RSSB A Better, Safer Railway

Understanding the conditions for successful mental health training for managers

A randomised control trial to evaluate two training methods

RESEARCH AND DEVELOPMENT

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Understanding the conditions for successful mental health training for managers: a randomised control test to evaluate two training methods

1: Background and aims

Research has shown that stress and poor mental health are the leading causes of long term absences in the rail industry (ORR, 2018)[1]. The report 'Costs of impaired health across the network' (RSSB 2014)[2] provides a strong business case for greater mental health and wellbeing support in the industry, which found 1.06m days per year are lost to sickness in the industry due to ill health in general.

In response to this, RSSB and the Rail Delivery Group (RDG) approved a railway Health and Wellbeing roadmap. The roadmap was developed with the participation of over 100 industry professionals and health experts and a key part of it is to better train railway line managers in health and wellbeing. The roadmap is overseen by the Health and Wellbeing Policy Group (HWPG). The HWPG regards it as important to understand the impact of health and wellbeing development within rail and regards Mental Health as a good focus area to begin with[3]. Accordingly rail companies are now investing more in the area of mental health training. There is increasing acceptance that there is no 'one-size fits all' MH training and that different sectors - and roles within those sectors - require different approaches.

In terms of role, line managers (LMs) and supervisors are key targets for training as they arguably represent the 'frontline' of wellbeing management and act a gatekeeper to referrals or other pathways to support. MH awareness training can empower managers to approach mental health more effectively with the potential to impact positively on their direct reports. Managers are also in position to address (or report) work stressors that can compromise mental wellbeing. An RSSB 'Knowledge search' recently set out the importance of giving mental health training to LMs, and equipping them with the skills they need to identify, discuss and effectively deal with any issues employees may have. Furthermore, it is concluded, LMs can 'lead by example, raise awareness, promote dialogue, tailor job design, and create an open environment around mental health' once they themselves have a good understanding the subject.

In 2017 RSSB commissioned the Institute for Employment Studies (IES) to conduct a research project to find the best way to support the rail industry in providing mental health (MH) training for managers. RSSB was committed to delivering MH training to this

1 http://orr.gov.uk/rail/health-and-safety/occupational-health/topic-specific-guidance/work-related-stress

2 https://www.workandwellbeing.com/wp-content/uploads/2014/11/2014-02-report-WHWP-costs-of-impaired-health-across-network.pdf

3 See: http://orr.gov.uk/rail/health-and-safety/occupational-health/topic-specific-guidance/work-related-stress

audience, but there were knowledge gaps regarding the best training methods and the best topics to cover.

Part 1 of the project was to review the available research evidence base and provide some recommendations for training to be piloted and evaluated in Part 2.

The review identified some themes common to effective courses and drew on authoritative sources of guidance to make recommendations about the main themes and topics that mental health training for LMs should cover. Table 1 shows these topics grouped by function.

Table 1 - Recommended topics for line manager training

Core	Line manager role	First response skills
1. Awareness of and knowledge about mental health 2. Communication skills (having conversations about mental health, handling disclosure)	3. Supporting mental wellbeing through managing workplace risks 4. Managing absence and return to work	5. Responding appropriately to signs and symptoms

The literature also highlighted some generic features of training courses that would be desirable:

- providing opportunities for interaction with other learners
- using real-life experiences to illustrate points, for example:
  - personal accounts of real employees who have struggled with their mental health (such as on video)
  - 'case studies' showing how particular situations were managed at work
- tailoring content as far as possible to participants' sector or job roles.

The academic literature also indicated the potential effectiveness of half day courses delivered either face-to-face or online. On that basis IES recommended that comparing these two methods would provide a useful addition to the current evidence base.

IES also recommended that the training should be bespoke to LMs and provided by an expert source with the capacity to deliver in at least four locations in the UK. Ideally this would be an established provider capable of scaling up should the evaluation show a particular type of training is suitable for further roll-out.

Finally we recommended that as many aspects as possible of the two training methods should be similar so that any differences in outcome could be attributed to method of delivery (rather than, for example, inconsistent quality or depth of training materials).

Consistent with RSSB's intention to conduct a randomised control trial (RCT) the trial would need to involve a control group to provide robust comparative data.

This report, therefore, presents the findings of an evaluation to compare the effects of those types of training with a control condition (no training at all). It is the first research of its kind to compare mental health training for line managers across modalities, not only within the rail industry, but worldwide

2: Methodical approach

During March and April 2018 RSSB conducted a procurement exercise to secure a provider who could deliver training to IES' specification. Mind was selected to deliver both the face-to-face and e-learning training to a line manager audience. Information about Mind's training content is included in Appendix Section A.

The training was delivered during July and August 2018 with data collection continuing into October 2018. Nine face-to-face training sessions were run in locations across Great Britain. The e-learning was made available to participants in a format that enabled them to access it in any location with internet access, via smartphone, tablet or PC.

This section documents the various stages of the evaluation in detail.

Training set up and participant recruitment

RSSB liaised with Mind to ensure that the training content was compatible with recommendations from IES' review and generalizable to the rail industry. Discussions involving IES were held to decide how evaluation materials could be integrated into the e-learning experience with minimum disruption.

RSSB also worked to secure the engagement of its member organisations, with the aims of achieving participation from a sample of employers reflecting the diversity of their membership and geographical spread across Great Britain. Nine rail industry companies participated; namely: Atkins, Colas, East Midlands Trains, Freightliner, HS2, Network Rail, Siemens, Southeastern Trains and West Midlands Railway LMs.

RSSB worked with named intermediaries at each company to secure participation of LMs. All staff who took part in the study consented to participation on an informed, voluntary basis.

Participants were allocated to five geographical clusters (of different sizes) to facilitate organisation of the face-to face training. Each cluster contained companies operating in that part of the rail network; some larger companies were represented in more than one cluster. Within each cluster suitable training venues were identified within a convenient travelling distance for all participants.

Study design and randomisation process

In order to compare the effects of the two types of training with each other and with a control group, a randomised control trial (RCT) study design was adopted. Because of this, one third of the LMs who volunteered to take part in the study needed to be assigned to a control group. The control ('no-training') group provided a 'benchmark' of how the wider population perform on the survey and enabled conclusions to be drawn about the specific impact of the training.

For ethical reasons these participants were put on a 'wait list' so they could be guaranteed training at the earliest possible opportunity after the study had ended.

Within each of the geographical clusters random allocation to the three study conditions was undertaken at intra-company level: random assignation was 'stratified' by company. In practice this meant that RSSB could provide assurance to each company that two thirds of their staff would receive training. It also meant that the training groups would be as similar as possible in terms of role and geographical location to those who had not received the training.

Evaluation activities

Mode of survey administration

Surveys to evaluate the training were administered at three time points. Figure 1 shows the timing and mode of delivery of survey administration over the course of the evaluation. Both training groups completed a survey before (the pre-training or 'baseline' survey) and after the training (the 'post-training' survey) to allow for the evaluation of the immediate impact of the training on knowledge, attitudes and confidence.

The control group completed the baseline and follow-up surveys during the same timeframe. This allowed for the outcomes that were observed over the longer-term for the training groups to be compared with those of the control group over the same period. All surveys administered electronically were distributed via an online platform (SNAP), which enables secure collection and transfer of personal data.

Figure 1 - Data collected from study participants and time frame

<table>
<tr><th>Study group</th><th colspan="2">June-July 2018
(baseline and post - training)</th><th colspan="2">Sept-Oct 2018
(follow-up surveys and interviews)</th></tr>
<tr><td>Face-to-face training participants</td><td colspan="2">Data in paper format collected by Mind on behalf of IES with secure transfer to IES</td><td>Electronic data collected by IES</td><td rowspan="2">(Optional) Interview recorded with permission by IES (Note-taking offered as an alternative)</td></tr>
<tr><td>E-learning participants</td><td colspan="2">Electronic data collected by Mind on behalf of IES with secure transfer to IES</td><td>Electronic data collected by IES</td></tr>
<tr><td>Control group</td><td>Electronic data collected by IES</td><td>Not applicable</td><td>Electronic data collected by IES</td><td>Not applicable</td></tr>
</table>

Paper *Electronic* *Telephone interview*

Survey contents

IES reviewed the content of all course training materials (PowerPoint slides and e-learning materials) to establish Mind's learning objectives and determine which learning outcomes were meaningful to test. Questions to assess training outcomes primarily required responses in a multiple choice format, with 'Likert' scales that asked respondents to rate their level of agreement with various statements (and other variations on this format). The questions used in the surveys are shown in Part 2 of the Appendix.

Table 2 provides an overview of the contents of each survey at each stage of the evaluation.

Table 2 - Survey data collected at each stage of the evaluation

Type of data or outcome	Pre-training/ Baseline	Post-training	Follow-up
Demographic and personal details	✓		
Thoughts about training quality and approach		✓	

Table 2 - Survey data collected at each stage of the evaluation

Type of data or outcome	Pre-training/ Baseline	Post-training	Follow-up
Self-reported knowledge about MH	✓	✓	✓
Attitude and perceptions of stigma	✓	✓	✓
Objective knowledge about MH (open 'exam-style' questions)	✓	✓	✓
Confidence to manage MH	✓	✓	✓
Confidence to support and talk about MH	✓	✓	✓
Actions undertaken to manage MH	✓		✓

Interviews and observations

Twenty-four structured interviews were conducted over the telephone, each of which comprised 12 trainees. These took place approximately six to eight weeks after each individual had completed their training. Communications with participants about the surveys provided opportunities for them to volunteer for interview. IES selected a subset of volunteers to approach for interview, with the aim of covering as many roles, locations and employers as possible.

The interview questions addressed many of the themes covered in the post-training and follow-up survey, but allowed more detailed information to be obtained about each participant's employment context, what they thought about the training they received, and it's mode of delivery. The interviews also allowed for the exploration of how they had applied what they had learned and any barriers to this.

Two further interviews were conducted with trainers to understand their approach to delivering RSSB's remit, and to obtain their views on the receptivity of the groups that they had worked with.

IES researchers also conducted two observations of the face-to-face training. These were undertaken primarily to understand how the trainers delivered the content in practice and also to observe participant engagement and reaction to the training in situ.

Data analysis

Survey data

Quantitative data obtained from the questionnaires were analysed using SPSS, a statistics package that runs advanced descriptive and inferential analysis.

Responses to the open-ended questions that tested knowledge were coded using a marking framework developed from the training materials. One mark was awarded per correct response; each question had multiple potentially correct responses. Participants were given a total score for each open question by summing the number of marks they received. Following coding this variable was included in the main dataset and analysed alongside other items.

Analysis of closed questions in all surveys followed the same process, Likert scale responses were numerically inputted into SPSS. Appropriate statistical tests were chosen based on the research design, type of data and distribution of the responses.

Interview data

Qualitative data from the participant interviews underwent thematic analysis using a coding framework developed for the study and structured around the discussion guide themes. All interview notes, which included direct quotes (obtained from recordings), were coded accordingly. Data from the trainer interviews and training observations were used to supplement and provide context to the participant interview findings. The completed coding framework provided a basis for the narrative structure of these sections of this report:

- Participant characteristics
- Reactions to the training
- Awareness and knowledge
- Taking action on mental health at work.

Presentation of findings in this report

Chapter *3: Participant characteristics* provides an overview of participant characteristics, their reflections on attitudes towards mental health in their company, and their prior experiences of addressing this area at work.

Chapters *4: Reactions to the training*, 5: *Awareness and knowledge*, and 6: *Taking action on mental health at work* provide a narrative of interview findings with illustrative quotes and descriptive statistics.

Chapter *7: Impact of the training* reports on the impact of the training in statistical terms. Chapter *8: Synthesis of findings and conclusions* section provides that, and answers to RSSB's research questions provided in the specification of this work.

3: Participant characteristics

This chapter describes the participants involved in the study, including their starting point with respect to the training subject matter and motivations to be involved.

Employment background

The study was successful in reaching individuals across the industry and a breakdown by job function is shown in Table 3. The most common categories were train staff and infrastructure.

Table 3 - Employment profile of participants

Employment type	%	(N)
Infrastructure	14.9	30
National delivery	1.9	4
Ops and customer service	7.9	17
Station staff	0.9	2
Train staff	22.8	49
Other	52.6	113
Total	100	215

Most (51.9 %) had worked in the industry for more than 11 years. This has implications for the potential of the rail industry to be influenced by other sectors: low turnover can result in an inward-looking perspective. On the other hand this means, for the most part, that the benefits of any training delivered are likely to stay within the industry.

Table 4 - Time employed in the rail industry

	%	(N)
Less than one year	5.6	12
1-5 years	27.6	59
6-10 years	10.3	22
11-20 years	24.8	53
More than 20 years	27.1	58
Not applicable	4.7	10
Total	100	214

Most participants came from England but, as previously described, participation extended into Scotland and Wales. The distribution across locations was affected by the size of the companies participating and/or the numbers of employees they were able to recruit to the study. A full breakdown of the demographic characteristics of participants can be found in Appendix Part C.

Table 5 - Role and responsibilities

Number of direct reports	%	(N)
0	10.8	23
1	5.1	11
2 or 3	13.4	29
4 or 5	11.5	25
More than 5 but less than 10	19.4	42
More than 10	39.0	83
Total	100	213

It was typical for LMs to report managing teams up to 9 but a sizable proportion (39 per cent) reported managing 10 or more. It is not known how many participants were managing direct reports in geographically remote places, but anecdotal reports of this frequently featured in interviews and during training observations.

Experience of managing mental health issues at work

50.2 per cent reported experience of (knowingly) managing someone with a diagnosed mental health problem. A similar proportion of interview participants reported some experience of dealing with MH issues at work. Depression and anxiety were frequently mentioned, but there had also been exposure to more unusual and severe examples of poor mental health such as self-harm and psychosis.

Table 6 - Managing mental health problems at work

	%	(N)
Experience of managing someone with a diagnosed mental health problem	50.2	106
Experience of managing, someone at work who appears stressed, in a low mood or in poor mental health	75.0	159

Table 6 - Managing mental health problems at work

	%	(N)
Experience of managing someone who has taken time off from work as a result of stress, low mood, or poor mental health	66.4	140

Many LMs who participated in the interviews felt that, prior to the training, they were endeavouring to be both compassionate and practical in their approach to mental health and wellbeing. For example a participant in a senior technical role described his experience of managing a member of staff who takes medication for anxiety. He felt it was normal in their working relationship to have open discussions around this and to consult her on how to support her to work as effectively as possible.

However some LMs described a tension between managing performance and showing concern. Circumstances where disciplinary or capability procedures had been actioned by HR had felt particularly difficult. One LM had maintained a line of communication via email but had felt guidance and support for them as a manager had been lacking.

> *My experience of this at the time was how disconnected I felt because that person effectively withdrew immediately from the moment they were made aware that they would be going through this procedure.*
>
> Face-to-face training participant

As a result of having a team member who suffered from poor mental health, one face-to-face trainee had learned to look out for symptoms of poor mental health, not 'to wait for them to come to me'. Some participants said that before the training they were already 'checking in' on wellbeing during 1-2-1s and being more watchful generally about the mental wellbeing of their direct reports.

One participant described successfully managing an individual back to work who had taken time off with stress. Speaking more generally he identified communication as the biggest hurdle to approaching this issue with a direct report.

> *The biggest challenge is the initial approach, knowing the individual well enough to see those visible signs of stress that are out of the ordinary, then to start that dialogue and conversation.*
>
> E-learning participant

Another observation from the same person was that there had been more openness about this topic of late, but practical information for managers to help them manage situations proactively had been lacking, ie the so-called 'what to do if…' processes.

Workplace culture and industry pressures

As would be expected, reported pressures in sections of the industry varied considerably according to job role and employment context. Reported stressors (on LMs as well as direct reports) centred on interactions with other people – dealing with not only members of the public, but also colleagues and partners could be stressful, particularly when different working cultures were required to co-operate with one another.

For example large infrastructure projects have the multiple pressures of working to tight deadlines and tasking contractors with competing priorities, in some circumstances amid government scrutiny of progress. Several participants mentioned the fast-paced nature of this work and the high emotions this could provoke.

A participant who had worked in the energy sector in the past felt that his previous employers had been 'generally quite good at dealing with this kind of thing', but described their current company as 'a bit slow' with respect to mental health. He thought that the processes for LMs to deal with staff who have mental health problems were not as embedded in management and HR processes as they could have been.

An aspect of rail infrastructure that was referred to frequently was the temporary or permanent geographical separation of teams. Staff could be working remotely from their managers and there was reportedly a lot of reliance on telephone communications. More than one participant described finding ways around this.

> *There have been times when I've given [another line manager] a call and suggested that they call [their direct report] because they're not looking right today, just to find out if there is anything that we should know about.*
>
> Face-to-face training participant

Awareness and profile of MH

The rail industry culture, viewed as a whole, was not generally seen as progressive in its attitudes towards mental health. However there was consensus that there had been small, positive changes recently and that there was the will to change.

> *[My organisation] have done a great job of getting awareness out there, and I think it's a much more acceptable thing to talk about now. When I first started working you would never go off with stress. There was more stigma around mental capability to do the job.*
>
> Face-to-face training participant

The male-dominated nature of many areas of the industry was seen as an important and possibly limiting factor in achieving change, and the difficulty of shifting mind sets on a company-wide or sector wide basis was acknowledged.

The company is really working towards helping an understanding of this area, but it's a largely male engineering environment, and men deal with this topic in quite a different way.

E-learning participant

Among accounts of a shift in recent years, there were also indications of attitudes that were less progressive, for example difficulties calling MH by its name and persisting tendencies to attribute mental health sick leave to physical causes.

Participants frequently referred to the mix of cultures within the rail industry and also the variation within and between companies.

One view was that corporate environments within the industry had a more accepting culture of MH and were more outward looking because higher staff turnover resulted in more people from other companies. The physical presence of an HR function with a diversity and inclusion focus was also seen as an influential factor.

[Company name] are really good at the wellbeing and communication, they try really hard and are serious about it. Messages come down from leaders, at corporate events, the intranet, and mandatory education and learning.

Face-to-face training participant

This was contrasted with the experience of those working out on the railways.

[At our company HQ] the attitude is very much to do with openly promoting good MH and having these conversations. Out on the coal face of the railway the turnover is less frequent and you tend to have a lot more embedded attitudes to these kinds of things.

E-learning participant

A common observation was that the rail industry has many employees who have been in the role for 20 to 30 years; this was thought to limit the potential for changes in other industries to filter through.

I think the rail industry tries extremely hard to recognise MH and manage it, but has very embedded behaviours across the whole business, from the people in the orange through to the senior execs in the offices.

Face-to-face training participant

Participants highlighted large infrastructure projects as environments that require employees from a mix of working cultures to work together, and indicated that some of these are more enlightened than others about mental health (such as parts of the civil service and private construction companies). It was acknowledged that this mix could create challenges (like stress) as well as opportunities (such as to learn).

Perceived need for the training

A participant who had already supported team members to stay in or return to work because of MH issues felt adequate processes were in place to support these processes. However he pointed out that this was within a senior leadership team context where 'open conversations can take place'. He felt LMs in other parts of the organisation were less privileged?

> *They would be highly supportive but I don't think they'd have the tools or framework to deal with it other than through escalation and going back to HR.*
>
> E-learning participant

Around half of participants (52 per cent) reported that they had attended mental health training before. Interviews indicated that there was a tendency for these this to have taken place relatively recently, consistent with the rapidly growing profile of mental health in the workplace and in rail in the last five years.

Table 7 - Prior experience of relevant training

Training course name or type	%	(N)
Mental health First Aid (MHFA)	8.2	16
Mental health awareness	23.2	46
Managing stress at work	21.4	41
Resilience	13.7	26
Trauma Risk Management (TRiM)	4.9	9
Samaritans Managing Suicidal Contacts	20.1	39
Samaritans Trauma Support Training (Back on Track)	14.1	27
Other	7.8	7
Total	113.4	211

In the interviews several other interventions, including training courses and in-depth briefings, were mentioned by name. In many cases prior training had focused on first response: what do when encountering an individual in a crisis. Other programmes had focussed on stress and resilience. Several participants were able to identify clear differences in emphasis in the current training particularly in regard to its practical focus. For example a manager in the construction sector (a face-to face training participant) particularly appreciated the understanding of organisational context in Mind's training and felt this had been lacking in previous training provision.

Motivations for participation and appetite for training

In contrast with traditional training opportunities, participants volunteered for this study with the knowledge that they could be allocated to a control group. Most of the LMs taking part in the study (62 per cent) were motivated by personal interest in the topic. Among other reasons given (the question allowed participants to select multiple options) were 'encouragement from managers/HR' as a reason (41 per cent) as and wanting to increase their confidence in supporting staff (32 per cent).

Table 8 - Reasons for taking part in study

Option selected	%	(N)
I was encouraged by managers/ HR	41.30	88
I was encouraged by colleagues	6.10	13
I have a personal interest in the topic	61.50	131
I was hoping to be allocated to the face-to-face training group.	15.00	32
I was hoping to be allocated to the e-learning training group.	3.80	8
I have had to support staff with mental health difficulties and want to increase my confidence	31.50	67
Other / Prefer not to say	6.60	14
Total	1.40	3

Among interviewees the appetite for training was particularly obvious where there had been significant organisational change and, as a consequence, training for line management was felt to have been overlooked.

> *Managerial responsibilities get tagged onto somebody's already busy job, and some individuals who may not have an awareness of mental health are suddenly managing nine people and [they] can sometimes think 'oh they can manage themselves I've got a lot of work to do'.*
>
> E-learning participant

A primary motivating factor for one manager had been her own experience of absence with work-related stress. She had felt unsupported and 'let down' and wanted her own direct reports to have a better experience. Several others had volunteered because they had been personally affected by poor mental health, and one had been personally impacted by the suicide of someone close to them.

I like to think that I consider MH when I'm line managing, though I was doing this before the training too. [Personal events] have completely changed how I think about MH and I am able to bring my experience to how I consider MH with my people.

E-learning participant

In considering the study's findings, it is important to take on board the high level of interest in the area of mental health that is apparent in many interview quotes. As in many studies, a self-selecting audience can be more positively pre-disposed towards the intervention being tested than a mandated audience, so this potential bias should be borne in mind.

The next three chapters are focused on different areas of change consistent with the model set out by Kirkpatrick[4].

- Reaction: what participants thought and felt about the training and the way it was delivered (satisfaction, 'happy sheets')
- Learning: resultant increase in knowledge and/or skills and/or change in attitudes
- Behaviour – transfer of knowledge, skills, and/or attitudes from classroom to the job (eg change in job behaviour due to training programme)

4 Steensma H and Groeneveld K (2010), 'Evaluating training using the "four levels model', Journal of Workplace Learning, Vol. 22 (5), pp.319-331

4: Reactions to the training

This chapter describes participants' thoughts about both types of training methods and their fit with individual learning preferences. Aspects of delivery and reactions to this are also discussed in detail.

General views

Both types of training were met with high levels of approval, although more face-to-face training participants said they would recommend the training to a colleague than those participating in e-learning (95 per cent vs. 59 per cent). Note that this difference does not translate to the measures of training effectiveness as reported in Chapter 8. All of the interviewees were positive about the focus on LMs and felt they had accessed a high quality product.

> *I've never had anything as good quality as the Mind input before.*
>
> Face-to-face training participant

> *Informative, helpful, interesting, and engaging. Lots of useful techniques and blooming helpful.*
>
> E-learning participant

Some felt the involvement of Mind provided reassurance of the quality of the training and in several of the interviews it was compared favourably with prior training people had received addressing the same topic.

Table 9 - Satisfaction with training

	%	Very satisfied	Satisfied	Neutral	Dis-satisfied	Very dis-satisfied	(N)
Overall, how satisfied or dissatisfied were you with this training session?	F-t-f	42.9	46.8	6.5	0.0	3.9	85
	E-learning	33.3	63.5	1.6	1.6	0.0	74

It was unusual for dissatisfaction to be expressed. In one case an individual felt that another initiative in his sector had been more influential to his attitudes and beliefs around MH, which had possibly limited the impact this training might have made.

> *It was good training but I'm not sure there's something I can pinpoint that stood out for me or that I hadn't been thoughtful of.*
>
> E-learning participant

Relevance and usefulness of content

Consistent with Mind's intention to make their training generic to most working environments, the vast majority of participants across both training groups were satisfied with the level of applicability to their industry. One other indication of its relevance was that the training prompted several participants to think of previous instances which, with hindsight, they could have handled better.

> *There were some useful tips and tools in there, things I recognised from my own experience thinking: 'yes, that would have been helpful for me to know then.*
>
> E-learning participant

A particularly emphatic endorsement came from an engineer working on a large infrastructure project who noted that other contractor who were also in the group were 'clearly engaged very actively with it all'. The same participant had been involved in group discussions with staff from a freight operator and felt they had actively engaged with the content as well.

> *It definitely spoke to the challenges they face in terms of lone working and the stress of that job and the suicide risk, that's a lot of responsibility.*
>
> Face-to-face training participant

Several observations about course content centred on its compatibility with 'just being a good line manager' and having an open and authentic approach. Therefore managers possibly more well-versed on soft skills found some parts quite generic and more about good people management.

> *So you could actually strip a lot of the MH away from it and what it's essentially saying is 'just be a good LM and be open and approachable', which is transferable to many other things.*
>
> Face-to-face training participant

There were concerns that Mind overestimated the accessibility of HR support, the level of familiarity LMs have with 'who does what' and the ease of getting in touch with a geographically distant function.

Some participants would have welcomed more content on their own mental health, particularly when they reflected on situations that could be emotionally demanding to manage (such as absence cases that had resulted in escalation such as disciplinary action).

> *You've got the LM's MH to worry about as well. That even though you're senior, you can be also having a tough time and hide it.*
>
> Face-to-face training participant

Some e-learning participants thought that the examples and videos were skewed towards office workers, and issues arising from the site-based element of the rail industry were missed. It was also felt that some stressors prevalent in the rail industry were not addressed directly, including long hours, shift work and fatigue. A minority said they would have preferred a more tailored e-learning package.

After the training, some e-learners were not sure that they would know how to initiate a conversation, and one participant suggested that by doing the face-to-face training 'maybe you could act out these scenarios'.

There were also thoughts about further roll-out and what would happen if e-learning was mandatory with concerns that some managers would 'skip through it and not really engage'.

Delivery and format

Clarity of delivery and pace of learning

Table 10 - Accessibility of face-to-face training and e-learning

	(%)	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	(N)
The information given was clear and easy to understand.	F-t-f	3.9	0.0	1.3	39.0	55.8	85
	E-learning	1.6	1.6	0.0	52.4	44.4	74
The information was presented at a pace I could follow.	F-t-f	3.9	1.3	5.2	33.8	55.8	85
	E-learning	1.6	0.0	1.6	50.8	46.0	74

The length of the face-to-face training was felt to be about right, although some felt the complexity of the topic could have merited an extra hour or two. Comments included 'people at all levels of the organisation should receive similar training like this'.

Those participating in the e-learning offered a wider range of thoughts about its pace and general tone. Feedback was positive about the pace of learning, and it was described as 'not patronising'. The interface was described as easy to navigate.

> *I can't fault it in that way actually it was quite succinct; the key points weren't lost among a lot of jargon.*
>
> E-learning participant

It was pitched at a very good level…too often with e-learning courses they are either too slow or too fast and you're not able to flick through content and animations you may have known before.

E-learning participant

On the whole, those with prior training on the topic felt there was good consistency and where there was overlap it had not been wasted time.

[The courses] tended to reinforce each other which was quite refreshing and certainly not a bad thing.

E-learning participant

Table 11 - Duration of face-to-face training and e-learning

		Too long (%)	About right (%)	Too short (%)	Not sure (%)	(N)
The length of the training was:	F-t-f	5.2	77.9	14.3	2.6	85
	E-learning	9.5	87.3	3.2	0.0	74

Participants' comments suggested there was low potential for fatigue with the e-learning as the learner could pause at any time. Others valued being able to click quickly through material more familiar to them.

One participant wanted to take notes during the e-learning, and found themselves pausing it throughout to do so, which made the training a little longer. They would like to have extended access to the training, so they could check what to do should a team member need support in future.

A minority view was that the face-to-face training was too short, and that it had felt more like a taster. Perhaps inevitably for such a complex topic, some felt that it had only 'scratched the surface'.

Presentation style

Table 12 - Balance of presentation styles used in face-to-face training and e- learning

	F-t-f (%)	(N)
There was too much time spent listening to presentations.	10.4	8
The balance was about right with a mix of presentations and interactive elements	85.7	66
There was too much time spent on interactive elements	0	0
Not sure	3.9	3

Reactions to face-to-face training

An obvious advantage of the face-to-face format was the opportunity for interaction, not just with the trainer, but with other LMs from within and between companies. It was felt their experiences offered insight into how principles from the training had real-life applicability in the workplace and allowed knowledge to be picked up on an ad hoc basis.

> *You were able to hear direct thoughts from other people and their personal experiences, and see that people were happy to talk about their personal experiences. This was quite interesting, because you were able to put that into context for the job that you do and apply to people who might be feeling similar.*
>
> Face-to-face training participant

As well as access to opinions and experiences of other trainees, the trainers were frequently described as 'upfront' and honest. Their willingness to talk about their own experiences was felt to add credibility to the course content.

> *I thought it was done in a really nice way so that people could express what they wanted to and not worry about what others might think, and actually feel positive about it even if it was about a difficult topic.*
>
> Face-to-face training participant

On a more personal level, participants felt the trainers were personally invested in the topic in an authentic way. They were also perceptive and good at eliciting involvement from those who engaged less.

There were mixed views about the ratio of content versus group engagement; this seemed to be a matter of personal preference.

> *I think we did a bit too much group chat and a bit too little discussion of some of the slides.*
>
> Face-to-face training participant

There was relief that the trainer 'didn't rely solely on PowerPoint' and was open to answering questions. The video that the trainer used at the end of the session about having more open conversations also met with approval.

There were some suggestions for improvement, usually centring on course materials, such as a preference for receiving slides at the beginning (to write on); also some participants would have liked additional resources and hand-outs to take away and refer to later.

Reactions to e-learning

The presentation style of the e-learning course was viewed positively and the lack of large quantities of dense text was appreciated. Participants were generally positive about the variety of approaches used in the e-learning, which included slide-based presentations, 'talking heads' and mini-quizzes. There were also opportunities to download materials.

> *It was good; I thought the length was just right. I thought it stretched into different areas and was quite visual and helped you understand. I liked that you could download things for future reference; this was the best thing for me and I downloaded quite a lot of the articles.*
>
> E-learning participant

Delivery and modular format

Several participants singled out the videos of individuals talking about their own mental health experiences as particularly helpful. Many participants also thought the video content demonstrating signs and symptoms was effective. It allowed them to think more deeply about what they knew already and had learnt during the training in a real-life scenario.

In a minority of cases participants said they would have preferred a more interactive form of learning.

> *I'm a doer rather than a reader. For something as important as this, personally I would feel that a classroom-based session where I could discuss things or maybe role-play would be more helpful.*
>
> E-learning participant

There was agreement that the e-learning format would suit those who don't have time to attend a face-to-face course but might find it realistic to fit one module at a time around a busy work schedule. Participants liked the potential to 'dip in and out' as well as having the option of watching videos in part, to their full duration, or several times. For many this seemed to fit their preferred style of learning.

> *It was useful that it was broken into chunks, which were long enough for you to concentrate and get something substantial out of it, but not so long that you had to rearrange your diary. It was manageable.*
>
> E-learning participant

> *One advantage of doing it online rather than sitting in a room, was the fact that you could stop if you needed a break to go and get a brew and clear your head a bit. You could do it at whatever time you wanted.*
>
> E-learning participant

Ideally most e-learning participants said they had to complete the modules more quickly than they would have preferred because of research timetable constraints. Others had completed it in one go for fear of starting it and forgetting or not getting around to doing the rest.

> *For me I thought if I don't do it in one go, having volunteered to do it, there was a danger that it might not get done.*
>
> E-learning participant

A participant working in the construction sector felt she derived the most from the training by allotting undistracted time to work through the whole thing.

> *I blocked out in my calendar and tried to treat it like I was on a proper training course which I think works better than dipping in and out of it. I think it's something you probably need to immerse yourself in without any distractions, but whether everyone would do that is another issue.*
>
> E-learning participant

Some participants thought it would be difficult to access e-learning 'in the operational world'; some workers would not have sufficient access to a laptop or computer. It was felt that face-to-face training or briefings would work better in some roles where there were fewer opportunities for scheduled screen time.

There was a feeling among some e-learners that the training fell short with respect to leaving them fully equipped to do things differently, and thought that face-to-face training would have offered more benefits.

> *I would recommend it, because I think it's better than not doing anything at all. But I think it's more valuable to do an in-person course where you can ask questions and also hear from the experiences of others. And I know you hear from some experiences in the videos, but it's not quite the same as being able to go 'oh, and what did you do when?'*
>
> E-learning participant

Accessibility and user-friendliness

In general the interface was easy to navigate and all the videos played well. The tests met with a mixed reception.

> *I found the module 1 test to be a lot about remembering certain stats rather than broad themes, depending on how good you are at remembering figures in this situation.*
>
> E-learning participant

There were some minor complaints about being directed to different sites to download documents at multiple points throughout the e-learning, which they found rather distracting and jarring. The chance to download these at the end of the e-learning in one go was suggested as a preferable option. One participant said they would have like liked summary notes with links to the documents referred to for future reference.

> *My one regret now that I've completed it is that I didn't keep a folder for myself so that I could easily dip back into that information.*
>
> E-learning participant

There were some minor complaints about not being be able to download documents all in one go (such as WAP) rather than, as offered, at different times throughout the training. Some participants had looked at the action plan but there were few reports of saving documents down.

5: Awareness and knowledge

This chapter reports data from the participant interviews. It focuses on the topic areas covered by the training and, in particular, lessons participants felt they could apply in their LM roles.

Awareness about mental health and challenging stigma

The training emphasised the proactive nature of managing wellbeing and promoted a watchful approach to line management. Participants in both groups said they had come away with a heightened awareness of small changes that could be indicative of someone struggling.

> *[The training] made me think that there are a few things that I should be watching out for. A few things that I think, in the past, I may have dismissed as slight eccentricities when, actually, I should be thinking of them as warning signs.*
>
> Face-to-face training participant

The training also prompted new understanding of stress and its causes. For example one participant said that he had not appreciated before that tiredness could often be attributed to mental rather than physical exertion. There was also new appreciation of the contribution of other lifestyle factors such as diet, sleep and use of alcohol to mental wellbeing.

Importantly there was new awareness of what good mental health looked like and one idea that chimed from both forms of training was about MH being on a spectrum and that a healthy individual's MH could move up and down regularly, even within the course of a day.

> *I hadn't thought about it before, that you have good days and bad days the same as physical health. It sounds obvious now but it wasn't when I went in. Before I'd thought about it almost like a switch.*
>
> Face-to-face participant

Another issue reported to hit home was the idea that 'work is good for your MH'. One participant described how he could relate to that because his job had offered a sense of purpose and belonging when he experienced marital breakdown.

Among participants who already felt quite informed about MH issues there were no indications that the training was redundant in these circumstances; often they reported that the training refreshed prior knowledge or offered a fresh perspective. Likewise some participants who already considered themselves open-minded noted that they had

learned valuable detail about the various manifestations of poor MH and/or particular mental health problems and the symptoms associated with them.

Attitudes and stigma

Interviews indicated that participants, as volunteers to the study (hence there was a potential bias), tended not to hold negative prejudices about mental health. For example, several already perceived parity of MH with physical health before the training. However, there were many comments along the lines of the training being 'eye opening' and challenging old ways of thinking.

Some participants had not thought about the effects of life events on mental health. It was helpful for some to have the link between bereavement and mental ill health made explicit. This served to normalise poor mental health and show how everyone was vulnerable.

Shared experiences and personal disclosures during face-to-face training allowed some participants to find out directly that MH issues were more common than they realised. This offered a fresh perspective to those less familiar with the topic.

> *One of the things that struck me on the course was that, although I don't have anyone in my immediate team who are suffering from issues, there were other people I knew on the course [from their organisation]. From some of the things they said, I realised there were more and more people in the wider organisation who are having issues. The was no identification of individuals, but the fact these people were talking about things in their own area made me think that it's closer to home than I thought. So that was a bit of a wakeup call.*
>
> Face-to-face training participant

There were some insights which arose from personal reflections on past situations. One manager said he could now look more sympathetically at employees who he has seen in the past as 'playing the blame game', when they said mistakes were not their fault and attributed responsibility elsewhere. Following the training he was more inclined to see this as a defence mechanism that some people used when they were highly stressed, and that he should see that as a cue to action.

One interview offered an interesting perspective of the motivations behind the survey responses on stigmatisation. An e-learning participant said that after training he still held the same view on whether he would vote for a politician if they'd experienced MH issues (he said he would not) on the basis of the stress he associated with political roles. Arguably face-to-face training would have allowed this perspective to be challenged (with the idea that lived experience can bring useful insights to many roles). Obviously e-learning obviously cannot offer this option.

Managing mental health at work

Communication skills and confidence

A small number of participants articulated a new confidence in talking about issues and tackling the subject of mental health more generally. New (or renewed) awareness of issues helped them feel they could better respond to workplace difficulties with implications for a colleague's mental wellbeing. Interestingly e-learning was just as likely to have led to this type of change as face-to face training.

> *It's raised my awareness, it's raised my confidence to deal with any situations that come up and, perhaps, deal with things before situations need to come up, like if I think something's not right with somebody.*
>
> E-learning participant

There was recognition of the need to get the context right as well as the content of conversations. There was also acknowledgement that people were less likely to open up unless a 'safe space' was created to help them do so. Another important learning point was about the boundaries of the LM role. It was reassuring to several participants that they were not expected to be mental health experts.

> *I think it's one of those things that, I'm never going to be an expert, I'm not a psychologist, I don't do it as a professional. So I will always be a bit nervous about getting it right but I think that the techniques are well explained and, provided you keep that in your head, stick to those techniques and don't try to own the problem, then I think it's very good.*
>
> E-learning participant

Some of the actions resulting from increased confidence in this area are described in the next section.

Promoting wellbeing and talking about mental health

A message apparently received loud and clear was the importance of building good relationships with direct reports and initiating open conversations. This allows a proactive approach to wellbeing to be taken so that problematic issues can be identified early and support can be offered potentially before a situation escalates into a health issue.

> *I think what did come out of it was not necessarily just relying on those 1-2-1 sessions…it's also a case of looking at how people are during the course of the month, rather than just a given hour every month to see generally how they are.*
>
> Face-to-face training participant

More than one trainee highlighted the examples the trainer offered on how to word questions about mental health in a way that felt comfortable to them and their direct reports. For example rather than directly asking 'how is your mental health', it was suggested that 'how have you been feeling lately?' or 'how are things outside work?' could work better.

Some managers felt they had this confidence anyway (a female participant described her own version of this behaviour as 'mothering') but they were glad of the reassurance that they had been doing the right thing.

> *[I learned] to keep that practice [ie checking regularly whether direct reports are alright], up I suppose, and know [now] that this is the right thing to do.*
>
> Face-to-face training participant

Wellness Action Plans[5] (WAPs) are recommended by Mind as an approach to helping support the mental health of individuals at work. Although this was a completely new idea to almost all participants, many felt positive about conducting them and it was thought that introducing this process might have the potential to reduce sickness absence in the long run.

One face-to-face attendee had been a member of the CIPD and so had done a lot of 'people planning', but had never heard of a plan for MH and thought this was a powerful idea.

> *The Wellness Action Plans I really liked and I want to give a bit more thought to that. I may even do a bit of a session about it in one of my team meetings, build on the stuff that's available…Just to get people thinking about what they can do and get it out into the open a bit.*
>
> (E-learning participant)

The main appeal of this approach was the *'logic and method'* behind it; the structured format.

The training highlighted that some LMs were keen to take ownership for this process and one suggested that training materials should be in the same place on the staff intranet as the hotline available for sickness and MH.

> *I think now I've had the training if I was presented with a case, I would reference the material [Wellness Action Plan in particular] to go back to, and I would like the material to be readily available through the organisation I work for.*
>
> (E-learning participant)

5 https://www.mind.org.uk/workplace/mental-health-at-work/taking-care-of-your-staff/employer-resources/wellness-action-plan-download/

Participants were asked if they thought that their direct reports would have noticed a difference in their management approach after the training. A number said they would like to think that their colleagues have noticed a difference but were not sure they actually had and thought this would take time.

Managing absence and making workplace adjustments

Many recipients within each training group felt their knowledge of practical steps to take in this situation had increased. However it was unusual for them to report that they would manage absence differently as a result of the training. This was often because they felt they would be unsupported to do so and/or that processes were in place that were seen as rigid.

> *It's not a failing of the training by any means, but it assumes that that support would be there …the people who do the training cannot guarantee that your own industry or company does have that support.*
>
> E-learning participant

In relation to making adjustments, the main message participants had taken was the importance of listening to what the individual needs for their own situation. For some there was new confidence about 'striking a balance' between the needs of a person and the needs of the business. Others felt more empowered to let the absentee talk about their requirements.

One e-learner felt that the training enabled him to work towards making improvements in this area within the context of his company policy; a stand out learning point had been the usefulness of developing a personal action plan for return to work and making adjustments.

Another was committed to managing RTW in a thoughtful way, motivated in part from her own experience of depression and in part by the training.

> *If you broke your leg, you wouldn't go back and do exactly the same thing again! So you have to look at what has happened at work. Something at work needs to change before you go back.*
>
> E-learning participant

A recipient of face-to-face training highlighted the difficulty of balancing concern with business needs; showing empathy while at the same time *'making sure that their problems are not used as an excuse to perform poorly'*. They felt that the training had successfully tackled approaching those situations head on.

Both courses covered the tricky task of handling a conversation with someone whose performance may have been affected by symptoms of poor mental health. This covered the importance of planning and giving the other person sufficient space for them to volunteer information.

Others thought that the training validated what they were already doing but felt it was valuable to hear *'this is the right way to approach things'*, so that they could have more confidence in continuing to manage people in that way.

Supporting a person experiencing a mental health problem

It was welcome news for some managers that simple approaches that were relatively easy to apply could make a difference. The interviews indicated that e-learners benefitted from this type of information as much as those receiving face-to face training.

> *It was about just having the conversation, giving them the space to just talk. So it was just the little things…slowing everything down… to allow those silences.*
>
> E-learning participant

The training addressed dealing with someone showing signs of distress, which can be daunting for some. Several participants reported their wariness in relation to this and fear of making a situation worse or appearing insensitive. The training was felt to be reassuring as it spelled out simple approaches and emphasised that LMs could not and should not be expected to react like specialists.

> *I can personally feel 'are we doing the right thing?' to the point of such paralysis about potentially saying the wrong thing to somebody. The training gave me some confidence in just being there for somebody and keeping it simple. You don't have to be an expert in the field, to just be honest when we don't know things.*
>
> Face-to-face training participant

Participants appreciated clear information about what action to take and, perhaps more importantly, clarification of the kinds of situations that lay beyond their remit as a LM and required escalation. One participant talked of a culture where *'we always do our best to fix things'* and found it helpful to learn *'when you do just need to step back and, potentially, call an ambulance'*.

It was noted that the training on escalating a matter within the company was *'generic'* and participants felt that the onus was somewhat on them to go away and research what their own company offered.

> *I need to look at what support our company does offer in that situation. [Company name] are quite good at advertising stuff on our website, though it would be good if it was all together in one place.*
>
> E-learning participant

6: Taking action on mental health at work

This chapter focusses on tangible impacts of the training on the LM role and explores reasons why some participants had not been able to apply their training in practice. These findings concern training participants only; it does not compare these effects with the behaviours of the control group. Statistical comparisons of this type are described in the next chapter.

Changes made since the training

Reacting to situations with new awareness

There was a tendency for participants to report changes in mind-set, such as being more reflective, *'not just reacting to a situation but considering it more'*. Others said they were more mindful of the *'taking the temperature'* process advocated by Mind when dealing with direct reports, and *'being more aware of how they're doing'*.

After taking on board the importance of listening rather than trying to find solutions one participant felt she was now more inclined to sit down and think about how to approach a difficult situation. Helped by the course she had now come to realise that helping people with poor mental health is a long, on-going process.

> *[It taught me] to listen and not come up with solutions. I'm a natural problem solver, so if somebody comes to me with a problem I try and solve it. But sometimes that solution isn't something that you come up with [independently]; it's a solution that they have to come up with.*
>
> Face-to-face training participant

This new awareness had led to one participant being more reflective about their own mental health, and having a conversation with their own LM about stress as a consequence of this. This represented a significant step for that individual who did not feel he would have done so otherwise.

> *That has never been a consideration of mine to do that, so the fact that I've done that so soon after doing the training probably isn't a coincidence. It's probably given me the confidence to say 'actually, there is support out there and all you have to do is have that conversation and seek it out'. So, in that respect, I think it has been incredibly beneficial.*
>
> E-learning participant

Having conversations about mental health

Some LMs were not able to report an immediate difference in their interactions with their direct reports at work but were giving the way they interacted with their direct reports this serious thought.

> *It definitely made me think I should probably spend more time to sit down on a one-to-one basis to check in with people in my team more often.*
>
> E-learning participant

Several participants declared positive intentions to go about the LM role differently and had been reflecting on what felt realistic and comfortable for them individually.

> *The next time I have a 1-2-1, it may be something I do broach…Rather than having a conversation about mental health issues, I may broach it by saying 'look, if you are having mental health issues then you can talk to me and we'll sort you out as best we can'…you'd like to think that's obvious, but if it hasn't be made explicit then it might not be obvious.*
>
> E-learning participant

It is interesting to note that e-learning, the least interactive mode of presentation, was effective in helping participants to feel empowered to have better, more open conversations about mental health.

> *It's given me more confidence on how to approach stuff. So around what conversations I can have, what I need to be looking at and, also, when you get to a certain point you might have to get others involved.*
>
> E-learning participant

> *I think it did revise my awareness of mental health I would say, and it also prompted me to talk about it in a team meeting which I probably wouldn't have done had I not done it.*
>
> E-learning participant

Some participants felt their conversational approach had already changed as a result of the training. One felt this was because he had acquired a more nuanced way of thinking about mental health which went beyond seeing MH purely in terms of stress.

> *Some of it was around having conversations, which I think I'm good at having with my people…it's just I never really had them in the same way as I do now. I could see people were stressed, but MH is not always about stress.*
>
> Face-to-face training participant

An experienced LM felt the training had made a huge difference already in this respect.

> *I was thinking about it in the context of how I could use all this in my current situation. So as well as being interested in it, I was thinking about how I could*

apply it. And I did when I spoke to my colleague, in my head I was applying what I'd learnt on the training to what I was doing. I've still got my notes, and I'm more comfortable talking to people, more probably now than I was before.

E-learning participant

As a result of the face-to face training one project manager gained the confidence to speak to an employee he had been concerned about for time. Although that individual didn't disclose anything formally, they had agreed to a Wellness Action Plan being formulated alongside their normal review process.

Those who were in positions of influence were able to affect the culture of their organisation more widely. In an example of the effects of the training being cascaded, a senior LM whose direct reports were also managers has taken the initiative to ask them to report on the wellbeing of their teams.

I'm certainly thinking about MH differently, and I think about my staff a lot more now, and I ask my team leaders about the wellbeing of their staff. I do it every time I meet with them now which I didn't before. Nothing major, but little things that I feel make a difference.

Face-to-face training participant

Another face- to face participant had created openings for mental health to be discussed in performance reviews, thereby incorporating messages from the training into standard HR processes.

A LM in a corporate role said she had felt more emboldened to voice concerns about situations that could put the wellbeing of others at risk. After the training she had spoken out on behalf of a direct report whose much needed leave was in jeopardy.

There was an issue this week where someone had booked annual leave but was also being called to a three line whip meeting by a very senior manager, more senior than me. I contacted them on my staff member's behalf and said that they've booked this day off, they've already cancelled two days off in the last fortnight and I don't want to ask them to cancel any more leave. They were excused from the meeting.

E-learning participant

Other actions to support wellbeing

Soon after the training one LM was required to make workplace adjustments for an employee experiencing a period of stress. In line with the training they collaborated in forming a plan.

> *[We were] looking at small adjustments that we could make around the nature of the work. So one thing I suggested was that, 'when people feel like this they may want to be at home, and I don't mind if you work from home, that's absolutely fine, we can talk by phone.' may want to be at home, and I don't mind if you work from home, that's absolutely fine, we can talk by phone.'*
>
> E-learning participant

As a consequence of the enthusiasm the training generated about Wellness Action Plans several participants had looked at the Mind website for further material on the topic and downloaded relevant documents.

Others had been prompted to seek out sources of help within their own company, either by looking at online material or talking to colleagues within HR. Before the training one LM had not known about the existence of his company's EAP or Mental Health First Aiders. At his next departmental meeting he planned to highlight these sources of support as well as *'my takeaways from Mind's training'*.

One operational head had circulated the notes from the training to their peers, and had raised the possibility of running some mental health awareness exercises at a company away day. As mentioned above there was a trend towards more senior individuals capitalising on their positions within the company to raise awareness. The options for those further down the management chain to influence wider company culture appeared to be (predictably) more limited.

Facilitators and barriers to implementing actions

Personal confidence and capability

A mark of the training's success is that there were no instances of LMs declaring an unwillingness or opposition to change in principle. Participation in both types of training appeared to result in significant buy-in to the aims and overall ethos embedded in Mind's training objectives.

It is an important finding that e-learning, the less interactive of the two training approaches, was successful in instilling an intention to make changes. However, for some people it may have fallen short of fully equipping people with the skills to enact those changes, and for some there was a gap between the desire to do things differently and the confidence to do so. The training brought about new awareness of many issues (as detailed in the previous chapter) but did not necessarily change behaviour.

For example, one e-learner thought he would be more confident in broaching a conversation around mental health than he was before, but didn't feel that the training provided the tools and techniques to do so. He did not feel the training provided the step-by-step guidance they would need in that situation.

> *The fact that I'm thinking of doing it [having a conversation with their direct report], that is down to the e-learning all by itself. How I would go about it, and how the e-learning may have given me those tools, I don't really think that is really there.*
>
> E-learning participant

Another e-learning participant felt the training did not leave him equipped to deal with a situation where obvious distress was apparent. He cited a situation that had occurred since where a colleague at a nearby desk was in tears and he did not know what the appropriate response would be.

> *I think it's a great cause which is why I volunteered to do the work, however I still don't feel equipped to deal with a situation where MH and distress is involved.*
>
> E-learning participant

A participant with an HR background with insight into training methods felt strongly that role-play exercises (not included in Mind's half day training due to time constraints) would be the most appropriate medium for training people in how to have difficult conversations or to interact with those they manage differently. She felt the e-learning course, as a one-off intervention, was insufficient to bring about change in LMs learning about these issues for the first time.

> *If [others] were managing somebody with a mental health issue for the first time, then it probably wouldn't be enough. As I say, it's better than nothing, it's useful, but probably not enough to give people a real understanding of how to deal with situations.*
>
> E-learning participant

However interviewees felt that some characteristics of the rail industry could serve as practical barriers to making changes outlined in the training, particularly features that hampered communication or relationship building.

In relation to making workplace adjustments, one e-learner felt he would forget what he needed to know by the time a situation arose and would like access to materials to fall back on.

> *It would be very useful for me to have the ideas and initiatives in the training as reference somewhere that I could access if the situation arises with one of my direct reports.*
>
> E-learning participant

A different e-learner felt similarly that the e-learning was not sufficient to help her bring about as many changes as she would like.

> *It's up to the manager and senior staff to show staff that we are supportive, that people can talk to us, and that there is lots of help on offer. Then this message does pass down. But I don't feel though that this is something I can do just from the e-learning, not enough of it has sunk in.*

E-learning participant

Lack of opportunity

It was typical for participants to feel in the weeks following the training that they had not had the chance to apply what they had learned. Several said they had not behaved differently with their direct reports, as they had seen no indication of stress or poor mental health.

Somewhat ironically, for some, pressures at work and/or working culture were felt to have got in the way of taking action.

> *The situation we're in is quite a difficult one, we're among the worst-hit department in terms of the pressure we're under, and I don't think people 'get' [mental health] that well or are quite tuned into it enough.*

Face-to-face training participant

Another participant felt he had simply been too busy to introduce the topic of MH into a conversation and because of business pressures his approach was more likely to be reactive than proactive. Also, like several other participants, there was an intention to raise wellbeing in 1-2-1s which had not yet manifested.

> *Various maintenance and engineering works are dominating everybody's thoughts right now, so one-to-one welfare conversations aren't happening. But if somebody comes to us with an issue then we'll deal with it, but at the moment we've got a lot going on; such is life.*

Face-to-face participant

Company infrastructure

Several participants reflected on the impermanent nature of teams and geographical distance as a challenge to applying the training. Some felt that the training could be more readily applied to an office environment and/or cultures where there was more continuity of working relationships.

> *One challenge I would say is that we're not necessarily all in one place, [in contrast to] a lot of jobs [where] you're in your office, that's your office, and you know who you're dealing with on a day in day out basis.*

Face-to-face participant

Because we're dispersed around the country, somebody's own LM might not be available to see how they're doing on a day-by-day basis

Face-to-face participant

As described in the last chapter a significant number of participants thought Wellness Action Plans were a good idea and could be workable in their environment.

However it was raised several times that implementing WAPs autonomously as a LM was not realistic and that LM activities are naturally constrained by existing processes and policy. There was an appetite to see the necessary infrastructure put in place to support their introduction with training on offer to those unfamiliar with it.

[HR would need to say] 'this is something we would like you to utilise and this is the template that you use'.

Face-to-face participant

It would be a significant step if the Wellness Action Plan got promoted as an explicit standardised template that LMs could also use a resource.

Face-to-face training participant

An e-learner thought that the Action Plan would be good as a form of risk assessment to use with direct reports but said that having access to a worked example would increase her confidence and the likelihood she would use it.

There was recognition that LMs could not achieve change within a company and, furthermore, that they would not always be the right person for staff to approach. Reflecting on the e-learning training a manager in the construction sector felt that his team could benefit from a MH champion or rep to be a reference point for other staff. This champion could be charged with reminding staff that the Mind resources are available on the intranet or as hard copies. He also felt the organisation could benefit from a Mental Health First Aider as a neutral point of contact.

Looking ahead

It was recognised that a critical mass of trained people would be needed to bring about real change. One participant with a safety role in a large infrastructure project contrasted their own *'more programme-focused'* company with the rail network more generally. He viewed the latter culture as less progressive and thought this was a challenge for the sector as a whole.

Similarly another participant working in a corporate environment noted the difficulty of pushing more progressive attitudes towards mental health out into the *'far corners of our business'* referring to more entrenched cultures remote from company headquarters.

We don't always get 90 or 100 per cent [buying into] these things and it's hard to get the traction.

E-learning participant

Regarding culture several felt that senior management needed to be direct recipients of the training.

> *If we can get a wide spectrum from the top to the bottom, because people speak to their peers about it. So you might not have all senior managers attend, [but] they're likely to speak to other senior managers about it. But if you can get a wide spectrum of people attending, then I think that would be quite beneficial.*
>
> Face-to-face training participant

Interestingly making its delivery more widespread would *'normalise'* the training and that would serve as a means of combatting stigma. A possible outcome of broadening its audience, (particularly if it became mandatory), would be that people would see it in a similar light as safety training.

> *It's like the fundamentals of physical safety in the workplace, or fire wardens, like all of those basics. But it isn't something a lot of people come across and some people will feel uncomfortable, so the more you make it 'normal' the better it will be for everybody.*
>
> E-learning participant

There was widespread optimism that this training represented an important first step and sent a signal to LMs about the expectations on them. It was apparent from the interviews that there is an increasing emphasis on acquisition of 'soft' people management skills in some parts of the sector and that Mind's training was in keeping with that.

> *I do feel that the organisation is on a path at the moment that is trying to get everybody to be trusting, confident and open. With MH being put within wider LM upskilling, all it can really do is to help keep that momentum, letting staff know that they can speak to their LMs, and LMs and bosses have to realise that if you take on that role, that's what comes with it too.*
>
> Face-to-face participant

A recurring theme was recognition that there is a long path towards organisational change and it is unlikely that colleagues who have not been trained would adhere to the principles of the training. However it was felt that was not a reason not to be the first. Among some participants there was a tangible sense of pride in being innovators.

> *Even if these behaviours are not consistent across the organisation, I know that my team realise I care about how they're doing.*
>
> E-learning participant

One participant expressed a hope that the training would encourage LMs to reach out and make a genuine connection with their staff. She felt that this would provide a basis for more open dialogue so that problems could be discussed before they potentially escalated into wellbeing concerns.

> *If this training can get the message across to more and more managers how important that regular connection is, where people may feel at one moment that they can share that they feel uncomfortable with their workload or that something is going on at home.*
>
> Face-to-face participant

The same participant felt strongly that checking on the wellbeing of others should be seen as normal and expected management behaviour. This required a culture change that may be some way off and could only be achieved incrementally. She believed that Mind's training could be instrumental to this.

> *In terms of the culture…if you go step by step, person by person, every time someone goes on that training [they will realise] that it is actually ok to keep asking people 'are you alright?'*
>
> Face-to-face participant

Participants were not directly asked whether further training would be helpful. An e-learner thought that it could be useful to follow up the e-learning with *'maybe a couple of hours'* of face-to-face training with the rest of his entire team.

> *I would certainly think it would be useful to have refreshers on it, [although] I think more than annually would be overdoing it.*
>
> E-learning participant

As reported in earlier chapters some participants felt they would have benefitted from summary notes to take away from their training. Others took notes because they were concerned they would not remember key points. Interestingly an e-learning participant who had received face-to-face training in the past about workplace mental health issues felt that Mind's e-learning had served as a *'good refresher'*. This suggests that some sort of support to implement the training would be welcome.

Another idea reported earlier, that making delivery more widespread would *'normalise'* the training is supportive of further roll-out. Comments indicating the incremental and slow nature of culture change are also consistent with this.

7: Impact of the training

This chapter focuses on statistical comparisons between the control group and the groups who received both types of training. It describes initial tests carried out to check that the composition of each group was similar. It also describes the results of factor analysis which was conducted to group survey responses in a statistically meaningful way and, in doing so, help interpret the survey data.

The chapter focuses on the findings of most relevance and interest in the context of RSSB's research questions. Additional technical details and charts can be found in the Appendix Part C.

Demographic details and response rates

In total, across all of the three training conditions, 216 individuals started at least one of the questionnaires that were administered during the various evaluation time points. Of those participants, 212 progressed beyond the demographic questions at the beginning and provided useable data for the analysis. Table 13 provides the response rate for each questionnaire.

Regarding demographics, overall 33 per cent of respondents who completed the baseline questionnaire identified as female. With respect to company type the largest group worked in infrastructure (34 per cent), followed by those working for contractors (32 per cent), TOCs (28 per cent) and FOCs (7 per cent). Further information about the demographic characteristics of those participating is provided in Appendix Part C.

Table 13 - Response rates at each phase of the evaluation

	Provided outcome data				
Group	**Pre**	**Post**	**Post response rate (%)**	**Follow-up**	**Follow-up response rate (%)**
Control	54	NA	NA	39	72.22
E-learning	73	62	84.93	33	45.21
Face-to-face	85	76	89.41	46	54.12
Total	**212**	**138**	**87.34**	**118**	**55.66**

A statistical test (chi square) was conducted to ensure there were no significant differences in between the groups at baseline, at the beginning of the study.

It confirmed that all training conditions and demographic groups behaved in the same way at baseline; this is a pre-requisite for an RCT design where it is important that any

observed differences can be attributed to the study intervention(s) and not any other influence (see Appendix Part C).

Identifying themes using factor analysis

To explore the impact of the training, exploratory factor analysis (EFA) was used to group related survey questions into underlying 'factors'. The aim was to identify factors comprised of a number of individual survey questions which, clustered together, measure an overall theme. This technique reduces the number of questions and allows analysis to take place at the 'theme' level. In total, four usable factors were extracted. A brief description of each extracted factor is below and full details can be found in Appendix Part C.

- Factor 1: Preparedness to take action as a manager (five items)
- Factor 2: Knowledge about mental health (three items)
- Factor 3: Attitude and misconceptions (four items)
- Factor 4: Confidence to talk about mental health (three items)

In order to be used in analysis factors have to be 'reliable', meaning that they accurately measure the underlying theme. Reliability is measured by Cronbach's alpha[6]; an alpha of 0.7 or greater means the factor is acceptable to use for analysis. All factors demonstrated a reliability score greater than 0.7, meaning they could be used in statistical analysis as outcome measures. Table 14 shows how the factors map on to questions used in the baseline, post-training and follow-up surveys.

Table 14 - Results of factor analysis

Item	Cronbach's Alpha
Factor 1: Preparedness to take action as a manager	
I understand what steps I can take to promote mental health and wellbeing at work.	.80
I know where to find information about mental health.	
I understand what a Wellness Action Plan is and how this can be used with a person I supervise to manage mental health and wellbeing in the workplace.	
I feel confident to manage situations where someone I manage is absent from work due to poor mental health.	
I know ways to manage risks associated with stress at work.	

6 Nunnally, J. C. (1978). Psychometric theory (2nd ed.). New York:McGraw-Hill

Table 14 - Results of factor analysis

Item	Cronbach's Alpha
Factor 2: Knowledge about mental health	
I have a good understanding of mental health issues.	.85
I can recognise signs that someone I manage may be experiencing a mental health problem.	
I know/understand what factors have a negative effect on mental health.	
Factor 3: Attitude and misconceptions	
Mental health problems indicate personal weakness.	.76
People with mental health problems are dangerous.	
If I had a mental health problem I would not tell anyone.	
I would not employ someone if I knew they had been diagnosed with a mental health condition.	
I would not vote for a politician if I knew they had been diagnosed with a mental health condition.	
Factor 4: Confidence to talk about mental health	
I feel confident that I am able to have a conversation about mental health with someone experiencing problems.	.82
If a friend had a mental health problem, I know what support to give them.	
I feel confident that I am able to have a conversation about mental health with my team.	

Analysis procedure

The analysis was conducted in two distinct phases.

Phase 1

The first phase was designed to assess the immediate impact of the training and sought to answer two questions:

1 Was there an improvement in the outcome measures immediately after the training?

2 Did outcomes differ depending on training group; so, was one training method more effective than the other?

To answer the questions above, survey data collected before the training (baseline/pre-training) was compared to the data collected immediately afterwards (post-training). This enabled the impact of the training as a whole to be investigated, as well as a comparison to be made between the two training conditions (e-learning and face-to-face).

The outcomes measured in the first phase were:

- preparedness to take action as a manager (five items)
- knowledge about mental health (three items)
- attitude and misconceptions (four items)
- confidence to talk about mental health (three items)
- knowledge about mental health (objectively measured using open-response questions).

Phase 2

The second phase of analysis explored the sustained impact of the training – outcomes in the longer-term – and sought to answer the following questions:

1 Was there a sustained improvement in outcome measures one month after the training?

2 Did longer-term outcomes differ depending on training group; so, was one training type better than the other in the longer-term?

To answer these questions, baseline data from each of the training groups was compared to the data from the follow-up survey and with data from the control group. In addition to the outcomes analysed in phase one, phase two also explored the impact on in-work behaviours. Changes of this type would not be expected immediately after the training so this was not addressed in the post-training survey.

For both phases, a two-way ANOVA with planned contrasts was used. This statistical test is very powerful because it matches the data for each participant over time. It allows

baseline data to be directly compared to their follow-up data, controlling for factors that cause any variation between the participants. If the test shows that differences over time and/or between time points are 'significant' this means they were very unlikely to have occurred due to chance.

However to be included in this type of analysis requires that participants must have completed the survey at each time point. Additionally, this test requires a number of assumptions to be met, and therefore the dataset must be carefully prepared before analysis.

Immediate impact of training – pre/post survey results

This 'pre- vs post' analysis explored the immediate impact of the training on all of the identified factors as well as objective measures of knowledge.

Factors 1-4 (Self-reported 'preparedness', 'knowledge', 'attitude' and 'confidence to talk about MH')

In a comparison of 'pre' and 'post' survey responses the results demonstrated that immediately after the training there was a statically significant improvement in all four areas identified by the factor analysis.

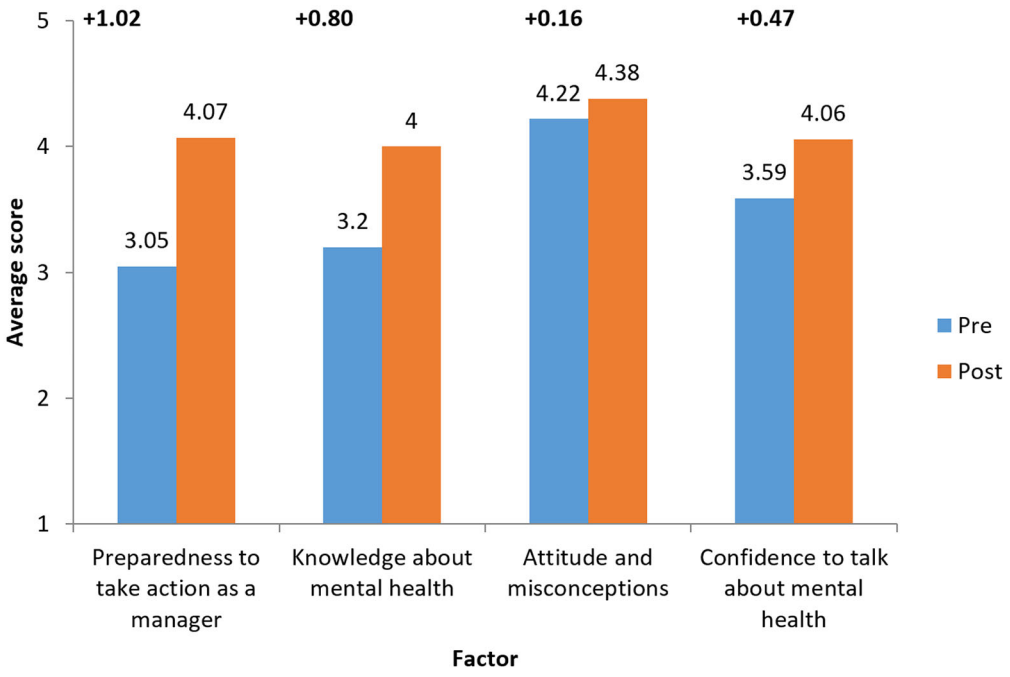
That is, regardless of training method, Mind's training appeared to have had a positive immediate effect on self-reported preparedness to manage MH, knowledge about MH, attitude towards MH and confidence to talk about mental health.

Further analysis explored any differences in the outcomes depending on which method (e-learning or face-to-face) a participant was assigned to. The findings showed that were no significant differences in performance between the training conditions on any factor.

A key finding therefore is that the e-learning and face-to-face training had a similar impact on the immediate outcomes.

Figure 2 shows the mean pre and post score for each outcome measure for both training conditions combined (as there were no significant differences between conditions) and the average change after the training.

Figure 2 - Average pre- and post-training scores, self-report factors

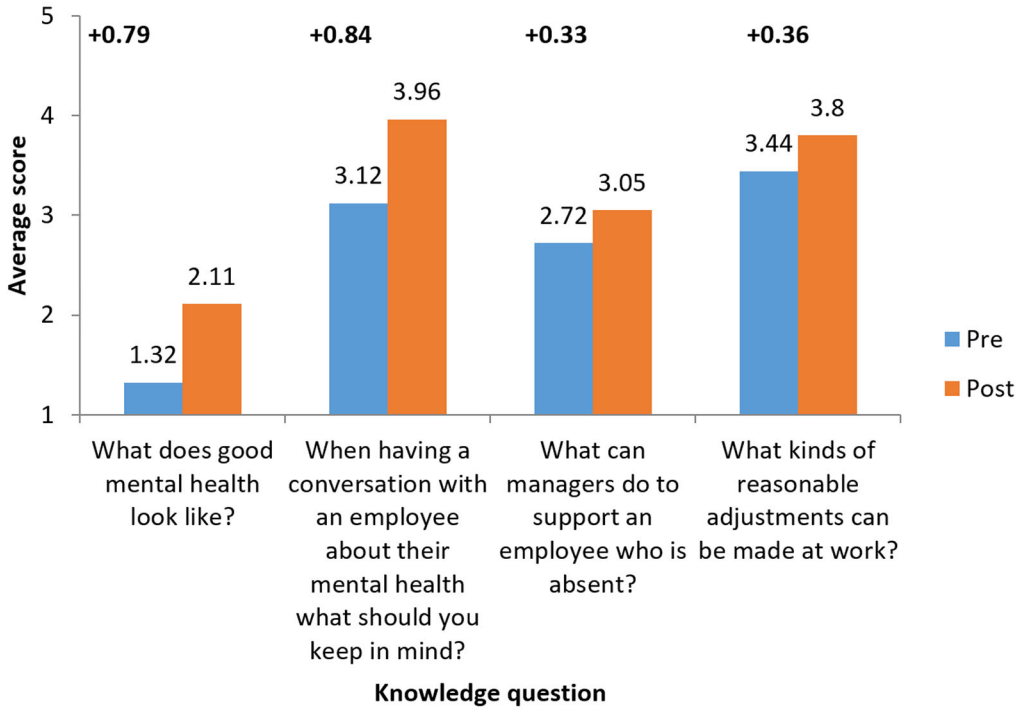


Objective knowledge

Four specific areas of knowledge were measured objectively using open text questions. The results from the knowledge questions are presented item by item rather than thematically. The findings show that, regardless of training method, there was a statistically significant improvement in objectively measured knowledge immediately after the training. The extent of the improvement varied across the four questions, but the biggest improvement was seen in the understanding of 'what to keep in mind when having a conversation about mental health. All of these results were highly significant. , meaning they were very unlikely to have been due to chance. Figure 3 shows the pre and post score for all four knowledge questions.

Furthermore, in line with the findings for the four main factors, no significant differences in knowledge outcomes were found between the two training conditions.

Figure 3 - Average pre and post training scores, 'knowledge questions'



Sustained impact of training – follow-up survey results

To assess the training's longer term impact, the follow-up survey was distributed to participants four to six weeks following the training. The survey asked the same questions and measures the same outcomes as the pre/post survey, with the addition of behaviour change questions to asses any impact in terms of on the job behaviour. As previously described, the six measures were:

- preparedness to take action as a manager (five items)
- knowledge about mental health (three items)
- attitude and misconceptions (four items)
- confidence to talk about mental health (three items)
- knowledge about mental health (objectively measured using open-response questions)
- self-reported behaviour change.

As explained in Chapter 2, identical data were also collected from a control group at the same time as the baseline (pre-training) and follow-up surveys. This served to provide a 'benchmark' of how the wider population perform on the survey measures and enables conclusions to be drawn about the specific impact of the training. In order to attribute a

change in score between the pre-training survey and follow-up survey, the results from the training conditions must be significantly different to those of the control group.

Factors 1-4 (Self-reported 'preparedness', 'knowledge', 'attitude' and 'confidence to talk about MH')

The analysis showed that approximately one month after receiving the training, there was a sustained positive impact which was significantly different from the control group in two of the four factors: 'preparedness to take action as a manager' and (self-reported) 'knowledge about mental health.

Further analysis was conducted to explore any significant differences between the training conditions. As with other findings, there were no differences in the sustained outcomes of the e-learning and face-to-face training.

Table 15 shows average changes in scores for the training and Figure 4 shows these changes compared to a control group. Full results are reported in Appendix Part C.

Table 15 - Preparedness to take action as a manager and self-reported knowledge about mental health

Factor	Pre mean	Post mean	Change
Preparedness to take action	3.13	3.95	+.83
(Self-reported) Knowledge about mental health	3.24	3.91	+.68

Figure 4 - Sustained and significant improvement in preparedness to take action as a manager

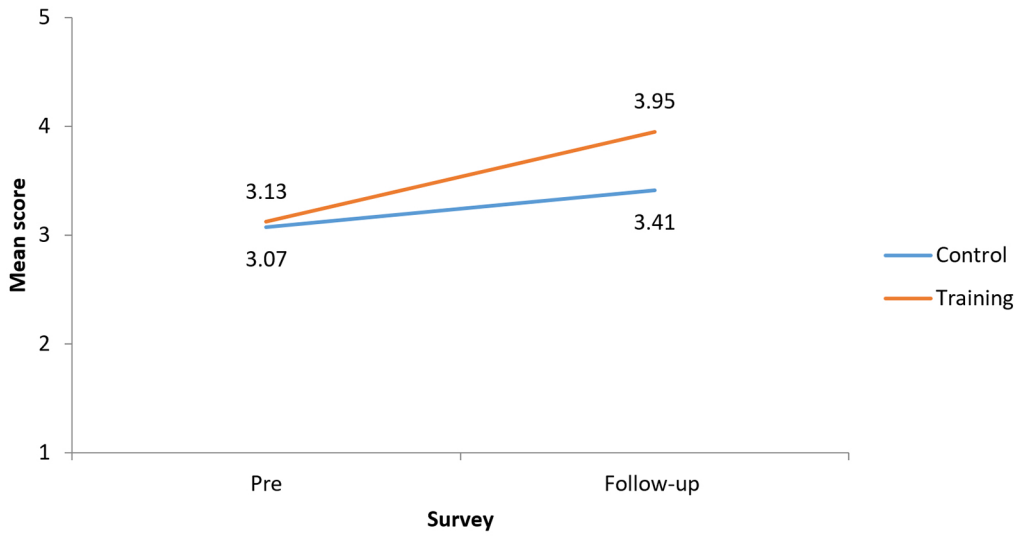
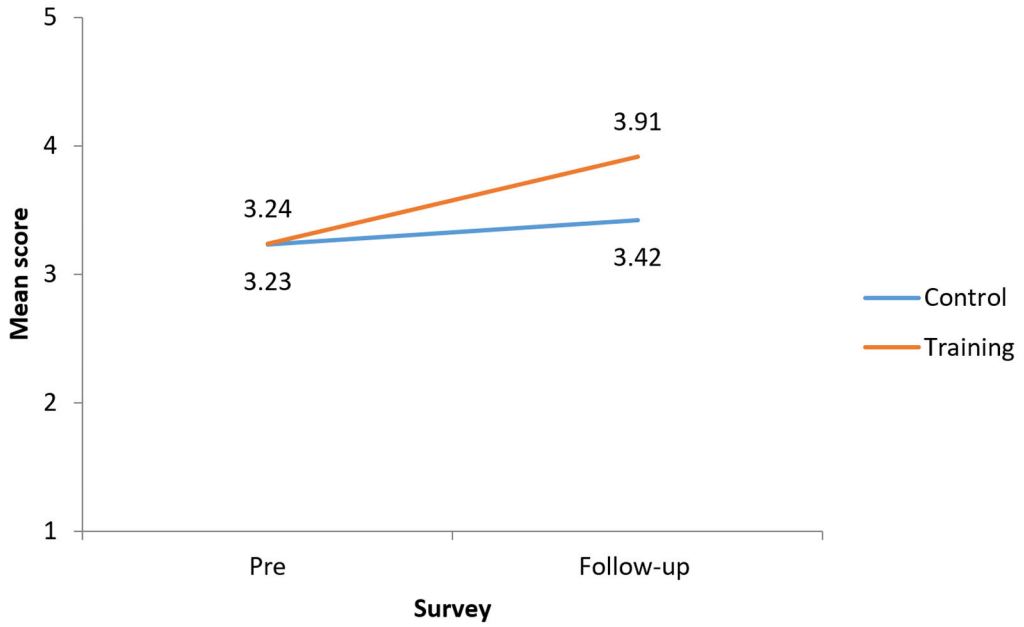


Figure 5 - Sustained and significant improvement in self-reported knowledge about mental health



It is important to note that two factors, 'Attitudes and misconceptions' and 'Confidence to talk about mental', did not show a sustained improvement in performance compared to the control group. The initial improvement in these factors that was observed in the post-training survey was not maintained over the longer-term in comparison to a control group. Part C of the appendix reports the results for all four factors.

Objective knowledge

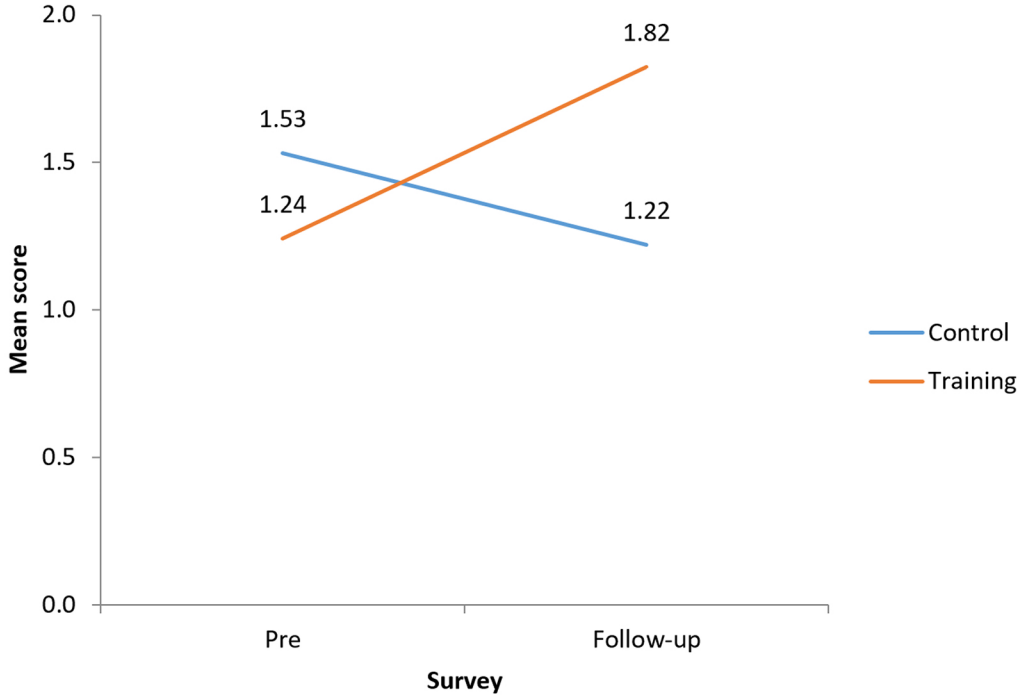
Analysis of participant's responses to open-text questions in the survey showed that, performance on one of the four questions, 'what does good mental health look like?' was statistically different to the control group.

At the follow-up stage, those who had been through the training demonstrated a sustained increase of 0.58 of a mark, ie the training had a sustained positive impact on this aspect of understanding. This is shown in Figure 6.

Once again, the findings showed no difference in performance on this question between e-learning and face-to-face groups. These findings mean that both training methods significantly improved participant's knowledge of good mental health over the longer term.

However, crucially, the remaining three knowledge questions did not show any sustained improvement over time in comparison to the control group.

Figure 6 - Sustained and significant improvement in knowledge of 'what good mental health looks like'



Behaviour change

Four behaviour change questions were included in the follow-up survey asking whether participants had engaged in particular activities that were addressed in the training:

- I pay attention to the mental health and wellbeing of my colleagues at work. ('attention')
- I have taken steps to improve the work/life balance of one or more members of my team in the last month. ('balance')
- I have had a conversation about mental health or mental wellbeing with someone I manage in the last month. ('conversation')
- I have taken stock of the wellbeing of my team as a whole in the last month. ('stocktake')

There were three possible responses to these: yes/no/don't know. However, for the purposes of analysis, 'don't know' responses were excluded.

Logistic regression was used to estimate the impact of the training on the behavioural change of the participants. However, due to the lack of variation in the responses to 'attention' questions (most people answered 'yes', see Appendix Part C), it was not possible to analyse this.

The findings demonstrate that the training had a significant positive impact on 'stocktaking' behaviour. The estimated odds of a positive change in 'taking stock' were seven times higher for the e-learning group compared to the control group and four times higher for the face-to-face group compared to the control.

Despite the difference in the odds, there was not a significant difference between the estimated effects for the two training conditions. The behaviour change, in this respect, did not differ according to training method.

However, the results show that for questions about 'work-life balance' and 'having conversations', there were no significant differences between the observed change in the control and training groups.

Results summary

In summary, the results demonstrated a highly significant improvement immediately after the training for all self-reported and objective outcome measures:

- preparedness to take action as a manager
- (self-reported) knowledge about mental health
- attitudes and misconceptions
- confidence to talk about mental health
- all four knowledge questions.

Over the longer-term, the training had a sustained significant positive impact on a number of areas:

- preparedness to take action as a manager (factor described in Chapter 8, Conclusions)
- (self-reported) knowledge about mental health (factor described in Chapter 8, Conclusions)
- (objective) knowledge of 'what good mental health looks like' (single question)
- line-manager behaviours to 'take stock' of their team's mental health (single question).

Effect sizes for each of the factors identified by the factor analysis are shown in Table 16.

Table 16 - Factors identified in evaluation data analysis and size of effects

Factor	Pre-training mean score (min = 0, max =5)	4-6 weeks follow-up mean score (min = 0, max =5)	Change	p[a] Effect size (Partial Eta squared) (ηp^2)
Preparedness to take manager action on mental health	3.13	3.95	+.83	0.000***0.128 (Medium effect)[b]
Knowledge about mental health	3.24	3.91	+.68	0.000***0.141 (Large effect)
Confidence to talk about mental health	3.57	4.04	+.47	0.337 0.019
Attitudes and misconceptions	4.24	4.34	+.10	0.109 0.038

a. The lower the p value, the less likely it is that the result has been produced by chance. For the findings marked *** in the table this is equivalent to a probability of less than 1 in 1000.

b. The effect size indicates how big the difference is between the pre-training scores and the follow-up scores.

The analysis demonstrated that the mode of training did not impact the outcomes of the training. Therefore, e-learning and face-to-face training were considered equally effective.

Discussion: study design and potential sources of bias

The RCT approach taken by the study enables a high degree of certainty that observed impacts could be attributed to the training rather than (for example) increased awareness of mental health over time among the general public, more enlightened attitudes within the industry as a whole or exposure to other workplace campaigns. Tests showing equivalence of participant groups with respect to background add further credibility to the findings.

A possible limitation of the study arises from the low completion rate for the final, follow-up questionnaire. This was 56 per cent across groups although this compares favourably with the level of drop-out (50 per cent) reported my Milligan et al in a similar study[7], albeit

7 Milligan-Saville, J.S., Tan, L., Gayed, A., Barnes, C., Madan, I., Dobson, M., Bryant, R.A., Christensen, H., Mykletun, A. and Harvey, S.B. (2017) 'Workplace mental health training for managers and its effect on sick leave in employees: a cluster randomised controlled trial', The Lancet Psychiatry, 4(11), pp. 850-858.

with a longer follow up period (six months). Those authors note that loss to follow-up is more likely to underestimate than overestimate the true effect of the intervention.

The largest potential source of bias is the lack of certainty regarding the representativeness of the sample of LMs across the rail industry. Because of the voluntary nature of participation, it is likely that LMs who were more interested in or more sympathetic to mental problems issues took part. This could have resulted in them having higher scores at baseline than the general population and therefore less potential to improve. On the other hand they may have attended to the training more closely than the wider population increasing its effects.

On the basis of how interview sample described their role it seems likely that HR professionals and senior managers may have been over-represented in the study as a whole; this potentially limits the generalizability of the findings to staff at less senior levels or in more operational/technical roles. Another possibility is that females were over-represented (bearing in mind the level of male dominance in the wider industry), comprising 33 per cent of the study sample.

The next chapter provides a synthesis of findings drawing from both the quantitative and qualitative analyses.

8: Synthesis of findings and conclusions

Synthesis of findings

Participant profile

The participant sample drew from 9 employers, covering TOCs, FOCs, railway infrastructure and contractors. The sample comprised LMs representing an array of roles and responsibilities, and there was also varied prior experience of managing MH at work.

Some aspects of the rail industry culture were not seen to be conducive towards progressive attitudes around mental health. However there was consensus that there had recently been positive changes and that there was a will among employers to make improvements.

There was agreement that MH has a higher profile than it used to, and half the sample had previously received some sort of mental health training. But, there was no evidence that mental wellbeing training specific to the LM role had previously been addressed. The interviews conducted in this study highlighted the variation of starting points of the participants, and the range of workplace environments in which they would be expected to apply their training.

Reaction to the training

Both types of training met with approval from most participants, sufficient for them to say they would recommend it to colleagues. Participants welcomed the LM focus and felt that the involvement of Mind assured the quality of the training.

The vast majority of participants in both training groups were satisfied with the level of applicability to their industry. The training prompted several participants to think of previous instances which, with hindsight, they could have handled better. Other positive comments about the training's relevance centred on its compatibility with *'just being a good LM'* and having an open and authentic approach.

There was widespread approval of the degree of clarity and accessibility of the information presented. The length of the face-to-face training was felt to be about right, although some felt that the complexity of the topic merited some additional time. Some participants would have welcomed more content about their own mental health, and there were also some calls for hard copy or downloadable resources to be available after the training.

Some findings were specific to the face-to-face training: the opportunity to ask the trainer questions was the most obvious advantage of this method. This format also offered the opportunity to hear other participants' experiences and, in doing so, enabled 'ad hoc' access to practical knowledge. The willingness of Mind trainers to talk about their own experiences was felt to add credibility to the course content.

With regard to e-learning, participants liked the mix of techniques that were used to illustrate signs and symptoms of poor mental health and demonstrate good practice. The freedom to either complete the entire course in one sitting or alternatively dip in and out of it meant that people with different learning needs and routines could adapt their training experience to suit them. A minority felt that (in contrast to having a trainer) the lack of human interaction made it hard to learn.

Awareness and knowledge

There were immediate positive effects of both types of the training in all of the areas shown in the table. More importantly Mind's training led to a positive change in self-reported knowledge about mental health that was sustained four to six weeks after the training. Participants' ability to answer an 'exam-style' question on the definition of good mental health was also sustained. A very important aspect of these findings is that the effects of training were the same regardless of training method: face-to-face and e-learning were similarly effective.

Table 17 - Knowledge awareness and attitudes towards mental health, areas of improvement as a result of training

Time following training	Immediate		4-6 months	
Factor/area	F-t-f	E	F-t-f	E
Self-reported knowledge about mental health	✓	✓	✓	✓
Attitudes and misconceptions	✓	✓	--	--
Objective knowledge (4 questions)	All	All	1	1

In the participant interviews both groups said they had come away with a heightened awareness of small changes that could be indicative of someone struggling. The training also prompted new understanding of stress and its causes, and how it could be exacerbated by lifestyle factors.

There was improved awareness of what good mental health looked like and appreciation that there is a spectrum ranging from very good to poor mental health.

There were no indications from the interviews that the training was redundant for participants who already felt quite informed about MH issues; often they reported that the training refreshed prior knowledge or offered a fresh perspective. Some participants had not thought about the effects of life events on mental health and the normality of consequences for wellbeing.

The opportunity to share experiences and listen to personal disclosures during face-to-face training allowed some participants to find out directly that MH issues are more common than they realised.

Among the learning points concerning workplace practices, it was common for participants to report better knowledge of how to have a conversation with people about mental health. Some participants who felt their awareness of mental health and communication skills were already good felt that the added value of the training was a better understanding of the manager role. In particular they felt they benefited from a heightened understanding of how to get the best outcome when applying formal processes.

A message received loud and clear was the importance of building good relationships with direct reports and initiating open conversations, allowing a proactive approach to wellbeing. Some managers felt they were confident in doing this beforehand but benefitted from the reassurance of an authoritative source that they had been doing the right thing.

Both methods of training were successful in demonstrating simple tips to make it easier to talk and listen to someone experiencing poor mental health. It was also felt to be helpful when the face-to-face trainer offered advice on how to word questions about mental health in a way that felt comfortable to them and their direct reports.

Both types of training covered Wellness Action Plans[8] (WAPs), which are recommended by Mind as an approach to helping support mental health individuals at work. Although this was a completely new idea to almost all participants, many felt they would be helpful. The structured approach this offered to managing a 'soft' issue was appealing for many.

Some participants felt they had gained a lot of usable knowledge about absence management. In particular there was new understanding of the importance of planning return-to-work in consultation with the returnee. This brought about new confidence in 'striking a balance' between the needs of a person and the needs of the business.

Changes to attitudes and misconceptions

Immediate changes were not sustained at follow-up but this is not surprising for a half day training session. Research has demonstrated that key to changing attitudes and beliefs about mental health is a shift to a psychosocial causal model (Read, Haslam & Magliano, 2013)[9]. It is possible that the improved of awareness of the role of stress and lifestyle factors following the training will provide a foundation for consequent attitude change, however it likely needs to be built upon though wider systemic changes.

8 https://www.mind.org.uk/workplace/mental-health-at-work/taking-care-of-your-staff/employer-resources/wellness-action-plan-download/

9 Read, J., Haslam, N. & Magliano, L. (2013). Prejudice, stigma and 'schizophrenia'. In J. Read & J. Dillon (Eds.), Models of madness: Psychological, social and biological approaches to psychosis (pp.157–177). London: Routledge.

A study of impacts of the 'Time to Change programme'[10] found a dose-response relation between campaign exposure and stigma outcome; regions of England that achieved greater awareness of the Time to Change campaign showed greater positive increases in knowledge and attitudes. The authors suggest that changes can be successfully brought about from both direct exposure to campaign media and indirect effects facilitated by, for example, increased discussion and openness around mental health problems in the community.

Both of these studies indicate that training alone is unlikely to result in lasting attitudinal change and that experiences that enhance understanding of emotional distress in a real-world context are more likely to bring about sustained attitudinal change than didactic approaches that focus on labelling and diagnostic categories.

Taking action on mental health at work

Similar to the above findings there were immediate positive effects of both types of the training in the areas shown in the table below. A key finding is that Mind's training led to a positive change in self-reported 'preparedness to take action as a LM', which was sustained four to six weeks after the training. Both types of training were also positively associated with taking action, specifically the item 'I take stock of the wellbeing of my team'. As before, a very important aspect of these findings is that the effects of training were the same regardless of training method.

Table 18 - Knowledge awareness and attitudes towards mental health, areas of improvement as a result of training

Time following training	Immediate		4-6 months	
Factor/area	F-t-f	E	F-t-f	E
Preparedness to take action as a manager	✓	✓	✓	✓
Confidence to talk about mental health	✓	✓	-	-
Taking action (4 areas)	Not asked		1	1

The increased 'preparedness to take action' indicated by the survey findings was echoed by IES' interviews with participants from both training groups, all of whom had positive intentions to approach line management differently.

There was some indication that a new awareness of mental health had led to new personal insights and subsequent information-seeking. For example some participants had sought out information from their company about sources of support on mental health. Others had downloaded materials from Mind, either for personal use or

10 Evans-Lacko S, Corker E, Williams P, Henderson C, Thornicroft G (2014a). Effect of the Time to Changeanti-stigma campaign on trends in mental-illness-related public stigma among the English population in 2003–13: an analysis of survey data. Lancet Psychiatry 1, 121–128.

dissemination within their company. Some participants reported a change in mind-set and felt they had been more reflective before reacting to workplace situations.

Some LMs were able to report an immediate difference in their interaction with others at work; their comments paralleled the finding that LMs were statistically more likely to 'take stock of the wellbeing of their team' after the training. Interviewees not able to report any action taken said they were giving serious thought to the way they interacted with their direct reports. There was a suggestion that LMs felt more knowledgeable about new ways of communicating, but interviews suggested that few felt equipped with the skills or confidence to make all the changes they would like. Several apparently highly-motivated training participants did not feel the training left them sufficiently confident to broach mental health in a conversation or react to someone in obvious distress. This chimes with the finding that 'confidence to talk about mental health' was not sustained in the aftermath of the training.

Another area which was felt to be important but challenging was striking a balance between the interests of the business (such as the need to manage performance) and empathy. Both training methods addressed the scenario of dealing with someone whose performance may have been affected by symptoms of poor mental health; generally participants had not been in a situation of this type in the period following the training.

Facilitators and barriers to taking action

As described above, opportunities had not arisen for the interviewee to apply some elements of the training during the course of the relatively short evaluation period. Also, other priorities such as business pressures meant that some LMs were more inclined to be reactive (to something being obviously wrong) than proactive (actively monitoring wellbeing in the course of their working day) during this period.

A lack of confidence among many participants was evident; it was felt that it would be helpful to have continued access to reference materials which could be consulted when a difficult situation arose. The possibility was raised that role-play might have been helpful to practice difficult conversations.

Some interviewees felt that structural features of their part of the rail industry, such as geographical separation from teams, could serve as practical barriers to making changes. Others felt that the transience of teams could provide a barrier to fostering openness or noticing when something was 'not right' with a team member.

There was appetite for organisational implementation and promotion of Wellness Action Plans (WAPs), but organisational support was felt to be a prerequisite for implementing these. More generally there was recognition that LMs alone could not achieve change within a company, and backing at boardroom level as well as support from HR and OH specialists would be needed to complement this.

Looking forward

Significantly, there were no instances of LMs declaring an unwillingness or opposition to changes in principle. There were no reported adverse outcomes associated with the training. The training was successful in achieving significant buy-in to its aims and overall ethos. There was optimism that this training represented an important first step towards sector-wide change. This was felt to be in keeping with an increasing emphasis upon 'soft' management skills.

The findings suggest that mental wellbeing training for LMs is one element of intervention that needs to happen alongside others to achieve cultural change in the wider system. Because their peers had not received Mind's training, those who intended to make changes recognised that they may be somewhat isolated in doing so. It is perhaps unsurprising, given the sensitivity of the topic, that confidence to talk about mental health proved difficult to sustain. Similarly, attitudes and misconceptions proved difficult to shift.

But among some participants there was a tangible sense of pride in being innovators. The lack of confidence about some aspects of the training appears to reflect normal difficulties in instigating behavioural changes as a result of training. The sensitive aspect of the training content is likely to have compounded this.

Participants were not directly asked whether further training would be helpful; however, their comments indicated that some sort of support to implement the training would be welcome. Comments also supported the idea of wider role out and it was felt this would 'normalise' the concept of mental health training for LMs.

Conclusions

The conclusions of the study are grouped under RSSB's research questions that IES's evidence review (Part 1) and the current evaluation were designed to address.

What are the best methods available to train LMs in mental health and wellbeing?

A very important aspect of these findings is that all reported effects of training were the same regardless of training method. This is a very encouraging endorsement of the effectiveness of Mind's training and suggests that both methods could be considered outright when commissioning training on this topic.

However participant ratings indicated a preference for the face-to-face format and were more likely to say that they would recommend it to a colleague. Anecdotally the presence of others also helped those attending better understand the pressures within their industry and appreciate the commonality of mental health problems in the working population. Also Mind's trainers were able to tailor aspects of the session to suit the

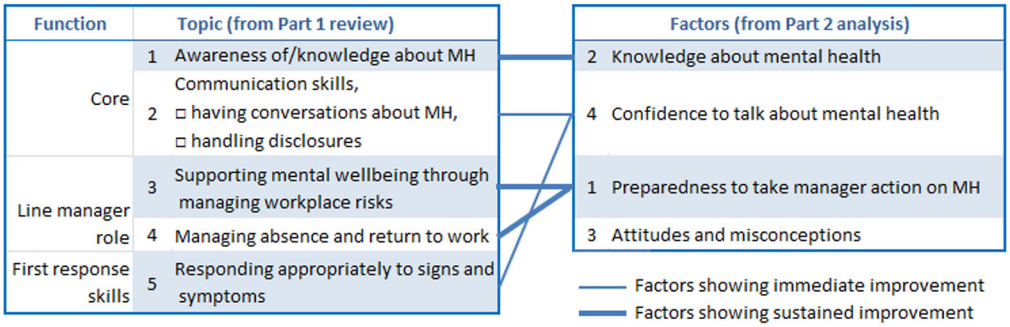
audience in an ad hoc manner, answer questions, and sensitively challenge misapprehensions about mental health.

Those commissioning training should note that the above finding is based on aggregate statistics and the design of this study did not allow for the identification of the best kind of training for particular individuals. Learning needs, as well as an analysis of the training needs of the organisation, are an important consideration. Personal preferences for 'reading' vs. 'doing' were evident from some interviews, as was the remote nature of work for some employees.

What are the best mental health and wellbeing topics to teach to LMs?

An aim of Part 2 was to evaluate training containing the recommended training topics recommended in Part 1. IES's familiarisation with Mind's course materials and their formal observations confirmed that both training methods covered the areas specified in IES's recommendations from Part 1 of this study, (listed on the left hand side of Figure 7).

Figure 7 - Mapping of recommended topics for line manager training with factors identified in evaluation data analysis



The factors shown on the right-hand side were derived from analysis of survey data from the evaluation. The sustained improvement in 'knowledge about mental health' suggests that training participants grasped core elements of understanding about mental health in line with topic area (1). Improved knowledge may be a precursor to changes in 'attitudes and misconceptions' where sustained improvements were not shown. Sustained improvements observed for the factor 'preparedness to take action as a manager' could be seen as evidence of the success of the training in addressing the wellbeing management aspects of the LM role; in topic areas (3) and (4).

Consideration of other evaluation findings suggested that confidence may be lacking to apply some elements of the training on return to the workplace. Arguably the training did not have as much impact in topic areas (2) and (5). This is supported by qualitative data

indicating nervousness about *'saying the right thing'* to direct reports who appear to be struggling and or initiating difficult conversations more generally. However the factor 'Knowledge about mental health' included a question about recognising signs and symptoms which could be assumed a precursor of responding appropriately.

What is the most appropriate way to support the costs of providing training?

The robust, RCT design of this evaluation combined with in-depth qualitative analysis provides high quality evidence to support future investment in this training. Both types of training were shown to be fit for purpose.

To put IES's findings in context, it is helpful to appreciate that the impacts of training can occur at various different levels. In his widely adopted model of training evaluation Kirkpatrick[11] sets out the following four levels of impact:

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 (like change in job behaviour due to training programme)

4 Results - the final results that occurred because of attendance and participation in the training programme (including monetary or performance-based improvements).

Kirkpatrick notes that useful evaluation at Level 3 and above should occur three to six months after training. Some Level 4 impacts may take longer periods to observe. IES's findings support investment in mental health training for LMs at a number of levels. After the Mind training, analysis of qualitative and quantitative data showed:

- Participants found the training worthwhile and vouched for its quality. They thought that it was relevant to their sector as well as to their LM role (Level 1).
- Participants reported feeling more knowledgeable about mental health (Level 2).
- They also reported that they were able to gain insight into principles of good management practice in this area and effective approaches to communicating about the topic (Level 2).

Analysis of quantitative data demonstrated that after 4 to 6 weeks the training brought about these impacts:

- A significant improvement in LMs' understanding of 'what good mental health looks like' (assessed objectively) (Level 2).

11 Steensma H and Groeneveld K (2010), 'Evaluating training using the "four levels model', Journal of Workplace Learning, Vol. 22 (5), pp.319-331

- Sustained positive shifts in self-reported knowledge about mental health and preparedness to take LM action in this area (Level 2).
- Significantly greater likelihood that LMs 'take stock of the mental health and wellbeing of their colleagues at work' (Level 3).

The usual aim of training interventions is ultimately to achieve organisational impacts (Level 4). But, such effects would not be expected within the time frame of the present study. Potential Level 4 impacts include (for example) less sickness absence as a result of MH (as reported by Milligan-Saville et al, 2017)[12], reduced 'presenteeism' and shorter return-to-work times following absence. Other potential organisational gains could include increased productivity and staff engagement. A more open organisational culture around mental health is another potential Level 4 impact, albeit one that is difficult to measure.

A roundtable held with RSSB stakeholders concluded that Level 4 outcomes of this type would be highly desirable. However it was also acknowledged that detecting these lies outside the remit of any evaluation that is focussed on the recipients of training rather than the people they manage or the wider working environment.

In conclusion the current evaluation provides a firm evidence base to support the costs of the training within the boundaries of what was possible from research of this type. Arguably, impacts on the industry as a whole would be expected over a longer time frame or until a 'critical mass' of LMs had been trained.

How can rail companies measure the beneficial impacts created through the training?

Where possible training companies should be encouraged to use rigorous approaches and validated measures that capture meaningful change rather than traditional 'happy sheets' which gather immediate, subjective impressions. Ideally companies should use an evaluation framework (similar to the one used in the present study) designed with realistic objectives they want to achieve in mind.

The most meaningful beneficial impacts that rail companies should note are those which are sustained into the longer term, four to six weeks after training. These can include changes in self-reported knowledge, objective knowledge (tested with 'exam-style' open questions), confidence or readiness to apply the training and, where this is a desirable training outcome, changes in attitudes. Participants should also be asked whether they have put their training into action and how.

12 Milligan-Saville, J.S., Tan, L., Gayed, A., Barnes, C., Madan, I., Dobson, M., Bryant, R.A., Christensen, H., Mykletun, A. and Harvey, S.B. (2017) 'Workplace mental health training for managers and its effect on sick leave in employees: a cluster randomised controlled trial', *The Lancet Psychiatry*, 4(11), pp. 850-858.

The process of translating new knowledge into action is not straightforward. An obvious point, also noted in the training literature, it that participants need the opportunity to apply newly trained behaviours in the work they do or 'trainees are likely to forget what they have learned and/or to view it as unimportant'[13]. Qualitative work can provide insights into barriers and facilitators to training application that may be relevant to the work environment.

The roundtable found agreement that sickness absence data was the most obvious potential source of ROI data, although not necessarily the best. It can be challenging to collect rigorously and may miss nuances, such as reasons for absence. Other data sources were identified, including occupational health (OH) data, Employee Assistance Programme (EAP) usage, and number of return to work plans implemented. To maximise detection of beneficial impacts IES recommends conducting follow-up work some months after training, beyond the post-training period addressed in the current study. Ideally this follow-up work should occur several months after the training. This maximises the chances of participants encountering a range of LM experiences (such as managing direct report through a period of stress, or managing return to work).

Examples of questions follow-up work could address are:

- How have participants been able to put their learning into action over that period and what changes do they report?
- What are the determinants of success for putting training into practice and what are the challenges?

Culture change was highlighted as a priority for the industry. It is therefore important, as was done in the current research, to apply research tools and methods to capture 'soft' changes such as confidence to communicate openly about mental health, attitudinal shifts and preparedness to take action.

Specific actions could be explored such as participants were able to report having a conversation about mental health or mental wellbeing with someone they manage in the last month, whether they have taken steps to improve the work/life balance or implemented a Wellness Action Plan.

What is the most appropriate way to maintain ongoing training activity within rail?

Satisfaction ratings were very high for both training methods and opinions provided in interviews were also very positive. There were no shortcomings of either method apart from the obvious point that e-learning cannot offer the 'personal touch' of a trainer and the opportunity to learn and discuss issues with others from the same industry.

The majority of participants said they would recommend the training to others regardless of which type they had received. Several reflected that achieve changes in culture more

13 Salas, E., Tannenbaum, S., Kraiger, K., and Smith-Jentsch, K. The science of training and development in organizations: What matters in practice. Psychological Science in the Public Interest, 13(2) 74–101

LMs should be trained. The study's findings more generally make a strong case for rolling out the training more widely to LMs in all parts of the rail industry.

The lower cost and convenience of e-learning make it the obvious candidate for wider roll out but some benefits of face-to-face training should be borne in mind that are not replicable in e-learning. Learning in a group enables participants to gain insights from others' experiences and trainers are able to address questions and misconceptions in an ad-hoc manner and deploy their interpersonal skills to encourage open debate. Ongoing training activities should be sustained in consideration of organisational training needs. For example, e-learning may facilitate training of staff in remote locations or isolating shift patterns; whereas if a company is trying to create a cultural shift within one specific depot, training multiple LMs face to face could better facilitate embedding.

Looking forward training participants should be encouraged to disseminate their learning as much as possible. In some instances participants had already shared training materials with their peers and/or reported back on their training in company meetings. Ideally LMs should be supported to develop and implement a post-training action plan so their immediate colleagues receive maximum benefit and employers obtain maximum return on their investment.

Participants also require support from relevant specialists and the wider organisation to ensure that they can transfer new knowledge and skills to their management role. For example, if LMs are expected to implement Wellness Action Plans, HR policies and processes should be put in place to facilitate this. Likewise OH referral processes and other sources of organisational support should be transparent and easily accessible to help LMs respond to any concerns they have about the mental health of a member of staff.

This study shows that some aspects of learning, in particular confidence to talk about mental health, fade over time. IES recommends that the possibility of providing 'refresher' training should be explored to address knowledge attrition and skills fade. The training research literature indicates the importance of this for embedding learning from the original training[14]. As the least resource-intensive training method, it would be logical for this to be delivered online.

Finally LMs interviewed for this study felt that a critical mass of trained people would bring about real change in the industry. While mandatory mental health training for all LMs would require considerable investment, the findings of this study make a strong case for wider rollout across the sector.

14 https://pdfs.semanticscholar.org/0181/b9aa533fd262df009ff113aci2a887afdf95.pdf

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