Enhancing the Knowledge and Skills of Advisory and Extension Agents in Mental Health Issues of Farmers.

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1 Executive Summary

The Centre for Rural and Remote Area Health received funding from the Foster's Community Grant for an innovative program aiming to improve the mental health of farmers through the use of industry Advisory and Extension Agents (AEA) trained to recognize behaviour raising concern for the mental wellbeing of their farmer clients.

The funding has covered the cost of coordinating, monitoring, reporting on and training the AEAs; and from partner organizations — the Queensland Department of Primary Industries and Fisheries, the Queensland Department of Natural Resources and Water, the Queensland Murray Darling Committee and the Condamine Alliance and AgForce — there has been recognition and endorsement of the project, encouragement of participation by their AEA employees in the program and support for them to participate.

As a result of this training AEAs will be able to:

- recognize signs of mental health problems and offer support;
- build resilience in farmers though support and advice;
- advise the farmers on resources, whether educational materials or health professionals;
- develop local networks of information and referral pathways;

and, with regard to their own development,

- demonstrate an observable improvement in reflective listening and empathy skills.

1.1 Background

Australia's agricultural industries' productivity depends upon its rural farming communities, so their health is vitally important.

Worrying evidence is appearing of a recent rapid decline in the mental wellbeing of Australian farming communities and the increasing incidence of suicide (ABC News, 2006; Hussey, 2007; Perry, 2005): there is an urgent need to initiate effective measures to address diagnosis, treatment and support of this vulnerable group.

In the last few decades, farming life has dramatically changed (Blainey, 2001) as farmers age, work harder and longer, and the 'family farm' disappears (Todd, 2004): this may contribute to the situation wherein rural people have above-average rates of premature mortality and death through heart disease, cancer and suicide (Australian Institute of Health and Welfare, 2002). The rural communities are subject to a number of stresses unique to their occupation, many of which have been aggravated in recent years by economic factors and by changes in farming practice; and these are a likely part of the explanation for the rate of suicide in farmers and farm workers — the highest of any occupational group. Suicide is usually associated with mental illness; and this, in farming communities, appears to be particularly stigmatized and poorly understood (Gregoire, 2002). For men, suicide rates across most age groups are higher in rural and remote areas, where for women they are higher

in the 30-44 year age group (Caldwell, Jorm, & Dear, 2004; Brumby, Martin, & Willder, 2005).

The effects of natural disasters like prolonged drought are felt by the entire community (Farberow, 1985), and rural and remote communities suffer additional disadvantage because of their isolation and thus limited access to health and mental health resources (Judd, 2003; Judd et al., 2002; Stain et al, 2003). Natural disaster can give rise to feelings of loss of control or mastery, and to fear, helplessness and futility; and in the long term there may be an increased risk of psychiatric morbidity (Raphael, 1986). The distress arising from drought is likely to be associated with mental illnesses like depression and anxiety (Sartore et al., 2008).

Community surveys of mental health literacy have found that many members of the public lack knowledge of mental illness: they do not correctly recognize specific illnesses, have beliefs about treatments at variance with those of health professionals, have simplistic beliefs about causes, and frequently hold stigmatizing attitudes (Angermeyer et al., 2005; Croghan et al., 2003; Jorm, Angermeyer, & Katschnig, 2000; Lauber et al., 2003; Magliano et al., 2004; Martínez-González & Trujillo-Mendoza, 2005; Jorm et al., 2007; Priest et al., 1996). This lack of knowledge and degree of stigma contribute to the lack of appropriate support that could be offered to sufferers by colleagues and family members. In many cases it is simply because they do not know *how*: there is a gap between the required and existing knowledge, skills, attitudes and aptitude needed to support people in efficiently and effectively solving their mental health problems. Partly as a consequence, employees from unrelated services who have regular contact with rural residents are often the first access points for those with mental health issues (Turpin et al., 2007).

An initiative arising from this is the delivery of needs-based mental health training directed at the AEAs working with farming communities: these service providers being, as mentioned, the first port of call for emotional support and referral by farmers, remain limited by their qualifications, skills and role (Fuller & Broadbent, 2006; Turpin et al., 2007). They are at the forefront of contact with farming communities, so would benefit greatly from knowledge regarding assisting them: training them in mental health issues and individual resilience would provide the increased knowledge and skills to recognize and support those farmers in need of help.

1.1.1 Next Step

A training program was developed aiming to improve farmers' mental health through industry advisory staff who would utilize it to recognize behaviour raising concern and to provide advice on resources (such as educational materials or available health professionals). The AEAs involved in this program included Extension Officers, Landcare Officers, Financial Counsellors, Agribusiness Officers, Catchment Management Officers, Customer Service Officers, Facilitators, and Farm Inspection Officers.

The program used an existing training package; Mental Health First Aid (MHFA) developed by Jorm and Kitchener (2002a) We modified the existing material to create a package that was suitable for the intended audience.

MHFA training is a twelve-hour course entailing four sessions of three hours each, usually run over two days: it is conducted via a five-step approach not dissimilar to traditional first aid. The program begins by giving a broad overview of the mental health problems in Australia, then goes on to explain the five steps and how they can be applied in specific situations. The course addresses depression, anxiety disorders, psychosis and substance use disorders, but assessing suicide risk is paramount and precedes all other actions (Kitchener & Jorm, 2002a).

This innovative program aims to enhance the knowledge and skills of the AEAs regarding how to recognize the symptoms of mental problems, provide initial help, offer the referral pathway for appropriate professional help, improve reflective listening and empathy skills, lower job stress and achieve an increase in reported wellbeing among farming communities. Eventually this training will alleviate the mental illness of the farming communities through early intervention, building resilience, community education and support.

1.2 Ethical Issues

Ethical clearance for the study was received from the University of Southern Queensland's Human Research Ethics Committee.

1.3 Three-Phase Approach

The project has been carried out into three phases and is reported on accordingly.

1.3.1 Phase I: Farmers' Mental Health Issues/Measures

Three focus groups were held in 2007, involving representatives from farmers, rural organizations/agencies and health professionals. Five areas were discussed in order to gain insight into the participants' perceptions of the mental health issues affecting farmers and what measures were thought necessary to resolve them:

1) current pressures on farmers and their families,
2) the incidence and significance of mental health issues,
3) the impacts on extension staff and other staff,
4) initiatives to deal with mental health issues in rural communities and/or amongst staff,
5) potential benefits and outcomes of training field staff.

The focus groups' participants identified the following major issues and measures:

- isolation in its various forms affects rural farming individuals, families and communities and is a major contributor to a significant increase in mental health issues;
- the ongoing drought is exacerbating the problems of and exerting additional pressure on farmers already struggling with other issues;
- increasing Government regulation, negative media portrayal and the urban–rural schism puts undue pressure on farmers and will result in further mental health issues;

- the issues that affect farmers also affect the people who interact with them;
- rural organizations and agencies are already concerned about the mental health of their staff, and have put some internal protocols in place to address this;
- in rural organizations and landholder sectors there is a general lack of awareness and understanding of mental health issues, which could be addressed through training;
- there is a stigma surrounding mental health issues that inhibits the seeking of help;
- a tradition of stoicism and resilience in farmers further inhibits help-seeking behaviour;
- training in mental health areas is perceived as beneficial;
- an understanding of the various issues that farmers face should be a key element of training, in order to promote empathy.

1.3.2 Phase II: MHFA Training/Assessment

Mental Health First Aid training was provided to 32 AEAs, in two groups, during September 2007 and March 2008. Pre- and post-training assessment data were collected to determine if:

1) the training had resulted in changes to mental health literacy;
2) demographic factors like age, gender, work experience and/or experience with mental health problems affected the training;
3) the training materials were relevant and easy to understand.

After the course, the majority of the AEAs indicated they would be able to recognize the symptoms of mental illness provide initial help and offer a referral pathway to appropriate professional help. The participants also reported that the course materials were new, well-presented, and relevant. Further, they indicated that the course was easy to understand, was extremely enlightening, and should be very useful to anyone working with people experiencing mental illness. They stated that the course gave them a better understanding of how to handle situations and also how to break down their own stereotypical thinking.

Six months after this training a competency-based assessment was carried out. On this occasion the participants stated that the training had significantly improved —

- their ability to recognize mental health symptoms,
- their knowledge of referral pathways,
- their knowledge of and ability to recognize risks factors in mental health,
- the stigmatized attitudes they had themselves developed, and
- their own personal, physical and mental health.

1.3.3 Phase III: Impact and Use of MHFA

A follow-up study was undertaken approximately 12 months after the training, seeking to determine whether the course had had real impact on the way participants interacted with clients who had mental health issues.

The study methods comprised a survey of course participants, interviews with the participants' supervisors and the three focus groups of farmers, agency/organization staff and health professionals.

The key research evaluation questions were:

- what are the current issues facing rural farmers, and how have they changed since the training was undertaken?
- how do participants view the course retrospectively, and how beneficial have they found it in terms of interacting with colleagues and clients exhibiting signs of mental distress?
- what examples are there of participants using the information in the way it was intended, and the consequences?
- what (if anything) should be done to build on the findings of this pilot program?
- what conclusions can be drawn from these findings in terms of the value of providing training to rural service providers?

The major findings were that:

- stakeholders and course participants see this type of training as very much needed and highly beneficial;
- participants had positive experiences with this particular MHFA training course, and gained personally from it;
- some supervisors have already observed some change, and all are supportive of this type of training;
- course participants improved in their ability to deal with colleagues, farmers and friends exhibiting symptoms of mental health problems;
- a number of participants used the new knowledge and skills from the training to directly assist others;
- organizations are beginning to adopt this type of training into their own staff development programs.

1.4 Conclusion

The study has indicated strongly that providing training in mental health issues to rural service providers can be very beneficial to their landholder clients and their social network, to them personally and to the colleagues with whom they interact.

2 Phase I: Farmers' Mental Health Issues/Measures

2.1 Methodology

There was initially a plan to develop mental health training for the AEAs, but a review of literature revealed that the ORYGEN Research Centre in Melbourne has developed a Mental Health First Aid course: it was reviewed and found suitable. To customise the training program, three focus groups were held in July 2007, with representation from farmers (n=8), rural organizations/agencies (n=6) and health professionals (n=11).

The farmers were all mature and experienced people, identified through agricultural agencies and contacted directly by the researchers with invitations to the focus group; the participants from rural organizations/agencies were senior staff; and the health professionals were all nominated by their agencies as persons known to have considerable experience with mental health issues in rural communities.

A facilitator initiated the discussion around general questions designed to gain an insight into the perceptions of mental health issues affecting farmers and what measures were thought necessary to resolve them. Those questions sought opinions on:

1) current pressure on rural farmers and their families,
2) the incidence and significance of mental health issues,
3) any impact on extension and/or other staff,
4) initiatives to deal with mental health issues in rural communities and/or amongst staff,
5) the potential outcomes/benefits of training field staff.

Participants were asked to suggest course inclusions for mental health training, and for the parameters for measuring the training's success; the two accredited MHFA trainers contracted to run the courses attended the workshops as observers; each focus group session took approximately one hour and 45 minutes; and the recordings from each session were transcribed immediately upon session completion in a manner that allowed participants to remain anonymous.

2.2 Results

The qualitative data gathered from three focus group sessions were organised according to the themes and sub-themes of the questions.

2.2.1 Current Pressure on Farmers and their Families

2.2.1.1 Ongoing drought

Participants were unanimous that the ongoing drought is a major source of pressure on farmers and their families. They were careful however, to point out that the drought was *in addition to* other pressures already faced. *The length of the drought, that's become an economic problem for a lot of people.* Many of those affected were said to feel that there is no way out of their current financial difficulties. One health worker noted that there is *an increase in a sense of hopelessness*.

2.2.1.2 Isolation

The changing social structure was emphasised by all groups: rural communities are shrinking as residents move away for employment. On farm stations there are fewer and smaller families; longer working hours and dwindling finances leave little time or resources for socialising. This isolation has led to farmers feeling abandoned by the Government, abandoned by society and *we're now marginalised.*

There was a general consensus that mental health is an issue for the whole community and that key people should encourage entire communities to get involved to overcome the isolation. One participant offered *that a nice outcome would be people sort of start caring about individuals… developing those social community networks again that they're lost a little bit of.* Another individual described this sense of social networking as *community connectedness*.

2.2.1.3 Legislation and regulation

Exacerbating this sense of isolation is the pressure brought to bear on farmers by growing Government legislation and regulation of rural industries. All three focus groups agreed that this ever-increasing and time-consuming paperwork is an additional strain on farmers.

2.2.1.4 Ageing farming community

The ageing farming community and the loss of older, experienced workers was of concern to organizations and landowners: it was seen as contributing to the weakening social structure. A related concern amongst all three groups was generational loyalty, succession or family tradition — the convention where a property is inherited by the next generation. For some their young people have moved away so there is no one to leave the property to; for others the property has been running at a loss for so long that there's nothing of any value to leave. This results in a perceived failure of their traditional role as farmer and provider, and that they have failed the family and themselves, and failed to uphold the standards of earlier generations.

2.2.1.5 Resilience and stoicism

Health workers also raised as an issue the traditions of resilience and stoicism common to farming men. *This isolates farmers further and inhibits them from seeking help*, as one health worker described. Farmers are restrained by *ideas of manliness that you don't disclose your feelings and you just soldier on.*

2.2.1.6 Cost of labour and supplies

The rising costs of labour and supplies represent another burden. In rural Queensland other industries are having a huge impact on farming.

2.2.1.7 Support

The final key matter noted by farmers and health workers was the perceived decline in support for farmers in general — what was referred to as *enmity between city and rural*. There was a sense that society, government and traditional agencies for agricultural support were no longer behind the farmers. *People feel that they're being just not appreciated, not thought of and there's just this sort of a feeling of 'like the black dog'*.

Farmers were acutely aware of the decreasing numbers of field agents and noted that *they're under contract… pressed for time… there's so few people and they've got to get returns*. One rural landholder participant saw extension officers as adding to stress: *it's almost a 'them and us' and that they're actually against us.* Members of other focus groups admitted that this may in part be due to having younger, less experienced staff dealing with farmers in difficult situations: *it is way out of their league to be able to handle.*

2.2.2 Incidence and Significance of Mental Health Issues

Anxiety, depression, suicide or suicidal thoughts were all mental health themes commonly raised by the focus groups: all three groups felt that mental health issues were growing in prevalence. Farmers highlighted the difficulty in gauging the mental health of their peers: *even those people that are really close, you don't know when someone's really depressed*.

All three focus groups said that social stigma was an obstacle to seeking help, with a reluctance to do so by the stereotypical 'strong' farmer because *they've got to save face and not be depressed because there is a stigma attached.*

The health workers' focus group spoke of seeing increased alcohol consumption, family dysfunction, anger and frustration and feeling that everything's out of their control. The group was concerned with the impact on the younger generation, and they spoke of seeing more depression and anxiety in children and adolescents. *All the family dysfunction, all the suicide, the alcohol, what are we going to see in mental health issues in children who are growing up in those families?*

Exposure to affluent lifestyles and changing societal values was considered to have raised lifestyle expectations and increased the difficulty to cope with the ongoing daily struggle.

2.2.3 Impact on Extension Staff/Others In Contact with Farmers/their Families

There was a strong view that the pressures facing rural farmers and their families were also impacting on field staff. It was suggested that the most directly affected field staff were the farm financial counsellors who were bearing the brunt of stress on a day-by-day basis.

Health workers considered field staff to be in a vulnerable position and being vicariously traumatised: they're finding it really, really difficult… to deal with the stroppy client, the crying client, the person the same as their father bursting into tears and that sort of thing. There was suggestion from the organizations that the use of sick leave may be reflective of the stress these staff members are under.

2.2.4 Initiatives to Deal with Mental Health in Rural Communities/Amongst Staff

Health workers were the most aware of the numerous mental health initiatives available from Government and non-Government agencies; however, all participants were familiar with 'Beyond Blue', 'Lifeline' and 'Men's Line'. A problem was noted of *people not quite knowing when they're at that point of needing help.*

The farmers' group complained of being referred from person to person, and wished that they could speak to just one person about their myriad concerns. Health workers were concerned that the rural doctor crisis meant many areas either didn't have a permanent GP or had a short-term GP, so there was little opportunity for continuity in relationships.

2.2.5 Potential Outcomes and Benefits of Training Field Staff

Some organizations already offer support to their staff, including workshops, referral schemes and the availability of psychologists or psychiatrists. But greater awareness of mental health issues amongst their clientele was unanimously seen as a potential benefit of training field staff. The unanimous hope was that training would provide people with the ability to understand mental health issues and recognize symptoms, as well as have the skills to appropriately refer a person for additional help.

The agencies/organizations and the health workers spoke about *empowering* or *enabling* staff to equip them to deal with *bad endings as a potential outcome of training*; and that it was important for field staff to understand they're not going to be held responsible for putting right anyone's mental health.

2.3 Suggested Course Inclusions for Mental Health Training

It was agreed by each of the focus groups that strong emphasis needs to be placed on communication skills in the training: it must be a very big *communication* issue — one of openness and honesty. *Just being aware that strong communication skills are a tool of their trade* and having *the ability to be able to talk to people* were opinions voiced: reassuring people about the benefits of seeking help requires these skills.

Other persistent themes thought necessary in training were empathy and an understanding of the differences between rural and urban Australians. *I think in any training that's given it would be important to promote… that rural Australia is really doing it tough. They need to be perhaps more sympathetic and empathetic with landowners — not this them and us feeling that is there.* Another possible inclusion was information about the links between drug and alcohol use and mental health. One landholder queried whether there ought to be some information on genetics and mental health, asking *should there be some sort of emphasis put on the genetic side of it, like if your family has a genetic issue in their family with depression?*

2.4 Measuring Success

There was a number of valuable ideas from each of the three focus groups regarding how best to measure the success of AEA training. The organizations/agencies spoke of a reduction in staff turnover's being one possible indicator; this was bolstered by the health workers' suggestion of attempting to assess job satisfaction. Having had some exposure to these testing techniques, one health worker participant suggested that a test such as the Occupational Stress Inventory be administered to field workers and *the scores should improve.*

The organizations/agencies group also stressed the importance of equipping people with something concrete and applicable, suggesting *practical applications of the training and not just about icebreakers and self-discovery and so on: some practical application skills*.

This feeling was mirrored by the farmers' group, with a participant articulating *I don't know whether you're going to see a great result from your local extension officer saying, 'How are you feeling?'.*

The farmers just having effective networks in place would be a sign of success. A landholder participant described this as *if these people can identify that someone's got a problem, but they've got the backup of the people to refer them to, that's something.* Both the organizations/agencies group and the health workers groups reflected that *a greater uptake of the resources that are available* would be a useful way of measuring success. These two groups also suggested that some focus should also be put on the confidence of AEAs dealing with and referring the farmers. A member of the organizations/agencies group suggested: *see if they felt their self-worth with dealing with people in those situations had increased.*

One health worker participant said that as there are so many factors involved it would be difficult to measure the success of all potential outcomes. There was agreement that there were many potential benefits but that not all can be objectively measured, and described the situation as *more understanding people contribute to the community by just having awareness of mental health issues and how to respond to people in a more helpful way, and also how to break down some of the stereotypes that exist out there.*

2.5 Group Wrap-Up

There was general consensus that mental health is an issue for the whole community. It is desirable that key people be involved in areas of mental health in order to encourage whole communities to become involved. One participant suggested *a nice outcome would be people sort of start caring about individuals… developing those social community networks again that they're lost a little bit of.* Another individual described this sense of social networking as *community connectedness*.

There were also some suggestions about mental health awareness training, such as *to make it part of induction training when people move to rural and remote areas*, although it was also put forward that this type of training could be incorporated into University curricula.

The final issue to be raised was a positive one: there was agreement that although the stigma surrounding mental health issues still exists, it is improving: there are less negative perceptions of everything involved in mental health than there once were. This shift in thinking was elucidated by a participant: *I think it is starting to become that little bit more… in that we talk about people's wellbeing and not so much their mental health. We're doing a mental health session; we call it a 'wellbeing' session'.*

2.6 Conclusions

The conclusions arising from the group wrap-up were that:

1) isolation in its various forms affects rural landholding individuals, families and communities and is a major contributor to a significant increase in mental health issues.

2) the ongoing drought is exacerbating problems for and exerting additional pressure on rural farmers already struggling with other issues.
3) increasing Government regulation, negative media portrayal and the urban–rural schism puts undue pressure on farmers and will result in further mental health issues.
4) the issues that affect rural farmers also affect the people who interact with them.
5) rural organizations and agencies are concerned about the mental health of their staff, and already have some internal protocols in place to address this.
6) in rural organizations and rural landholder sectors there is a general lack of awareness and understanding of mental health issues, which could be addressed by training.
7) there is a stigma surrounding mental health issues that inhibits the seeking of help.
8) a tradition of stoicism and resilience in farmers further inhibits help-seeking behaviour.
9) increasing social networks and community connectedness will be beneficial to rural communities.
10) training in mental health areas is perceived to be beneficial.
11) an understanding of the various issues that farmers face should be a key element of training in order to promote empathy.

3 Phase II: Mental Health First Aid Training/Assessment

To our knowledge, the evaluations we report on are the first carried out independent of the developers of MHFA.

3.1 Participants

There were 32 AEAs involved in the training course, recruited from the Department of Primary Industries & Fisheries, the Department of Natural Resources & Water, the Queensland Murray Darling Committee, AgForce and the Condamine Alliance.

Earlier meetings with each organization had revealed interest in the program, and the organizations solicited self-nomination from their staff. Once identified, the participants were divided into two groups, balanced as much as possible re employer, sex and age. The initial intention was to do this randomly; but because of ongoing job commitments some participants self-selected into a group. The final distribution was 17 AEAs attended training in September 2007 and 15 in March 2008.

3.1.1 Personal profiles of Participants

- In *both* groups the highest proportions of participants were female;
- Ages ranged from 21–60 years, the average being 38 (SD =13.14) years;
- In group *two* the majority were above 45 years of age;
- 77% of group *one* participants had 5 years or less work experience in the field, compared with 33% in group *two*;
- The highest proportion of respondents in *both* groups had no experience in mental health situations; however,
- The majority indicated that their family members had experience in mental health problems.

3.1.2 Participants' Knowledge Levels

The knowledge assessment questionnaire contains 25 questions on how to identify symptoms of mental illness, referral pathways (who to go to for help), how to take action and the right medications. One point was given to each of the correct answers and the final score could range from 0 to 25, 0 indicating no knowledge and 25 the highest knowledge level. The calculated scores of participants ranged from 1–17 pre-training, and from 18–24 post-training: this difference was significant, demonstrating an improvement in mental health first aid literacy.

The effects of gender, age and work experience on mental health knowledge both pre- and post-training were determined by univariate analysis. Pre-training showed significant interaction between age and work experience: the participants who were ≤40 years of age with more than 5 years of work experience had better mental health knowledge than those

who were >40 years of old with 5 years of work experience Post-training there were no effects of age, sex or work experience on knowledge.

3.2 Methodology

Accredited MHFA personnel offered the training, full details of which can be found at the Mental Health First Aid Website (http://www.mhfa.com.au), and each participant had a course manual (Kitchener & Jorm, 2007).

The course gave an overview of the major mental health problems in Australia, introduced the five steps of MHFA, and then applied these steps to the problems of depression, anxiety disorders, psychosis and substance use disorders. There was also coverage of how to help:

- a suicidal person;
- a person having a panic attack;
- a person who has experienced a traumatic event;
- a psychotic person perceived to be threatening; and
- a person who has taken a drug overdose.

3.2.1 Data analysis

Using SPSS 15.0 for Windows, frequency counts and percentages as well as means and standard deviations were calculated for the descriptive data; and t-tests were used to determine whether there were significant differences in knowledge between the two groups of the participants. The resulting differences were tested for significance at $p<.05$. Qualitative data were analysed based on the established themes.

Testing of the knowledge, skills and experience of the 32 AEAs attending the training was based on MHFA assessment material. Competency-based assessment included:

1) knowledge of the ability to recognize mental health symptoms;
2) knowledge of referral pathways;
3) knowledge of and ability to recognize risks factors for mental health;
4) their own stigmatized attitudes;
5) their own personal, physical and mental health.

Pre-training and six-month follow-up after training data were collected from both groups of participants: two follow-up mails were sent out with an intent to increase the response rate.

3.3 Evaluation of Program

3.3.1 By Participants

The participants were asked to evaluate the course based on the newness of the materials, ease of understanding, presentation format and relevancy of content; they reported that they

had not seen the course material beforehand, and that it was easy to understand, was presented very well and had content very relevant to them.

In their open-ended comments, they noted that the course covered *a broad range of relevant topics. Course materials were easily understood and the manual was clear and concise*. They considered accredited teachers well-informed: *gave me a better understanding of how to handle situations for safety and a positive outcome*. They also said it helped them to break down their own stereotypical thinking: *better understanding that people with mental illness can live a normal life if they take medication.*

They said they enjoyed the course and appreciated the fact that it was presented in a clear way. *This course was presented well with facts & provided insight into mental health as well as the treatments.* The AEAs now understand the differences between various mental health disorders: *good balance with videos of application — for example, flight or fight, 'Beyond Blue', understanding schizophrenia and understanding manic depressive illness.*

The participants stated that the course should be offered to more people who work with people at risk. They indicated that this course should be a part of conventional first aid training. Some quotes are: *something I have wanted to do*; *received new materials that would help to understand people with mental illness*; *it was very helpful information that I can use personally and at the work place with clients*; and *gives me a much greater awareness of mental health.*

They further indicated that more interactive sections — e.g., more role–playing — should be included in the course.

3.3.2 By Assessment

Pre- and immediately post-training assessment of knowledge and skills was carried out, as well as the course content evaluation at the end of each training session.

Pre-training assessment of knowledge and skills was undertaken with the MHFA Literacy Assessment Tool, now widely used by the MHFA trainers (Kitchener & Jorm, 2007): its questionnaire contains 25 questions, covering how to identify symptoms of mental illness, referral pathways, how to take action and the right medications. One point is given for each correct answer, so the final score ranges from 0–25.

Evaluation of the AEAs' experiences of the course itself used an existing 9-item questionnaire developed by the originators of MHFA for evaluation of their own course (Kitchener & Jorm, 2007): four questions, based on the newness of the content to the participants, ease of understanding, presentation, and relevancy of content to the trainees. The participants were asked to evaluate those four questions on a 10-point scale, with 1 indicating not at all/very hard/really bad and 10 indicating very much/very easy/really good. Five open-ended questions asked participants to comment on the strengths, weakness, other issues and overall comments on the program.

3.4 Results

3.4.1 Confidence in helping someone with a mental health problem

Respondent confidence was calculated based on a 5-point scale (1=not at all, 2=a little, 3=moderately, 4=quite a bit, 5=extremely). More than one half (59%) of the pre-training respondents indicated a little bit of confidence in helping someone with a mental health problem, whereas after six months of training 85% indicated they had moderate to quite a bit of confidence.

Confidence Level		Pre-training (%)	After 6 months of Training (%)
Confidence in helping someone with a mental health problem	A little	59	15
	Moderate	31	56
	Quite a lot	10	20
Totals		**100**	**100**

Distribution of respondents by confidence and training

3.4.2 Mental Health Knowledge

The six-month follow-up assessment questionnaire was employed, ascertaining that the MHFA training had improved the participants' mental health literacy significantly: 37% of respondents scored high levels in mental health knowledge at follow-up compared with 9% pre-training.

3.4.3 Referral pathways

3.4.3.1 Seeking help

Twelve helpful referral pathways were assessed, based on the three scales: 1=helpful, 2=neither and 3=harmful in managing mental depression.

- The participants in both groups expressed similar responses: dealing with self is harmful in mitigating depression; and a GP/family doctor or counsellor are both helpful, followed by a social worker, telephone counselling services, a psychiatrist, a psychologist, close family, close friends and someone from the clergy.
- Out of 12 sources of help, only two — social worker and herbalist — showed up differently between pre-training and after six months of training: at the latter point the participants indicated that these services are helpful.
- The males stated that seeking help from a psychiatrist was helpful; after six months of training both male and female participants would seek help from all twelve potential sources to manage depression.
- After six months participants saw similar improvements in seeking help for depression management: the >5 years of working experience group felt seeking help from the clergy is more helpful than did the participants with ≤5 years of work experience.
- No differences in the responses were found based on their experience in mental health problem.

3.4.3.2 Taking medication

Eight medications were assessed based on the three scales: 1=helpful, 2=neither and 3=harmful in managing mental depression.

- The participants showed mixed responses: they saw medication as having both helpful and harmful effects. Fifty nine percent of the participants in group *one* indicated that pain relief such as aspirin or paracetamol is harmful, as compared with 29 percent in group *two*. Both groups indicated that antidepressants and antibiotics are helpful in relieving depression but stated that sleeping pills, antipsychotics and tranquillisers are harmful.
- After six months of training the participants saw taking St John's Wort as helpful. No differences were based on gender in taking medication.
- Pre-training more of the younger age group (≤40 years) indicated that taking vitamins and minerals are helpful than did the group above 40 years; however both groups stated similar levels of response after six months.
- Based on work experience, no significant differences were found in pre-training assessments; on the other hand, after six months of training the participants indicated significant differences regarding taking St Johns Wort, sleeping pills and anti-psychotics.
- Both pre- and after six-month training assessments showed significant differences regarding taking vitamins and minerals between the participants who had experience in mental health problem and those who didn't: the experienced group indicated that taking vitamins and minerals is helpful in managing mental illness.

3.4.3.3 Taking action

Thirteen helpful actions were assessed based on a three-point scale: 1=helpful, 2=neither and 3=harmful in managing mental depression.

- Overall, both groups reported that taking counselling, become physically active, getting out and about more, attending relaxation courses and reading about people with similar problems were all very helpful, compared with cutting alcohol, psychotherapy, hypnosis, cognitive behaviour therapy, special diets, admission to a psychiatric ward, having occasional alcohol and electroconvulsive therapy.
- Cutting out alcohol altogether ($t=2.18$, $\alpha=.03$) and psychotherapy ($t=2.66$, $\alpha=.01$) showed significant differences between pre- and post-training; but after six months the participants felt both actions to be helpful.
- Getting out and about more showed significant differences between the groups.
- There were differences in taking counselling($t=-2.38$, $\alpha=.02$) and admission to a hospital psychiatric ward ($t=-1.98$, $\alpha=.05$) between males and females at pre-training assessment, the males indicating these as helpful in mitigating depression more than the females; whereas after six months of training, significant differences were seen

regarding admission to a psychiatric ward (t= -3.71, α=.01), where the younger age group (≤40 years) indicated that this is not helpful in managing depression.

- Significant differences were found, pre-training, regarding taking courses on relaxation and stress management (t=-2.13, α=.04): those with ≤5 years of work experience in the field indicated these are helpful in managing mental illness; and, based on their work experience after six months of training, differences were found in taking courses on relaxation, stress management, meditation or yoga to manage depression (t=-2.13, α=.04).
- There were also significant differences in responses between participants who had only read about people with problems of mental illness and those who had dealt with them (t=1.98, α=.05); and in getting out and about more after six months of training between participants who had experience of mental health problems and those who had not.

3.4.3.4 Social distance

Five actions related to the social distances of the participants were measured on a four-point scale: 1=definitely willing, 2=probably willing, 3=probably unwilling and 4=definitely unwilling.

- After six months of training, 59% of participants indicated they were definitely willing to move in next-door to mentally ill people as compared with 32% pre-training; and 52% were definitely willing to start working close to them as compared with 33% percent pre-training.
- At the six-month follow-up there were significant differences among the groups over three statements: group *two* had shown more willingness than the group *one* in spending an evening socialising with mentally ill people (t=-4.52, α =.01), in making friends with them (t=-2.75, α=.01) or in having to start working closely with them (t=-2.75, α =.01); but no differences were found based on gender or age of the participants.
- No differences were found in responses based on period of work or mental health experience at pre-training or at the six-month follow-up.

3.4.3.5 Stigmatized attitudes

There were 19 statements pertaining to participants' stigmatized attitudes: nine were related to their personal attitudes and the other ten were perceived attitudes. The mean ratings were calculated on a five-point Likert scale: 1=strongly agree, 2=agree, 3=neither agree nor disagree, 4=disagree and 5=strongly disagree.

- Although there were no significant differences in mean ratings between males and females, at pre-training females rated higher in almost all statements than did males.
- Six months after training, no differences were found between males and females in all but one of the personal attitudinal statements: *If I had a problem like Mary's I would*

not tell anyone (t=-1.98, α =.05) — the female participants disagreed with their male counterparts here.

- There were some differences of opinion based on participant age six months after training, but they were statistically insignificant.
- Based on work experience, at pre-training stage significant differences were found in four personal attitudinal statements. Work experience also exhibited significant influence on overall personal attitudes (t=-2.38, α =.02): those who had >5 years of work experience mostly disagreed with the ≤5–years of work experience group.
- No significant differences were found in perceived attitudes except in the case of *Most people believe that it is best to avoid people with a problem like Mary's so that you don't develop this problem* (t=-2.05, α =.04): the >5 years' work experience group differed significantly in this statement with those of ≤5 years of work experience.
- After six months of training, no significant differences were found in personal and in perceived attitudes except *it is best to avoid people with a problem like Mary's so that you don't develop this problem* (t=2.34, α =.02): the ≤5 years' work experience group rated higher mean scores than those with more experience.
- Significant differences were found in four personal attitudinal statements, based on participant experience of mental health problems: this area also exhibited significant influence on the overall personal attitude of the participants (t=-2.57, α =.01) at pre-training.
- No differences were found in perceived attitude except for *Most people believe that people with a problem like Mary's are dangerous* (t=-2.11, α=.04): those who had no experience of mental health problems differed significantly from participants who had experience.
- Significant differences were found in two statements relative to personal attitudes*: People with a problem like Mary's are dangerous* (t=-2.21, α =.03) and *I would not employ someone if I knew they had a problem like Mary's* (t=-2.66, =.01) after six months of training. The participants with experience of mental health problems differed significantly from those with none in overall personal attitudes (t=-2.07, α =.05). No significant differences were found between the groups in their perceived attitudes, except *If they had a problem like Mary's most people would not tell anyone* (t=3.02, α=.01).

3.4.3.6 Personal Physical and Mental Health of Participants

The respondents showed similar levels of nervousness at pre-training (16%) and after six months of training (37%); and showed more restless or fidgety after six months of training (63%) than at pre-training (42%).

After six months 89% of participants stated that they were not depressed at all as compared with 71% percent at pre–training; and only two indicated that most of the time they

were *feeling everything was an effort*. After six months 81% were feeling more worthwhile at than pre-training (77%).

After six months 61% of participants indicated that they were less depressed than at pre- training (10%) during the last 30 days; but there was a small increase in seeing a doctor. Pre- and post-six months of training they stated that their physical health problems were almost static.

3.5 Some Derived Findings

3.5.1 Confidence

The immediately post-training and six-month follow-up assessments showed significant improvement in confidence when dealing with mentally ill people. Experience in mental health problems and being in the older group of the participants impacted on confidence levels:

- group *two* participants demonstrated higher confidence levels;
- ≤40 years group showed significantly higher level of confidence;
- females demonstrated more confidence than males; and
- >5years of work experience group exhibited higher level of confidence than the ≤5 years.

3.5.2 Knowledge

The participants who had had contact with mentally ill people before training showed significant improvement in their mental health knowledge and ability to indentify problems: prior experience may help them to link up the training with their experience and thus become able to better identify the mentally ill within the community.

Compared with pre-training, the knowledge level of participants significantly improved from low to high in immediately post- and after six months of training. Significant differences were also found in their mental health knowledge based on their ages: the younger their age the better their understanding.

Both male and female participants showed significant improvement in knowledge of mental health; however, female groups showed higher levels of progress (47%) than the males (25%) after six months of training. Work experience in the field showed almost similar levels of improvement: ≤5years gained a 35% higher level of knowledge as compared with 40% of the >5 years group.

The participants in both groups having some experience with mental health problems exhibited significant improvement in their knowledge levels: their understanding moved from 18% at pre- to 36% after six months of training.

3.6 Conclusions

The results show that the MHFA training is effective in enhancing the mental health knowledge and skills of course participants. The training also enhanced the participants'

knowledge of various issues and their ability to recognize various symptoms of mental disorders: this might help them change their personal attitudes and deal more effectively with mentally ill clients.

In our social milieu there are strong, stigmatizing beliefs about mentally ill. Those participants with prior experience of mental health had a more positive attitude towards people with mental health issues, pre-training; and this difference was non-existent post-training.

Following training, AEAs are better able to recognize mental disorders and more competent to provide help to anyone with mental health problems. Their personal attitudes towards those suffering stigmatizing illness have been changed: the AEAs are more willing to work with and now know to whom to refer them to for help.

Social distance results are equivocal. Only one of the groups showed a significant change in attitude, but it was a positive one.

4 Phase III: Impact and Use of MHFA Training

The second follow-up study was undertaken approximately 12 months after training, and sought evidence of whether undertaking the course had had an actual impact on the way participants interacted with clients or colleagues with mental health symptoms.

The key research evaluation questions were:

- what are the current issues facing rural farmers, and how have they changed since the training was undertaken?
- how do participants view the course retrospectively, and how beneficial have they found it in terms of interacting with colleagues and clients exhibiting signs of mental distress?
- what examples are there of participants using the information in the way it was intended, and the consequences?
- what (if anything) should be done to build on the findings of this pilot program?
- what conclusions can be drawn from these findings in terms of the value of providing training to rural service providers?

In addition to the follow up of the participants we also determined how ~~was the course~~the course was viewed by the participants' supervisors and other rural stakeholders. They were asked for their views in light of their direct experience with this course or similar courses, or from simply hearing of the responses from course participants.

4.1 Methodology

The methods used were:

- a survey of course participants;
- interviews with participants' supervisors; and
- focus groups of farmers, agency staff and health professionals.

4.1.1 Course Participant Survey

The aim of the survey was to interview all available participants. Of the 32 participants who had attended the training, 21 were available for interviews and 15 agreed to participate in the survey process.

Interviews were held by an independent professional consultant during November and December 2008.

4.1.2 Supervisor interviews

Six supervisors of the course participants were interviewed by telephone.

4.1.3 Focus groups participants

Two focus group sessions with agency senior staff, farmers and health professionals were held in November 2008 to collect qualitative data on the impact and use of MHFA training. Each focus group session was facilitated, and each ran for about two hours.

Recruitment for these focus groups was through letters to the stakeholders who had been invited to the original focus groups at the start of the project in 2007. The invitation explained that there were a number of reasons for further collection of information from them, including:

- hearing their views on how the context had changed since the first focus group (what has improved? – what is worse?);
- discovering their views on the impact of the training of the AEAs;
- providing them with an update of what had occurred and the feedback from/impact on participants that we had collated;
- seeking their response to this feedback;
- considering ways of building on what had been learned.

A total of nine people participated: two from DPI&F, one from Condamine Alliance, three farmers and three health professionals. The focus groups were recorded and subsequently analysed for themes; and copies of the reports were sent to the focus group participants for verification.

4.2 Results

The results are presented in accordance with the evaluation research questions.

4.2.1 Current issues facing farmers

Focus group participants considered there to be ongoing pressures on farmers as a result of fuel costs, increased, value of the land. The ageing farming population and restricted access to medical services in isolated areas were also raised as issues. New pressures were seen to include the financial market downturn, the follow-on effects of the increase in grain prices, climate change, competition with the mining industry for agricultural land, and the changes in legislation imposed by local, state and federal Governments. Participants provided evidence for increases in depression, divorce, suicide and debt.

One positive was observed in the way some communities were working together to combat mining's depredations.

The focus group participants identified pressures that rural communities are currently facing — principally economic, climate change, health, mining, governance, family breakdown and loss of infrastructure.

4.2.1.1 Economic

Economic hardship was one theme taken up by all participants, with a combination of factors —including the long-term drought, high interest rates, dramatic/exponential increases in farm

input costs and the depressed financial markets — all contributing. One health professional said that although grain prices have gone up *people are carrying a lot of debt*. A farmer noted that increased grain prices were cancelled out by elevated input costs and high interest rate rises and *this had [put] farmers in a pretty concerned mood*. Another farmer specifically identified the costs of fertilizer and fuel, stating *that infrastructure costs went up and your productivity/produce went down*. It was observed by one of the farmer participants that the remote locations of many farmers meant farmers had to bear increased costs of fuel and education for their children. The major increases in fuel prices had an effect on social contact, conflicting with the demands of today's generation regarding travelling around to sporting events and other activities.

4.2.1.2 Climate change

One health professional noted with concern that as Governments have started to work together to address climate change, they have been distracted from dealing with the economic crisis: *I feel personally depressed about that because there was a chance that Kyoto would get signed off … and farmers are very aware of the problems of climate change*. It was also pointed out by an agency participant that climate change is big pressure, and that farmers and rural community are *expected to do something about it and we don't really know what it is that we need to do.*

4.2.1.3 Health

Ageing and medical issues were raised by all participants; these included the problems of long waiting lists for hospital treatment, and the link between pain and depression. Care for ageing family members (including those with dementia and those who have lost the ability to function normally in their family or work roles) was also seen to add to financial and emotional pressure; and the lack of health services in rural areas to add to this stress.

Health professionals considered that the main impact of the pressures on rural people was on their mental health, manifested particularly by an increase in levels of depression. Reference was made to the high rate of suicides in local regions — every participant could provide examples of this. One agency participant stated that suicide had been increasing in the local district, with an increase in older men; a farmer knew of two suicides in his locality in the last 6 months; and an agency participant was aware of one district where *80% of the primary producers are on anti-depressant medication.* Participants stated that in recognition of the increase in suicides a multi-agency Suicide Task Force had been established.

4.2.1.4 Mining

Mining was also seen as a pressure on farmers: *that's huge … farms are being bought up and people are losing their way of life … farmers are getting compensation for their land, but sons who were expecting to take over the farms now have to look for other land, not as good … and will lose the community networks they have built up over generations*.

Significant pressures observed by an agency participant included the elevated value of replacement land resulting from mining and real estate interests and potential revenue from selling water licenses. A farming participant noted that fear of their land/farm being taken from them was a big pressure on farmers. Some of the large mines had taken prime

agricultural land, and *these lands would never be the same*. It was also observed that the mining industry offered large salaries with which farmers could not compete for the rural workforce.

However, one positive impact of the pressure from mining was noted by an agency participant, who described how some farmers had come together in an innovative community approach to fight for their land (although the participant observed that this community togetherness *would be temporary*).

4.2.1.5 Governance

An agency participant noted that there were increased pressures on farmers and agencies due to changes in federal and state Government regulations, stating that the *current government is not 'rural–friendly' ... which has ... a fairly significant impact and ... farmers have certainly noticed that*. The recent amalgamation of Local Councils was seen by the farming participants as another big pressure, with increases in rates and other costs. One participant stated that his amalgamated Council went from being several successful local councils which *have looked after the community* to now being *run by the bureaucrats, which is totally different to the way it was run out there on a one-to-one personal basis*. But another farming participant believed that amalgamation was desirable on a more local level, with smaller towns getting together in the region rather than a large amalgamation of large towns, *making them more efficient rural councils*.

4.2.1.6 Family breakdown

A view by a professional health worker was that once people are faced with financial problems and disruption there is an increase in divorces: *combine divorce with debt and you get death*. Another health worker observed that for *a lot of farmers* (facing this situation) *the last thing they would ever do is go to a hospital and look for help to do with mental health ... no matter how bad things were*. It was pointed out by someone else that pressures on relationships were increased because men are not prepared to discuss their mental health concerns with their wives or family; but they are more likely to talk with other men, if given the opportunity.

4.2.1.7 Loss of infrastructure

One landholder participant noted that a big impact on farmers was road travel which was becoming unsafe with *an increase in traffic and the money is simply not there to make roads satisfactory*. This was backed up by an agency participant who added that the *infrastructure is getting worse and deteriorating more quickly*.

4.3 Retrospective Views

4.3.1 AEAs

One year after their training, AEAs were very positive about the course in terms of the way it had been run and the relevance of content. The course had had a positive impact on their confidence and their understanding of mental health issues. Key messages AEAs said they received from it were the concept of relating mental health training to traditional first aid, the

importance of talking about suicide and depression, and learning how to recognize warning signs of suicide.

Course participants were asked to rate their levels of gain in understanding about mental health issues and pathways on a 1-10 point scale where 1=no gain in understanding and 10= significant gain in understanding. They were also asked to rate their level of gain in confidence in using this knowledge in their interaction with clients and colleagues. The AEAs indicated moderate to good gains in understanding (mean=6.8) of mental health issues and pathways to address them but, importantly, also indicated a gain in confidence (mean=6.9) with respect to recognizing mental health problems and guiding people to appropriate assistance.

The benefit of the MHFA training course was also rated by participants on a 1–10 point scale, where 1=little benefit and 10=high level of benefit. Analysis of data showed that the respondents rated the course as moderate to quite beneficial (mean rating 6.5); but some expressed difficulty in representing their levels of gain on a single scale.

Improved confidence at work emerged as a common theme in their comments. Some respondents also benefited personally and professionally from having a better understanding of mental health issues: *I have the satisfaction of knowing that I can do my job better and that I'm not missing any of the signs now.*

The majority (11) made positive comments about the course, with many commenting on the new skills and understanding of mental health issues that the course had given them. There were no negative comments; and those quoted are indicative of the general feeling among respondents:

1. *In terms of the concept, I think it is good and targeted at the right audience. However, the way it is related to rural situations could probably be improved by providing case studies of farmers.*
2. *When I speak to people about the course, I tell them that it is one of the best courses I have ever attended in terms of gaining a new realization about the raft of mental health issues that are out there. I have also developed a new attitude to people with mental health issues.*
3. *The course was very intense because we were being confronted with a lot of stuff we didn't know about, and it turned out to be very relevant. We didn't think we needed to know about it beforehand but then realized how relevant it really was.*

Since completing the training, most respondents (12) had come across clients/colleagues suffering from stress, depression or other mental health issues: all said the knowledge gained at the course helped increase awareness of the situation and provided them with the ability to identify the problems. They also said that they engaged with the person differently from how they would have done prior to attending the course. Five participants reported further that they had improved levels of confidence in both identifying a mental health problem and in providing initial interventions. A few respondents reported greater levels of understanding and empathy towards clients and colleagues suffering from mental

health problems: *The course gave me a greater understanding of a particular client's behavior. I realized he is probably manic depressive, and understanding his mood swings made me more patient and less defensive and reactive.*

More than half (56%) had referred someone for help since attending the course: in most cases this took the form of suggesting a mental health professional or a support service. Some (20%) were able to provide initial counselling before making a referral to professional services. In one case, a respondent used specific advice given by the course facilitator to help a family member: *I have a colleague who was feeling overwhelmed, stressed and depressed. I gave her the contact details for a psychologist I know, who could help her work through the issues.*

4.3.2 Focus Groups

A number of the stakeholder focus group participants had had some personal experience with the course (or similar training), and were very positive about what they had seen or observed. Supporting information, tools and associated Websites were also referred to as positive initiatives.

The need to target people coming into close contact with farmers was emphasized by an agency participant, and a farmer noted that there may be other people in addition to AEAs who may even be better placed to help the farmers — for example, agronomists, experienced producers, etc.

The same farmer was concerned whether *a little bit of knowledge can get you into a lot of trouble ... and if there was a possibility of a person ... giving their own personal advice and getting involved ... rather than referring on to professional help*, and whether this possibility was acknowledged in the training. He was answered by an agency participant who had actually undertaken the training, and who stressed that the whole aim of the course was to recognize and refer on to professional aid, drawing a parallel with first aid training.

4.3.3 Supervisors of the AEAs

Five respondents reported that one of their staff members had undertaken an MHFA course — one had been in a different position at the time, not supervising the staff member who attended the course.

Supervisors understood that the course was about suicide prevention and awareness training in a rural context. They understood the aim of the course was also to equip their staff with the skills to detect and respond to potential mental health problems, particularly among farmers with whom they come in contact.

Most supervisors (6) felt that it was beneficial for their staff to have a better understanding of mental health issues in order to better interact with farmers, many of whom are in stressful situations and prone to depression or suicide. One supervisor was impressed by the first aid concept and was keen that his staff learn to identify early warning signs. Two supervisors also identified personal benefits for employees who attend such a training course. One supervisor had received feedback from a staff member that the course had provided new ideas while another reported that the employee was now better able to identify mental health

issues with clients. One reported that a staff member now seemed to have improved skills in social interaction, and another commented that the staff member had an increased level of awareness as a result of attending the course.

4.4 Reaction to Results/Impact of the Training

All the focus group participants were positive about the results of the training and its impact on participants. One health professional participant reflected that she *thought it was a great concept when I heard about it ... pleased to see the results ... seemed to have worked.* Another noted the example where one participant, reflecting on a client, had said *at first I thought he was nuts* and was then able to relate to the client positively after the course: *that's a great result and things like that will help mental first aid.* He also commented on the value of linking networks together as a positive action which would impact on mental health in rural communities. An agency participant commented that *the results weren't surprising ... in that they made a positive impact*.

A health professional participant noted that *the work has been very beneficial ... and confirms what we have found with our work with the older people ... and would be interesting in linking into any further activities.* He pointed out the value of building on the MHFA course by encouraging further training opportunities. An agency participant noted that it is *always a good thing to do to tackle the network which is most influential.* It was observed by an agency participant that he had *heard stuff here today that I hadn't heard before and thought it was really encouraging and could make a difference.*

4.5 Building on the Findings

Stakeholder focus group participants were very positive about the results of the research to date and raised the subject of the value in extending it to private sector service providers.

- Health professional participants expressed interest in the results of this study for their staffs/organizations — *particularly if in a more user-friendly format than published papers ... that would be fantastic*. The value of building on the networks and being able to make staff aware of other organizations, initiatives, information and training was also raised as important follow-up; and there was interest in having such training evaluated.

- All farmer and agency participants agreed that further training and follow-up was needed, with one participant reflecting *you take a lot of things for granted and when it happens in your back door… Let's hope it gets followed through further and something comes out of it because it is very important thing to deal with.*

- One agency participant likened the MHFA training to first aid, being concerned whether the theoretical knowledge could be applied in a practical scenario, and saw the *value of ongoing training*. This was backed by all participants, who acknowledged that a refresher course would be valuable follow-up to the training.

- A farmer stated that in his grain-growers' association they are looking for ways to service their members and stated that *there is really no more important way to service*

their members than this… this is probably one of the most important things that could and should be done for farmers, and there was wholehearted agreement.

- Another noted that although going through agronomists and such networks was a good thing for men, there was very little contact with women. This participant queried how many women were also suffering and which networks would benefit them.
- All participants thought the research needed to be built upon. An agency participant suggested that it was necessary to continue *to take advantage of the innovative approach of being the first cab off the rank*. One farmer commented that there needs to be more awareness of mental health issues in the community; and reference was made by other participants to 'Beyond Blue' and groups run by RHealth.
- Taking the research and results to the politicians, to heads of Government agencies and to health agencies was thought by many participants as one way to build on the work and carry on the program. Reference was also made by a few of the participants to the need to target the popular press and to contact local radio.
- An agency participant recommended that to build on this work, a network of people who have trained in Queensland needs to approach groups/communities, in order to create an environment of understanding and openness about these issues.
- An agency participant reflected that *this is important research … depression affects everyone and it* (the program) *needs to be continued.*
- One AEA said: *The majority of respondents would like to have further training in mental health. Most have interest in a refresher course to keep our skills sharp, while some would like more advanced training in specific areas — identifying stress over the phone, e.g., and role-playing real-life scenarios… I think that, as with first aid courses, it would be good to do a refresher course. This is because if you're not using the tools all the time, you might need the opportunity to refresh your skills so that they'll be sharp when you need to use them.*

4.6 Wrap-Up/Re-Statement

It must be noted that this is only a pilot project: at best can only gain insight to inform future actions and decisions, rather than provide definitive quantitative conclusions. However, the project was extensively evaluated using quantitative tools to gauge gains in knowledge and confidence and changes in attitudes before and after training; and this follow-up impact evaluation has captured details of how it impacted on individual participants of the course.

The aim of the pilot was to explore the notion: is it beneficial to target rural service providers with basic knowledge of mental first aid as a targeted way of providing such support within the rural community — particularly farmers, who are isolated and lack the institutional support provided in urban areas?

The initial quantitative analysis rigorously demonstrated that participants who undertook the course did gain in knowledge, skills and confidence; and also showed changes

in attitude towards those with mental health issues, and towards the value of the various actions to address these.

These findings are congruent with previous studies (Hossain et al., 2009; Innovative mental health crisis support gains foothold in U.S, 2008; Jorm, Kitchener, & Mugford, 2005; Kitchener & Jorm, 2002a; Kitchener & Jorm, 2002b; Anon, 2007; and Shortt, Fealy, & Toumbourou, 2006), and these exposures help the AEAs in changing their personal attitudes to deal with mentally ill clients more effectively.

This follow-up study has demonstrated that:

1) pressures on rural people are increasing;
2) stakeholders and course participants see this type of training as very much needed and highly beneficial;
3) course participants had positive experiences with this particular MHFA training course, and gained personally from it;
4) some supervisors have already observed some direct changes, and all are supportive of this type of training;
5) course participants gained in their ability to deal with colleagues, farmers and friends exhibiting symptoms of mental health problems; and
6) course participants have directly used the new knowledge and skills from the training to assist others.

It can be concluded satisfactorily that providing training in mental health issues to rural service providers can be very beneficial to their farmer clients and their social network, to them personally and to the colleagues with whom they interact.

It is recommended that:

1) the findings from this pilot are summarized and made available to others through fact sheets, press releases and seminars;
2) politicians working in both civil and industrial portfolios are particularly targeted, so as to make them aware of the type of training and resources available for appropriate groups and to encourage them to take action; and
3) this type of training should be encouraged amongst other rural service providers and in particular private sector providers.

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