

Effects of mental health training on capacity, willingness and engagement in peer-to-peer support in rural New South Wales

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Abstract

Issue addressed: Rural Australians experience significant barriers in accessing mental health services, some of which may be overcome by increasing mental health literacy in rural communities. This paper evaluates Mental Health Support Skills (MHSS), short training courses developed by the Rural Adversity Mental Health Program (RAMHP). MHSS was designed to build the capacity of community members and gatekeepers to identify people with mental health concerns and link them to appropriate resources or services.

Methods: Program data from April 2017 to March 2020 were analysed to assess the reach and outcomes of MHSS training. Training feedback was collected through a post-training survey, completed directly after courses, and a follow-up survey two months after training. An app used by RAMHP coordinators (the trainers) recorded the geographic and demographic reach of courses.

Results: MHSS was provided to 10,208 residents across rural New South Wales. Survey participation was 49% (n = 4,985) for the post-training survey and 6% (n = 571), for the follow-up survey, two months post-training. The training was well-received and increased the mental health understanding and willingness to assist others of most respondents (91%-95%). Follow-up survey respondents applied learnings to assist others; 53% (n = 301) asked a total of 2,252 people about their mental health in the two months following training. Those in clinical roles asked a median of 6 people about their mental health, compared to 3 for those in nonclinical roles. Most follow-up survey respondents (59%, n = 339) reported doing more to look after their own mental health in the two months after training.

Conclusion: These results are encouraging as they suggest that short-form mental health training can be an effective tool to address poorer mental health outcomes for rural residents by improving the ability of participants to help themselves and the people around them.

So what?: Serious consideration should be given to short mental health courses, such as MHSS, to increase literacy and connection to services, especially in rural areas.

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KEYWORDS

capacity building, health literacy, health promotion theory, mental health, rural population

1 | INTRODUCTION

One in five Australians aged 16-85 years old experience a mental illness each year; while almost half (45.5%) will experience a mental illness during their lifetime.¹ The rate of mental illness is comparable between urban and nonmetropolitan Australians, however, rural residents have poorer mental health outcomes and rates of suicide and self-harm are higher outside of the major cities.²⁻⁴ People who live outside Australia's major cities have considerably less access to mental health services,⁵ and experience serious structural and attitudinal barriers to their use.⁶⁻⁸ Service access issues are complex, involving provider-level barriers, such as affordability and appropriateness, and service user level challenges such as reaching and engaging with services.⁹ Attitudinal barriers to service use that may be more prevalent in rural areas include low mental health literacy,^{6,10} high levels of stigma associated with mental illness,¹¹ perceived lack of anonymity using specialist services in small communities and stoic, self-reliant attitudes about help-seeking.^{11,12} The diversity of factors affecting service use suggests that increased funding for services alone will not necessarily solve the rural access problem, rather that varied and tailored interventions are needed.¹³

Training in mental health has been consistently recommended as a strategy to improve mental health outcomes.¹⁴⁻²² Training has commonly focused on improving mental health literacy, which has been defined as the "knowledge and beliefs about mental disorders which aid their recognition, management or prevention".²³ Poor mental health literacy is associated with poor mental health outcomes.²⁴ Mental health outcomes have been improved by training designed to increase people's ability to recognise mental illness and seek mental health information, and by training designed to increase people's knowledge of risk and protective factors, self-treatment and professional services.¹⁶⁻²² Mental health training can increase participants' confidence to help others, the likelihood they will advise people about professional care and resources, their concordance with professional recommendations for treatment, reduce the stigma associated with mental health¹⁴⁻²⁰ and improve the mental health of participants themselves.²⁶⁻²⁸ Thereby increasing people's mental health literacy and ability to seek and provide support. Additionally, training key stakeholders with existing relationships and networks in rural communities has been suggested as an effective way to improve rural mental health.²⁹

This paper focuses on the Rural Adversity Mental Health Program's (RAMHP) Mental Health Support Skills (MHSS) courses delivered between April 2017 and March 2020. The geographic and demographic reach of courses and the training outcomes are described. Findings are used to assess the value of RAMHP training courses in building participants' capacity, willingness and engagement in peer-to-peer support in rural New South Wales (NSW). The results will inform program strategy for future community training,

enabling broader engagement and may be of broader interest to mental health organisations.

1.1 | The RAMHP program

RAMHP is a key program of the Centre for Rural and Remote Mental Health, University of Newcastle. It has been funded by the NSW Mental Health Branch since 2007. Nineteen RAMHP coordinators are funded by the Centre and employed by NSW Health in rural Local Health Districts (LHDs) to deliver mental health training, disseminate mental health information and work in partnership with rural organisations to create integrated responses for priority groups and issues. Further details of RAMHP strategies, context and history are described on the website³⁰ and elsewhere.^{31,32}

1.2 | The RAMHP training intervention

RAMHP provides mental health training to rural and remote residents of NSW. The training model assumes that upskilling as many people as possible, geographically and demographically, will increase the capacity of rural communities to assist one another to find support for mental health concerns. Therefore, the purpose of RAMHP's training model is to build mental health literacy and how to translate that knowledge to action. Building community capacity capitalises on social cohesion that may be stronger in rural areas.³³ RAMHP focuses equally on delivering training to community members (to support their own wellbeing as well as to assist family, friends, colleagues and work clients) and to gatekeepers (professionals whose role brings them into regular contact with people at risk of mental illness).

Training offered by RAMHP includes Mental Health First Aid,^{27,34} tailored training (courses tailored for stakeholders) and short MHSS courses for different community groups including workplaces, volunteers and the general community. MHSS courses (1-3 hours, no participant cost) were developed in response to community feedback that it was difficult and unaffordable to attend the two-day Mental Health First Aid course. The core content and learning objectives of the MHSS course are outlined in Table 1.

1.3 | Training reach

RAMHP provided Mental Health First Aid, tailored training and Mental Health Support Skills training to 32,232 people between April 2017 and March 2020. Of these, 10,208 people attended MHSS (the focus of this paper) in 582 separate courses in rural NSW (see Table 2). This information was captured using a purpose-built

TABLE 1 Overview of RAMHP Mental Health Support Skills training objectives and content

Objective	Content
To improve knowledge of mental health and mental health problems	<ul style="list-style-type: none"> • What is mental health? • What is stress and how can it affect mental health?
To build capacity to identify someone experiencing a mental health concern, raise it with them and link them to services and resources	<ul style="list-style-type: none"> • Signs to look for in someone who is experiencing mental health problems • Suicide risk • Having a conversation with someone we are worried about
To improve awareness of relevant services and resources	<ul style="list-style-type: none"> • Where to get help • Self-care

TABLE 2 Training audience type of Mental Health Support Skills participants in rural NSW, April 2017-March 2020 (n = 582)

Training audience	Courses
	% (n)
Government or council	17% (101)
Primary industry	17% (96)
Community group or organisation	12% (69)
General community members	9% (54)
Private business	7% (42)
Mental health staff	6% (34)
Other ^a	32% (186)

^a'Other' comprises small sector groups, none of which account for more than 5% of the total (including physical health professionals, education, emergency services, social services and sports groups).

app (described elsewhere³⁵). The number and distribution of training courses differ in part according to the number of RAMHP coordinators employed in each LHD, which varies over time, and the areas they serve that vary considerably in population and geography.³⁶ Figure 1 shows the location of MHSS courses in NSW, the number of courses and full-time equivalent RAMHP coordinators in each LHD and geographic information. The Central Coast and Sydney LHDs (0 and 19 training courses respectively) are excluded due to the metropolitan population.

Training courses were mostly delivered to people employed in government or council (17%, n = 101) or primary industries (17%, n = 96), followed by community groups or organisations and general community members (Table 2).

2 | METHODS

While RAMHP has conducted monitoring and evaluation of training since 2007 there was no systematic collection of reliable program data before 2016.³² Training evaluation that was quick and easy to conduct and acceptable to RAMHP coordinators was of key importance. Kirkpatrick's four-level training evaluation model informed the design of survey tools to ensure the collection of meaningful data. Kirkpatrick's levels 1-3 were utilised; level 1 'reaction' (the degree to

which participants find the training useful, engaging and relevant), level 2 'learning' (the degree to which skills, attitudes and knowledge are acquired) and level 3 'behaviour' (the degree to which training participants apply the learnings after training). Level 4 'results' (the degree to which targeted outcomes occur as a result of the training) was not utilised due to limited evaluation resources.³⁷

Immediate, level 1, training outcomes included participants' mental health skills (awareness, ability, confidence) and knowledge, and their satisfaction with RAMHP training. Two months after the course, level 2 and 3 outcomes were assessed by querying participants' application of what they had learned or how they had changed their behaviour, including self-help and supporting others to access services.

2.1 | Data collection

Three sources of data contribute to these analyses: extraction of RAMHP app data,³⁵ a post-training survey and an online follow-up survey conducted two months after training. The RAMHP app records training activities, including the location, date and type of training, audience sector or description and the number of participants.

RAMHP coordinators provided an anonymous paper-based post-training survey to participants at the end of training courses. The survey was designed to be completed in three minutes. Participation was voluntary and course attendees completed the surveys themselves. It examined the perceived usefulness of training for participants' 'personal life' and their 'role or job' and assessed changes resulting from the training using a 5-point scale from 'strongly agree' to 'strongly disagree'. Additionally, the post-training survey assessed participants' satisfaction with the training rated on a 5-point scale from 'very satisfied' to 'very dissatisfied'.

An optional, anonymous, online follow-up survey was emailed to consenting participants two months after training. A quarterly prize draw (\$60 shopping voucher) encouraged participation. The follow-up survey questions assessed if participants applied the learnings from training and whether the training increased the likelihood that they would seek help if they needed it. Types of support were rated on a 4-point scale from 'extremely likely' to 'extremely unlikely'. Those who reported assisting others were asked how many people they had helped in the two months since the training. They were also asked whether talking with people about their mental

Local Health District	Courses	Area (km ²) [†]	Rural Population [†]	RAMHP Coordinator (FTE)			
				2017	2018	2019	2020
Far West	45	194,949	29,828	1.0	1.0	1.0	1.0
Hunter New England [‡]	167	131,785	751,433	2.0	2.9	3.7	4.2
Illawarra Shoalhaven [‡]	17	5,687	194,333			0.8	1.0
Mid North Coast	47	11,335	216,412	1.1	0.7	1.0	1.0
Murrumbidgee	48	125,242	240,965	2.0	1.7	1.7	1.8
Nepean Blue Mountains [‡]	5	9,179	166,372			0.7	1.0
Northern NSW	57	20,732	296,531	2.0	2.0	2.0	2.0
Southern	46	44,534	205,281	0.9	2.0	2.0	2.0
Western	150	250,000	279,422	1.6	2.0	2.5	3.9
Grand Total	582			10.6	12.3	15.4	17.8

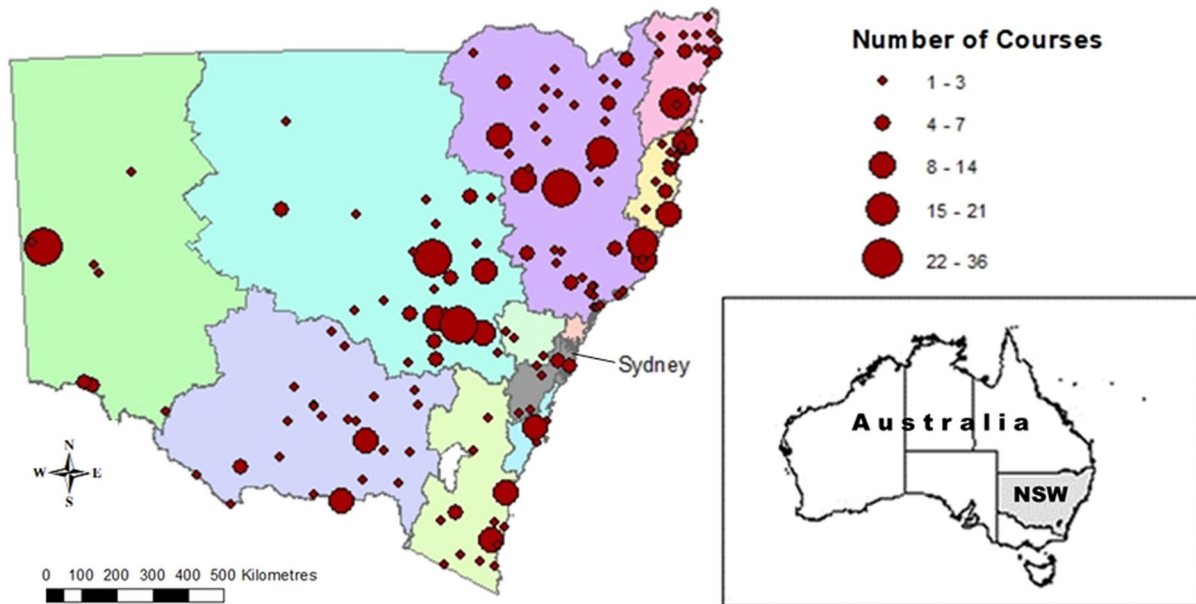


FIGURE 1 Location of Mental Health Support Skills courses delivered in New South Wales, April 2017-March 2020. [†]Data from HealthStatsNSW. [‡]Rural population for these LHDs (HNE, ISH and NBM) have their major urban centres removed – less Newcastle, Wollongong and Penrith (LGA level). ArcGIS 10.6.1 was used to map training locations

health was a formal requirement of their role or job. The survey took approximately seven minutes to complete.

2.2 | Data analysis

Authors used Statistical Package for the Social Sciences 26 (SPSS) to produce descriptive statistics, including frequencies, mean, median and range. Due to the limited variation in the data, the Likert-scale for the post-training survey was simplified to a 3-point scale where 'strongly agree' and 'agree' were combined, as were 'strongly disagree' and 'disagree'. Participants in clinical and nonclinical roles were separated in the analyses from the follow-up survey as participants in clinical roles are more likely to, or expected to, talk to clients about the client's mental health as part of their role. This allowed the analyses to

examine whether lay community members talked to someone about that person's mental health following the training. This paper was not focused on whether there was a significant difference between non-clinical and clinical participants. They were analysed separately in the level 2 and 3 results so that the clinical participants' results did not skew the numbers to return a large effect that would not be representative of participants in nonclinical roles. As such, only descriptive statistics were used. It was not possible to separate these two groups in the post-training survey based on available data.

3 | RESULTS

The post-training survey was offered at 72% (n = 417) of Mental Health Support Skills courses, 4,985 (49% of all MHSS training

participants) people completed the survey. Of these, 3,126 agreed to be contacted for the follow-up survey and 571 people (18% of those offered the survey, 6% of all MHSS training participants) completed the survey. Table 3 shows demographic information of survey respondents.

3.1 | Capacity and willingness to provide appropriate support (post-training survey)

Immediately after the training, 55% of respondents were 'very satisfied', 42% 'satisfied', 2% 'neither satisfied nor dissatisfied' and 1% were 'dissatisfied' or 'very dissatisfied' with MHSS (Table 4). Most respondents agreed that the training had increased their knowledge of mental health and their capacity to provide appropriate peer-to-peer support (Table 4). Almost all respondents reported that they were more willing to connect someone experiencing a mental health concern to appropriate services and information 91%. Most respondents found it useful for their role/job (91%) and their personal life (95%) (see Table 4).

3.2 | Engagement in peer-to-peer support (follow-up survey)

In the two months after the training, over half (53%) of the respondents had asked or spoken with someone about their mental health,

31% had provided someone with self-help resources and 27% had provided contact details for a mental health service or health professional (Table 5). Respondents reported speaking with a total of 2,252 people about their mental health (median = 4, IQR = 5) following MHSS training.

Most survey respondents (79%, $n = 451$) were not employed or volunteering in clinical roles. About half of the nonclinical respondents (49%, $n = 221$) had spoken with a total of 1,244 people about their mental health since the training (median = 3, IQR = 3). Of these 221 attendees, 78 (35%) had provided someone with self-help resources such as a website, book or pamphlet and 68 (31%) had provided contact details for a mental health service or health professional.

In contrast, of respondents in clinical roles (21%, $n = 117$), 67% ($n = 78$) had asked about or spoken with someone about their mental health since the training. Clinical respondents reported speaking with 952 people (median = 6, IQR = 10), and 59% ($n = 46$) provided self-help resources such as a website, book or pamphlet, while 60% ($n = 47$) had provided contact details for a mental health service or health professional.

3.3 | Engagement in self-help for mental health (follow-up survey)

Most respondents in the follow-up survey had become more aware of their own mental health as a result of the training (81%,

TABLE 3 Demographic characteristics of survey respondents, April 2017-March 2020

Characteristics	Post-Training Survey Respondents ($n = 4985$) ^a	Follow-up Survey Respondents ($n = 571$)
	% (n)	% (n)
Gender		
Female	61% (2875)	71% (405)
Male	39% (1863)	29% (163)
Age		
Under 25	8% (394)	6% (31)
26-35	17% (809)	22% (123)
36-45	23% (1069)	19% (111)
46-55	27% (1307)	27% (155)
56-65	18% (850)	20% (115)
Over 65	7% (343)	6% (36)
Identified as Aboriginal and/or Torres Strait Islander	6% (283)	5% (31)
Occupation		
Employed (all sectors)	81% (3840)	85% (487)
Volunteer	8% (401)	8% (46)
Student or apprentice	5% (218)	1% (6)
Other (jobseeker, carer, retired)	6% (260)	6% (32)

^aMissing post-training survey data are indicated where characteristics do not total 4895 respondents.

Measure ^a	Agree	Neither agree nor disagree	Disagree
	% (n)	% (n)	% (n)
This training increased my knowledge of mental health.	92% (4600)	5% (224)	3% (127)
This training increased my awareness of available mental health services and resources.	95% (4661)	3% (162)	2% (114)
This training increased my ability to recognise when a person is experiencing a mental health concern.	91% (4495)	6% (312)	3% (120)
This training increased my confidence to connect someone experiencing a mental health concern to appropriate services and information.	91% (4453)	7% (340)	2% (122)
This training increased my willingness to connect someone experiencing a mental health concern to appropriate services and information.	91% (4451)	7% (356)	2% (109)
This training is useful for my role or job.	91% (4431)	7% (333)	2% (104)
This training is useful for my personal life.	95% (4680)	3% (158)	2% (100)

^aMissing data and 'I don't know' are indicated where rows do not total 4985 respondents.

n = 464), and a majority had done more to look after their mental health (59%, n = 339). A third (34%, n = 193) had spoken to a friend or family member about their mental health, 20% (n = 112) had used a self-help resource such as a website, book or pamphlet and 8% (n = 47) had contacted a service or health professional (Table 5).

Eighty-one percent (n = 464) of respondents reported that the training made it more likely that they would seek help if they were concerned about their mental health. Among these, most would approach a doctor or General Practitioner (93%, n = 421), a friend, family member, partner or colleague (91%, n = 422) or a mental health professional (86%, n = 390). Less popular options for support were employee assistance programs (62%, n = 267) and phone helplines (50%, n = 218).

4 | DISCUSSION

Over three years, RAMHP provided short Mental Health Support Skills training to 10,208 residents from a broad range of geographic locations and sectors in rural NSW, suggesting that MHSS effectively reaches many rural people. The reduced commitment of short courses may make it easier to attract participants, keep them engaged and train a larger population. RAMHP designed MHSS courses for different groups including workplaces, volunteers and the general community to increase its audience appeal and relevance. Evidence suggests this approach can make the lessons from the training and subsequent behaviour changes more likely and more sustainable^{38,39} as well as more appropriate for diverse audiences.¹³

TABLE 4 Rural NSW post-training survey respondents' reported utility of Mental Health Support Skills, April 2017-March 2020 (n = 4985)

The training was well-received and useful to most survey respondents (91%-95%) in both their role/job (91%) and their personal life (95%). Most respondents to the follow-up survey reported using the training to assist others and/or for self-care. The 301 respondents who talked with someone about their mental health after the training, supported a median of 4 people, which highlighted the broader community reach and suggests that the training led to rural people assisting one another. Several respondents reported supporting over 20 people in two months. While the outcome of this support is not known, these people represent a valuable resource in building support networks and encouraging conversations about mental health.⁴⁰ It seems that short-form mental health training, such as MHSS, can contribute to national mental health goals by increasing the visibility of mental health and making it easier to seek support.⁴¹⁻⁴³

Among clinicians and nonclinicians who had reported speaking with someone about that person's mental health since the training, nonclinicians reported lower application of learnings, including providing self-help resources (clinical 59% vs nonclinical 35%) and contact details for mental health services or health professionals (clinical 60% vs nonclinical 31%). Further investigation is needed to determine how the training could be more effective in building capacity to support peers for nonclinical participants. Building capacity among community members to assist one another with mental health concerns is important as findings suggest that people may seek help from a friend, family member, partner or colleague as much as from a doctor or General Practitioner. This supports findings from other studies and suggests that without building capacity in communities, providing greater funding for clinical services alone will not necessarily achieve better rural mental health outcomes.⁴⁴⁻⁴⁶

TABLE 5 Rural NSW follow-up survey respondents' reported use of Mental Health Support Skills to assist others and for self-help, April 2017-March 2020

Training outcome	All respondents ^a (n = 571)	Nonclinical role (n = 451)	Clinical role (n = 117)
	% (n)	% (n)	% (n)
<i>To assist others: As a result of RAMHP training I have...</i>			
Been more aware of other people's mental health	83% (475)	84% (379)	79% (93)
Asked about or spoken with someone about their mental health	53% (301)	49% (221)	67% (78)
Provided someone else with self-help resources such as a website, book or pamphlet	31% (179)	25% (114)	55% (64)
Given someone contact details for a mental health service or health professional	27% (154)	21% (95)	48% (56)
Done some reading in relation to someone else's mental health	26% (151)	22% (98)	44% (52)
Contacted a service or health professional on someone else's behalf	8% (47)	4% (20)	23% (27)
None of the above	14% (79)	15% (68)	9% (11)
<i>Self-help: As a result of RAMHP training I have...</i>			
Been more aware of my own mental health	81% (462)	81% (365)	81% (95)
Done more to look after my own mental health	59% (339)	57% (257)	68% (80)
Spoken to a friend or family member about my own mental health	34% (193)	31% (141)	44% (51)
Done some reading in relation to my own mental health	20% (116)	18% (80)	30% (35)
Used some self-help resources such as a website, book or pamphlet	20% (112)	17% (77)	29% (34)
Contacted a service or health professional about my own mental health	8% (47)	6% (27)	15% (18)
None of the above	12% (67)	13% (59)	7% (8)

^aThree cases did not state whether their job/role was clinical.

Assessing the geographical and demographical reach of MHSS (Figure 1, Table 3) enables managers to determine whether training is reaching particular groups and whether gaps exist. For example, in response to the recent drought, RAMHP has prioritised training to frontline staff of NSW Farmers, the Department of Primary Industries, Local Land Services, Stock & Station Agents, WaterNSW, Essential Energy and the Department of Planning, Industry and Environment. RAMHP's geographic and sector reach are broad, however, survey data suggest that MHSS is attended predominantly by middle-aged, employed women. Harder to reach groups, some of who may be at greater risk of suicide,^{47,48} such as men, the young and elderly, unemployed people and Aboriginal and/or Torres Strait Islanders were under-represented in the courses. This information has informed new projects targeting specific groups, such as the You Got This Mate⁴⁹ tailored website for men's mental health and the partnership with the Baggy Blues Cricket Tour which uses sports to engage men in mental health promotion.

4.1 | Limitations

There are three important limitations to this evaluation. Survey response rates of 49% (post-training survey) and 6% (follow-up survey) are low and it was not possible to generalise findings to a broader

population. Those who completed surveys may have been more engaged in the training than those who did not. Additionally, there was no control group for either survey.

Secondly, two months is a short follow-up time, and a longer period may allow training participants (particularly those in nonclinical roles) more opportunity to apply learnings. A longitudinal study would be valuable to assess the application and sustainability of learnings. Although difficult to evaluate, ideally, Kirkpatrick's level 4 'results' (the degree to which outcomes occur as a result of the training) should be evaluated, that is, whether training improves service use and the mental health of those who are assisted by training participants.⁵⁰

Finally, the novel survey tools used were designed specifically for the evaluation and aligned with the RAMHP logic model and evaluation framework. This survey achieved face validity with the trainers who were nonresearchers (RAMHP Coordinators) and was designed to be easily understood by training participants with a range of literacy skills.

5 | CONCLUSION

The shorter MHSS training courses developed by RAMHP appear to be valued by respondents and associated with a willingness to seek help for mental health concerns and to assist others. This training

may help address the poorer mental health outcomes for rural residents. The learnings are encouraging in the context of the current governmental and public focus on mental health and well-being, and the difficulties in accessing mental health care by some rural residents. Mental health service providers, NGOs, funders and policymakers should continue to examine and enable effective and appropriate methods to address mental health concerns and promote well-being, particularly for rural residents.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

ETHICS APPROVAL

Ethical approval was obtained from the University of Newcastle Human Research Ethics Committee (QA141).

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