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ORIGINAL RESEARCH

Value of Mental Health First Aid training of Advisory and Extension Agents in supporting farmers in rural Queensland

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ABSTRACT

Introduction: This study was a pilot project responding to the increasing levels of stress, depression and other mental health issues in Australian rural areas resulting from prolonged drought and a changing economic and social environment.

Methods: Thirty-two Advisory and Extension Agents (AEAs) attended a training course held in 2007 and 2008 in Queensland, Australia. A year after the training, data was collected to determine its value. Interviews were conducted with course participants and their supervisors and focus groups were held with stakeholders (farmers, agency staff and health professionals).

Results: The findings show that Mental Health First Aid training improved the participants' confidence level and their knowledge of mental health issues and increased their empathy toward persons with mental health problems. Furthermore, providing training on mental health issues to AEAs was perceived by stakeholders to be beneficial to both farmers and AEAs.

Conclusion: This study demonstrated that stakeholders and course participants see this type of training as very much needed and highly beneficial. Further, providing training in mental health issues to rural service providers can be very beneficial to their farmer clients and their social network.

Key words: attitudes, capacity building, confidence, farmers, knowledge, mental health, symptom.

Introduction

Advisory and Extension Agents (AEAs), who are variously named extension officers, landcare officers, financial counsellors, agribusiness officers, catchment management officers, customer service officers, facilitators, and farm inspection officers are employed in Queensland by both government and non-government organisations to provide advice and support to farmers.

Offering Mental Health First Aid (MHFA) training to AEAs was a pilot project which responded to the increasing levels of stress, depression and other mental health issues in rural areas resulting from the prolonged drought and floods and other pressures facing people 'on the land' (farmers). The project sponsored a number of AEAs from agencies working with farmers in Queensland, Australia to undertake a mental health training course. As well as hoping to directly benefit the participating staff and the farmers with whom they interacted, the project was aimed at providing a basis for determining the investment value of this type of training.

In comparison with urban communities rural and remote communities suffer additional disadvantage owing to their isolation and limited access to health and mental health resources[1-4]. Natural disasters can give rise to feelings of loss of control and mastery, fear, helplessness and futility, and in the long term there may be an increased risk of psychiatric morbidity[5]. The distress arising from drought is likely to be associated with mental illness such as depression and anxiety[6]. These situations suggest a need to initiate effective measures to address diagnosis, treatment and support of this vulnerable group. One initiative is the delivery of need-based mental health training directed to AEAs who are involved in working with rural farming communities. Service providers such as these are often the first port of call for emotional support and referral for farmers[7].

The AEAs who have regular contact with farmers are in a position to be the first to recognise a mental health concern and provide initial support, yet they are limited by their qualifications, skills and role in what support they might offer[8]. At a series of workshops held in 2007[4] with AEA employer agencies, farmer representatives and health professionals it was recognized that, by being at the forefront of contact with farming communities, AEAs could benefit from the knowledge of how to assist people in the community. By training them on mental health issues and individual resilience, it was anticipated that they would have increased knowledge and skills in recognising mental health symptoms, referral pathways and supporting farmers who were experiencing difficult times.

This initiative took the form of training and the significant benefits were intended to build the capacity of the AEAs, that is, increased knowledge and confidence and changes in attitudes toward people with mental health problems. Thomson and Pepperdine defined capacity building as 'an ability to act'[9]. That is, capacity building programs increase the ability of individuals to alleviate stresses, worries and frustrations through provision of resources and greater understanding of attitudes and values.

The mental health training program involved 12 hours of training over two consecutive days[10]. The course gave an overview of the major mental health problems in Australia, introduced the five steps of MHFA (ie assess risk of suicide or harm, listen non-judgementally, give reassurance and information, encourage to seek professional help, and encourage self-help strategies), and then applied these steps to the problems of depression, anxiety disorders, psychosis and substance use disorders. Participants learned the symptoms of these disorders, possible risk factors, and where and how to get evidence-based effective help. The course also covered how to help a person in the following mental health crisis situations: a person who is suicidal, a person having a panic attack, a person who has experienced a traumatic event, a person who is acutely psychotic and perceived to be threatening, and a person who has taken an overdose of drugs. Further details of the course can be found at the Mental Health First Aid website (www.mhfa.com.au).

The same accredited instructors taught all the courses in Toowoomba, Queensland, Australia and used scenarios for instruction that were relevant to the participants.

In 2007 and 2008, 32 AEAs were recruited from both government and non-government organisations working in Queensland, Australia, namely the Department of Primary Industries and Fisheries (DPI&F), the Department of Natural Resources and Water (DNRW), the Queensland Murray Darling Committee (QMDC), AgForce and the Condamine Alliance (CA) to participate in the MHFA training. The participants self-nominated and were sponsored by their employers to attend the training

Purpose

Some early results of this project have been presented elsewhere[4,11,12]; this article reports on data collected a year after the training to determine whether involvement in the *Mental Health First Aid* training course had an impact on participants' post-training. The specific research objectives were to describe the views of :

1. The AEAs in terms of usefulness of the course materials and the benefit of interacting with clients exhibiting signs of mental health problems.
2. The AEAs' supervisors and other rural stakeholders in the light of their direct experience with this course.

Methods

A year after the training an independent evaluator was recruited to assess the use and impact of the training. The time since training was chosen in order to provide a reasonable amount of time for participants to apply the knowledge and skills gained from the training. This research determined the perceived value of the training by: (i) the course participants and their immediate supervisors; and (ii) stakeholders, namely farmers, other AEA employer staff and health professionals. The study used a survey of course participants, interviews with participants' supervisors and focus groups with farmers, agency staff and health professionals to determine the use and impact of the mental health training.

Ethics approval for the study was given by the Human Research and Ethics committee of the University of Southern Queensland.

Data collection

Thirty-two AEAs from 5 organisations participated in the mental health training course. They were recruited from both government and non government organisations working in Queensland, Australia; DPI&F, DNRW, QMDC, AgForce and CA. Prior meetings with each organisation had revealed interest in the program and the organisations solicited self-nomination from within their staff. Once identified, the participants were divided into two groups, balancing employer, sex and age distribution between the groups as much as possible. The initial intention was for random selection into the groups; however, owing to ongoing job commitments some participants self-selected into a group.

Of the 32 AEAs, the independent evaluator was only able to contact 21 for interviews in October and November 2008, of whom 15 agreed to participate in the survey process. Potential survey respondents were initially contacted via email and then telephoned to arrange an interview time. Responses were entered into a shadow survey online for collation purposes. Twelve months after the training contact was made with six supervisors of the course participants and they were interviewed by telephone using a semi-structured interview schedule to discover their opinions about the value of the MHFA training for supporting farmers.

Two focus group sessions with senior agency staff, farmers and health professionals were held in November 2008 to collect qualitative data on the use and impact of MHFA training. Each focus group session was of approximately 2 hours' duration and was conducted by a professional facilitator. Before the session participants signed a consent

form to indicate their consent to participate in the program. Participants were identified by their participating organizations (DPI&F, DNRW, QMDC, CA, and AgForce) and letters of invitation were sent to agency staff, natural resource management bodies, farmers and health professionals to attend a focus group session.

Data analysis

A total of nine people participated in the focus groups – two from DPI&F, one from Condamine Alliance, three farmers and three health professionals. Quantitative data were analyzed using the program SPSS 17.0 (SPSS; Chicago, IL, USA; www.spss.com). Descriptive statistics such as frequency distribution, means and standard deviations were analyzed. Qualitative data derived from the focus group were recorded, transcribed and subsequently analyzed for themes.

Results

Demographic profiles of course participants

Fifty-nine percent of course participants were female. The age of participants ranged from 21 to 60 years (mean 38, SD =13.14). Fifty-six percent had 5 or fewer years of work experience. Nine of the participants indicated that they had experienced a mental health problem sometime in their life and 21 indicated that at least one of their family members had experienced a mental health problem (Table 1).

Views of course participants

One year after their training AEAs were very positive about the course in terms of the way it was run and the relevance of the course content. The course had a positive impact on their confidence and understanding of mental health issues[11,12]. Key messages the AEAs said they took from the course 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.

Understanding mental health issues

Course participants were asked to rate their level 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 on the same scale. This scale was used to measure the participants' understanding and confidence in using the MHFA training.

The AEAs indicated 'moderate' to 'good' gains in understanding (mean = 6.8, SD = 3.29) of mental health issues and pathways to address them but, importantly, also indicated a gain in confidence (mean = 6.9, SD = 2.89) with respect to recognizing mental health problems and guiding people to appropriate assistance.

Benefit of Mental Health First Aid Training

The *benefit* of the MHFA course was also rated by participants on a 1–10 point scale, where 1 indicated 'little' benefit and 10 a 'high level' of benefit. Respondents rated the course as 'moderate' to 'quite beneficial' (mean 6.5, SD = 3.34).

Improved confidence at work emerged as a common theme in their comments. Some respondents (AEAs) 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.*

Table 1: Participants' demographics and experience of mental health problems

Variable	*N* (%)
Sex	
Male	13 (41)
Female	19 (59)
Age (years)	
< 25	4 (13)
25-34	11 (34)
35-44	6 (19)
≥45	11 (34)
Years working as an AEA	
≤5	18 (56)
>5	14 (44)
Ever experienced a mental health problem?	
Yes	9 (28)
No	23 (72)
Has someone in your family ever experienced a mental health problem	
Yes	21 (66)
No	11 (34)

AEA, Advisory and extension agent.

The majority of respondents ($n = 11$) 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:

> *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.*

> *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 ($n = 13$) had come across clients/colleagues suffering from stress, depression or other mental health issues. All of them said that 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 behaviour. I realized he is probably manic depressive, and understanding his mood swings made me more patient and less defensive and reactive.*

Nevertheless, the majority of respondents would like to have further training in mental health. Most have interest in a refresher course to keep their skills sharp, while some would like more advanced training in specific areas, for example identifying stress over the phone, 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.

Stakeholders' views

Focus group participants: 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'.

A number of the stakeholder focus group participants had some personal experience with the MHFA course and were very positive about what they had seen or observed from such training. Supporting information, tools and 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.

Another 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.

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. The 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.

Similarly, 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 a 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 said that his grain-growers' association is looking for ways to serve their members and stated, with general agreement:

> *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.*

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 the support organisation 'Beyond Blue' (www.beyond blue.org.au) and to support groups run by the regional Division of General Practice, Rhealth (www.rhealth.com.au).

Taking the research and results to politicians, heads of government agencies and 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. Another agency participant reflected that 'this is important research … depression affects everyone and it [the program] needs to be continued'.

Supervisors' views

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 ($n = 6$) 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 at risk for depression and 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.

Discussion

It should be noted that this was a pilot project. While the results can inform future actions and decisions it is not possible to draw definitive conclusions. However, the pilot has been evaluated, using quantitative and qualitative methods, to examine gains in knowledge and confidence, and changes in attitudes[11,12]. This 12 month follow up focused on the impact of the MHFA course on participants.

The aim of the study was to explore whether acquisition of basic knowledge of MHFA by rural service providers, by participating in a MHFA training course, is useful in providing support to farmers in a rural community who are isolated and lack the institutional support provided in urban areas. The study demonstrated that course participants (AEAs), their supervisors and other stakeholders see this type of training as highly beneficial. Some supervisors indicated that they have observed some direct changes, with all being supportive of this type of training. After the training the AEAs indicated that they had been given new

skills and understanding[11] of mental health problems. Kitchener and Jorm[13] had previously evaluated the impact of the MHFA course and our results are congruent with their findings.

The training has improved the mental health knowledge[11,12,14] of the AEAs and they are more confident in dealing with colleagues, farmers and friends exhibiting symptoms of mental health problems. These findings fit with the capacity building notion[9]. Thomson and Pepperdine stated that capacity building programs improve the abilities and attitudes and values necessary for alleviating stresses, worries and frustrations.

The AEAs also stated that they have directly used the new knowledge and skills from the training to assist others.

This pilot should be replicated in other, similar, client-oriented services.

Limitations

One of the limitations of this study is the relatively small sample of AEAs in Queensland. Another possible limitation is that although the study was conducted with employees of the largest organisations employing AEAs in Queensland they are not necessarily representative of the whole country. There is a possibility that in other states of the country, with different characteristics, the opinions of AEAs may vary.

Replication of the study on more diverse and larger groups of AEAs is vital to determine whether the findings on confidence and knowledge towards the people with a mental health problem can be generalized. In addition, the present study is a pilot for future intervention studies on similar issues.

Conclusions

The training enhanced the AEAs knowledge about mental health problems and confidence in their abilities to recognize symptoms of mental disorders, and in their capacity to deal more effectively with clients with mental health problems. This follow-up study has demonstrated that:

1. Stakeholders and course participants see this type of training as very much needed and beneficial.
2. Course participants had positive experiences with this particular MHFA training course, and gained personally from it.
3. Some supervisors have observed some direct changes, and all are supportive of this type of training.
4. Course participants gained confidence in their ability to deal with colleagues and farmers exhibiting symptoms of mental health problems.
5. Course participants have directly used the new knowledge and skills from the training to assist others.

It can be concluded that providing training in mental health issues to rural service providers can be beneficial to whether improved knowledge and confidence among the AEAs actually results in benefit to their farmer clients is an issue for investigation.

The results of this study suggest that this type of training should be encouraged with other rural service providers, including private service providers.

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