SUMMARY REPORT

A rapid evidence assessment of interventions to promote the resilience, mental health and well-being of An Garda Síochána members and staff

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BACKGROUND

In 2024, An Garda Síochána and the Policing Authority commissioned a rapid evidence assessment (REA) to understand 'what works' in enhancing the wellbeing, mental health and resilience of first responders/ blue light service personnel (i.e. police, fire service, ambulance, and search and rescue). The REA was undertaken by an independent team of researchers from the University of Huddersfield.

An REA is a structured and rigorous approach that involves searching for and summarising existing evidence on a particular topic. In this case, we focused on studies that tested the effectiveness of strategies and interventions designed to promote the health and wellbeing of police, fire, ambulance, or search and rescue personnel. In addition to summarising study findings, we also appraised the quality of the research methods used. This is important because 'better quality' studies are more likely to provide reliable information about how effective a strategy or intervention really is.

There was a particular interest in 'primary' or 'upstream' interventions. These are designed to proactively boost wellbeing and the ability to deal with stress – ultimately preventing mental health problems from developing in the first place. Moreover, they can usually be rolled out across entire organisations and have the potential to benefit all staff, including those performing different roles or facing a wide variety of challenges in the workplace. Nevertheless, we adopted a comprehensive approach that also included 'secondary' and 'tertiary' interventions. Secondary interventions are designed for people who have been exposed to highly stressful situations or traumatic incidents that might present a 'risk' to their wellbeing and/or those who are showing early signs wellbeing issues. Meanwhile, tertiary interventions are intended for people who are suffering more acute mental health problems. As such, these interventions are targeted at a much smaller number of staff and are only offered following the emergence of wellbeing or mental health concerns.

REAs are designed to be conducted in a relatively short period of time, but we wanted to ensure that our conclusions were based on as much evidence as feasibly possible, so took the decision to include studies that had been conducted in any European country from 2010 onwards. That said, it stands to reason that differences in culture

and organisational factors might affect the suitability of interventions – something that was successful in a certain country or for a particular blue light service might not transfer equally well to a different setting. This meant that we also needed to consider whether the interventions included in the studies would be a good match for An Garda Síochána staff and members. Last but not least, we provided information about the likely cost and resource implications of adopting the intervention.

SPECIFIC OBJECTIVES

1. To evaluate evidence on the impact and effectiveness of interventions designed to promote resilience, mental health, and well-being of blue light personnel/ first responders.
2. To determine the applicability of the interventions to An Garda Síochána members and staff.
3. To include an analysis of required organisational inputs and cost-effectiveness of the interventions identified.
4. To learn lessons to support the development of the next An Garda Síochána Health and Wellbeing Strategy.

SUMMARY OF METHODOLOGY

We searched for studies using a series of online academic databases, Google and Google Scholar. Rigorous procedures were in place to ensure that we identified as much relevant evidence as feasibly possible.

- For all of the studies included in the review we:
    - Summarised findings on the effectiveness of the intervention – is there any evidence that it actually enhances wellbeing, mental health, and resilience to stress/trauma of first responders?
    - Evaluated the quality of the research methods – because ‘better quality’ studies are more likely to provide reliable information about how effective a strategy or intervention really is.
    - Appraised the extent to which the intervention appeared relevant to meeting the needs of An Garda Síochána staff and members – we called this ‘cultural applicability’. This took into consideration factors such as, the feasibility of rolling out the intervention organisation-wide; the potential to proactively enhance wellbeing and resilience across all staff regardless of role or duties; and the capacity to produce a supportive culture across broad teams.
    - Gauged the likely cost and resource implications of delivering the intervention.

** A detailed account of the methods used in this review are available in the appendices.*

KEY FINDINGS

Based on our extensive search for evidence, we identified **45 studies** that tested the effectiveness of strategies and interventions designed to promote the health and wellbeing first responders/ blue light service personnel.

Studies were conducted in 13 different European countries, but United Kingdom accounted for the largest proportion of studies from any single country (14 studies).

Studies were most often conducted with police officers (28 studies), with fewer based on firefighters (6 studies) or paramedics (4 studies). There were no studies that focused solely on search and rescue teams. 7 studies were based on staff from a combination of different blue light services.

Just over two thirds (33 studies) were based on 'upstream' interventions designed to enhance wellbeing and resilience and prevent the development of mental health problems. A much smaller number were concerned with strategies to assess and manage potential health and wellbeing concerns following exposure to traumatic incidents (5 studies), or interventions for the treatment of more acute mental health problems (7 studies).

The vast majority (40 studies) used self-report surveys to test the effectiveness of the intervention. Participants typically completed the survey before and after the intervention – scores at the two timepoints were compared to see if the intervention produced any positive changes in health or wellbeing. The surveys were often designed to track changes in several different indicators of wellbeing, such as everyday quality of life, sleep quality, feelings of stress, coping strategies, or symptoms of anxiety, depression, or trauma. **Only three studies revealed that the intervention had absolutely no significant impact on the psychological outcomes measured – the remainder implied that the intervention had a significant positive impact on several (if not most) indicators of wellbeing.**

As shown in Figure 1, the methodological quality of the studies varied substantially. Although poor study design does not necessarily guarantee that the findings are 'inaccurate', it certainly affects levels of confidence in the findings. As such, we felt that it was important the findings were interpreted cautiously, particularly for those studies rated as poor for methodological quality.

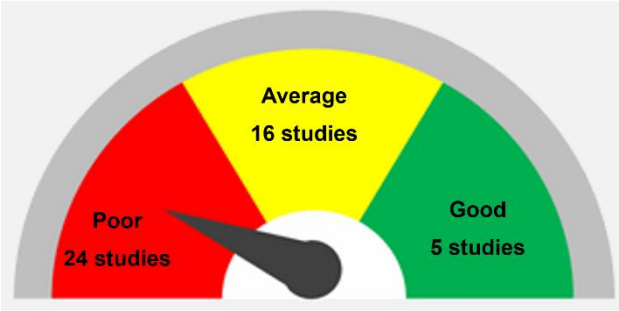

Figure 1: Quality of study methods

The number of participants included in a study can also affect confidence in the findings. In the studies that used self-report surveys, the number of participants ranged from a minimum of 15 to a maximum of 704, but just over half (24 studies) relied on a 'modest' sample that did not exceed 100 participants. Small samples are also more likely to lack diversity (i.e. in terms of participants characteristics and work history), so even if the intervention appeared effective for the current group, there is a chance that it might not work so well for another group of staff with different characteristics.

The 45 studies were categorised according to the intervention's approach to promoting wellbeing, resilience or mental health (see Table 1). There were a small number of studies per category, and even within a single category, the contents and format of the interventions varied quite considerably. This presented a considerable challenge in terms of comparing the effectiveness of the different types of interventions.

Table 1: Types of interventions	
Stress management, resilience and relaxation programmes	7
Cognitive-behavioural therapy	6
Mindfulness interventions	6
Physical activity and health-promotion	5
Assessment and management	5
Technology-assisted interventions	5
Leadership and mentoring programmes	3
Counselling and psychotherapy	3
Positive psychology interventions	3
Frameworks and policies	2

As shown in Figures 2 and 3, the interventions were ranked according to cost-effectiveness and their potential to meet the specific needs of An Garda Síochána staff and members (referred to as 'cultural applicability').

It was often the case that studies and interventions were rated favourably in some but not all areas. For example, the intervention could be rated high for cultural appropriateness and high for cost-effectiveness, but then the study methods were ranked as poor, creating uncertainty as to whether the intervention was genuinely as effective as the study claimed. This meant that there was no category of intervention that performed 'best overall'. However, there were some interventions that seemed to show promise in certain areas:

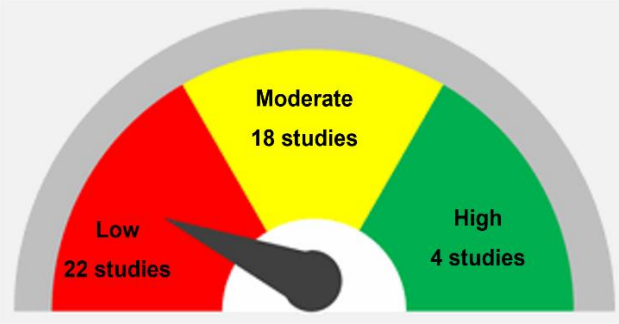

Figure 2: Cost-effectiveness of interventions

- Mindfulness interventions, certain physical activity programmes, and leadership and peer mentoring programmes ranked favourably in terms of cultural appropriateness, and there was some encouraging evidence to suggest that they might be effective in promoting wellbeing and resilience. The peer mentoring programmes also seemed to carry lower delivery costs, but the others were much more expensive to run.

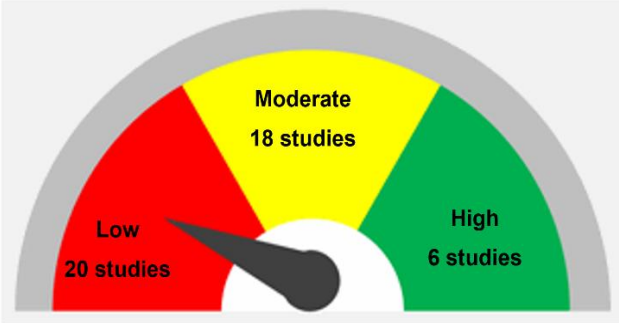

Figure 3: Cultural applicability of interventions

- Other interventions that carried lower delivery costs were walking/exercise challenges that used personal devices (i.e. mobiles or smart watches) and in-built apps to track activity, and peer-based schemes for the assessment and management of potential mental health concerns following exposure to traumatic incidents. There were too few 'good quality' studies to conclusively state whether these interventions were effective or not, but the walking/exercise challenges were also rated positively for their cultural appropriateness.

CONCLUSIONS

This REA provided an important overview of research evidence on 'what works' in enhancing the wellbeing, mental health and resilience of first responders/ blue light service personnel. In addition to summarising findings on the effectiveness of strategies and interventions, we also evaluated the quality of study methods, the cost-effectiveness of interventions, and the relevance of the interventions to meeting the specific needs of An Garda Síochána staff and members.

The review identified 45 relevant studies published in Europe between 2010 and 2024. Two thirds (30 studies) of these were published in the last five years (i.e. between 2019 and 2024) and they most often came from the United Kingdom. The UK launched Oscar Kilo (OK) in 2017, followed by the National Police Wellbeing Service (NPWS) in 2019. Since then, there have been a number of high-profile campaigns to highlight the challenges faced by blue light service personnel. Therefore, it seems to make sense that there has been rapid increase in research on strategies and interventions designed to support the health and wellbeing of first responders in recent years, particularly in the UK.

Although the number of studies does seem to be growing, it would be fair to say that more research is needed to gain a better understanding of what types of strategies or interventions are most effective. The 45 studies included in our review covered 10 different types of interventions, meaning that there were relatively few studies per intervention type. Although the vast majority of studies seemed to indicate that the interventions were effective in enhancing mental health and wellbeing, 24 of them were rated as 'poor' for methodological quality, which meant that we were not entirely confident in the reliability of these findings. In addition to increasing the volume of studies, there is also a need to increase the quality of methods.

There are a variety of reasons that might explain the relatively low number and quality of studies. Wellbeing interventions can be expensive and time-consuming to pilot, let alone roll out for more widescale delivery. There are also a number of challenges to conducting research with blue light services, such as limited funding opportunities, tight project deadlines, and difficulties securing permission to access personnel.

Despite this, there were some signs of promising practice in certain areas. Mindfulness interventions, certain physical activity programmes, and leadership and peer mentoring programmes appeared well suited to meeting some of the key needs and priorities of An Garda Síochána staff and members, and there was some encouraging evidence to suggest that they might be effective in promoting wellbeing and resilience. However, some of these interventions were not without sizeable delivery costs. Interventions that appeared to carry lower delivery costs included walking/exercise challenges that utilised personal devices and in-built activity trackers, and peer-based schemes for the assessment and management of potential mental health concerns, but unfortunately, there were too few 'good quality' studies to conclusively state whether these interventions were effective or not.

It seems likely that the number of studies in this area will continue to grow, so it is important that blue light services keep up-to-date with newly emerging evidence. If new studies are considered in conjunction with this REA, we might begin to see mounting evidence that points towards the effectiveness of a particular type of intervention. It is also important that blue light organisations adopt evaluation methods to monitor the effectiveness of their own interventions in both the short- and long- term.

APPENDIX: FURTHER DETAILS ON METHODOLOGY

In line with best practice guidelines for conducting REAs, we began by establishing clear and detailed procedures for the research. This would ensure that members of the research team adopted a thorough and consistent approach to identifying and selecting as many relevant studies as possible.

We searched for studies by entering multiple combinations of key search terms (e.g. “police, “paramedic”, “emergency service”, “intervention”, “strategy”, “mental health”, “wellbeing”) into Google, Google Scholar, and a series of academic databases that mostly contain peer-reviewed journal articles.

Our initial search revealed over 16,000 sources of information, such as research reports, conference presentations, and journal articles. These were carefully examined to check if they contained relevant information about the effectiveness of strategies and interventions to improve the health and wellbeing of first responders/ blue light service personnel. Studies had to meet certain criteria in order to be selected, but as can be seen in Table 1, we adopted a comprehensive approach that included a broad range of intervention types and study designs.

We began by scanning titles and summaries - reports/articles that were clearly “off topic” were discounted. The next stage involved reading the whole report/article to confirm that it met the criteria for inclusion. We double checked decisions made by each other – there was over 90% agreement about what to include/exclude.

Selected studies were carefully analysed, and key details were systematically recorded in a database (e.g. country, study methods, intervention type, key findings).

Evaluating the quality of study methods: When studies are well-designed and carried out to a high standard, we can be more confident that the findings are an ‘accurate’ representation of the strategy or intervention’s ability to boost health and wellbeing.

Based on well-established academic guidelines, we developed a standardised scale that enabled us to grade the methodological quality of studies. Between 0-9 points were available and studies were rated as poor (0-4 points), average (5-6 points), or good (7-9 points).

Appraising the cultural appropriateness of interventions: The interventions included in the studies were delivered across a variety of contexts, including different countries and blue light services. In order to consider whether the interventions could be successfully transferred to An Garda Síochána, we developed a set of practical criteria that enabled us to gauge whether the design of the intervention was well suited to meeting the needs of its staff and members. Interventions that incorporated more of the approaches listed in Table 2, were ranked as more appropriate.

Table 2: Culturally appropriate approaches
Study findings demonstrated that the intervention was effective among a group of staff similar to An Garda Síochána.
An 'upstream' approach designed to proactively boost wellbeing and resilience and prevent the onset of mental health problems.
An organisation-wide approach – something that can be offered to most (if not all) staff and members.
An approach that is designed to benefit broad teams, e.g. by promoting a supportive culture.
An approach that is designed to alleviate 'hindrance stressors', such as fatigue, burnout, and emotional exhaustion.

Furthermore, if the study provided evidence that the intervention was actually effective in delivering what it set out to do, it was ranked *even more* appropriate. For instance, an upstream intervention that was not only designed to enhance resilience but was actually demonstrated to produce long-term benefits to staff members' health and wellbeing, was rated even more favourably.

Based on a standardised scoring process that awarded between 0-12 points, interventions were ranked as low (0-4 points), moderate (5-8 points), or high (9-12 points) in terms of appropriateness.

Appraising the cost-effectiveness of interventions: None of the studies included in the review provided detailed information about how much it cost to deliver the intervention. Instead, we developed a standardised scale that enabled us to gauge the level of direct and indirect costs involved. This included things such as delivery by qualified practitioners, purchase of equipment, development of resources, and the amount of staff time away from duties.

The scale also took into consideration findings related to effectiveness – an intervention that produces long-term benefits for staff members' health and wellbeing could be considered as providing 'value for money', Ultimately, the most cost-effective interventions are those which produce the best outcomes at the lowest possible cost.

Between 0-12 pints were available for cost-effectiveness, and interventions were rated as low (0-4 points), moderate (5-8 points), or high (9-12 points) in this respect.