were new to working in Blue Light services, especially those who had not previously received any mental health awareness or resilience training. Nearly all recruits who attended Part 1 (91 per cent) felt the information was relevant to their workplace. Although participants were generally satisfied that the training was highly tailored to their role some felt there could have been more of an explicit focus on preparing new recruits to deal with potentially distressing aspects of incidents they attended.

Unsurprisingly participants were not wholly in agreement about the elements that worked well or less well; however, the 'Black Dog' video stood out as a universally-liked element which was successful in depicting the experience of depression. The 'Planet' role-play exercise, which focused on concrete versus abstract thinking, received a mixed reception. Many participants felt they could have grasped the concepts it intended to demonstrate without the task, which was regarded by some as overly artificial. Others thought this aspect of the training was slightly redundant as their role had already trained them to respond to situations in a practical, solution-focused way. However, some new recruits were able to report that they had applied their new understanding of different thinking styles and found it beneficial.

Contrary to expectation, the evaluation did not yield clear, consistent messages about what worked/worked less well for specific Blue Light services. This was surprising given that the cohorts across the services were quite different in terms of demographic composition (for example in terms of gender balance and career histories) but this arguably illustrates the wide appeal and relevance of the training. However, some aspects

of the training did not always hit the right tone for all participants. Some recruits found elements of the training ''preachy' or overly prescriptive about the right ways of coping. A small minority disengaged because they felt uncomfortable, but Mind's trainers felt that this was an inevitable consequence of nudging some participants out of their comfort zone and challenging misperceptions, ie not an indicator of lack of success.

Fewer participants attended Part 2 (only 55 per cent of the 223 who attended Part 1) but those who did were generally positive about that experience. There was no evidence that 'no-shows' at Part 2 stemmed from lack of satisfaction of Part 1 or rejection of the material. It seems likely that many participants simply had competing priorities or felt free to drop out of training that was not compulsory. Among recruits at Part 1, 71 per cent stated that it was compulsory and 19 per cent had cited personal interest as one of their reasons for attending. However the evaluation design did not enable researchers to reach non-attendees or take a systematic approach to understanding the reason for their absence.

Recruits who had acquired some practical experience in their role were especially positive about the opportunities provided by Part 2 to discuss and reflect on their experiences and wellbeing techniques. Those with little or no experience 'in the field' felt that they had not had much opportunity to utilise techniques from Part 1. Some new recruits indicated that they had found some aspects of Part 2 repetitive but this was a minority.

There was a general consensus that the training should be delivered during the first year of a recruit's training journey, preferably before they had attended incidents that could cause distress or trauma. More than half of recruits who attended Part 2 training (57 per cent) felt that the training had been offered to them at the right time. However, it was felt that Part 2 would offer most benefit if it were delivered after recruits had acquired experience of responding to incidents for at least a few weeks.

The alteration of training format for some participants allowed the evaluation team to test whether a more concise course could achieve the same results. Findings were interesting in this respect; objective data suggested learning outcomes did not differ but research interviews with both trainers and trainees suggested that this reduced the time available for spontaneous queries, disclosure and discussion. This pacing issue is important in training on potentially emotive issues where some participants may benefit from the opportunity to gain peer support, or hear about others' experiences during the session.

Overall, participants did not in general find fault with any aspect of the training and the level of apparent relevance and engagement. This would suggest that Mind do not need to reconsider their approach. The course as it stands appears to be sufficiently relevant and engaging without any major review or significant change of approach.

7.1.2 How can we most effectively increase new recruits' mental health knowledge, help-seeking behaviour, and use of coping skills?

The training demonstrated impacts both in terms of understanding and knowledge, and initiating changes in behaviour during the training period. The research signalled strongly where the training was most effective.

Changes in knowledge

Recruits' demonstrated relatively good levels of knowledge and understanding of mental health prior to Part 1 training: 78 per cent reported that they had good understanding of the difference between good and poor mental health and this increased to 97 per cent immediately after Part 1. Self-reported measures of understanding mental health all increased after Part 1 training and while these decreased between Parts 1 and 2, they still remained above baseline levels. However, measures of actual knowledge showed limited impact: while there were slight changes in scores, there were no statistically significant changes. It should be noted that, as baseline levels of knowledge were already high, there was limited potential for scores to improve further. For example more than three-quarters of participants (82 per cent) reported that they already had a good understanding of some common signs of poor mental health prior to Part 1.

The most impact was found with regards to understanding resilience and knowing ways to build personal resilience. There were significant increases in both self-reported and actual knowledge of this. Self-reported understanding and knowledge of resilience, as well as recall of course content on this, increased substantially after Part 1 (the proportion who felt they had a good understanding of what resilience is rose from 68 per cent to 97 per cent) and although this fell over the course of the follow up period, participants were still reporting higher levels of knowledge and understanding than they started with (84 per cent in the previous example). Measures of actual knowledge of resilience building techniques also showed increases.

Whereas recruits tended to have relatively high levels of understanding around mental health, self-reported and actual measures indicate that knowledge around resilience was lower. Prior to Part 1 training, only 48 per cent of recruits agreed or strongly agreed that they knew ways to build resilience, whereas this increased to 93 per cent immediately after Part 1 training. This suggests that training on resilience and psychological coping strategies offers the most potential for impact; this is one of the key findings of the evaluation.

The training resulted in significant positive changes in self-reported knowledge about where to seek help. Recruits who had been in their service for more than six months reported better awareness of sources of support than more recent recruits, suggesting that this is an important topic to cover for the newest recruits.

Changes in behaviour

There was limited evidence of changes in behaviour during the training period. However, the period between Part 1 and Part 2 of the training ranged from eight to sixteen weeks which is a relatively short time to allow for any changed behaviours to emerge.

At the start of Part 2, some recruits had already started incorporating techniques or ideas from Part 1 into their working lives. More than a third (32 per cent) had applied a coping technique that they had learned in Part 1 and a further fifth (20 per cent) intended to try. The most popular techniques were mindfulness, meditation and sharing experiences with colleagues. Similarly, more than a third (36 per cent) felt that the Part 1 training had already made a difference to how they performed their role. There was increased understanding of the support needs of people with mental health problems but also a recognition of the boundaries of their role, ie not having the expectation that they should be able to 'fix everything'.

Part 1 of the training was also successful in raising awareness of and engagement with Mind's Blue Light resources. Between Part 1 and 2, awareness of the Blue Light Infoline rose from 43 per cent to 90 per cent. Furthermore, the proportion of recruits who had accessed Blue Light booklets increased from nine per cent prior to Part 1 training to 20 per cent by the start of Part 2 training.

There were no changes in self-reported behaviours around recruits paying attention to their own mental health and that of colleagues. As may be expected from staff in the Blue Light sector, baseline figures suggested that recruits were already concerned about their own mental wellbeing and that of colleagues: 81 per cent reported that they paid attention to colleague's mental health and wellbeing, and levels are similar immediately prior to Part 2 training (82 per cent). However, anecdotally there was evidence that training participants had made small changes in approaches or techniques for managing their mental health such as recognising the importance of a coffee break when they felt stressed.

There was also no evidence that recruits changed their preferences regarding who they would approach for support at work. Prior to Part 1 training, recruits were most likely to consider approaching an occupation health professional (71 per cent) or someone who supervises their work or studies (66 per cent). During interviews, some recruits voiced reservations about confidentiality or the culture at their organisation which may contribute to the lack of change. However, there was evidence that recruits fully took on board the message that it was acceptable to ask for help if you were struggling and that you didn't need to wait until you were at crisis point.

Mind's current approach appears to increase understanding and knowledge around mental health, resilience building and help-seeking behaviours at least in the short- to medium-term which was the period that the evaluation was able to address.

7.1.3 If there are any changes, how long are these sustained?

The evaluation investigated outcomes over the period that training was delivered; the time between recruits receiving Part 1 and Part 2 training ranged from eight to sixteen weeks. For this reason, it has only been possible to investigate medium-term impacts of the training; short-term measures of impact show increased levels of knowledge between Parts 1 and 2 but there was some deterioration from the levels recorded immediately after Part 1 training.

It is interesting to note that some measures of knowledge dropped back to baseline levels between Part 1 and Part 2. However, there was a lot of variation in individual recall, as would be typical of any diverse training audience. Nevertheless, this suggests that for some people it is difficult to retain new knowledge for more than 8-16 weeks. Learning styles vary considerably, some good 'rote learners' can retain large amounts of new knowledge with relative ease.

Reflecting on the second session, participants thought that it had helped cement their learning and hence raised the likelihood of them making changes in the longer term. It also provided a second opportunity to reflect as a group (not always the same group) on what had been learned and how much difference it had made in a work context.

However, retaining facts is less consequential to wellbeing than adopting minor lifestyle changes which have the potential to become entrenched habits. The most powerful changes appeared to be about prompting individuals to reflect on their domain of control: what problems they can (or should) realistically intervene to solve and what is best left to other professionals. These changes were particularly impactful when working with the public. If new approaches and behaviours can become successfully embedded as changes in practice, then this increases the likelihood of long-term change.

It is relevant to consider that there was considerable variation in baseline knowledge. People started at different learning points and those new to mental health as a topic, especially individuals without prior inclination to reflect on their mood or state of mind, may need more reminders to do this.

Achieving long-term impact is a challenge for any training provider but the two-session model appears to enhance the potential for meaningful change. Some participants felt that sustained and impactful change could be more effectively achieved if their line managers had been trained also; they felt a 'whole-organisation' approach (which the Blue Light programme has arguably taken throughout its delivery) would be ideal so that they felt supported in adopting healthy coping strategies.

7.2 Final reflections and recommendations

- The 'Mental Health and New recruits' training was delivered to more than two hundred recruits, more than double Mind's originally projected numbers. This suggests that there is a strong appetite among the Blue Light services for this training. Therefore, this supports the idea that a wider roll-out would be well-received and we strongly recommend this.
- Our findings show that the two-session training package is an effective one. However, any future roll out should be accompanied by a requirement to attend both sessions as there was substantial drop-out between Part 1 and Part 2 of the piloted training. Ideally this would have the backing of senior management within services. Work pressures and scheduling was an issue for some recruits and there was anecdotal evidence that some organisations had chosen to make Part 2 attendance voluntary.
- Evidence suggests that making training compulsory may help achieve a more representative balance of genders. Among those who attended Part 1 on a voluntary basis almost three-quarters were female. In contrast, women made up only a minority of those mandated to attend. It is important to recognise that the basis upon which the training is offered affects the composition of training groups.
- Findings suggest recruits with less personal familiarity with mental health and its impacts were under-represented among groups attending voluntarily. Mandatory training would ensure that all recruits, regardless of their background, would be able to benefit from the course content. Ideally, senior management within services would endorse the requirement to attend.
- There is a strong indication that refresher training would be beneficial. However, it lies beyond the scope of the evaluation to be prescriptive about the form refresher training should take. For example, e-learning or webinars could be an effective mode of delivery. Mind should also consider the possibility of issuing prompts and reminders to new recruits about sources of support via routine Blue Light themed emails or briefings.
- Improvements in confidence to cope are particularly important to sustain; as careers progress and responsibilities are stepped up it is essential Blue Light professionals maintain the ability to deploy strategies that work for them. In the longer term refresher training would need to have an approach that took professional development (ie beyond the new recruit stage) into account.
- Baseline knowledge and understanding of mental health was high among recruits; some recruits received training on aspects relevant to their role. Due to this, impacts around mental health knowledge were limited, whereas understanding of resilience building showed larger impacts. Mind could consider shifting the emphasis of the course to where there is most potential for new learning, ie psychological coping and resilience.
- An additional suggestion would be to emphasise the coping skills content more strongly when promoting the course to recruits and services; a change in title could overcome

resistance from those who feel they know about mental health already. Language used to publicise the training could highlight the relevance of the training to work scenarios.

- We strongly recommend that Mind make printed or electronic content available to enhance learning outcomes. Some recruits felt they would have liked to have received course materials that they could refer to afterwards and this could be a way of catering to diverse learning styles.
- Changes in course duration should be introduced with caution. Condensing training can result in valuable time spent in open discussion being lost. Potential to change attitudes and increase empathy can be compromised. Evidence suggests that recruits particularly valued the opportunity for open and honest group discussion offered by the course; particularly as some recruits noted that they had little opportunity to talk with colleagues during shifts.
- Finally, this evaluation allowed investigation of short to medium term impacts of the training. To assess whether lessons from the training are sustained into the longer term would require a longitudinal research approach. This could potentially assess organisational impacts of the training such as job retention, sickness absence and employee engagement, and provide insights into return on investment.