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Evaluation of the Trusted Advocates Network Trial (Farmers' Trial) and the Seafood Industry Mental Health Supports Trial (Fishers' Trial)

Final Report

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Abbreviations used in this report

The Department	Australian Government Department of Health
LHD	Local Health District
MHFA	Mental Health First Aid
PHN	Primary Health Network
SIA	Seafood Industry Australia
TA	Trusted Advocate
TM	Trial Manager

Executive Summary

In April 2019, the Australian Government announced funding of $463,815 to nine PHNs in drought affected areas to "help farmers and communities to deal with the uncertainty, stress and anxiety of drought conditions". The funding was to provide support and mental health first aid through a network of unpaid volunteers known as **Trusted Advocates** (TAs) who would be trained and supported to assist them in providing mental health peer support in their local communities. It was a supplement to the Empowering Our Communities grants to the same nine PHNs, which distributed $24.4m over two years, starting in 2018. The Trusted Advocates Network Trial is referred to in this report as the **Farmers' Trial**.

Following lobbying from Seafood Industry Australia (SIA), the Department announced $600,000 from April 2020 to April 2022 to broaden the scope of the Trusted Advocates Network Trial to the commercial fishing industry. This program, the Seafood Industry Mental Health Supports Trial, is referred to in this report as the **Fishers' Trial**. It has three additional components, besides the network of Trusted Advocates: communications support for the seafood industry; community resilience grants; and broader training and community awareness activities.

With up to 10 Trusted Advocates in each target farming community, and three each in the three fishing communities selected by SIA, the Trial had the potential to result in 99 volunteer peer support positions with appropriate training and supervision. Program funds were to be used to reimburse the volunteers for expenses such as fuel, accommodation or food when engaging with community members (for example, if travel is required); those involved in the Fishers' Trial will also each receive $10,000 at the conclusion of the Trial to recognise their contribution of time and effort.

Another key difference between the Trials is that SIA, in consultation with industry, selected the three target communities after receiving the funds, whereas the Farmers' Trial funding was tied to specific communities chosen by the Department of Health. There are six Trial sites in New South Wales, two each in Queensland and Victoria, and one each in South Australia and the Northern Territory (Table 1).

Table 1 Trusted Advocates Trial sites

Community	Trial	State	Population
Longreach	Farmers' Trial	Qld	2,970
Goondiwindi	Farmers' Trial	Qld	6,355
Cooma	Farmers' Trial	NSW	6,681
Coonabarabran	Farmers' Trial	NSW	3,290
Narrandera	Farmers' Trial	NSW	4,375
Newcastle	Fishers' Trial	NSW	457,192
Portland	Farmers' Trial	NSW	2,424
Scone	Farmers' Trial	NSW	5,624
Darwin	Fishers' Trial	NT	157,920
Tailem Bend	Farmers' Trial	SA	1,665
Lakes Entrance	Fishers' Trial	Vic	4,810
Sale	Farmers' Trial	Vic	13,673

The Centre for Health Service Development, University of Wollongong was engaged by the Mental Health Supports Branch of the Australian Government Department of Health to conduct an independent evaluation of both the Trusted Advocates Network Trial (Farmers' Trial) and the Seafood Industry Mental Health Supports Trial (Fishers' Trial). The evaluation was undertaken between October 2020 and April 2021 and this is the final evaluation report covering the period October 2020 to May 2021. It updates and extends the Interim Report (February 2021) and presents information on the implementation and outcomes of the program.

Evaluation data were obtained from two stakeholder groups: the Trusted Advocates (TAs) themselves, and "Trial Managers" (TMs), who are staff of PHNs and other stakeholders including organisations commissioned to provide training and support for the volunteers and coordinators. Data collection from users or "clients" of the program was beyond the scope of the evaluation.

There were two rounds of semi-structured interviews with TMs, the first in November/December 2020 (n=14) and the second in April/May 2021 (n=12). Interviews were also conducted with a purposive sample of TAs (n=28) across eight implementation sites between November 2020 and May 2021. To ensure all TAs had the opportunity to contribute to the evaluation, and to collect data on the extent of their activities, an online survey was run during April and early May. In addition, the evaluation team reviewed documents provided by the Department and the Trial sites, and activity data was requested Trial sites that had recruited volunteers.

As the two Trials have different funding arrangements and the Fishers' trial has additional objectives beyond the recruitment and training of Trusted Advocates, progress on each is reported separately.

Implementation and outcomes of the Farmers' Trial

The implementation of the Farmers' Trial was variable across the nine Trial sites. There was no implementation at three sites as the PHNs were not able to recruit volunteers or to engage with partner organisations to deliver the Trial. Two sites recruited and trained a small number of TAs in partnership with organisations that were well established and equipped to support a volunteer workforce. Four sites implemented the program fully: one PHN elected to deliver the program directly, with support from a steering committee; one engaged early with an external, community-facing partner; and two began with direct delivery and later sought to engage an external partner to provide additional training, support and supervision for the volunteers.

Stakeholder engagement was an essential first step to implementation. Trial sites utilised their existing networks and directly contacted many local organisations and individuals. They also used social media, industry-specific and local media outlets, and written materials to spread information about the program. In some cases, this led to productive partnerships with organisations that were well equipped to deliver the program, or enabled the PHN to recruit Trusted Advocates. At other sites, however, TMs reported that their efforts to establish partnerships with service providers, or to recruit volunteers directly, had been unsuccessful as there was apparently little interest or capacity within the target community to participate in the program. COVID-related social isolation and travel restrictions certainly had an impact, as did distance between the PHN offices and the target communities. There was also a view that stakeholder engagement could have begun earlier, before the selection of target communities. This would have allowed an assessment of needs, and avoided overloading communities where there was considerable drought and bushfire recovery work already occurring and local supporters were at capacity.

Establishing **partnerships with service providers** to deliver the program had notable benefits for the PHNs, allowing them to connect with organisations that had mental health promotion as "core

business", with established infrastructure and systems for training, supervising and supporting volunteers. It also enabled PHNs to leverage off existing initiatives with similar aims. When such a partnership could not be established, some PHNs took on service delivery by default, and for others the implementation stalled. One PHN chose not to commission an external provider because the program was seen as within the organisation's capacity; this approach was perceived as advantageous because the limited program funding could then be used to support the volunteers. The direct delivery approach required a large commitment of time and energy from the PHN and relied on the availability of a staff member who could take on the tasks of project management and ongoing contact with the volunteers. Even with a partner organisation to handle the day-to-day business of program delivery, the program still requires some ongoing input from the PHNs.

Recruiting volunteers with the right skills, qualities, and community connections was not a trivial task; when such people were identified, they were not always willing or available to take on the role of Trusted Advocates. One approach was a broad "call to community" using marketing and media strategies, but this was less successful than targeted approaches. Stakeholders contributed lists of individuals they thought might be suitable and the PHNs or partner organisations contacted them directly, often through a personal phone call. This method tended to be productive, albeit time consuming, resulting in a pool of potential recruits who were then invited to an information session or workshop. Barriers to participation included lack of time or opportunity, especially among younger people and those juggling multiple jobs and roles. Seeking people with lived experience meant that some were struggling with their own mental health and other issues, such as the financial impacts of the drought. The most significant barrier was the stigma around mental health issues; people seemed reluctant to be recognised as someone who had special training in this area.

TMs acknowledged the value of formal **training of Trusted Advocates**. The types of training suggested in the program guidance – Mental Health First Aid (MHFA) and Accidental Counsellor – are intensive courses requiring a considerable time commitment. To make training more accessible, Trial sites offered a wider variety of courses including modified, shorter versions of these two established courses. Flexibility and consultation around the timing of the training has also proved advantageous in keeping the volunteers engaged and committed to the program.

Ongoing **clinical supervision and support** was seen as essential for the Trusted Advocates, with emphasis on maintaining their own physical and psychological safety. There was an awareness of risk, both to the individual and to the organisation, in this type of volunteer role. Trial sites and partner organisations have worked to help TAs maintain appropriate boundaries around their role as volunteers and not go outside the scope of peer support. Partners with experience in training and managing volunteers are well placed to offer monitoring and clinical support around scope and boundaries, as well as debriefing to protect the volunteers' mental health.

Perspectives of Farmers' Trial Trusted Advocates

Interviews with TAs participating in the Farmers' Trial offered some insight into the extent to which they felt adequately prepared for, and supported in, their volunteer roles. Most TAs felt that the training they received to assist them in performing their role was adequate. The more positive training experiences related to face-to-face learning experiences where there was more scope for participant interaction. The degree to which TAs felt supported by the host organisation was mixed depending upon the Trial site. Positive feedback about support provided by host organisations related to regular communication between the TAs and the Trial project manager and the availability of up to date service provider directories.

However, many of the TAs were unclear how they would translate their understanding of the role into practice and would have preferred more guidance or training around how to approach people and initiate conversations. Consequently, the level of confidence in helping someone with a mental health problem was mixed. The impact of COVID-19 and the associated social distancing measures made it more difficult to contact and communicate with members of the public who may benefit from mental health support.

Despite these challenges, six of the 18 TAs interviewed had approached "clients" (that is, members of their communities who were experiencing mental health issues) and initiated conversations. Activity data from one site indicated that a wide range of issues were discussed, including concerns about family and friends, stress and relaxation advice, building trust to approach service providers and attend appointments, support with literacy, dealing with anxiety about recent bushfires, drug and alcohol use, and financial problems.

Implementation and outcomes of the Fishers' Trial

Implementation of the Fishers' Trial progressed quickly during the second half of 2020 and is now well advanced. This has been facilitated through the support of an expert steering committee with existing strong links to the seafood industry and the recruitment of a project officer with highly developed skills in networking and communication. The Fishers' Trial has been branded and marketed (under licence) with the name "Stay Afloat", which is associated with similar interventions in Tasmania and South Australia. The rationale for this was that the name was already well known and links with these two existing programs could be beneficial.

Selection of the three target communities took place following a national consultative process which ensured that each site had a clear commitment to the Trusted Advocates model. Agreed selection criteria and job description were developed to establish an understanding of the qualities and skills required. There was extensive networking with the fishing industry across Australia and particularly in the three target communities, using the contacts of the steering committee to link with potential sources of volunteers. Due to the pandemic travel restrictions, networking was limited to online and phone conversations.

Three volunteers were recruited at each of the three sites; this is the full complement of expected Trusted Advocates for the Fishers' Trial. Each TA participated in "on-boarding" webinars providing detailed information on the role, reporting, housekeeping, confidentiality and the processes of referral to local health services. Trusted Advocates were asked to sign formal Volunteer Agreements which set out the terms of engagement, defined the expectations and role, and presented a list of eight performance standards by which they must abide. All have completed the full, accredited MHFA training, either face-to-face or online.

Self-care of the TAs is considered paramount and clinical support is provided through a monthly group session led by a clinical psychologist who is also a MHFA master trainer. This process is designed to help each TA maintain appropriate boundaries and stay within the scope of the role, handle sometimes difficult conversations, and look after their own mental health and wellbeing. Additional support is available as required.

There has been significant progress on the other three components of the Fishers' Trial (see Section 3.2.4 for details). The smooth implementation of this Trial has been facilitated by careful and detailed project planning and monitoring, including weekly meetings between the project officer and steering committee. Data collected through a national survey, which explored the needs of fishing communities with regard to mental health support and education, has informed project planning.

Perspectives of Fishers' Trial Trusted Advocates

Interviews with seven Fishers' Trial TAs showed that overall they were satisfied with the training they received. They all had a good understanding of their role in the Trial and felt supported by the host organisation. They also valued the opportunity to participate in the monthly TA forums and access to a psychologist for clinical support as required. Peer-to-peer support was also a key feature of the Fishers' Trial given that many of the TAs worked closely together in the local seafood industry.

Due to the later starting date for this Trial, these TAs were in the early stages of engaging with community members. Nevertheless, four out of the seven interviewed had successfully had meaningful conversations with at least one "client". In terms of the challenges that TAs felt in performing their roles these included a perceived lack of time and the relatively low profile of the Trial. Activity data provided by the program manager indicates that despite these challenges, the nine Fishers' Trial TAs have had a total of 330 documented interactions with the public over a five-month period including 72 conversations with individuals.

The internal evaluation of this Trial will continue, reporting to the Department in May 2022.

Discussion and conclusions

The results and discussion sections of this report are structured around the evaluation questions.

1. How well have the Trials been implemented?

Trusted Advocates Networks have been implemented fully at all three Fishers' Trial sites and four of the nine Farmers' Trial sites, with partial implementation at another two Farmers' Trial sites. Analysis of the interviews with TMs highlighted factors that facilitated or created barriers to the smooth implementation of the Trials.

Implementation facilitators included partnerships with local organisations; utilising existing resources and networks; building on previous programs; systematic project planning and management processes; and the commitment and enthusiasm of volunteers.

Implementation barriers included the absence of these facilitators, plus issues around the selection of target communities, difficulties in stakeholder engagement, and lack of clarity around goals and deliverables. The impacts of the COVID-19 pandemic were felt throughout the program.

2. How appropriate were the Trials' designs for the identified needs?

The prescriptive nature of the targeted grants for the Farmers' Trial affected attempts to engage with partner organisations to deliver the Trusted Advocates model, and also had impacts on recruitment of TA volunteers. In contrast, the selection process for the Fishers' Trial ensured that target communities had a demonstrated need for and interest in mental health promotion activities, and the infrastructure to support program roll-out. This suggests that greater opportunity to engage with Farmers' Trial stakeholders across the PHNs at the inception of the program, and involvement of those stakeholders in the selection of the target communities might have been beneficial.

Interviews with TMs revealed inconsistencies in the understanding of program goals and definitions of success. The perceived lack of written guidance or an evidence-based model had impacts on the progress of implementation at some sites. It is likely that this has also contributed to the observed divergence among sites in the way the model has been interpreted and operationalised.

3. What difference are the Trials making?

There is sufficient evidence to conclude that the program has increased the capacity of TAs to deliver mental health support. This has occurred in nine of the 12 target communities: six Farmers' Trial sites and three Fishers' Trial sites. In total 56 TAs were recruited and trained, of the (maximum) 99 volunteers anticipated. The reach of the training has extended beyond Trusted Advocates because of particular training and education strategies employed at some of the Trial sites. A variety of clinical supervision and support models are in place; the most effective strategies are proactive, regular, and involve both personal and professional supports.

Of the original 56 TAs, 52 were actively involved in the program at the time of the final evaluation interviews, across eight Trial sites. There is, therefore, potential for delivery of support and mental health promotion across rural and coastal communities resulting from the program. It was not feasible for the Trials (or the evaluation) to demonstrate impacts on service use or mental health outcomes for the recipients of the mental health support provided by Trusted Advocates.

TAs had high levels of confidence in their roles and most felt well supported. They understood the importance of being good listeners and building rapport. For some, their activities were enhanced by the insights and personal experiences they could share from their own struggles with mental health. There were several specific examples of actions by TAs which had immediate, positive impacts on the people they were trying to help, such as encouraging a person who had suicidal thoughts to seek professional treatment. Some sites have had very positive feedback from the public.

The strong interest in sustainability and spread from some Trial sites is a positive sign that the Trusted Advocates model has demonstrated feasibility and potential benefits under certain circumstances.

4. Were there unintended consequences?

Through a review of documents and inductive analysis of the interview data, the evaluation was able to detect and document several unintended consequences:

- The risk of volunteers experiencing vicarious trauma and stress;
- The risks involved in managing a volunteer workforce;
- Unexpected difficulties in engaging with the public at some Farmers' Trial sites;
- Aggravation of pre-existing community tensions at one Farmers' Trial site.

5. How could the Trials be improved?

There is potential to improve the program by engaging stakeholders in the selection of target communities or sub-populations, developing a clearly articulated, evidence-based Trusted Advocates model, issuing more informative implementation guidelines, and establishing requirements for minimum data collection and outcome reporting across sites. Findings on potential improvements, as well as the challenges encountered, have informed the evaluation recommendations.

Recommendations

1. The Department could reconsider the way in which the program is targeted; for example, by providing guidance rather than mandating the choice of target communities, and allowing flexibility to change target locations within a certain period of time if implementation initially proves unfeasible.

2. The Department could consider developing and evaluating Trusted Advocates Networks that target particular locations, sub-populations or industry groups, with a longer term view to building mental health literacy and community resilience (rather than short-term crisis support). Stakeholder consultations and requests for expressions of interest from representative, community-facing organisations may provide a foundation for selection of program targets.

3. Future efforts to implement the Trusted Advocates Network model should draw on the academic and grey literature around MHFA and other first responder training programs, including what is known about enabling trainees to make meaningful connections with those who might need mental health support. This information should be provided to all Trial sites at the outset of the program, along with the implementation guidance.

4. Rather than funding single communities, the Department could consider establishing centralised planning, implementation, marketing, communications and management of Trusted Advocate Networks at a regional or industry-specific level, with access to expert advice/governance (i.e., steering committees or advisory groups) and a systematic approach to providing ongoing, proactive support and supervision of the volunteers.

5. Any expansion or extension of the Trials should include early development of program logic, linked with consistent data collection and reporting requirements across Trial sites.

1. Introduction

The Centre for Health Service Development, University of Wollongong was commissioned by the Mental Health Supports Branch of the Australian Government Department of Health to conduct an independent evaluation of the Trusted Advocates Network Trial (Farmers' Trial) and the Seafood Industry Mental Health Supports Trial (Fishers' Trial). The evaluation was undertaken between October 2020 and May 2021 to provide the Department with formative and summative evidence on which to base decisions about future development of the Trials.

This is the final evaluation report. It describes the evaluation methods (Chapter 2), reports findings for the five evaluation questions (Chapters 3-7), and makes conclusions and recommendations in relation to the two Trials (Chapter 8). It builds on the findings of the interim report (February 2021).

The remainder of this chapter provides background information about the origins and goals of the program for the two Trials. A description of the funded sites is included to aid understanding of the implementation context. The chapter concludes with brief information about the Trusted Advocates model of mental health peer support, its evidence base and intended implementation processes. In addition to program documents provided by the Department, we have drawn on publicly available sources of information including Australian Bureau of Statistics data. Conversations with Departmental officers have also informed this section of the report.

1.1 Background to the Farmers' Trial

1.1.1 Drought-related stress

Although the prevalence of mental illness is similar across Australia, people living in rural and remote areas are less likely to use Medicare-subsidised mental health services (Farmer et al. 2020). The Australian Government's response to a Senate committee inquiry into accessibility and quality of mental health services in rural and remote Australia (Australian Government 2019b) noted that the rate of access to such services in very remote areas was 81 encounters per 1000 people, compared with 495 encounters per 1000 people in major cities. Significant levels of distress are evident in the relatively high numbers of suicides and emergency department presentations for mental illness in these communities. People in geographically remote areas are at greater risk, as are younger people, those who live and work on farms, and those experiencing financial hardship (Austin et al. 2018).

Ongoing, structural problems such as socio-economic disadvantage and poor knowledge of and access to suitable services are exacerbated by environmental challenges such as drought and bushfires (Farmer et al. 2020). It can be extremely distressing for farmers to see their work come to nothing as crops fail, land deteriorates, animals have to be laboriously hand fed and breeding stock sold (Australian Government 2019a). Financial pressures on farms have flow-on effects to local businesses and communities, which can create high levels of stress across a region (Australian Government 2019a). To make matters worse, help seeking may be impeded by stigma around mental illness, a culture of stoicism, and the logistical difficulties of leaving jobs and properties to access health services (Farmer et al. 2020).

Rather than seeking help through the mental health system, farmers are inclined to try to manage stress and mental health issues themselves. At least initially, they would prefer to talk informally to a trusted friend or acquaintance and seek their advice on where to go for help (Brew et al. 2016). Such encounters provide non-threatening pathways into care for people who may otherwise not access formal help through the mental health care system (World Health Organization 2003). A recent review found good evidence for the effectiveness of community-based wellbeing initiatives that

promote awareness, start conversations, provide mental health first aid, and build social connectedness (Farmer et al. 2020). PHNs and local government are well placed to carry out capacity building activities such as these. Through their local connections, these organisations can facilitate place-based solutions to mental health issues in communities (Farmer et al. 2020).

1.1.2 The Joint Agency Drought Taskforce

In August 2018, the Australian Government announced the appointment of a Coordinator-General for Drought, Major General Stephen Day, to establish a Joint Agency Drought Taskforce. The Taskforce of 25 individuals included experts in agriculture, environment, health and social services; dedicated communications specialists, military planners and strategists; and central agency advisors with budget, coordination and Cabinet experience. The Taskforce's key aim was to improve the coordination and responsiveness of the Government's drought response.

In October 2018, the Joint Agency Drought Taskforce held a National Drought Summit to discuss ways to increase resilience among farmers and within drought-affected communities to better manage the consequences of drought in the future. This Summit was attended by over 80 delegates from industry, government, banks and not-for-profit organisations. Outcomes from the Summit together with consultations in drought affected communities provided insights "that communities were looking for someone to talk to within their community who would listen to them rather than treat them" (Western NSW Primary Health Network 2019).

1.1.3 The Trusted Advocates Network Trial

In April 2019, following the conclusion of the taskforce's consultation process, the Australian Government announced the provision of $463,815 funding to nine PHNs (Figure 1) in drought affected communities to "help farmers and communities to deal with the uncertainty, stress and anxiety of drought conditions" (Australian Government 2019a). This was a supplement to the existing Empowering Our Communities funding of $24.4m over two years, which began in the 2018-19 financial year. The purpose of the Trusted Advocates initiative was to provide support and mental health first aid through a network of volunteers selected from among established and respected members of the community, such as members of service and sporting clubs or groups such as the Country Women's Association, local pharmacists, councillors, or stock and station agents. These volunteers would be known as **Trusted Advocates**. Although they would not be paid for their time, Trusted Advocates would receive reimbursement of expenses and would be linked with each other in local networks. The goal of the Trusted Advocates Network was to ensure these individuals had the skills and strategies to manage these kinds of sensitive discussions. To this end, they would be provided training and support (including clinical debriefing as required) to assist them in their roles.

Figure 1 Funded communities

Primary Health Network	Community
Western New South Wales	Coonabarabran
Hunter New England and Central Coast	Scone
Murrumbidgee	Narrandera
Darling Downs and West Moreton	Goondiwindi
Western Queensland	Longreach
Country South Australia	Tailem Bend
South Eastern New South Wales	Cooma
Nepean Blue Mountains	Portland
Gippsland	Sale

Each of the PHNs managing the Trial at the nine locations had received a share of the Empowering Our Communities funding. This program aimed to enable "small to medium community groups or organisations to provide free group-based activities, for support and to reduce the stigma associated with mental illness in nine drought-affected communities" (Australian Government, 2019b, p.6). It funded workshops and training on mental health topics including mental health first aid.

1.2 Farmers' Trial sites

The target towns or regions for the Farmers' Trial were chosen following consultation with the Department of Agriculture and Water Resources and based on Australian Bureau of Agricultural and Resource Economics and Sciences rainfall deficiencies data from the Australian Bureau of Statistics State and Local Government Areas digital boundaries.

Table 2 provides demographic information about the trial sites including state, population and Socio-Economic Indexes for Areas (SEIFA) information. SEIFA is a composite index where a lower score indicates more disadvantage than a higher score which indicates more advantage. The index is constructed using a number of different variables that indicate both advantage (i.e. high income, having a degree qualification) and disadvantage (i.e. unemployment status, low income, not enough bedrooms). For example, lower educational attainment, more people in low-skilled occupations and low employment are indicators of disadvantage.

Table 2 Summary of Farmers' Trial sites

Town	Electorate	State	Population	SEIFA Score*	Decile**
Tailem Bend	Barker (Liberal Party)	SA	1,665	867	1
Coonabarabran	Parkes (National Party)	NSW	3,290	896	1
Narrandera	Farrer (Liberal Party)	NSW	4,375	902	1
Portland	Calare (National Party)	NSW	2,424	910	2
Cooma	Eden-Monaro (Labor Party)	NSW	6,681	963	3
Sale	Gippsland (National Party)	Vic	13,673	970	3
Scone	New England (National Party)	NSW	5,624	984	4
Longreach	Maranoa (Liberal Party)	Qld	2,970	997	5
Goondiwindi	Maranoa (Liberal Party)	Qld	6,355	999	5

***SEIFA score**: A score for a collection district (CD) is created by adding together the weighted characteristics of that CD. The scores for all CDs are then standardised to a distribution where the average equals 1000 and roughly two-thirds of the scores lie between 900 and 1100.

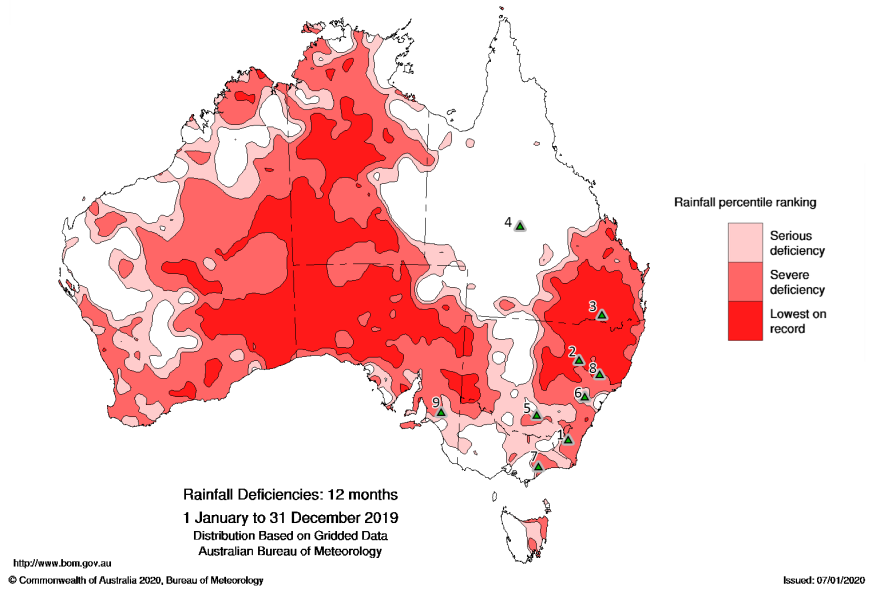
****Deciles:** Decile 1 contains the bottom 10% of CDs (most disadvantaged), Decile 9 contains the top 10% of CDs (most advantaged).

All of the nine sites fall below the average SEIFA score of 1000. Four of the pilot sites fall in the lowest decile or second-lowest decile, which means they are among the most disadvantaged areas in Australia.

Each of the nine site were affected, to varying degrees, by the impact of drought. At the time of funding (during the first six months of 2019) rainfall for this period was below to very much below average over most of Australia. In particular, much of north-eastern New South Wales and south-eastern Queensland and pastoral South Australia received their lowest annual totals on record. This period was preceded by several years of below average rainfall over parts of Queensland and New

South Wales (Bureau of Meteorology 2021a). A 2019 rainfall map summarising rainfall deficiencies in relation to the nine pilot sites is shown in Figure 2.

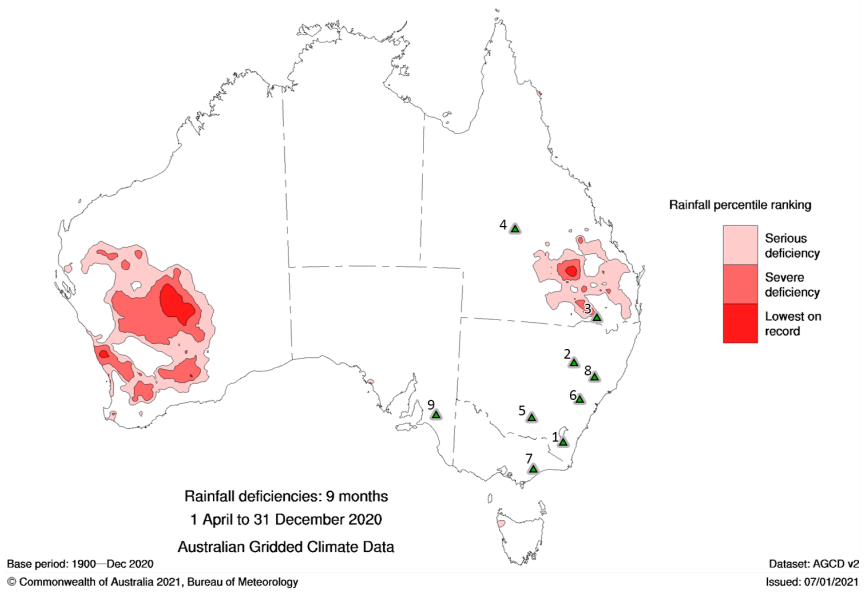
Figure 2 Farmers' Trial sites and rainfall deficiencies (1 January to 31 December 2019)



Key					
1	Cooma	4	Longreach	7	Sale
2	Coonabarabran	5	Narrandera	8	Scone
3	Goondiwindi	6	Portland	9	Tailem Bend

However, during 2010, drought conditions eased throughout most parts of Australia as rainfall deficiencies contracted. Despite this, serious or severe rainfall deficiencies continued in parts of the greater southeast Queensland (Bureau of Meteorology 2021b). A national rainfall map depicting rainfall deficiencies during the period 1 April to 31 December 2020 in relation to the nine pilot sites is shown in Figure 3.

Figure 3 Farmers' Trial sites and rainfall deficiencies (1 April to 31 December 2020)



Key					
1	Cooma	4	Longreach	7	Sale
2	Coonabarabran	5	Narrandera	8	Scone
3	Goondiwindi	6	Portland	9	Tailem Bend

The following section provides a brief summary of each of the pilot locations in relation to the characteristics of each PHN and the availability of state-based mental health services.

1.2.1 Cooma (South Eastern New South Wales PHN)

Coordinare, the PHN covering South-Eastern NSW, includes a population of approximately 625,000 people and includes 11 LGAs and one Commonwealth Territory (Jervis Bay). The PHN has a head office in Wollongong which is about 350km from Cooma where the TA initiative is being piloted.

Cooma is located in Southern NSW LHD and the closest inpatient mental health services are provided by Bega Mental Health Inpatient Unit which is located at South East Regional Hospital. Community mental health services are also provided by the LHD.

1.2.2 Coonabarabran (Western New South Wales PHN)

Western New South Wales PHN covers an area that includes both Far West and Western NSW LHDs across a total area of 433,379 square kilometres, making it the largest PHN in NSW, covering just over 50% of the state. Just over 300,000 people reside in the area, within 27 Local Government Areas (LGAs) of which more than a third are classified among the most disadvantaged nationally.

The PHN's main office is located in Dubbo with satellite offices in Broken Hill, Bathurst and Orange. The TA program is managed out of the Orange office, approximately 300km from Coonabarabran where the TA initiative is being implemented.

Coonabarabran is located in the Western NSW LHD. With regards to mental health services, the closest LHD inpatient mental health and drug and alcohol service is based in Dubbo with an 18 bed

24/7 adult inpatient psychiatric unit. There is also a community mental health service operating out of Dubbo that serves the outlying region of the LHD including Coonabarabran.

1.2.3 Goondiwindi (Darling Downs and West Moreton PHN)

Darling Downs and West Moreton PHN covers 95,500 square kilometres of Queensland with a population of approximately 560,000 people. The area includes 10 LGAs. The PHN has a head office in Toowoomba and a satellite office in Springfield, Central Queensland. The TA program is being managed by head office which is 220km away from Goondiwindi where the TA initiative is being piloted.

Goondiwindi is located within the Darling Downs Hospital and Health Service. The health service delivers ambulatory and community mental health services from Goondiwindi Hospital. The closest inpatient specialist mental health services are delivered at Toowoomba Hospital.

1.2.4 Longreach (Western Queensland PHN)

Western Queensland PHN covers a land area of 956,438 square kilometres which equates to approximately 55% of the state of Queensland. It is populated by just over 60,000 people and includes 20 LGAs.

The PHN has offices in Mount Isa, Roma and Winton. The Mount Isa office is managing the TA initiative. Longreach, where the program is being piloted, is approximately 650km away.

Longreach falls within the jurisdiction of the Central West Hospital and Health Services. The Central West Mental Health and Wellbeing Service at Longreach Base Hospital provides mental health support through a multidisciplinary team. The team provides three different services: Psychological Therapies, Low Intensity Counselling services and Mental Health and Wellbeing Promotion.

1.2.5 Narrandera (Murrumbidgee PHN)

Murrumbidgee PHN covers 124,413 square kilometres of NSW with an estimated population of approximately 240,000 people living in 21 LGAs. The PHN has a headquarters in Wagga Wagga and the TA initiative is being piloted in Narrandera which is approximately 100km away.

Narrandera is located within the Murrumbidgee LHD. Specialist inpatient mental health services are provided by the local LHD in Wagga Wagga. The LHD also runs Narrandera Health Service which provides community mental health support.

1.2.6 Portland (Nepean Blue Mountains PHN)

The area covered by Nepean Blue Mountains PHN includes a population of over 360,000 people and four LGAs. The head office for NBMPHN is in Kingswood which is about 120km from Portland where the TA program is being piloted.

Portland is located in the Nepean Blue Mountains LHD. The closest inpatient and community mental health services are provided by Blue Mountains Inpatient Unit located in Katoomba.

1.2.7 Sale (Gippsland PHN)

Gippsland PHN includes a population of over 270,000 people and spans six LGAs. The PHN has three office locations in Gippsland: Traralgon, Wonthaggi and Bairnsdale. The TA initiative is being

managed by the Traralgon office which is located approximately 50km from Sale where the TA initiative is being piloted.

Latrobe Regional Hospital in Traralgon provides inpatient mental health services. The hospital also provides a community mental health team to support the Sale community.

1.2.8 Scone (Hunter New England and Central Coast PHN)

The area covered by Hunter New England and Central Coast PHN covers 130,000 square kilometres of NSW, stretching from the Queensland border to Gosford, and has a population of approximately 1.2 million people served by 23 LGAs. The PHN has three offices to cover the region: Erina (Central Coast), Newcastle and Tamworth. The TA initiative is being rolled out in Scone and managed by the Newcastle office which is approximately 150km away.

Scone is located within the Hunter New England LHD and the closest inpatient mental health services are provided in Maitland. Mental health crisis support and treatment is also provided in the community by the LHD.

1.2.9 Tailem Bend (Country South Australia PHN)

Country South Australia PHN covers 99.8% of the state of South Australia and includes a population of approximately 540,000 people. This area also includes seven out of the ten Local Health Networks in South Australia. The PHN has a head office in Nuriootpa. The TA initiative is being run out of the Whyalla office, which is about 460km from Tailem Bend where the TA initiative is being piloted.

Tailem Bend is located in the Riverland Mallee Coorong Hospitals and Health Services Network. Local community mental health services are provided by the Murray Mallee mental health service. The closest inpatient mental health service is provided by Glenside Health Services in Adelaide. This includes a mental health unit for acute care and inpatient rehabilitation.

1.3 Background to the Fishers' Trial

1.2.2 Mental health issues in the commercial fishing sector

Commercial fishers report significantly higher levels of psychological distress than the Australian population overall (King et al. 2019). Around 22% of respondents to a recent survey of the fishing industry reported high or very high distress, which they attributed to uncertainty in relation to government regulations, 'red tape', negative media, and poor public image of commercial fishing (King et al. 2019). Fishers may be subject to immediate closure or quota reduction under the guidelines of the *Environmental Protection and Biodiversity Conservation Act 1999.* Uncertainty about the security and tenure of fishing concessions (quotas and licences) drives a sense of chronic insecurity over livelihoods, contributing to high levels of stress, depression and suicide in the commercial fishing sector (King et al. 2015).

In addition to these stressors, fishers report a sense of social isolation and lack of social support (King et al. 2019; Shaw et al. 2011). They are also more likely than most Australians to suffer physical pain; more than half of survey respondents said their pain interfered with normal activities (King et al. 2019). Chronic pain is a risk factor for mental health problems (Hooten 2016; Tunks et al. 2008).

Like farming communities, fishing communities may be distant from health services. Traditional values around self-reliance and independence impede help seeking, as mental illness is stigmatised and seen as shameful. Family members of commercial fishers may also suffer poor mental health:

> *…the amalgam of changes such as revised regulations, marine park rezoning, fisheries reviews, licence buybacks, the effects of global economics and climate change, have influenced the ability of fishers and families to withstand these changes, personally, professionally, and financially. For some, it has triggered serious mental health concerns and family repercussions. (Shaw et al. 2011, p. 52)*

1.3.1 Inclusion in the Trusted Advocates Network Trial

In 2018, Women in Seafood Australasia launched Project Regard to start a conversation about mental health issues in the commercial fishing industry. This features videos of individual fishers speaking out about their own and others' experiences. Since then, peak body Seafood Industry Australia (SIA) has lobbied for greater resources to support the mental health and wellbeing of people in the industry, leading to the inclusion of fishing communities in the Trusted Advocates Network Trial. The Fishers' Trial was designed to be rolled out at up to three target communities and will continue to April 2022 with total funding of $600,000.

The Fishers' Trial involves: (1) appointment of paid Fishers' Mental Health Support Coordinators; (2) training and community awareness for support coordinators, general practitioners, and other health professionals; (3) communication activities aimed at enhancing access to existing services; and (4) community resilience grants to fund networks and events which raise awareness and address issues of mental health stigma and social isolation.

The objectives of the Fishers' Trial are to:

- implement and deliver a mental health support/co-ordinator service that assists members of the seafood industry who have or are at risk of mental illness to effectively navigate and seek treatment and access supports;
- provide education and training, and enhance communications that support help seeking behaviours;
- link up network members and others with a range of local, state/territory and commonwealth mental health support services; and
- implement and deliver enhanced community resilience building capacity within the sector through accountable and transparent grants process.

In contrast to the Farmers' Trial, the Fishers' Mental Health Support Coordinators are paid positions. During the Trial, Coordinators will be reimbursed for reasonable expenses (as are the Farmers' Trial Trusted Advocates). At the end of the Trial, each Coordinator will receive a gratuity of $10,000 recognising their contribution of time and effort. Another key difference between the Trials is that SIA, in consultation with industry, selected the three target communities after receiving the funds.

1.4 Fishers' Trial sites

A modified version of the Trusted Advocates program is being delivered in three regions nominated by SIA: Lakes Entrance, Newcastle and Darwin. Following a national consultation process, these three regions were recognised by the SIA Steering Committee as communities in need of, and willing to engage with, mental health supports. They are also areas that have not had a history of support activity to date and have a member body infrastructure that is supportive of involvement in the program. Table 3 provides more information about the Fishers' Trial sites including electorate, state, population and Socio-Economic Indexes for Areas (SEIFA) information.

Table 3 Summary of Fishers' Trial sites

Town	Electorate	State	Population	SEIFA Score	Decile
Lakes Entrance	Gippsland (National Party)	Vic	4,810	910	2
Darwin	Solomon (Labor Party)	NT	157,920	1066	9
Newcastle	Farrer (Liberal Party)	NSW	457,192	1073	9

Only Lakes Entrance falls below the average SEIFA score of 1000 and is in the second lowest SEIFA decile which equates to the bottom 20% of most disadvantaged CDs. The other two pilot sites are in the top 10% of the most advantaged CDs.

The next sections outline the rationale for selection of the three sites in Lakes Entrance, Newcastle and Darwin, based on documents sent to the evaluation team from the project team at SIA, and describe mental health support at each site provided by state-based mental health services.

1.4.1 Darwin – Northern Territory

Commercially there are approximately 200 fishing licences in Darwin which includes about 190 vessels. Darwin fishers face similar issues to their peers in NSW and Victoria which has resulted in a decrease in the number of smaller operators and an increase in the number of larger operators.

However, particular to Darwin, the following two issues have had a significant impact on the local fishing industry. First, Coastal Lines reforms have resulted in many commercial operators restricted to running their business in unviable areas. Second, ongoing negotiations between Indigenous landowners and commercial fishers to have control of intertidal waters (covering about 6,000 kilometres of coast and waters) have resulted in a lack of certainty for all involved.

These issues are exacerbated by the nature of the fishing industry in the NT. The barramundi fishing industry involves vessels going out to sea for months at a time only to return to months of inactivity. Also, the mud-crab fishers (mostly immigrants with limited English speaking skills) live for months at a time in rudimentary fishing camps away from their families.

Added to this is the fact that the industry infrastructure to support the fisheries in the NT is somewhat limited. As a result, the Northern Territory Seafood Council (NTFC) welcomed the introduction of the Fishers' Trial pilot.

Mental health services in Darwin are supported by Top End mental health services through the Northern Territory Mental Health Line. This is a free, confidential 24-hour hotline for emergency help or support for anyone experiencing a mental health issue, or those concerned about another person's mental health or wellbeing. Also, the Royal Darwin Hospital includes the NT mental Health Access Team and from here patients can be referred to a wide range of specialist mental health services including inpatient and community services.

1.4.2 Lakes Entrance – Western Region Victoria

Lakes Entrance is responsible for approximately half of Victoria's seafood catch and the industry employs about 800 people in primary and secondary production. The challenges facing the local fisheries community include:

- closure of the Gippsland Lake Fishery;
- 80% reduction in catch for particular fisheries due to local seismic testing;

- transfer of quotas from commercial to recreational fishers resulting in reduced income in the commercial sector.

SIA Steering Committee consultation in the local area together with the results of the targeted "Wellness in Seafood Communities Survey" (2020) highlighted much support for the pilot from those in both the Commonwealth and State fisheries in the region.

The main provider of inpatient mental health services in this area is Latrobe Regional Hospital based in Traralgon (about 160km from Lakes Entrance). Closer to Lakes Entrance, in Bairnsdale (approximately 40km away), the Prevention and Recovery Care Service also provides mental health treatment and recovery, but in a residential setting. Bairnsdale Community Mental Health Services also provide services to Lakes Entrance.

1.4.3 Newcastle – North Central Coast NSW

Newcastle is the largest fishing community in NSW. The value of the local seafood industry is approximately $76 million per annum and it employs more than 700 people. However, there have been significant impacts from recent industry reforms across the industry, specifically:

- a reduction in quota and catch limits;
- the introduction of new compliance, enforcement and monitoring measures including vessel monitoring systems, electronic monitoring and catch reporting;
- changes to NSW commercial fishing license buy-back arrangements.

The consultation process carried out by SIA highlighted a lack of local industry-specific support. Stakeholders felt that Newcastle potentially had the most to gain from the Fishers' Trial.

Newcastle's mental health needs are supported by the local Calvary Mater Hospital located in Waratah. Mater Hospital includes a psychiatric emergency care centre, a psychiatric intensive care centre and short-term mental health facility catering for more acute cases. Various community mental health teams also operate out of the Mater. These services include mental health, psychiatry and rehabilitation.

1.5 The Trusted Advocates model

The total funding provided to each PHN to manage the Farmers' Trial was $44,000 and the anticipated finishing date for the Trial was June 2021. Using this funding, the PHNs were expected to recruit, train, and support up to 10 Trusted Advocates each. For the Fishers' Trial, the goal was to train and support up to three Mental Health Support Coordinators at each of the three sites. Thus, the program could potentially support up to 99 volunteers providing peer support to their communities.

In their peer work with farming and fishing communities, Trusted Advocates have been tasked with engaging with those who may be struggling with mental health issues, identifying risk factors for serious mental illness and suicide, and promoting self-help or help seeking from professionals, as appropriate. They require additional skills and support to enable them to perform confidently and effectively in this role. PHNs are expected to provide Trusted Advocates with either Mental Health First Aid (MHFA) or Accidental Counsellor training.

1.5.1 Mental health peer support training

MHFA was designed to help community members support people with mental health problems (Kitchener & Jorm 2002) and to encourage treatment seeking (Talbot et al. 2017). It teaches participants to recognise clusters of symptoms of different disorders and mental health crises, how to offer and provide initial help, and how to guide a person towards appropriate treatments (Morgan et al. 2018). MHFA is well-established in Australia and internationally; over 4,000 MHFA training courses are run in Australia each year (Mental Health First Aid Australia 2017). According to a systematic review and meta-analysis, MHFA has demonstrated effectiveness in improving mental health literacy and support, with impacts enduring up to six months after training (Morgan et al. 2018). Trials in Australian rural populations have shown the program can be implemented successfully in farming communities (Perceval et al. 2011) including areas affected by drought (Sartore et al. 2008). Sartore and colleagues (2008) found that MHFA was an effective part of a strategy to improve care systems and pathways to early intervention in rural communities by using local networks to provide mental health support.

Similarly, Accidental Counsellor training is aimed at people who have no qualifications in counselling, to enable them to feel confident in responding to others who have mental health needs. There is a strong emphasis on self-care of the Accidental Counsellor to avoid burn-out and trauma from exposure to other people's crises. The course equips participants to recognise when a person is undergoing a mental health crisis, respond in an appropriate and compassionate manner, and refer the person to a suitable service (Lifeline Harbour to Hawkesbury 2020). There are numerous providers who offer half-day or one-day courses in Accidental Counsellor training in Australia, and the program has been endorsed by the NSW Education Standards Authority, Australian Community Workers Association, and ACT Teacher Quality Institute (Human Connections 2021). To date, there do not appear to be any published evaluations of this course.

1.5.2 Expected implementation of the model

Program documents show that, in addition to recruiting and training volunteers, participating Trial sites are also expected to provide ongoing support and information to assist them in their peer support roles. The funding guidance to PHNs for the Farmers' Trial specified the following tasks:

- Identify up to ten Trusted Advocates within the identified community in the relevant PHN region and establish a local network.
- Deliver training for Trusted Advocates in mental health first aid or 'accidental counsellor' training to assist them in their role.
- Provide information to Trusted Advocates about the availability of online, face-to-face and self-help mental health and emotional wellbeing supports within their community, to promote self-help and improve referral pathways.
- Provide proactive support of, and mentoring to, Trusted Advocates and appropriate clinical support to provide debriefing opportunities as required.
- Have an oversight of the local network and manage Trusted Advocates to ensure the number of Trusted Advocates is sustained and supported.
- Administer reimbursement of expenses to Trusted Advocates for costs such as travel and incidentals.
- Provide high level reporting to the Department on the Trusted Advocate Network.
- Participate in an evaluation of the trial.

The Fishers' Trial is funded from 30 April 2020 to 30 April 2022. Soon after the Trial commenced, SIA submitted an Activity Work Plan to the Department, detailing deliverables for project set-up and the four program components:

Project set-up

- Recruitment of Program Manager
- Selection of three regional seafood communities to conduct trials
- Promotion of the Mental Health Supports Trial launch and objectives and development of communications plan.
- Creation and establishment of communication plan for the project

Program stream 1: Mental Health Support Coordinators

- Recruit mental health support coordinators in up to three regional communities where there is an active seafood industry
- On-boarding and training of mental health support coordinators in up to three regional communities where there is an active seafood industry
- Advertising and promotion of Trusted Advocates
- availability in target communities and supporting access and communication
- Regular oversight, supervision, clinical support and debriefing between Program Manager and coordinators.

Program stream 2: Communications support for seafood industry

- Gathering relevant and appropriate materials on mental health support and adapting for the for the seafood industry
- Adapting and designing (where necessary) relevant and appropriate materials on mental health support for the for the seafood industry
- Develop and launch a Mental Health Support for the Seafood Industry website and printed materials with information and contacts for people in the seafood industry to access and support help seeking behaviours.
- Develop and launch a Mental Health Support for the Seafood Industry printed materials with information and contacts for people in the seafood industry to access and support help seeking behaviours.
- Execute communications strategy and associated online and social media plan to promote uptake from industry of printed and website materials.

Program stream 3: Community resilience grants rollout

- Establish a Grants Approval Committee made up of SIA and WISA representatives with a Terms of Reference.
- Establish a grants process including application form, grants approval process and evaluation mechanism.
- Communication and promotion of Community Resilience Grants.
- Distribution of Grant Funds

Program stream 4: Training and community awareness

- Delivery of Mental Health First Aid training to people working in the seafood industry.
- Identify other ways to build awareness, reduce stigma and encourage help seeking behaviours in the seafood industry.
- Engagement, education and supply of materials to GP and health care workers in the three communities to promote greater awareness of specific challenges of working in the seafood industry.

Evaluation of Mental Health Supports Trial

- Establish an evaluation and monitoring process that provides reliable feedback from people in the target communities on their improved access to services, changes in mental health outcomes and possible improvements/changes to the 4 program streams.

2. Evaluation methods

The evaluation was designed to examine and document the processes of implementation at each of the trial sites and assess outcomes for communities, particularly the delivery of informal mental health support by the Trusted Advocates and their contribution to community wellbeing and help seeking behaviours.

The design of the evaluation was both formative and summative. Broadly, formative evaluation focuses on processes and summative evaluation on outcomes and impacts. The formative component focused on how the implementation unfolded at the various sites and gathered information to help shape ongoing or future program development and improvement. The summative component provided information on the extent to which anticipated results were obtained, to ensure accountability and value for money and draw conclusions about the effectiveness of the Trusted Advocates model for promoting community mental health.

Ethics approval (2020/ETH02980) was granted by the University of Wollongong/Illawarra Shoalhaven Local Health District Human Research Ethics Committee on 24 November 2020.

2.1 Evaluation questions

The evaluation is designed to address five evaluation questions, which were provided by the Department in the Request for Quote:

1. How well have the Trials been implemented?
2. How appropriate were the Trials' designs for the identified needs?
3. To what extent have the Trials achieved their intended outcomes of improving the provision of mental health support for local communities? What difference are they making?
4. Have there been unintended outcomes/consequences? If so, explain.
5. How could the Trials be improved?

2.2 Data sources

2.2.1 Interviews with Trial Managers

Baseline interviews took place over a three-week period in late November and early December 2020 with key informants, referred to in this report as Trial Managers. These were representatives of all nine participating PHNs and SIA, plus other stakeholders involved in the Trials through their work for organisations that have been commissioned to provide training and support for the Trusted Advocates volunteers. Follow-up interviews took place between late March and early May 2021, in most cases with the same key informants.

To recruit these key informants, we obtained a list of work contact email addresses and phone numbers from the Department and contacted them initially by email to request an interview appointment. PHN staff provided contact details for other relevant stakeholders. All participants were given a Participant Information Sheet and subsequently gave informed consent. Interviews were semi-structured and guided by interview schedules (Appendix 1 and Appendix 2) which were designed to elicit information about recruitment and training of volunteers, support provided (including clinical debriefing or group support), activities to raise community awareness of the program, and feedback from the community regarding the program.

A total of 20 individuals took part in the 14 baseline interviews, with an average duration of 44 minutes (range 22-72 minutes, total 610 minutes); 15 individuals took part in the 12 follow-up interviews, with an average duration of 35 minutes (range 15-59, total 416 minutes).

2.2.2 Interviews with Trusted Advocates

Interviews with volunteers took place in December 2020 and January 2021, with additional interviews in March, April and early May 2021. To recruit participants, we provided a template email for PHNs to send to the Trusted Advocates and asked key contacts in those organisations to follow up the email where necessary with a phone call to give as many volunteers as possible an opportunity to participate in the evaluation. The key contact person at each organisation then provided to the evaluation team a list of Trusted Advocates who had indicated they were willing to take part. Initially, we approached all six PHNs that had recruited Trusted Advocates. Four PHNs responded to this request within the time period available for data collection for the interim report, and the remaining two were followed up for the final report, one of which did not provide any names or contact details for volunteers. For the final report we also requested interviews with all the Fishers' Trial Trusted Advocates, and successfully contacted seven of the nine individuals recruited for the three SIA sites. Thus, the interviews covered eight of the nine sites that recruited volunteers.

A member of the evaluation team contacted those on the lists provided to arrange appointments for interviews. All interviewees were sent a Participant Information Sheet and had the opportunity to provide informed consent. Interviews were semi-structured, guided by interview schedules (Appendix 3). We asked Trusted Advocates about their motivation for participating in the program, the support available from PHNs or SIA, and the frequency and perceived effectiveness of peer support encounters. We explored how and when Trusted Advocates used the training they had received. In addition, the interview schedules included some standard questions from previous evaluations of MHFA. We also collected some information on the demography and background of Trusted Advocates.

In total, 21 volunteers were interviewed from five Farmers' Trial sites. The interviews ranged in length from 13 to 35 minutes (average 20 minutes). Thirteen interviewees were female (age range 25-73 years, average 55 years) and eight were male (age range 38-75 years, average 56 years). English was the first language of all the participants.

Seven volunteers were interviewed from the three Fishers' Trial sites. The interviews ranged in length from nine minutes to 31 minutes (average 19 minutes). Three of the interviewees were female (age range 23 to 58 years) and four were male (age range 53 to 68 years). Again, English was the first language of all the participants.

2.2.3 Online survey

In April 2021, all volunteers in the Farmers' and Fishers' Trials were invited to complete an anonymous online survey. The purpose of the survey was to investigate the experiences and challenges of volunteering, to assess average levels of confidence and perceptions of support following the training, and to obtain some data on the activities of volunteers in their communities. Construction of the questionnaire was informed by previous evaluations of MHFA and particularly by studies which examined the extent of participants' activities, knowledge and confidence following training; some of the questions were obtained from a study by Witry and colleagues (2020).

Trial managers at each trial site were asked to invite volunteers on behalf of CHSD to complete the survey as part of the evaluation. Volunteers were provided with a Participation Information Sheet

and web link to access the survey online and were then able to access the online survey in their own time. Up to 50 invitations were issued via email, across five PHNs and the three Fishers' Trial sites.

The survey was made available online via the QualtricsXM website enabling it to be accessed and completed using a mobile phone or personal computer. The survey was 'live' between 6 April 2021 and 5 May 2021. The questionnaire is provided in Appendix 4 and the participant information statement is shown in Appendix 4 and Appendix 5.

2.2.4 Program documents

During the interviews or afterwards (by email) we asked Trial Managers to send us copies of relevant program documents, such as training materials and summary data from training evaluations; promotional materials; plans for community awareness activities or events; any work done to establish referral pathways for escalating more serious cases to professional help; and the support provided to volunteers. Five PHNs and SIA responded (covering 8/12 sites) and our review of the documents we received from them has informed the findings of this report.

2.2.5 Program activity data

To understand the reach of the program within target communities, the evaluation team sought information from implementation sites regarding the numbers and types of contacts with community members and referrals to health services. The first round of interviews with Trial Managers established that there was no common system for recording the activities of the Trusted Advocates, and most sites did not have any data collection system in place. (The reasons for this are explored later in this report.) For the final report, we requested aggregated data (e.g., summaries of logs or records of peer support activities) from three PHNs and SIA. One PHN and SIA responded within the timeframe for the preparation of this report.

2.2.6 Program logic consultation

The interim report recommended that a program logic model be developed for the Fishers' Trial. The process for developing program logic is both analytical and consultative, involving review of program documents and working with stakeholders to understand how they view the program and its anticipated outcomes and impacts (NSW Health, 2017). When program logic is intended to inform and guide an evaluation, it is important to involve program staff and management (NSW Health, 2017). Consequently, the evaluation team reviewed the foundational documents of the Fishers' Trial (e.g., project plan, communications plan) and then led a consultation meeting (online) with the Trial steering committee and project manager on 19 April 2021. A one-page document was prepared and distributed in advance to orient participants to the task along with a guide downloaded from the Child Family Community Australia website[1]. Following the meeting, the evaluation team prepared a draft program logic model and submitted it to SIA for further consultation and feedback. More details about this process can be found in Section 3.2.5.

2.3 Data analysis

Interviews were recorded (with permission) and professionally transcribed through a company that ensures security and confidentiality. Transcripts were entered into NVivo and coded against interview questions (deductive coding) with attention given to any emerging issues (inductive coding). A modified Framework method was used for analysis, as this is useful for program

[1] https://aifs.gov.au/cfca/expert-panel-project/program-planning-evaluation-guide/plan-your-program-or-service/how-develop-program-logic-planning-and-evaluation

evaluations where the key questions and issues are established in advance, and allows comparison across and within cases (Gale et al. 2013). To ensure comprehensive capture of the issues raised by TMs, a process called "iterative categorisation" was used for thematic analysis (Neale 2016). This is a systematic and auditable method for moving from the coding stage through to interpretation of qualitative data. TA responses to all the questions in the online survey were exported from Qualtrics and saved in an Excel spreadsheet for separate analysis.

There is no intention to report data separately for each implementation site. Instead, findings will be integrated to address the evaluation questions and produce conclusions for each of the two Trials.

2.4 Presentation of findings

The following chapters address each of the five evaluation questions in turn. Findings are discussed in Chapter 8, which also presents limitations, conclusions and recommendations.

Direct quotations from interviews are presented below in blue italics. In accordance with the ethical principle of confidentiality, we have taken care to avoid identifying individuals, by minor editing of the quotes where necessary. In quoting, we have chosen not to assign codes to the interviewees due to the small sample size and the differences among sites; however, we have taken care to ensure that all voices are represented and no individuals have overly dominated the narrative. Direct quotations from documents are shown in black italics.

2.4.1 A note on terminology

The evaluation team is aware that different Farmers' Trial sites have adopted various names for those providing peer support in their communities, including Farmers' Friends and Wellbeing Ambassadors, while the Department has referred to the Fishers' Trial volunteers as Mental Health Support Coordinators. For simplicity, and to avoid identifying individual sites, we will refer to all these stakeholders as volunteers or Trusted Advocates (abbreviated in the text as TAs). Individuals directly responsible for implementation are referred to in this report as "project officers", and key informants (who may include project officers, as well as their managers or other stakeholders) are referred to as Trial Managers (TMs).

3. Implementation

This chapter addresses the first evaluation question: how well have the Trials been implemented? Based mainly on interviews with TMs, supplemented by a review of available program documents, it describes the tasks carried out to implement the Farmers' and Fishers' Trials. As the two Trials had different funding arrangements and the Fishers' Trial had additional objectives beyond the recruitment and training of Trusted Advocates, implementation of each Trial is reported separately.

3.1 Farmers' Trial implementation

We asked TMs in the Farmers' Trial about their approaches to the implementation, exploring issues around commissioning versus direct delivery, systems for managing the project tasks and timelines, and methods for delivering the intermediate outcomes of the Trial; that is, recruiting, training, and supporting Trusted Advocates. A number of ideas emerged from the initial thematic analysis, presented in the Interim Report:

- the importance of stakeholder engagement;
- benefits and challenges associated with establishing local partnerships;
- the skills, resources and systems required to manage the Trial;
- identifying and selecting the right people for the TA "job";
- tailored versus standardised training content and delivery; and
- supporting and supervising volunteers.

The second round of interviews confirmed these themes and expanded them, adding detail and perspective as the implementation unfolded over time. These themes are explored as we present the findings in the following sections of the chapter.

3.1.1 Stakeholder engagement

One of the early steps in implementing the Trial was identifying and engaging with stakeholders for a variety of purposes: connecting with potential partner organisations; providing information and developing community support; and identifying individuals who might be interested in TA roles. At the majority of the Trial sites, efforts to engage stakeholders were systematic and extensive. Most commonly, the PHNs drew first on their existing networks.

In both rounds of TM interviews it was apparent that PHNs had put a great deal of work into stakeholder engagement. For some this paid off with recruitment of volunteers or strong interest from local partners; other PHNs were less successful. The range of local organisations approached by PHNs was huge. It included: local and state government; health care providers; industry representatives; service clubs (Rotary, CWA, Lions); schools; workplaces, shops and businesses such as stock and land agents; local land councils or rural land protection services; and community centres. PHNs also approached individuals (e.g., psychologists, Rural Adversity Mental Health Program coordinators) and agencies (e.g., St Vincent de Paul Society, Red Cross, Salvation Army) involved in drought relief or bushfire recovery.

For the purpose of recruitment or linking with potential partner organisations, broad-based media and marketing approaches were less successful than direct, person-to-person contacts. One of the challenges was identifying "the right people" to approach. For example, one PHN offered money and training to a local service club to facilitate delivery of the program, but the offer was declined. The

TM was unsure why, and whether the outcome would have been different if they had approached the club in a different way or through a different person. Another PHN struggled with community engagement initially but once they made contact with influential individuals who were willing to take part, others started to express interest and then recruitment proceeded quickly. Another TM observed that having existing community contacts helped immensely as they could quickly identify people who were "community champions already and trusted in their communities".

During the first round of interviews, several TMs expressed the view that stakeholder engagement should have commenced earlier, to allow input into the design and targeting of the Trial. For example, one TM was concerned that the program might damage relationships with existing stakeholder networks because there was "no clear rationale behind the allocation of resources". One said engagement was made more difficult because the community was "tight knit" and the project officer was relatively unknown. Another commented that stakeholders were worried about the possible risk to their standing "if something went wrong" for a volunteer or client.

A common issue noted by TMs was that a great deal of drought-related and/or bushfire-related activity had been taking place in the target communities and therefore organisations and individuals who might otherwise have supported the Trial were already at full capacity. In addition to the drought – which had caused an extended period of strain – several of the participating sites had also experienced recent crisis situations such as the bushfires of 2019/20 and then the COVID-19 pandemic. Mustering community resources in this situation was challenging, to say the least.

3.1.2 Partnerships with local organisations

As numerous TMs pointed out, PHNs generally have a commissioning role.

> *It's not work that the PHNs would do as part of its normal business, in the sense of engage individuals to undertake initiatives. We're commissioners, not service providers.*

Consequently, the participating PHNs took a variety of approaches to delivering the TA program, ranging from placing responsibility for delivery more or less completely in the hands of a local organisation to managing some or all elements of the program within the PHN.

Decisions about whether or not to pursue a partnership to deliver this program appear to have been both strategic and pragmatic. Several of the PHNs cover very large territories and the organisation's reach was limited in the target community. With no staff based there, and considerable travelling required, it would have been very difficult to make contact with potential recruits. By partnering with a well-connected, "community-facing" local organisation, the PHN would be better able to identify and recruit volunteers.

> *There's community trust around that organisation, whereas I think we would have struggled as a Primary Health Network to be able to ring up people and say, well, hang on a minute, you were identified, they would have been like, what's the Primary Health Network and what are you talking about.*

> *From what I can see, from research, you get the most effective results when it's community driven rather than government led.*

The organisations chosen as partners included Lifeline branches and a local charity dedicated to suicide prevention. They all had mental health promotion as their "core business". They were well respected in their communities, and could leverage that reputation to establish the TA program. As one TM pointed out, the PHN could be confident of the partner's commitment because of the

reputational risk associated with any failure to "make it work". Another TM felt that people would be keen to take part in the program because they could already see the benefits of the partner organisation's other activities.

There were other perceived benefits in connecting the TA program with pre-existing initiatives with similar aims. Importantly, unlike PHNs, partners had infrastructure and systems for the training, supervision and support of volunteers working in the mental health promotion space. They were seen as better equipped to deal with logistics (e.g., handling expenses for travel, accommodation and technology to enable TAs to talk to farmers) and issues around managing risk, such as insurance and clinical supervision. Because the TAs would be working across extensive rural areas, provision of ongoing support and guidance was regarded as essential. Many TMs saw these tasks as beyond the normal remit or capacity of a PHN to deliver effectively.

Three PHNs established partnerships relatively early in the implementation period. At the time of this final report, two of these partnerships were continuing to support ongoing delivery of the TA program; the status of the other was unclear.

One PHN chose not to commission an external provider because the program was regarded as within the capacity of the organisation. This PHN had a staff member available who could take on the project management tasks, and an established steering committee for other drought-related mental health initiatives, which could support stakeholder engagement and program delivery. By delivering the program 'in house', the TM could ensure that the funding was directed towards supporting the volunteers. This TM felt that direct delivery gave the Trial "the best chance of success".

In contrast, five PHNs took on the task of delivering the program by default because they had been unable to establish a functional partnership, despite efforts to do so. Potential partner organisations were overwhelmed with work, or had concerns about the scope and boundaries of the program, including concerns about the PHN apparently moving into the "mental health service delivery space". All of these PHNs found it challenging due to various factors such as a lack of continuity in human resources (e.g., losing a staff member when short-term grant funding ended) and the logistics of delivering a program at a community that was distant from the PHN office, without strong community leadership or well-established connections between the PHN and the community.

In order to meet this need, some PHNs continued to seek partnerships even while rolling out the program themselves. By the second round of interviews, one of these five PHNs had engaged an external provider and another TM had prepared a proposal to do so, which was under consideration by the PHN executive.

At three of the nine PHNs, the inability to engage a project partner meant that implementation stalled and ultimately the TA program was not delivered at those sites.

3.1.3 Recruiting volunteers

Delivery of the Trusted Advocates model in farming communities relies on the recruitment of suitable volunteers from among community members; hence, one of the themes that emerged from our discussions with TMs was the challenge of identifying people with the skills and social connections to be effective in the "job".

Stakeholder engagement was an essential precursor to recruitment. As indicated above, broad marketing and media campaigns were generally unsuccessful whereas targeted approaches utilising existing community contacts were more productive. Some Trial sites started with the former strategy before progressing to the latter, gaining a few recruits from a general "call to community"

and later relying on targeted methods. Stakeholders – referred to by one TM as "people who might know people" – contributed to lists of potential recruits and then the TMs or partner organisations approached them, usually through a personal phone call. The first step was often an invitation to a community meeting or workshop where they could learn more. For example, one Trial site ran a workshop presented by a clinical psychologist, who facilitated a discussion around the mental health needs of the community and what could be done to address drought-related trauma.

At some Trial sites, this approach was remarkably successful, resulting a pool of potential recruits. (At two sites, there were more potential recruits than required for the program.)

At other Trial sites, although the meetings were well attended, there was little subsequent interest among potential recruits. They did not seem motivated "to take the next step" and commit to becoming TAs. This reluctance was attributed to various barriers to participation. In particular, stigma around mental illness was seen as a big issue in rural areas, especially for the older generation, described by one TM as "old school farmers who were just having casual conversations maybe at the sale yards, who are the people you want to get to". Perhaps because of this stigma, people appeared to be reluctant to be recognised in own communities as having undertaken training in mental health or wellbeing. Although they realised they were already doing this type of voluntary work, they shied away from formalising it, which would be a step too far. In particular, they did not want to be seen to be paid for the role, or even reimbursed for expenses.

One TM speculated that there may also have been concerns about what the training would involve, given the low levels of health literacy on average in the older, rural demographic. Among younger people there were additional barriers to participation: a lack of time and opportunity among those who may be already juggling multiple jobs and roles. Other potential recruits were struggling with their own mental health issues.

Those identified as most suitable for the role of TA were not always willing or able to take it on. This was a source of frustration to some TMs. Several TMs observed that relatively few people within small communities seem to bear most of the burden of volunteering; they already have many demands on their time.

> *The same people do everything, so a busy group of people wear multiple hats.*
>
> *The people we're trying to target, they're already operating their own business and farm. They're probably in some sort of organisation where they're volunteering already. So it is just another thing when they're very stressed, as well as everyone else in the community.*
>
> *All the volunteers were burned out. And to ask people to take on other jobs, it was just very hard.*

Three PHNs were not able to recruit any volunteers to the TA program. Others recruited some, but not all, of the anticipated 10 volunteers per site. In one case, a deliberate decision was made not to recruit the full complement of volunteers because it was not yet clear how much demand there would be from the farming community; the TM did not want individuals to be recruited and trained and then have little to do.

3.1.4 Selection and screening of volunteers

At some Trial sites the TMs prepared a set of selection criteria specifying desirable characteristics for a TA, such as:

- demonstrated interest in wellbeing and mental health;
- commitment to the community through involvement in community organisations as a volunteer or sponsor;
- broad network of family and friends;
- regarded as a "go-getter".

As one TM remarked, the TAs were "not just anyone"; they had to have well-established community connections in order to make the program work.

> *But ultimately, as was required, it's more people who already had that established connection with community rather than just trying to find randoms that didn't have that connection. We're also trying to build on where there was that – almost having that unofficial role already.*

One Trial site worked from a matrix of possible contact points in the community where TAs might be useful to ensure that no areas were under- or over-represented, compiled a short list and then approached them. (All said yes.)

> *People fundamentally want to help others so I think that's why we got such a good response. As part of this process we identified their character strengths. They all had kindness in their top five character strengths which I think was quite telling; that this is something they wanted to do to help others.*

Other sites were not so fortunate, and there was an awareness that the recruits were by necessity a restricted range of people. It was more difficult to recruit working people, younger people, and Aboriginal people. Not everyone could afford to volunteer; they may be under financial pressure, working several jobs, caring for families; they had different priorities. Those who could volunteer tended to be "a certain demographic": more financially secure with leisure time available. This analysis of the situation by TMs was not intended to criticise these individuals, just to point out that they did not necessarily represent or reach all the groups that needed help with their mental health.

> *You're relying on people who have retired and that may not be the most appropriate, like you know, it would be great to have some younger people and different demographics and all of that sort of stuff, but that just doesn't seem possible.*

This issue was summed up nicely by one TM who pointed out that those who do attend MHFA courses in rural areas are often service providers seeking some free professional development, whereas people in other kinds of jobs, unrelated to health, cannot take time off to attend:

> *But actually, [their] boss isn't going to give [them] two days off to attend that training, because it's got nothing to do with the job, working in a bakery or, you know, working at the shire in the yard.*

That being said, the TAs recruited represent a wide range of professional groups and some Trial sites are very satisfied that they have a cross-section of the community. Those involved are undoubtedly well-connected, compassionate and committed individuals.

> *He seems like a fantastic asset because he's been on the land all his life. He's been through fires and floods and he knows what it's like to struggle. And he's also been involved in the recovery programs. He's been out mending fences for people who lost their fences in the fire. He's been out doing the work already so he's a beautiful soul.*

In PHNs that were able to attract volunteers, recruitment was followed by a more or less formal appointment process, sometimes involving interviews followed by letters of appointment. Some TMs mentioned conducting criminal record checks prior to appointing the volunteers as Trusted Advocates.

3.1.5 Delivery of training

TMs regarded training for the Trusted Advocates as a vital component of program implementation. It was necessary, even among those with previous experience of peer support or an interest in mental health, because misinformed attitudes could be inadvertently damaging and perpetuate stigma. It was valuable to impart knowledge and skills around how to respond when someone was not okay; learning to listen and connect with the person, rather than to counsel and offer unwelcome advice.

> *I often speak to people in remote parts of [region] who say, "You know what? I think it's really important that R U OK day keeps getting promoted, but when people say to me, 'I'm not okay,' I don't know what to say." And that's where training is really important, actually.*

> *So, broadening their idea of what mental health means. It's not just about the serious cases of anxiety and depression or borderline personality disorder or psychosis. It's about people who are trying to deal with stress, and they might need a bit of support [so that] they're feeling a community connection and that sense of isolation is reduced.*

It was acknowledged that the types of training suggested in the program guidance, namely MHFA and Accidental Counsellor training, are both quite intensive and require a considerable time commitment. Some PHNs offered condensed versions of these courses. However, a couple of TMs would have preferred a different type of training, or a different way of delivering the training. One TM described MHFA as "very, very basic … a good starter", but felt that the TA role required more knowledge about what questions to ask and how to respond to someone in distress, which could be provided by other training courses. Another suggested that MHFA could inadvertently exclude those that the TA program was seeking to engage because some people would find the delivery style and language inaccessible:

> *Sitting in a classroom for two days is probably not the best way for people who haven't done that for many, many years to learn and develop skills.*

A variety of other courses were offered across the PHNs, depending on local availability and the focus of the program at those sites. Different training was available at different sites, covering topics such as: grief and loss training; setting wellbeing goals; understanding vicarious trauma and trauma-informed care; Gatekeeper training for suicide prevention, provided by Lifeline; training in supporting the supporters, provided by Red Cross; boundaries training; and workplace skills training.

Three sites mentioned the Weathering Well app, which was developed in western Queensland to guide people in having evidence-based conversations without "veering off on tangents" or offering unhelpful comments or advice. These TMs viewed the app as an ideal resource and some used program funds to provide TAs with the required technology (iPads) and trained them to use the app in their interactions with community members.

One way in which some Trial sites tried to make the training more accessible to volunteers was through flexibility around the timing, and by offering ongoing or follow-up training. Rather than requiring all volunteers to attend one block of training, one Trial site offered a variety of training

options regularly during 2020 for volunteers to attend when they were available. All but one of the TAs had been able to attend at least one training session. This allowed the site to maintain a core group of committed volunteers. Another site was tailoring training to the expressed needs of the group, supporting their interests and addressing specialised topics around identified local issues (e.g., recognising the signs of domestic and family violence).

3.1.6 Supervision and support

Once the TAs were recruited and trained, the program required ongoing input from the PHNs. This was the case even for PHNs with functional external partnerships. Several TMs commented on the amount of time and effort required to keep volunteers engaged, supported, and connected; therefore a dedicated, part-time project officer was seen as an essential element of program delivery.

> *It's pretty labour intensive, there's a lot of work that [the project officer] does, it couldn't work without some resourcing [to keep the volunteers engaged] … constant contact and also arranging the training and getting them together, COVID dependent.*

Ongoing training and professional development opportunities were regarded as vital, but challenging due to the competing demands of the volunteers who have "very busy lives". Translating lessons learned from training into the real world would be difficult and volunteers would continue to require support to implement what they had learned. This would require an ongoing investment of time and effort from the host organisation.

> *Having training available is great but having a supported program where these people feel supported through a process for a period of time, is much more beneficial.*

During both rounds of interviews, TMs discussed the importance of regular, one-to-one contact with individual volunteers. This included support around the use of technologies for those volunteers who were unfamiliar with mobile phones or computers. The task of "touching base" with TAs can be time-consuming, for instance to arrange a suitable time for a phone call, to assemble materials for distribution to the group, or to travel to the target community for meetings. Again, TMs emphasised that a dedicated person was needed to maintain contact with volunteers.

This process of checking in served various purposes: to see how TAs were going, to keep them up to date and provide information that might be useful, to refresh their skills, and generally to let them know they were valued and appreciated. For instance, one TM said they had needed to provide reassurance around the person's capabilities in the role:

> *Some of them have said I don't know how to have the conversation with others about it and I said, that's okay, because there will be time where somebody will say I'm really struggling with this and that's your opening to say you know what I used to struggle with that but now I'm doing this and it's made such a difference.*

Another TM said it was vital to continue promoting self-care and self-awareness:

> *… ensuring they understand where their role begins and ends whenever they're dealing with anyone in the community.*

Trial sites and partner organisations have worked to help TAs maintain appropriate boundaries around their role as volunteers and not go outside the scope of peer support. TAs have been given the message that "they are not to provide advice and that they should not feel responsible for the

welfare of another person" but they can suggest ideas, invite them to try new things, connect people together so they can support each other in an informal way. They are encouraged to take a realistic view of their capacities and responsibilities:

> *From very early days I just had to say, you know, this isn't a counselling position. You're not counsellors in this role. You're there for a listening ear, just support them.*

Events or training sessions where volunteers were able to gather as a group helped build morale and a sense of shared identity, and were sources of peer support. Most of the sites that had recruited successfully had run at least one group meeting or event during the past six months. One site had scheduled monthly meetings until disrupted by the pandemic social distancing requirements; since then, meetings were informal and initiated by the volunteers themselves. Another site held a dinner with a guest speaker as a treat for the volunteers at the beginning of the program, followed this up with a breakfast meeting, and will close the program with another event. Opportunities to make connections with other members of their own communities benefitted the TAs and enriched their experience of the program:

> *They just appreciated meeting people … they were working together with strangers, a really dynamic and different group of people, to deliver something to the town.*

3.1.7 Marketing and promotion

At some of the sites where volunteers have been recruited, an additional task has been marketing and promoting the program. The Trial sites made use of social media, industry-specific and local media, flyers and posters, and articles in school newsletters, to spread the word about the program. One site has had a banner donated to the program for use in promotion; another has a fortnightly segment on two local radio stations and a regular piece in the local newspaper. Several sites had events to launch the program. Remoteness and the pandemic travel restrictions meant that community events were limited at other sites.

Where marketing and publicity activities have taken place, TMs felt they were necessary for building trust and raising awareness so that the program would be utilised. This view was epitomised by the comment:

> *We are of the view of promoting it because if people don't know there's a service, no matter what the service is, if they don't know it's there it may as well not be there.*

This view was not universal among Trial sites, however. Sites with established groups of volunteers who were engaging opportunistically with their communities tended to see less need for ongoing marketing and publicity activities. One TM raised an interesting point about the possibility that publicising the program might be counterproductive. At this Trial site, there was some promotion through a Facebook page but this was handled carefully to avoid singling out the TAs from others who had received similar training in that community. There was also consideration of whether to put up posters and do other marketing, but volunteers were wary:

> *Some of them were feeding back to us that if people knew that they were part of the program they wouldn't actually talk to them. So we've been wrestling with that idea.*

One TM said they needed to be "careful" with publicity, to avoid fuelling underlying, pre-existing discontent in the target community. Another site had reservations about promoting the TAs because they did not want the program to be seen as a service or for misunderstandings to arise about the qualifications of the TAs:

The Trusted Advocates are not counsellors. The program is more for them to feel more resourced, to have some training, to feel supported in what they're doing in their community.

3.2 Fishers' Trial implementation

For SIA, one of the first implementation tasks was the formation of a steering committee, followed by the recruitment of a project officer, who started work on the Trial in early July 2020. The material in this section of the report is based on interviews with the project officer, program manager, and steering committee members, and documents provided to the evaluation team.

Implementation of the Trial in the three target communities appears to be proceeding smoothly and is well advanced. Progress has been facilitated by the appointment of a project officer with highly developed skills in networking and communication. This individual had previously conducted a small project with the fishing industry and had some prior knowledge of the mental health issues facing workers in that sector. Another facilitating factor has been the ongoing support of the expert steering committee and their knowledge of, and existing strong links with, the seafood industry. Meetings between the project officer and steering committee take place weekly, providing regular opportunities to check progress against project milestones and to discuss strategies, tasks and any emerging issues. This appears to be working well and was described by the project officer as a respectful, productive "balance of leadership and compromise".

Selection of the three target communities took place via a national consultative process (see Section 1.4). To be eligible for participation in the Trial, communities had to have an infrastructure to support involvement (e.g., a local organisation representing the fishing industry) and had to demonstrate willingness to engage with the Trusted Advocates model. One of the goals, from the perspective of SIA, was to "seek meaningful collaboration with, and education of, those delivering existing supports" in those regions. Soon after the target communities were identified, the project officer sent emails to local organisations requesting assistance with information about, and introductions to stakeholders where there may be mutual benefit in connecting with the Trial (e.g., individual community members, mental health service providers, and others). The email also provided brief information on the role of the Trusted Advocates.

Following successful negotiations with the Tasmanian Seafood Industry Council, the Fishers' Trial has been branded and marketed under the name Stay Afloat, which is associated with similar interventions in Tasmania and South Australia. The rationale for this was that the name was already well known and links with these two existing programs could be beneficial.

We pretty quickly started conversations about the power of that brand, the fact that it's already got some recognition nationally, the fact that we hope for this program to be sustainable into the long-term, and so we made a licensing agreement and named this program Stay Afloat. And so it's awesome because we've got this collaboration beyond the project where we're going to continue to be able to draw on the experiences of those two programs almost as if they were focus communities, although not in any formal way, but just keeping the conversations going about what's happening in other places for our future learning.

Due to COVID travel restrictions, the project officer (who is based in South Australia) was not able to visit the three target communities in the Northern Territory, Victoria, and New South Wales until early 2021. Instead, starting with a list of stakeholders provided by the steering committee, the project officer contacted organisations and individuals via phone and email to introduce herself and the Trial, find out about local needs and resources, and try to identify suitable TA candidates and

other stakeholders who may benefit from involvement. The project officer kept records of all contact points and discussions.

3.2.1 Recruiting and selecting volunteers

In a communication to stakeholders at the three target communities, requesting help with recruitment, a list of required skills and qualifications was provided:

- high level of emotional intelligence;
- a passion for supporting wellness in others;
- proven ability to develop trusting relationships with a diverse range of people and backgrounds;
- a local resident with strong local community networks;
- formal qualifications in mental health and related fields are preferred but not required; and
- experience / involvement in the seafood sector in the target community is preferred.

This document also stated that the expected time commitment for volunteers was 10-20 hours per month between September 2020 and April 2022, and the position was described as "best suited to a committed member of the local community who is prepared to act autonomously and confidentially with industry and is responsive to the varying needs of community".

The recruitment process itself was informal and iterative, but guided by the agreed selection criteria (above) and job description. Those involved in the Trial appeared to have a solid, shared understanding of what they were looking for, and what they should try to avoid. For instance, one steering committee member commented that it was not a good idea to have volunteers who were too close to the difficulties facing the seafood industry or struggling with their own issues.

> *And also, we wanted to make sure that the Trusted Advocate wasn't going to – that their role was really about the health and wellbeing of the person they're talking to, and not reinforcing the anger or the resentment. Because you can get into those conversations, and it can just wind you up further and further and further. So we had to find the right people who would be able to have a little bit of distance.*

Those considered suitable were recruited via "casual conversations" rather than "job application type arrangements", although the project officer did also instigate a screening procedure, using an interview template to check for "any hotspots, any concerns, or any worries that these people had, and also a good awareness of where they're at right now in terms of their knowledge and understanding and approach".

This process resulted in the recruitment of three volunteers for each of the three sites. Those interviewed said they were pleased with the diversity of those recruited, who were described as "not the same olds", that is, a broad-based group rather than only people who are relatively easy to recruit into volunteering roles but might not be the right people for the job.

All nine recruits were asked to sign Volunteer Agreements which set out the terms of engagement, defined the expectations and role of the Trusted Advocate, and presented a list of eight performance standards by which Trusted Advocates agreed to abide. These covered issues such as confidentiality, commitment to pro-active network building and messaging around mental health

within the industry, record keeping, confidentiality, contact with service providers, and encouragement of others to participate in "wellness activities" such as events, training, and hobbies.

3.2.2 Training and support

All Trusted Advocates involved in the Fishers' Trial undertook the full, accredited MHFA training, either face-to-face or online. The project officer also undertook this training and went further, to become an accredited MHFA trainer. It is hoped that this will allow the project officer to work with master trainers to create alternative scenarios (for use in the training) that are more relevant to fishing industry workplaces and get these approved by MHFA Australia "so that every part of the program is very watertight around our industry". Each recruit also underwent two, two-hour "on-boarding" webinars providing detailed information on the role, reporting, housekeeping, confidentiality, processes of referral to health services, and so on.

Trusted Advocates are being provided with ongoing education in the form of tips and tools which they can communicate to the target communities. These focus on positive well-being, prevention and early intervention; for example, managing stress, creating good habits, dealing with uncertainty. The program manager has created a monthly calendar of themes and conversation starters, "so that they're never wondering what they're going to talk about". Similarly to the Farmers' Trial, supervising and supporting the Trusted Advocates required an ongoing investment of effort.

> *I'm going to be really needing to spend a lot of time supporting the everyday questions and answers for them using the Mental Health First Aid knowledge because they [might be] put in a situation where someone's in a crisis and whilst they've been taught what to say it isn't necessarily going to jump back into their head like that.*

The main mechanism for clinical support is a monthly group session by a clinical psychologist who is also a MHFA master trainer; this combination of skills is intended to ensure that the supporter "knows very clearly the limits that are set in Mental Health First Aid about how to handle conversations appropriately" and can thus assist volunteers to keep their activities within scope. TAs are encouraged to prepare and come along to the sessions with questions or stories about their experiences. They go through scenarios together and discuss how they might respond, framed within the language of MHFA to keep embedding the lessons from the training. An average of five or six TAs attend these sessions each month.

The clinical psychologist who runs the group sessions is also available for 30-minute individual sessions if TAs "feel triggered or impacted by what they're hearing and seeing" and they also have the option of contacting the project officer for a talk, as needed. Regular phone meetings with the project officer are scheduled, as are virtual meetings across the three Trial sites at which TAs can talk, debrief, and learn from each other.

Occasionally, as in the Farmers' Trial, volunteers require reassurance about their capacity to fulfil the role or whether they are doing enough. One-to-one chats are needed to keep them engaged and motivated to achieve the long-term goals of the program around building a network of mental health support in target communities:

> *… keep reinforcing to them that this is not about how many conversations you have about mental health, it's about how you gradually build awareness around you so that people will gradually come to you for support as they need it.*

At times there has been a need for additional information to respond to incidents in the target communities that affect mental health, such as workplace injuries or deaths. The project manager

and clinical psychologist are available to assist, and peer support mechanisms also appear to be working well in these situations. It was noted that dealing with such incidents is more complex in fishing communities as those affected usually go back to work – and out to sea – soon afterwards, distancing them from potential sources of support and comfort.

3.2.3 Marketing and promotion

Publicity and communications are regarded as core activities of the program. They are guided by a communications plan which specifies 22 objectives, including raising awareness of the program itself, highlighting the "uniqueness and complexities" of mental health issues affecting Australian fishing communities, and building networks in target communities to reduce isolation and stigma. Development of the communications plan was informed by the MindFrame[2] best-practice guidelines for safe and responsible communication around mental health in order to minimise harm to vulnerable people or those bereaved by suicide.

The primary target audience for communications is the seafood industry, including friends and family of commercial fishers. The secondary audience includes the broader communities within which commercial fishing operates, plus media outlets. The communications plan sets out a timeline, budget, and detailed information regarding methods, materials, language and general approach. This was prepared not only to guide the Trusted Advocates component of the project but is also central to the three other components (see Section 3.2.4).

Centrally, the program has obtained promotional materials for branding of the program, such as hi-vis vests, caps and bucket hats with the Stay Afloat logo. There are plans to outfit the TAs in polo shirts with the Stay Afloat logo and the project is also printing 1000 copies of a self-help booklet on managing stress which TAs and grantees can give out to people who are not ready to seek help yet.

In addition to the centrally driven activities, promotional events have been organised locally by the Trusted Advocates, backed by the industry organisations that are supporting the program at each site. These have mainly consisted of informal gatherings such as barbecues. Those involved have found that inviting community leaders or influencers to these events can be a good strategy to attract others to attend:

> *One of the godfathers of industry came along and that was a deliberate invitation by one of our Trusted Advocates who said, 'If I get him along then people will turn up, they'll be really impressed'."*

The Fishers' Trial has also had an opportunity to contribute to knowledge translation through participating in the construction of a resource on industry-based mental health in the workplace programs which is being prepared by the National Mental Health Commission. The resource is part of the National Workplace Initiative[3] undertaken by the Commission and 15 other organisations to achieve a nationally consistent approach to mentally health work. It will define mental health at work and highlight ways to contribute to achieving this goal. The initiative aims to bring together existing industry programs, frameworks and resources and to understand the principles and strategies underlying successful programs. One product of the National Workplace Initiative will be a written resource presenting case studies of programs across the spectrum of maturity, sharing lessons learned. After hearing about the resource, the Fishers' Trial project manager contacted NMHC and she and the evaluation project manager were subsequently interviewed; the information provided will be presented in the resource as a case study of a promising, early-stage initiative.

[2] https://mindframe.org.au

[3] https://www.mentalhealthcommission.gov.au/Mental-health-Reform/National-Workplace-Initiative

3.2.4 Other components of the Fishers' Trial

There are three additional elements of the Fishers' Trial, beyond the appointment of Trusted Advocates. The Activity Work Plan submitted to the Department in May 2020 also sets out the following project objectives, each with a number of specified deliverables. Information on progress with these tasks was reported to the Department in October 2020.

Communications support for the seafood industry. Tasks included gathering information on mental health support and adapting this for the industry context, designing new materials where necessary, developing and launching a website, and distributed printed materials to support help-seeking behaviours. According to the October 2020 progress report, printed materials had been designed and distribution would commence with the launch of the program and website. The project communications strategy included plans to promote the website. A dedicated Facebook page had also been planned, with a weekly schedule of posts to keep people engaged. The program launch took place in November 2020 and was promoted through a media release, which was picked up by local and industry media outlets.

Community resilience grants. This component involved establishing a committee to design and oversee the grants process, producing supporting materials (application form, approval processes, and methods for evaluating applications), promoting the grants and encouraging applications from eligible organisations, and distribution of grant funds to support a minimum of 30 separate activities and events. The progress report to the Department noted that COVID had caused some delay to this component of the project, however the selection panel had been established, along with the application and approval processes, and the grants had been promoted. Steering committee members said they would know this aspect of the project had been successful if they had a good variety of events and activities funded, using clever ways to promote mental health; as one described it, "health by stealth".

A total of 26 applications were received by the closing date, proposing a variety of innovative ways to raise respect and build the image of fishers (for instance, meeting the fisher at a food festival; increasing awareness of abalone as a food, and how to prepare and cook it; information boards about the importance of the fishing industry with a launch event). All proposals were considered by the selection panel in April. Some examples of funded projects are:

- A bus tour of key infrastructure developments/opportunities plus lunch (Darwin)
- Funds to support entry fees to a community fun run/walk with the participants wearing Stay Afloat branded life buoys around their waists (Adelaide)
- Entry to a community fun run/walk followed by a barbecue with speakers with lived experience of mental illness (Port Lincoln).

Training and community awareness. In addition to the delivery of at least seven courses across the three target communities, the project will "identify other ways to build awareness, reduce stigma and encourage help seeking behaviours in the seafood industry". Training in MHFA will be extended beyond the volunteers to general practitioners and other health professionals in target communities. At the time of the final report, approximately 15 face-to-face training sessions were planned and the dates had been selected. The project officer's accreditation as an MHFA trainer had assisted in identifying contractors to provide this additional MHFA training and in the creation of three alternative scenarios – relevant to commercial fishing – to be used in the training.

3.2.5 Seafood industry survey

Via stakeholders, a survey was distributed to those working in the seafood industry to collect information on sources and experiences of stress in the workplace and at home, responses to stress (both adaptive and maladaptive), impacts of the COVID pandemic, support and information needs, and preferred delivery of advice on mental health and stress management. Responses (n=72) from across Australia indicated that work-related stress was prevalent; almost half said work issues and challenges caused them to feel stressed, and a similar proportion said a combination of work and other issues increased their stress levels. The COVID pandemic had exacerbated stress for 64% of respondents, particularly through financial impacts on seafood prices, businesses, and employment. Survey participants reported that stress had negative effects on their sleep, moods, work, diet, cigarette and alcohol consumption, and communication with others. One in five were interested in learning how to manage their own stress at work, and almost 30% were interested in learning how to help other people reduce their stress. Preferred methods for receiving help and information were online learning (34%) and one-to-one sessions with a trusted person (29%), followed by group information sessions (14%), workplace training (9%), written information available at work (7%) and other means (7%). Findings from the survey will be used to inform ongoing project planning.

3.2.6 Developing a program logic

Although it was not included in the brief for the evaluation, the interim report recommended that a program logic be developed for the Fishers' Trial. This would document a chain of logic linking program resources and inputs to outputs and anticipated outcomes, assist in identifying essential elements of the Trusted Advocates model, provide a framework for monitoring and reporting, and strengthen evaluation evidence. The goal was to assist SIA with the internal evaluation of the Fishers' Trial, which will continue for a further 12 months after this independent evaluation ends.

With agreement from SIA and the Department, the evaluation team worked with the Fishers' Trial project officer and steering committee to create a draft program logic model. Following a review of program documents, the evaluation project manager attended a virtual meeting of the Fishers' Trial steering committee to talk through the context of the program and the anticipated outputs and short- to medium-term outcomes. A technique called 'backcasting' was used: starting from the expected outcomes and working backwards towards the inputs, activities and outputs required.

"The benefit of backcasting, compared to approaches involving forecasting, is that it allows stakeholders to consider what is needed to create the future, rather than thinking about what is currently happening and trying to predict the future." (NSW Health, 2017)

Implementation of the Trusted Advocates model within the Fishers' Trial has been carried out in a consistent way across the three target communities. The program logic should add value to the program by enabling SIA to specify and measure outcomes and link them in a logical chain with the implementation of the Trusted Advocates model and the other Fishers' Trial activities, strengthening the rigour of the evaluation methods.

The draft program logic model is shown below. In Figure 4, program objectives and key assumptions are explicated, along with contextual factors that are likely to affect the implementation and outcomes of the program. In Figure 5, activities and participation are colour coded according to the four program streams, based on the deliverables from the Fishers' Trial project plan. Outcomes are not colour coded because they do not relate to specific program streams but result from the combination of all program activities. All the short-term outcomes collectively lead to the medium-term and long-term outcomes. The two shaded long-term outcomes are not direct goals of the

program but are desirable potential side benefits which might be influenced indirectly by the program.

Figure 4 Fishers' Trial draft program logic – part 1

<table>
<tr><td colspan="2">Program Objective:
To implement mental health supports within the seafood producing community, specifically: establish a "Trusted Advocates" service that assists community members to seek and access mental health care as needed; provide education and training and enhance communications that support help-seeking behaviours; establish and strength links between the mental health support coordinators, the community, and appropriate services; build community capacity and resilience through accountable and transparent distribution of small, local grants.</td></tr>
<tr><td colspan="2">Problem Statement:
Industry-specific factors contribute to chronic stress and uncertainty among people reliant on the seafood industry for their livelihood. This is indicated by high prevalence of psychological distress, work-related injury, and physical illness. Fishers are also vulnerable to short-term uncontrollable events such as changes in access to resources, which (against a background of chronic strain) may prompt mental health crises. There is a need to build social capital, individual help seeking, and access to health care providers with industry knowledge.</td></tr>
<tr><td>Assumptions:
• Non-specialists can be trained to provide effective mental health support.
• MHFA is an appropriate and effective training program for this project.
• Health behaviour change will result from greater access to information and support.
• Increased informal community discussion around mental health will lead to reduced stigma and prompt formal help seeking as required.
• Increasing the skills and willingness of community members to talk about mental health creates a durable community resource which is protective against shocks ("resilience").
• The "dose" of the program will be sufficient to mitigate against the industry-specific issues described above which affect fishers' mental health.</td><td>External Factors:
Variety of structural, social, political and environmental factors and events which may lead to changes in resource access, market access, prices, regulations, status and influence of commercial fishing industry, etc. and thus affect the mental health of fishing communities.</td></tr>
</table>

Figure 5 Fishers' Trial program logic – part 2

Inputs	Program streams	Outputs: Activities	Outputs: Participation	Short-term outcomes	Medium-term outcomes	Long-term outcomes
Project funding	Communications support	Tailored, relevant, accessible communications on mental health are made available to fishing communities.	Information about mental health is taken up (e.g., use of social media and website, distribution of written materials).	Individual community members know how to protect their own mental health and why this is important.	Fishers take better care of their mental health and well-being and manage stress more effectively.	Prevalence of psychological distress in fishing communities decreases.
Project planning and governance	Training and community awareness	Tailored information resources are distributed to health care providers (e.g., GP clinics).	Information about industry-specific issues affecting the health of fishing communities is taken up by GPs and other health care providers.	Local GPs have a greater understanding of the industry-specific factors that affect the health of fishing communities.	Fishers take better care of their physical health and well-being.	Incidence of mental health crises (e.g., suicidal behaviour) in fishing communities decreases.
Recruitment of program manager		Mental Health First Aid training is available, accessible and effectively advertised in fishing communities.	MHFA training is taken up within fishing communities (number & variety of trainees, reach within industry).	Individual community members understand when, how and where to access mental health support.	Fishers access mental health care and support when needed.	Improvements in physical health and reductions in chronic disease are seen in fishing communities.
Creation of communications plan	Community resilience grants	A transparent, accountable process is established for distributing grant funding, and information is disseminated to encourage good quality applications.	Quality and quantity of applications for small grants by individuals and groups within fishing communities is high.	A variety of innovative, relevant, effective mental health promotion activities take place in fishing communities.	There is improved community awareness of the risks to mental health in the seafood industry and how risks might be mitigated.	Improvements in workplace safety and reduction in workplace injury are seen in fishing communities.

Inputs	Program streams	Outputs: Activities	Outputs: Participation	Short-term outcomes	Medium-term outcomes	Long-term outcomes
Stakeholder engagement				Conversations about mental health take place via social media and face-to-face in fishing communities.	Fishers and their families feel connected and respected within their communities.	
Selection of three target communities	Mental health support coordinators	High-quality, well-connected candidates are identified and recruited into the role of Trusted Advocates.	Trusted Advocates are trained and supported to provide a listening ear and mental health first aid.	Trusted Advocates and others with MHFA training provide informal mental health support to individual community members.	Trusted Advocates act as a focal point for mental health support, activities and communications in their communities.	
				Trusted Advocates are a mutually supportive community of practice with strong links to the seafood industry.	Trusted Advocates feel respected and valued and have opportunities for ongoing personal development.	

4. Goals and design

This chapter addresses the second evaluation question: how appropriate were the Trials' designs for the identified needs? The primary data source was interviews with Trial Managers (TMs) supplemented by a review of available program documents and relevant literature.

4.1.1 Selection of target communities

The selection of target communities was an area in which Farmers' Trial TMs expressed strong opinions. TMs accepted that there was genuine need in the towns and districts they were directed to target. It was apparent, however, that the program could have been more successful if there was flexibility around the implementation sites, as there was with the Fishers' Trial. This would have provided several advantages.

First, greater flexibility could have allowed genuine stakeholder consultation and a needs assessment early on in the program, before the target communities were chosen.

> *I mean, the unfortunate thing is I guess everywhere could have benefited in terms of rural communities that were in drought and still are.*
>
> *One of the resounding things that kept on coming back to us from a number of sources was the rationale as to why [town name] was chosen over other sites given that there's much greater need across some of our other communities across our region … We couldn't really answer that question. So it put us in a very difficult spot.*

This could have avoided the problem encountered by some PHNs that the target community was already at "saturation point" in relation to mental health promotion, limiting the capacity of those key people who may otherwise have been able to assist. This sense of overload was seen an explanation for the lack of public interest in the program at those sites. It also would have provided opportunities to identify local challenges and to co-design and tailor the program with stakeholders (for example, adapting the training or targeting sub-groups within the population).

Second, greater flexibility could have enabled PHNs to leverage existing relationships with respected leaders and organisations that are embedded in rural communities. As the Fishers' Trial has demonstrated, identifying the focal points of influence allows easier access to the target group and more effective sharing of messages. Similarly, where PHNs have connected with partner organisations that have strong local presence and credibility, implementation has generally proceeded more smoothly.

One TM suggested that rural people often distrust government and are frustrated with government agencies that try to "tell us how to run our lives … when they've got no idea of where we live and what's going on". Local knowledge and trust is the key; the Trusted Advocates Networks do not need to be run out of mental health organisations, but they must have compatible goals and extensive networks. In this way, the Trusted Advocates Networks could potentially build onto and reinforce existing community resources.

> *It's the sort of program that really needs to be run by the community and have these community champions. So they sort of need to put their hand up and that's where it will be successful.*

Third, greater flexibility may have improved the fit with existing services and other short-term programs. The program is intended both to build capacity within individuals and communities and to encourage help seeking; however, it can also draw attention to gaps in service provision or areas where services cannot meet demand. There is a risk that if help seeking is not reinforced through good experiences with service providers, an individual may be reluctant to seek help again. Further, it was argued by many TMs that, within their jurisdiction, there were already multiple interventions (e.g. technical support and financial counselling for farmers, resilience and wellbeing programs, suicide prevention programs) aimed at the same audience. In the words of one TM:

> *The Trusted Advocates program just seemed to fall out of the sky from nowhere without any awareness of any other initiatives that were going on.*

Fourth, allowing flexibility could have facilitated more complete implementation of the Farmers' Trial. As it was, PHNs were not able to try implementing the program elsewhere when attempts in the target community were unsuccessful. For example, one TM said they believed at first that the program could work, until they looked at the population size. Ultimately, the small community was not able to support volunteer recruitment and the program was not implemented at that site.

> *I think the biggest barrier was the location. We were stuck with that location. We couldn't broaden the scope to try and get it out.*

> *I think there are other places that would benefit much more and we would have had much more traction in the community.*

4.1.2 Program guidelines and goals

Farmers' Trial sites received a four-page program implementation guidance document which was also sent to the evaluation team for information. This provided some background information about the origins of the program as an extension to the EOC initiative and arising from consultations undertaken by the Co-ordinator-General for Drought, Major General Day. The nine target communities were listed, and expectations for the PHNs in establishing the Trusted Advocates Network were outlined. There was a brief description of who the Trusted Advocates would be and how they would operate. The document also referred to the evaluation of the Trial.

Based on the consultation processes undertaken by Major General Day, there was an assumption that this type of support would be both desirable and effective in the target communities; however the evidence base for the model was not part of the background information given to the PHNs. The program goals were implied in the description of the Trusted Advocate role and the expectations of PHNs but were not stated explicitly.

In the first round of interviews, we asked TMs about the program goals; that is, precisely *how* the Trusted Advocates model would lead to improved provision of mental health support in farming and fishing communities. Responses indicated differences and inconsistencies among TMs in their understandings of what the program aimed to achieve and the mechanisms by which the program would achieve these goals.

The most common view of the program goals, mentioned in seven of the baseline interviews, was that the program was intended to support people who were, in turn, supporting others in their local communities. At one site, the program was focused on training these individuals to look after their own wellbeing and to model strategies for staying physically and mentally healthy. However, most often, TMs saw the main goal of the program as **building volunteers' knowledge and skills** to help them do a better job of what they were already doing. TMs spoke about:

- Training "everyday people" to recognise when others need help and giving them the knowledge to assist "in an informal capacity";
- Empowering "community champions", people who are already respected and approached for advice, and upskilling them so that can perform this "natural role" more effectively;
- Supporting those who are trying to help others in times of adversity;
- Teaching people how to respond to others who are in distress or "going through a tough time";
- "Acknowledging their great work and enabling them to continue that work during times of potential hardship."

One TM explicitly linked the program goals to the perceived needs of these "local champions":

> *With a small amount of funding, [we are] able to provide them with training and support, because often they were having those conversations with people, or they were noticing somebody wasn't well, or they were a bit concerned about somebody, but probably not having the skills or confidence to be able to have those conversations.*

The second most common focus for the program goals was on developing community resilience, **reducing distress and promoting wellbeing**. This would be achieved by reducing stigma around mental illness and talking about mental health:

> *It's trying to say that it's okay, through the Trusted Advocates, to admit that you're struggling some days.*

In this view of the program goals, the Trusted Advocates are the means of reaching out to people who are usually difficult to reach, who may be suffering mental ill-health but do not wish to see or talk to a health professional. The program is therefore designed to enable such people to talk privately with a trusted individual "without having to worry about it going any further". Ideally, this support person is available at the right time and has first-hand understanding of the issues facing the farming or fishing industry which distressed individuals may be dealing with. In short, the goal of the Trusted Advocates program is to develop "another avenue of support to people doing it tough … by providing someone that people can chat to, that they feel comfortable with".

Two other, less common, goals were discussed by TMs in the interviews. One of these focused on health system access and was based on the assumption that some segments of the community do not access mental health services when they need to, either because they are unfamiliar with what is available or because of stigma and unwillingness to be seen as having a mental health problem. The goal for the program is therefore to help overcome these "barriers". Trusted Advocates would link such people with formal service provision if that is required; in order to do so, they would need to be educated in how to recognise serious distress and also equipped with knowledge of the services available locally. Again, in this view of the program goals, the Trusted Advocates are means to an end, namely **improving health service access and use**. One TM described the TA role as "a go-between linking community to service providers, almost like a care navigator".

Useful indicators of success would include the number and appropriateness of referrals to mental health services; however, some TMs felt the number of referrals should increase, while another argued that this would fall due to greater community well-being overall.

The other goal was **prevention of mental illness and suicide**. One TM explained that drought was a unique stressor on mental health in farming communities, unlike bushfires or floods which could to some extent provide a focus for action, "something to go ahead with and fix":

> *But in a drought, it is relentless, and they wake up every morning and look out at that brown dirt and there's no rain. That's when this sort of program is really needed.*

At one site, suicide prevention was seen as the original goal of the Trial but this had been "flipped" by the Trial site to focus on wellbeing: "because nobody really can prevent suicide. And if somebody is going to do it, they're going to do it. But that's a lot of responsibility to put on people …" Another TM talked about the Trial as a way of intervening in communities that had suffered high levels of serious mental illness and suicidal behaviour in the past. The Trusted Advocates model would create "a safe zone" so that people could talk to others who had appropriate training. However, because suicide is a relatively rare event, it would be unrealistic to expect any measurable impact on suicide rates and therefore this would not be a useful indicator of success for the Trusted Advocates Trials.

4.1.3 Model fidelity

The mix of target communities, including some that were very remote, meant that Trial sites faced different types of challenges in implementation. For instance, it was argued that more remote sites required more time and resources to advertise the Trial to local communities in order to recruit volunteers.

> *Because with small communities, you really need to be known in the community for people to come to you and accept you and listen to what you have to say.*

The remoteness of sites also impacted on the way TAs could be trained; online training was impossible due to lower levels of digital literacy and poor internet connectivity and this was compounded by the unavailability of mental health professionals. Conversely, for those pilots in larger regional areas, host organisations felt challenged by having to deal with multiple LGAs and LHDs within their jurisdiction which had different levels of mental health support services available. This meant TMs had to be "flexible…to allow for local idiosyncrasies".

At several sites, the program funding was directed towards delivery models that were designed by the partner organisations. As a result, the Farmers' Trial sites diverged from each other in fundamental aspects of the program such as the ways of engaging with the community. For example, one site chose to replicate and extend a program which had previously been funded (as a trial) by a State Government. Help seekers contact the service and are connected to a volunteer who can offer assistance by phone or face to face. This delivery model – where assistance is actively sought and access to the volunteer is mediated by a third party – is within the spirit and scope of the TA program and has been implemented successfully (although not well utilised). Nevertheless, it appears to be quite different from what was originally envisaged as spontaneous conversations between TAs and acquaintances or others they may encounter by chance.

There was also variability in the level and type of support offered to volunteers. For example, some PHNs linked the volunteers to an Employee Assistance Program which they could access as required. Feedback indicated that this service was not utilised; this would not appear to meet the requirement for "proactive support" and "mentoring" outlined in the program guidance document.

4.1.4 Available resources

It was evident, from the comments of most of the TMs, that delivery of the Trusted Advocates model requires resources over and above the reimbursements to the volunteers; "it doesn't just run itself". This means the project officers – whether they are within or outside the PHNs – are crucial in the success of the program. TMs were able to identify a variety of qualities and skills considered essential for the role of the project officer:

- belief in the program, passion;
- experience in leading projects;
- knowledge of mental health issues;
- skills in networking and influencing, leadership and relationship building; and
- ability to communicate at all levels.

As indicated above (Section 3.1.6), project officers play a vital role in maintaining contact with the volunteers.

TMs were divided on the question of whether the funding provided for the program was sufficient. Several TMs commented on the small pool of funding for the Farmers' Trial, some even suggesting that - with the benefit of hindsight - they would not have accepted the funding based on their experiences of the project. This was due, in part, to the costs to the organisation of establishing and supporting the Trusted Advocates model.

Other TMs felt the funding was sufficient, particularly given that it was part of the larger EOC program. It was also seen as sufficient when supplemented by in-kind support (and sometimes additional funding) from partner organisations which employed the project officer. This support was forthcoming when partners perceived that the program was consistent with and complemented their existing community mental health support work. Costs were not evenly spread across the implementation but fluctuated according to the tasks at hand, with the main costs up front. Building the network and delivering or arranging training tended to be time consuming.

> *Once some key steps are in place and you've got the plan and the plan is working, and you're only working with those ten people, you can take on other projects as well, and that's how it's costed appropriately.*

However, several TMs indicated that the funding would not be sufficient if it had to cover the salary of a project officer employed by a PHN. In some cases, program funds are also being used to cover the costs of professional support and supervision for the volunteers.

4.1.5 Reimbursement versus payment

There was a variety of views on the issue of TA reimbursement. Several TMs strongly believed that TAs should be paid for their time, not just reimbursed for expenses, consistent with current practice around appropriately recognising the contribution of mental health peer work. Others saw no need even to reimburse for expenses, arguing that small incentives (such as group dinners or free training) were enough to keep the volunteers happy and engaged.

> *Not one volunteer asked for money and remuneration for driving their car out to people in the middle of the night, which happened. A couple of them were called out to farms, to people, just to have a chat.*

> *I don't think they're calling anyone out of hours, I don't think they're travelling out of hours. I think those funds have just been really put towards, like I said, getting the group together.*

There is an argument that lack of financial reward, combined with the demands of the program, might deter potential TAs from joining the program. Conversely, for those who suffering the financial impacts of the drought on their businesses, payment might make it more feasible to take on a TA role rather than (or as well as) a second or third job. It might also help attract a broader range of people to the role, rather than mainly those who were financially secure. Questions were raised about the ethics of asking people who were overstretched financially to take on an additional, unpaid role.

> *There was an interest but then once they delved in and found more about all the things they would have to do and the paperwork they have to sign and the clearances they would have to get, it's like, yeah, that's a lot to ask of a volunteer, and they've all stepped back.*

> *Sometimes they're able to prioritise it, if the role might bring them money, particularly at a hard time, if you know, their income has lessened because of the drought and there's something like this that might be passionate about, but they just don't have the time, but if they're getting paid to do it, it might change that situation.*

One TM pointed out that there may also be good logistical and legal reasons for paying the TAs, relating to insurance coverage and Work Health & Safety provisions. These views from those involved in mental health care planning and service delivery stand in contrast to the program guidance from the Department, which states that:

> *Anecdotal evidence from stakeholder consultation indicated that if community members were paid to provide support and guidance, this would likely compromise their role as a trusted member of the community who genuinely cares about the wellbeing of their community.*

Interestingly, TMs acknowledged that broaching the topic of reimbursement with the volunteers was "a challenging conversation" because they may find it insulting. As the interviews with TAs showed, some volunteers would prefer not to be paid, or seen to be paid. One TM summed up this contrasting point of view:

> *So they really loved the idea of the volunteer side of it. And I think it's a really under-utilised workforce, volunteers. They are out there in the community doing heaps of work, but nobody really knows how big it is and how much work they're actually doing. So in that sense, I think it's a really innovative way and the community really own it when there's no funding attached to it. So they want to be a part of it because they want to benefit the community, not because they're getting paid to do a job.*

5. Outcomes and achievements

This chapter addresses the key evaluation question regarding the extent to which the Trials have achieved their intended outcomes and the difference they are making in improving the provision of mental health support for local communities. The variety of ways of defining the program goals (Section 4.1.2) means that there are numerous potential indicators of success which could be applied to the Farmers' and Fishers' Trials. Nevertheless, the indicators that reflect most directly the focus of the Trial sites' implementation activities are measures around the recruitment, training, and support provided to Trusted Advocates, to enable them to perform their "natural roles" more effectively. These are the outcomes reported below.

5.1 Summary of program achievements

Table 4 summarises the achievements of the program for the program goals most commonly adopted by Trial sites; that is, recruitment, training and support of volunteers who are actively involved in their communities.

This information was assembled from the initial interviews with TMs. It indicates that, at the end of December 2020, six of the nine PHNs had recruited at least one TA (range 2-12) and SIA had successfully recruited TAs for each of its three sites. Across the 12 Trial sites, there were 56 Trusted Advocates in total. Training activities, sponsored by the program, had taken place at 11 sites, including some of the PHNs that were not able to recruit volunteers. At six sites (three PHNs and SIA), the TAs were at that time available as mental health first responders; at a seventh site, they were expected to be available by the end of February 2021; and at two sites, TA activities had begun but were then suspended. Ongoing support was available to the TAs at seven sites.

Table 4 Trusted Advocates outputs at end of December 2020

	Farmers' Trial (9 sites)	Fishers' Trial (3 sites)	Overall (12 sites)
Volunteers recruited	6	3	9
Training provided	8	3	11
… MHFA*	2	3	5
… Accidental Counsellor*	3	0	3
… other	5	3	8
Support provided**	4	3	7
… private practitioner	1	3	4
… EAP	2	0	2
… Lifeline	2	0	2
Activities commenced	5	3	8
Activities ongoing***	3	3	6

* Includes modified (shortened) versions
** Sites with volunteers only
***Activities suspended at two sites

By the time of the follow-up interviews with TMs, very little had changed at most of the Farmers' Trial sites. Four TAs were no longer involved (two at one site, one each at two other sites) leaving a total of 52 volunteers, all of whom had received training and were available as mental health first responders. One of the sites which had earlier suspended activities was now operating again; the other appeared to have finished the program altogether, from what the evaluation team could ascertain. The nine Fishers' Trial volunteers remained actively involved, fully trained and supported.

At one site, volunteers were invited to bring family and friends along to the training. At another, training was used as a recruitment strategy; the Trial sponsored two sessions of Accidental Counsellor training in the target community, both of which were well attended, although no-one signed up afterwards to be a volunteer. At another site, it was decided to use Trial funds to sponsor MHFA training in the broader community, because there had been no success in recruiting volunteers. This means that the program has increased the spread of knowledge and skills in mental health peer support beyond the numbers shown in Table 4.

> *So I guess the thought was even though we don't have networks set up as such, there's going to be a huge influx of people in that region that are trained in mental health first aid anyway.*

We asked TAs how they became involved in the program. Of the 21 Farmers' Trial TAs interviewed, approximately half indicated that they had previous or similar experience of the TA role. Similarly, approximately half had received previous mental health training. There was also clear evidence of lived experience of mental health issues, with 17 TAs saying that they had experienced a mental health problem and 16 indicating that a family member had also experienced a mental health problem. With regard to how they became involved in the pilot, 15 TAs said they were nominated or invited and six had volunteered out of community interest. This finding indicates that the program has at least partially succeeded in its objective of identifying key individuals who are already performing this role and offering the opportunity for training and support.

In the Fishers' Trial, only one of the seven TAs indicated that they had previous experience and mental health training relevant to the TA role prior to volunteering. Four out of the seven TAs had experienced a mental health problem and four indicated that a family member had also experienced a mental health problem. All seven of the volunteers were working or had worked in the fishing industry and were targeted by the project officer to volunteer in the pilot.

5.2 Interviews with Farmers' Trial Trusted Advocates

In the following section we present the perspectives of 21 TAs from five Farmers' Trial sites on their experiences, offering insights into the extent to which they felt adequately prepared for, and supported in, their volunteer roles.

5.2.1 Experiences of training

The TAs were asked whether or not they received adequate training. Seventeen out of the 21 respondents provided an answer to this question. Of the 17, 14 felt that the training was adequate for their role as a TA. Several TAs added to this response providing more detail why they felt the training was good. For example:

> *It was very laid back which was great… it was a lot of listening and a lot of video work on the presenter's behalf explaining what he's been through and how he formulated very basic concepts in regard to dealing with people which I enjoyed because… you know… you didn't have to write and formulate essays… so I was really rapt, and I thought I'm going to knock this over really quickly. It was enjoyable.*

For those who liked the training, a positive training experience related to face-to-face learning where there was scope for participant interaction. Many TAs commented about their preference for an environment where they were free to ask questions and learn from both the teacher and the other TAs in the room.

> *We have also had face-to-face training and I think that was very useful because various people who are acting as advocates would attend and you got to listen to what other people may be doing and why – their reasons for doing such a thing.*

Conversely, negative training experience related to the inability of the TAs to interact with the teacher and ask questions. Consequently, online learning was less popular with the TAs. Other TAs commented that they would have liked more sessions and more in-depth learning.

Ten TAs suggested ways in which the training could be improved. Most of these comments related to the quantity of training: they would have preferred more. There was also agreement that training should be ongoing and adapted to the volunteers' needs. Also a couple of TAs would have preferred less of a focus on online learning and more "hands-on" training that involved group work and case studies. One TA commented that they would like to learn:

> *Techniques on how to approach people, and just like, different scenarios of greeting and talking to clients.*

5.2.2 Perceptions of support from the host organisation

The degree to which TAs felt supported by the host organisation was mixed depending upon the Trial site. The level of support received ranged from "hardly any support at all" at one Trial site to "very supportive" at another site.

Positive feedback about the support provided by host organisations related to regular communication between the TAs and the Trial project manager. Knowing that someone was always available to answer telephone calls was comforting for many TAs. The availability of service provider directories to use when referring/recommending clients for additional support was also considered helpful. One TA commented:

> *I've had all the support I need and I believe all the participants would have had that.*

Another TA reflected:

> *Basically anything that we've said we're interested in, [project officer] has coordinated for us… tries to give us the information and not scare us off... have done as much as [they] could facilitating any training that was available… basically [they] said, 'What do you guys need?'*

Conversely, negative comments related to a lack of support. Comments that reflect this included feeling "on your own" or "in the dark", another TA felt "disappointed", "disheartened" and felt as if they were "being overlooked and dismissed" by the host organisation.

5.2.3 The importance of peer to peer support

TAs from three of the Farmers' Trial sites valued the opportunities provided by their project managers to encourage peer to peer support. Gatherings or meetings where the TAs got together to discuss their experiences and challenges allowed them to share ideas, discuss strategies for client interaction and offer each other emotional support. In the words of one TA:

> *"When we first got together, and we sat down and told everyone what we did…we opened up basically and said what's important to us and what we're doing this for…it bonded us as a group".*

5.2.4 Understanding the role of the Trusted Advocate

Prior to commencing their role, the majority of the TAs had attended orientation and information sessions. As a result, they had a broad understanding of what the position entailed. There was widespread agreement that removing some of the stigma associated with mental health was an important part of their role. TAs were also clear that it was not their responsibility to solve a client's mental health problem but to be a "good listener" and have the capacity to "refer the problem up the chain" and help the client "navigate the [mental health] system".

However, TAs were unclear how they would translate this understanding of the role into practice. Many TAs felt that the program lacked structure and they were unsure "what to do next". For many TAs, not much had developed since the orientation and training sessions and there was a lack of guidance from the host organisation. In the words of one TA:

> *…it was apparent to me that the people putting the program together were not really sure how this product was going to look either.*

As a result, levels of confidence amongst the TAs in helping someone with a mental health problem were mixed. Those TAs with previous experience in a similar role felt 'quite a bit' or 'extremely' confident. However, approximately a third of TAs interviewed felt only 'a little bit' or 'moderately' confident in carrying out their role.

5.2.5 Interactions with community members

Eight out of the 21 Farmers' Trial TAs interviewed had been active in providing help to community members (referred to here as "clients"). One had seven active clients, two had four clients each, one had three clients, two TAs had one or two clients and the other two TAs could not quantify the number of clients but had had many conversations with people about mental health. In terms of what interventions the TA carried out to support their clients, these could be divided into two categories: communication skills and referrals.

Each of the eight TAs commented on the importance of being a good communicator: "someone who could listen without making judgment", and with the ability to "talk about mental health issues and the way it was perceived". One TA commented that their shared experience of anxiety helped him to broach the subject of mental health with a client. They commented:

> *They were spiralling into anxiety and we were able to talk… they needed somebody to say, 'yeah, it's all right. Everybody's doing that at the moment. I'm feeling anxious too, because it's perfectly justifiable to be anxious…go and get help.'*

Being able to make the right referral for a client was also valued by the four of the eight TAs that had active clients. In one instance this process was supported by the host organisation. They commented:

> *I've been directed [by the host organisation] to look it up and to find out what is [services are] available… a lot of people don't do that… this has given me that opportunity to point out different organisations and government assistance that is available for people with mental health.*

Another TA used their own initiative for this process and was also able to accompany their client to a doctor's appointment:

I might sit with a person and research what's available… the free contacts that they can just call themselves. So… referral has been a really big thing for me. But also… all of those seven people… may not have literacy skills… I have been asked to sit with them and support them at their doctor appointments. I also transfer them to specialists.

5.2.6 Challenges faced by Trusted Advocates

The TAs faced many challenges in performing their role. Perhaps the most influential challenge has been the impact of COVID-19. In the words of one TA, "I think that COVID put the brakes on [the program] a lot". The lockdown associated with the pandemic made face-to-face contact difficult. Also, many community events (such as agricultural shows) that would have been attended by TAs were cancelled reducing the opportunity for social interaction. In the words of one TA:

But once again with COVID, yeah contact has been quite limited, I'm not going to nearly as many events, in fact, just about everything had been cancelled.

Another challenge faced by the TAs was a perceived lack of marketing by the host organisation. As a result there was a lack of knowledge and awareness about the Trial in the community. One TA commented "at the moment, people have no idea that we're even here". Many TAs felt that the Trial needed to "be more broadly promoted". As a result of COVID and a lack of marketing, the number of contacts with members of the local community has been disappointing to the TAs themselves.

Those TAs that did have active clients commented about the challenges they had experienced while performing the role. Two key themes emerged relating to the difficulty in "getting people to talk" and a lack of available mental health and support services in their local community.

Many TAs commented that guidelines were not available relating to successfully engaging with the public and instigating a meaningful discussion about mental health. TAs were therefore unclear how, and in what circumstances, they were meant to approach clients. The following quotes from TAs sum this up:

The biggest challenge is engagement with the public. We're not allowed to initiate. It's confusing, isn't it? We offer one-to-one, but we can't offer it; it has to be asked for.

I think my main challenge is still the fact that you've got to get people to come forward and talk. Or to approach them and start a conversation and then hopefully they'll open up. So that's probably the biggest challenge.

Making referrals could also be a challenge as there was a perceived lack of local mental health services available at some of the Trial sites. Many of the services that are available are visiting (fly-in fly-out) services and are not based in the local community. This is compounded by the fact that there is a waiting list for these services. One TA commented:

We have a lot of things that are available online or by telephone, and the people here don't – it's not what they want. So they see those things as being no health services…you could book into a service, it'll be here in two weeks…it doesn't cut it.

Another issue related to the fact that, in several instances, the TA did not reside in the town where the pilot was being trialled. This made it difficult for them to participate in meetings organised by the host organisation and engage in peer-support activities.

5.3 Interviews with Fishers' Trial Trusted Advocates

In the following section we present the perspectives of seven Trusted Advocates from the three pilot sites on their experiences of participating in the Fishers' Trial.

5.3.1 Experiences of training

Three types of training were provided to the Trusted Advocates: MHFA, Positive Psychology and 5 Ways to Wellness. At the time of the interviews two out of the three pilot sites had delivered MHFA training to the TAs, all three sites had delivered Positive Psychology and 5 Ways to Wellness. All TAs were satisfied with each type of training offered by the program, including the relevance and the delivery style.

> *I felt the first aid mental health is really good. It's certainly opened my eyes. And I think it's a good start to the basis of the program and what we're trying to achieve.*
>
> *As for the training, that was delivered by a number of really competent people, and it was good.*

In terms of what could be improved, a couple of issues were raised. First, some TAs indicated that they would like to receive regular top-up training to refresh their knowledge. One TA commented:

> *There was adequate training for the role as described, but it is going to evolve over time, and we may need some more in the future.*

Second, TAs recommended that each pilot site should have a "master trainer" available locally for them to consult with and to answer any questions as they arise.

5.3.2 Perceptions of support from the host organisation

The support provided to the TAs from the host organisation was highly valued. Positive comments particularly related to the input of the program manager and the monthly TA forums held via Zoom.

TAs felt that the program manager was extremely supportive of them both individually and in their role as a volunteer. Phone calls between the TAs and the program manager are scheduled frequently and the project officer is always contactable over the phone should urgent issues arise.

> *[program manager] just has that gift of speaking in such a way that [we] felt listened to and heard…If anything happened that I found particularly upsetting and hard for me to process, I'd feel that [program manager] would be right on it…I really don't have any fears of getting in a mess…*
>
> *…there when you need her…I find her support and enthusiasm very good.*
>
> *…after I had this initial contact with this bloke, I rang [program manager] and said, "Yeah, I'm just not handling this. I think I've been inadequate," et cetera and et cetera, and she supported me through it very, very well…I couldn't have asked for more.*

The TA forums proved a very effective tool to encourage team work and peer-to-peer support. These forums involve all Fishers' Trial sites getting together on a monthly Zoom call where participants get an opportunity to discuss their involvement in the pilot. Clinical support is provided at these forums through the involvement of a clinical psychologist who is also a MHFA master trainer. The psychologist is able to offer any clinical advice and guidance as required.

…we get an opportunity, yeah, to hear what the other advocates in different areas are going through and what their feelings are and things…and how they're dealing with things so it's very good.

5.3.3 The importance of peer to peer support

Peer-to-peer support has been promoted by the program manager through the TA forums mentioned above. Also, many of the TAs work or have worked in the seafood industry in a relatively small community and as a result are known to each other or, in some cases, work closely together. This familiarity has fostered a degree of informal support. For example, in many cases TAs informally meet up and chat to discuss individual cases or issues that are affecting the fishing industry.

I speak to [name removed] bi-weekly or something like that; there's a couple of issues floating around town in which we're monitoring.

5.3.4 Understanding the role of the Trusted Advocate

Each TA underwent an on-boarding webinar to orient them to their role as a volunteer in the Fishers' Trial. This webinar included information relating to the role, confidentiality and the process of referrals to other organisations such as the Local Health Districts. There was a clear understanding from TAs that their role was not to provide a solution to a client's mental health problem but rather to engage with those who may be struggling with mental health issues, identify any risk factors and promote self-help or help seeking from appropriate professionals.

We're not here to counsel and to take on any sort of role like that. We're the conduits, you know? We're there to … just help to make that link to the professionals.

Obviously, we're not going to be experts. We're not going to cure people. But it's enough to look at possible signs of issues and go from there.

There are things that you can do, small things that make a really big difference, like just reaching out to people and letting them know that there is help, so you don't have all the answers … I found that really reassuring, because I think, as an amateur, sometimes, you can be too scared to say anything at all in case you do harm.

One of the roles of the TA is to promote help-seeking behaviour and recommend clients to individuals or organisations that can offer assistance. An important part of this is an understanding of local networks so TAs can make relevant referrals. This was challenging at first given that TAs were new to the mental health space and may not have a good understanding of local agencies and individuals that can offer help.

…you know who to refer clients to…this was hard at first but part of the learning of the role. This knowledge was gained over time.

We now know pathways and have contacts and stuff to actually be able to progress this, rather than a year ago, you'd be chatting with someone on the end of the wharf and then, you know, what do I do? I do know of [referral] pathways now, so that's the really good thing about it.

5.3.5 Interactions with community members

Four of the seven TAs interviewed had successfully engaged with one community member (referred to here as a "client") and two TAs had had conversations with between five and ten clients. One TA

indicated that it was difficult to quantify the number of times they had engaged with someone about issues relating to mental health:

> *…it's really hard to quantify that stuff because there are things that you are just doing every day, talking with your colleagues and their family.*

In terms of what interventions the TA carried out to support their clients, these were consistent with the findings from the Farmers' Trial in that they could again be divided into two categories: communication skills and referrals to relevant agencies for mental health support. With regards to communication skills TAs were aware of the importance of being a good listener and maintaining a connection with the client. For one TA this meant "whenever he's in port … I would go out of my way to just have a little friendly chat with [the client]". For another TA one of their clients was someone within their workplace who was facing some personal struggles.

5.3.6 Challenges faced by Trusted Advocates

The biggest challenge for the TAs involved in the Fishers' Trial was time. TAs reported that they were very busy in their day-to-day lives with most TAs being employed full-time in the fishing industry. Many TAs commented that they did not have much free time to engage in conversations with people about mental health. In the words of one TA:

> *I thought part of the thing would be just to get down the wharf and just get the guys - and talking to people and whatnot. And I honestly haven't had the time to do it. I walk most days, past the wharf with the dog and I'll say G'day, across the wharf sort of thing. But I haven't really had the time to stop at leisure and talk …*

Another challenge was raising awareness about the program. Several TAs commented that it would take some time for the program to be widely recognised within the industry and to win trust from the local community.

> *We haven't established a relationship with the industry where they feel comfortable yet … the approach we are doing is just making everyone aware that it's there … not trying to hard sell it because there's still stigma of mental health and fishermen are very strange creatures. Like farmers to a degree but probably a little bit more isolated than farmers.*

> *I think it's going to take time for them [fishers] to be comfortable with that checking in with them … friendly checking in. But that's all … goes hand in hand with what the program's all about, to try and normalise things and get people more comfortable with these issues.*

Closely linked to this issue of program recognition is promotion and marketing. In terms of promotion, two of the Fishers' Trial sites hold monthly barbecues on the wharf where the TAs, under the banner of "Stay Afloat", try to promote discussion with local commercial fishers about mental health and wellbeing. However, there was a feeling amongst the TAs that the program needed to be marketed more in their local area to help build up and maintain community awareness. One TA indicated that the pamphlets designed to market the program were delayed.

> *There were some other marketing material that hasn't arrived yet, which we're waiting for, which will help, but … handing the pamphlets over is great, but we need something to be more visual on noticeboards and stuff.*

5.4 Online survey of Trusted Advocates

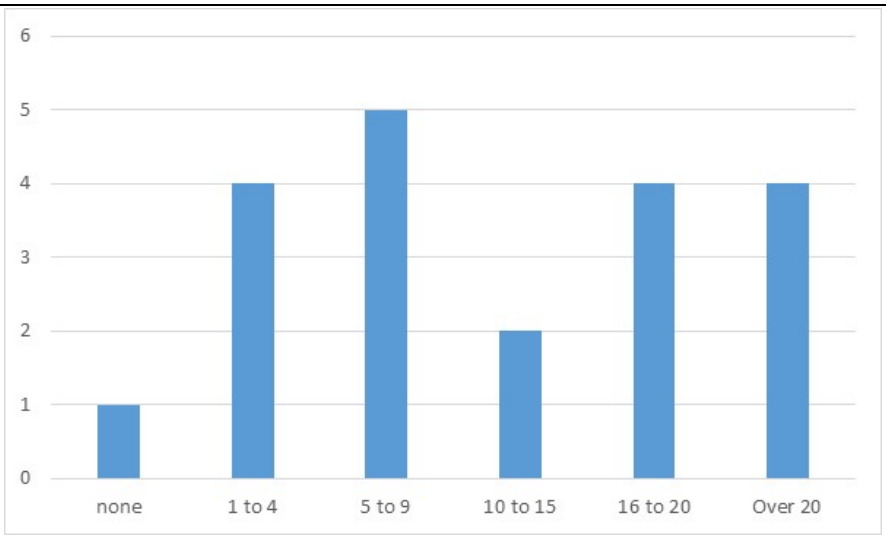
This section summarises the findings from the online survey which was designed to collect data on TA confidence in their roles, perceptions of support, and activities in the target communities. These are important outputs and short-term outcomes of the Trials.

The survey invitation was distributed to the 52 volunteers currently serving as TAs across the Fishers' Trial and five Farmers' Trial sites, with 22 responses (42% response rate). Thirteen respondents were female and nine were male. Over half of respondents were over 55 years old with men representing a slightly older cohort. All reported that English was their main language spoken at home and none identified themselves as being either Aboriginal or Torres Strait Islander.

5.4.1 Activities and experiences

Twenty of the TAs had initiated conversations about mental health with individuals in their community. The number of conversations is summarised in Figure 6 with approximately 50% of respondents having at least ten individual conversations.

Figure 6 TA number of conversations about mental health



Fifteen of the TAs described the type of help they provided to clients. The most common type of help was providing support through listening followed by making referrals. Other activities included raising awareness of the pilot and accompanying clients to medical appointments.

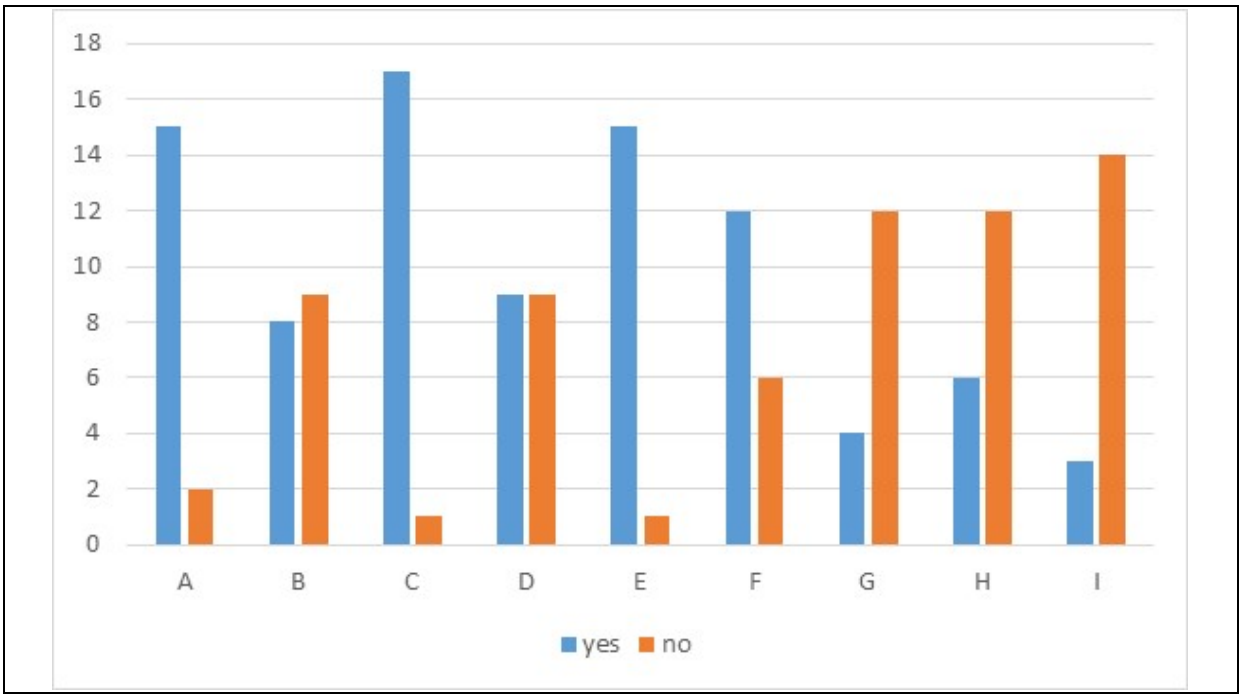
The next series of questions related to TAs' experiences of providing mental health support in their communities. They were asked to answer 'Yes' or 'No' to the following statements, with the question stem "Have you …":

A. Thought someone's behaviour might indicate they are having a mental health crisis
B. Thought someone's behaviour might indicate they are having suicidal thoughts
C. Asked someone about their distressed mood
D. Asked someone if they are considering suicide
E. Listened non-judgementally to someone experiencing a mental health crisis
F. Referred someone to appropriate resources because you were concerned they might be experiencing a mental health crisis
G. Referred someone to appropriate resources because you were concerned they were considering suicide

H. Engaged with a mental health crisis resource on behalf of someone
I. Engaged with emergency medical or police services because of someone experiencing a mental health crisis

Overall, most TAs responded that they had observed someone they believed were having a mental health crisis, had asked someone about their distressed mood and had been able to listen non-judgmentally (Figure 7). Half the TAs had asked someone if they were considering suicide. Over two-thirds of TAs had not: referred someone who was suicidal, engaged with a mental health crisis resource or with an emergency service due to someone experiencing a mental health crisis.

Figure 7 Types of activities undertaken to support mental health



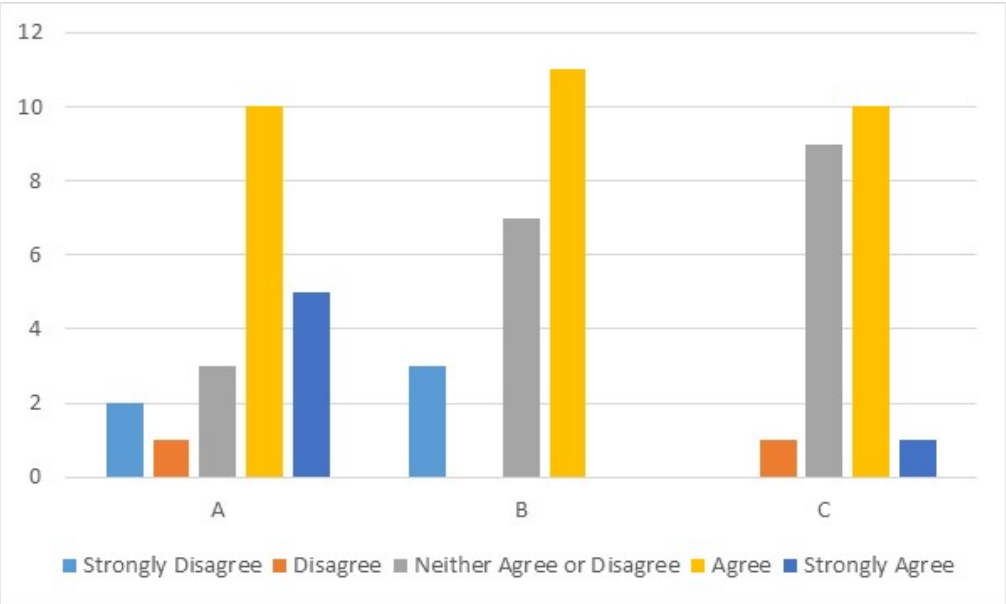
5.4.2 Perceived effectiveness and confidence

TAs were then asked to rate their level of agreement or disagreement with the following statements, which were indicators of whether they felt themselves to be competent or effective in the role:

A. My awareness of mental health care services and mental health resources has increased as a result of my role as a Trusted Advocate.
B. I am satisfied with the level of mental health support I have been able to offer people in my community in my role as a Trusted Advocate.
C. People in my community value and listen to me in my role as Trusted Advocate.

The results are summarised in Figure 8. The majority of respondents either 'agreed' or 'strongly agreed' that there awareness of mental health care services and mental health resources had increased as a result of their role as a TA (15/21 responses). However, the statement relating to the levels of mental health support offered by TAs in the community was more mixed. Approximately 50% of respondents (11/21 responses) 'agreed' to this statement whilst the other half were undecided or 'strongly disagreed'. Similarly, approximately 50% of respondents either 'agreed' or 'strongly agreed' to the statement about TAs feeling valued by community members.

Figure 8 Perceived effectiveness in the role of TA

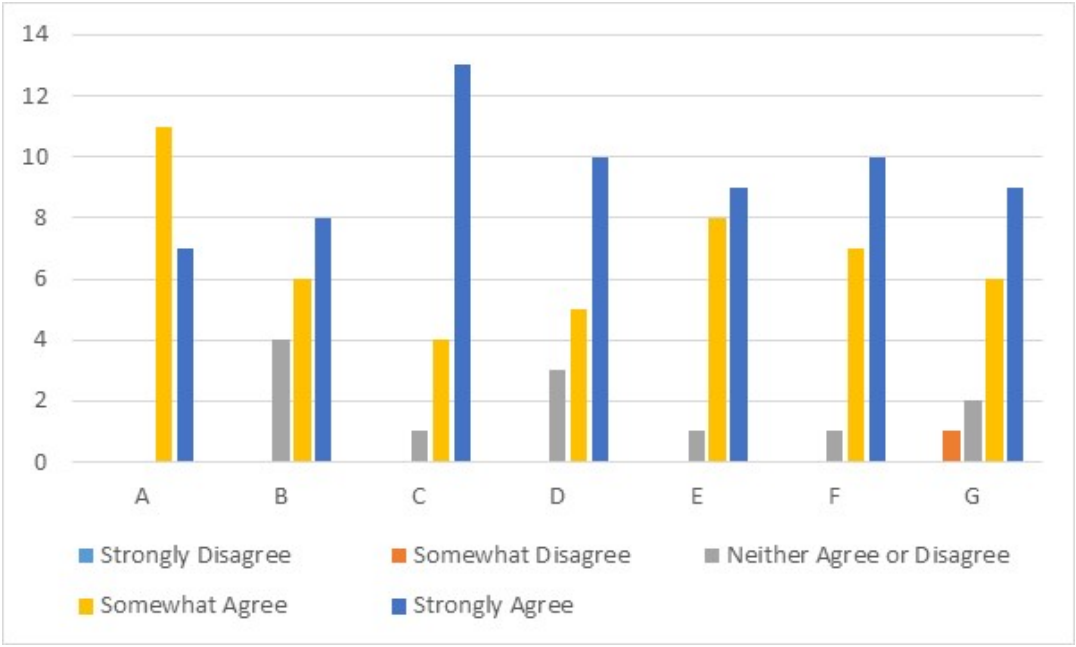


TAs were asked about their level of confidence in seven domains, with the question stem "I am confident I can …":

A. Recognise the signs that someone may need mental health support
B. Ask someone if they are thinking about suicide
C. Listen non-judgementally to someone experiencing a mental health crisis
D. Offer basic "first aid" level information to someone experiencing a mental health crisis
E. Offer reassurance to someone experiencing a mental health crisis
F. Encourage someone experiencing a mental health crisis to seek professional help
G. Encourage self-help strategies for someone experiencing a mental health crisis

Overall, TA confidence was high (Figure 9). Approximately 75% of respondents 'strongly agreed' or 'somewhat agreed' that they were confident in each domain. The highest levels of confidence related to recognising signs of mental health, listening non-judgmentally, offering reassurance and encouraging someone to seek professional help. Least confidence related to asking about suicidal tendencies.

Figure 9 Confidence in performing aspects of the TA role

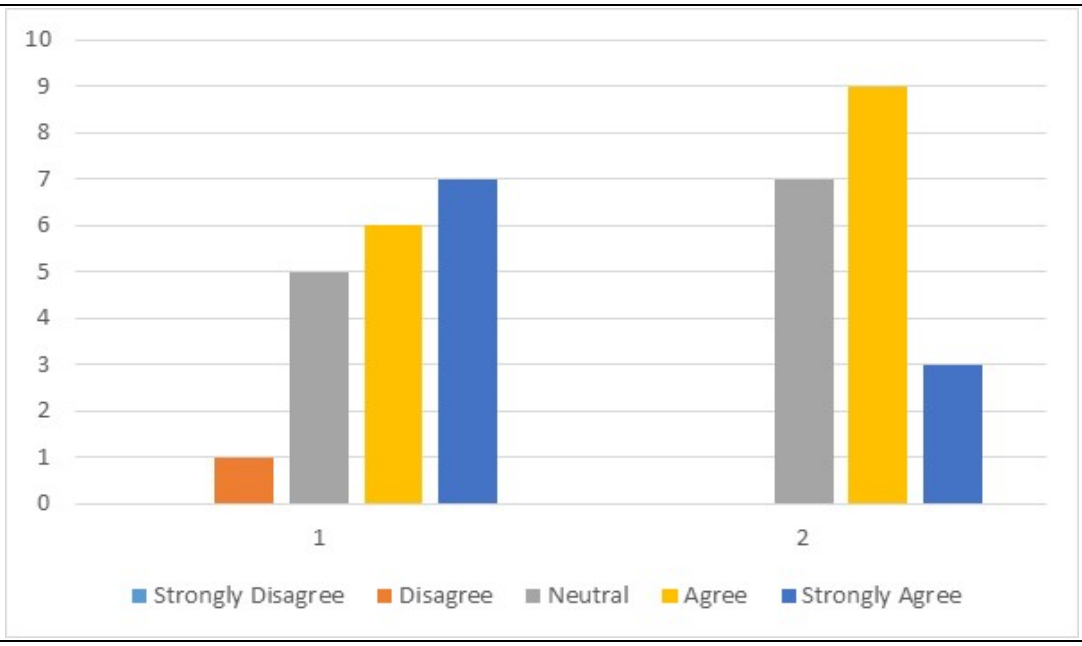


5.4.3 Support provided to the volunteers

The next two questions related to the level of support the TA felt they had received from the host organisation:

1. I have felt totally supported in my role as a Trusted Advocate
2. I have all the resources I need to perform my role as a Trusted Advocate

Figure 10 Support from the host organisation



The majority of TAs felt supported in these two domains, with answers of 'Agree' or 'Strongly Agree' (Figure 10).

Respondents were overwhelmingly positive about the role: 17 out of 18 TAs who responded to the question about whether or not they would volunteer for a similar role in the future indicated that they would. This indicates a strong degree of support for the Trials. The reasons for this were categorised by theme. The most common theme related to the fact that the TAs believed that they had the appropriate skills to help members of their community who might be struggling with their mental health. There was also a feeling that TAs wanted to support their local community:

> *[It's] "payback" for having been helped myself. I like helping where I can and building a better community.*

Several TAs commented that they liked the self-development aspect to the training.

> *It taught me a lot about myself and how to help others.*

> *I can see enormous benefit to myself, my family and my community.*

> *I feel confident in sharing my story and believe it makes a difference in people's lives. I feel safe in supporting others as it also helps me.*

When asked what the TAs liked most about volunteering, their answers indicated that they were motivated by being able to help other community members. When asked about possible improvements, first, TAs felt that they would like more face-to-face time with their clients and second, they felt the role should be more widely advertised to raise community awareness. Other themes that emerged included building closer relationships with local health professionals and continued and ongoing training. Some TAs felt that the Trial should be expanded to cover a wider area. Finally, TAs were asked if they had any other thoughts about the program. The majority of comments were positive:

> *I feel it's well run and can make a real difference.*

> *Please continue it, it's a wonderful initiative.*

5.5 Activity data – Farmers' Trial

None of the Farmers' Trial sites responded to the evaluation team's request for activity data before the cut-off date for inclusion in this report. One Trial site did respond by saying they did not require regular reporting by the volunteers. Instead, the program manager collects some data informally during phone calls using a template to record who was supported (e.g., friend, neighbour), the age group and cultural connections, and whether they were referred to a service. No data were sent to the evaluation team; however, information was provided on the types of issues that the TAs assisted with at that Trial site:

- Support with physical and mental health supports
- Supports with relaxation and supports
- Drug and alcohol issues
- Financial issues
- Building trust with services and supports
- Support with reading and writing
- Checking into to see if they are attending their appointments
- Links to local supports such as the farming community counsellor

- Recently been affected by the bushfires and were scared
- Concerns around family and friends

Although no quantitative data were available from the Farmers' Trial sites, information about the extent, type and impacts of volunteer activities could be gleaned from the TM interviews. One of the questions put to the TMs was whether they thought the program had resulted in an increase in the number of people seeking mental health support services in their area. A typical response was:

> *In terms of increased service use, I can't say. I think the program definitely helps rural communities to be better equipped to provide informal supports. Whether that results in increases in reaching out for more formal, clinical support, I can't say.*

As another TM pointed out, there was no guarantee that the farmer would take the next step and follow up on the referral recommended by the TA:

> *People [farmers] are happy to talk to the people that go to their door but then they don't make the next step or even if they are supported and they are offering to call, there's a barrier there.*

The TM at one site expressed doubt that the program could have any detectable impact on uptake of support services because of its limited reach and the difficulty of demonstrating causal links. Similarly, another TM wondered whether having people named and identified as Trusted Advocates added much, over and above other efforts to enhance mental health literacy and reduce stigma:

> *So now with the title Trusted Advocate I don't know necessarily whether that … Are we getting more out of those people or were they doing that anyway … you want to be able to upskill the whole of the community, not just necessarily ten people.*

A contrasting view was presented by the TM at one site where the program had been redesigned somewhat to promote wellbeing actively, rather than focusing on mental health support *per se*. This alternative approach appeared to be highly successful in engaging the community. Volunteers were invited to speak at community events and meetings and had also been approached in public.

> *It's totally normalising conversations around mental health and wellbeing in this town. At a function the other night there was a woman there who said this was just a gift to our community. I love to hear that. There is a real gratitude for what is being delivered.*

5.6 Activity data – Fishers' Trial

The following information was provided by the program manager for the Fishers' Trial and summarises the activities of the Trusted Advocates within the three target communities for the period November 2020 to March 2021. This was assembled by the program manager from the monthly reporting templates completed by the nine Fishers' Trial volunteers.

Altogether, 330 interactions with community members were reported by Fishers' Trial Trusted Advocates over a five-month period (Table 5). The vast majority of these took place in small group settings and consisted of general chats about the program or about health and wellbeing. TAs had a total of 72 one-to-one conversations, all of them in person (there were no telephone conversations). For six of these, the TA just had to be a good listener, and for another seven conversations they listened and then encouraged the person to seek professional help. On two occasions, the person requested assistance to seek professional support with mental health issues.

Table 5 Self-reported activity of Fishers' Trial Trusted Advocates

Types of interaction	Provided a listening ear only	Provided a listening ear and encouraged professional support	Person wanted support to seek help	General chat about the program	General chat about health and wellness	Total interactions
1:1 in person at their workplace	4	5	2	25	19	55
1:1 in person somewhere else – e.g., meeting room, cafe	2	2	0	9	4	17
1:1 via phone	0	0	0	0	0	0
Small group informal chats – number of chats	2	4	0	60	22	88
Small group informal chats – number of people at BBQ	20	4	0	98	48	170
Total interactions	28	15	2	192	93	330

6. Unintended consequences

Jabeen (2018, p. 268) notes that unintended outcomes can be uncovered in evaluation through "people-oriented enquiry": a combination of open-ended interviews, observations, and a review of relevant documents. Two of these three methods were available to the current evaluation (due to pandemic travel restrictions, site visits/observations were not feasible).

Unintended outcomes can be categorised according to:

- Knowability (whether foreseeable or unforeseeable);
- Value (whether effects are positive, negative, or neutral);
- Distribution (whether effects are felt by all participants or only some, and whether they extend to non-participants and/or the system); and
- Temporality (whether they occur during or after implementation of the program; Jabeen, 2018).

In this chapter, we use this framework to assess unintended consequences arising from the Trusted Advocates Trials, to address the fourth evaluation question. Findings are summarised in Table 6 and described below.

Table 6 Assessment of unintended outcomes

Outcome	Knowability	Value	Distribution	Temporality
Managing volunteers	Foreseeable but unforeseen	Negative or neutral, depending on whether/when a partner organisation was engaged	Impacts were felt mainly by trial managers within PHNs	Impacts occurred during program implementation
Community tensions	Unforeseeable	Negative, can aggravate mistrust and exacerbate trauma	Impacts were felt mainly by volunteers, also by trial managers, with potential for system effects	Impacts occurred during program implementation, may continue after the program
Vicarious trauma, stress and burnout	Foreseen	Negative if not managed supportively	Impacts were felt by volunteers, with implications also for trial manager workloads	Impacts occurred during program implementation, may continue after the program
Difficulty engaging farmers	Foreseeable to some extent, but also affected by unforeseeable events (COVID-19)	Negative, has the potential to reduce positive program outcomes	Impacts were felt by volunteers and trial managers, with effects on morale and motivation	Impacts occurred during and after program implementation

6.1 Managing volunteers

When PHNs recruited, selected and appointed volunteers as Trusted Advocates, those volunteers acquired an "official" status and therefore required ongoing supervision, monitoring and professional development, with emphasis on maintaining their own physical and psychological safety. In turn, the PHNs assumed a duty of care. In the words of one TM, the volunteers are "not from this world" of regular, professional work in the mental health care space:

> *They're just flying by the seat of their pants trying to be a good neighbour, and then they see this as a more formal title because they're now employees of the PHN – or volunteers of the PHN. So then they do require that extra support.*

Among the TMs, there was an awareness of risk, both to the individual and to the organisation, in this type of volunteer role. A number of risks can arise when a group is set up to identify people at risk of mental health problems and support them to access services. For example, one TM pointed out that the program was rolled out in small communities so any breaches of privacy (in the disclosure of private information to volunteers) could have serious impacts on individuals and the program's reputation. Others expressed concern about the volunteers themselves, particularly around risks associated with travel (e.g., to farms or outlying towns) and working unsupervised in remote areas.

> *It needs to be attached to an organisation that has all those sorts of insurance, policies, connections and is appropriately place to support a volunteer workforce because they are different.*

> *Well-meaning isn't well-doing; what you think might be useful isn't necessarily what the evidence shows is useful. And at an individual level what someone does could be potentially harmful or at best disempowering, it could be rescuing. So I think there's a whole load of concerns there about volunteerism that perhaps we could have thought through a bit more.*

The types of people likely to volunteer as TAs tend to be passionate and driven to help others, often motivated by their own lived experience. According to one TM, this is what makes them effective but also vulnerable and in need of ongoing, proactive support. There are risks that they may overshare information about themselves and their own situations, and it is important to monitor their own well-being:

> *… to recognise in themselves what is triggering, to reflect on their responses and the needs of individuals versus their own personal needs. So that has also been part of the conversation that we try and regularly have.*

Managing a volunteer workforce requires specialised skills which would not necessarily be available in PHNs. The program was therefore a step outside the usual scope of operations. In this respect, the unexpected consequence was foreseeable but unforeseen (Jabeen, 2018, p. 264) and could have been prevented through additional efforts by the funding body to identify and address the risks associated with a volunteer workforce in advance. For example, PHNs may have benefitted from more guidance around how the networks of TAs would be supervised and overseen to protect the safety of the volunteers and the people they were supporting, including information about insurance coverage and Work Health and Safety procedures. This could have relieved some of the pressure on TMs, particularly those in PHNs which attempted direct delivery of the program.

> *There was … not a lot of guidance either or understanding of how those networks would be supervised and would be overseen in terms of their safety and the people that they were supporting.*

However, some TMs observed that, in general, volunteers do not necessarily see the need for governance mechanisms that restrict their activities. As one TM explained, when people volunteer they don't want a lot of oversight, they prefer to define their own scope, so it was not unusual for them to go beyond what was originally envisaged for them or what they had been trained to provide. Moreover, it was especially difficult to manage that risk (e.g., by providing monitoring and quality checks) in rural or remote settings.

Partners with experience in training and managing volunteers are likely to be better placed to offer the required level of monitoring and clinical support around scope and boundaries, as well as debriefing to protect the volunteers' mental health. At one site, the TM reported that the Trusted Advocates had indicated they felt well supported by the partner organisation. They were "doing something they'd already been doing", but with more support and "perks" in the form of reimbursement for fuel or coffee catch-ups. This type of comment suggests that functional partnerships or active internal management of the program could help mitigate some of the risks.

6.2 Community tensions

At one Farmers Trial site where the program was originally delivered internally, the activities of the Trusted Advocates was suspended in September 2020 after negative feedback was received from the target community. As no formal complaint was made directly to the PHN, it was not possible to investigate the feedback to either verify or discount the claims made. Instead, volunteers were sent an email advising of the PHN's decision to put the program on hold and asking them not to arrange or undertake activities under the name Trusted Advocates until a Code of Conduct could be developed. The program did not resume until February 2021 when a partner organisation was engaged to provide additional training, supervision and one-to-one support for the volunteers.

As far as the evaluation team has been able to ascertain, the feedback related to a pre-existing dispute or disagreement among community members, some of whom had been recruited as volunteers in the program. This situation pre-dated the program by many years. However, the advent of the program appears to have exacerbated these old tensions within the target community.

> *The data suggests that region needs something like this, this would be a good place to test it, but if you don't understand what is underlying the trauma in that community then you just can add another layer to it.*

This is a genuinely unexpected consequence; it is not something that could have been foreseen by the program designers. The major impacts were on the TA volunteers, who expressed disappointment and frustration. A further impact was the suspension of the program activities, which until that time had been implemented effectively by the PHN and pursued with enthusiasm by the local volunteers. There may also be the possibility of system impacts (e.g., influencing decisions around funding or expansion) if this negative experience is interpreted as due to flaws in the program itself. It is worth noting that no such experiences have occurred elsewhere.

6.3 Vicarious trauma, stress and burnout

The nature of the program means that volunteers will come into contact with people, some of whom will be experiencing psychological distress. The extent to which this is happening may be difficult to quantify because it is generally an extension of what they were already doing anyway:

> *That's hard for them to gauge as well because they don't realise that they're doing the great work. When she's strolling through the shops and having a yarn about how horrible everything is - blah, blah, blah - she doesn't count that, because that's not a formal engagement.*

TMs commented that for many TAs, it was difficult to get a sense of their workload as "by nature" they want to help other people. In performing this supportive role so "naturally" in the community many TAs were unaware of the levels of vicarious day-to-day stress they experienced.

This was an unintended but not unanticipated consequence of the program – indeed, the program set out deliberately to address it, through the requirement for proactive support of volunteers. For example, the Fishers' Trial has addressed the potential for vicarious trauma by making individual appointments with a clinical psychologist available. This type of support has so far been offered to two of the volunteers.

One TM suggested that it was important for TAs to "remove [themselves] a little bit … not get too immersed in it". There is potential for TAs to suffer burnout, particularly as many of them have experienced their own mental health issues in the past. In some cases, the lived experience that was such an asset to the Trials also limited participation:

> *Two of the potentials that I thought were going to be fantastic actually dropped out of the program because of their own mental health issues as well … it was probably … the confrontation of having those conversations …"Something is seriously not right, how can I best support my friends, my neighbours, the people in my community? How can I do all of that?"*

There was also a sense of powerlessness associated with being a TA as there was no guarantee that clients would engage with them or follow up on their advice: "we just don't know how to feed people into local health services, and how do you convince them that they need to go?" This issue is related to a need for TAs to understand the parameters of their role. It will not be possible for TAs to fix every problem with which they are confronted.

> *We've been just advocating for them to be very supportive in an informal way and … they don't take the responsibility on to themselves of making sure that this person then goes and gets the treatment that they might clearly need …*

6.4 Difficulty engaging farmers

The program is based on a premise that trained TAs, who are well connected in their communities, would easily be able to identify, connect and engage with people who may be struggling with mental health issues. In the words of one TM:

> *Complete the training part and then it will just be a ripple effect out into the community.*

TMs in the Farmers' Trial felt that this premise was over-simplified and there was uncertainty and disagreement as to how TAs would even approach farmers in the first place, let alone develop a client base within their farming communities. This uncertainty was based upon the widely held belief that farmers are "stoic" and have not traditionally demonstrated help-seeking activities. This was compounded by a feeling that farmers were just too busy to worry about their mental health. Similar concerns were raised by the TAs themselves:

> *Meeting somebody, unless I got it incorrectly, meeting somebody in the street … I'm sorry, in my opinion … there's a drought … farmers never come to town, they're trying to keep their cattle alive.*

> *If somebody else says that he is struggling, well right, work out whether he does come to town, or whether he doesn't. Or does he go down to the local pub, not that you sit at the local pub and say, how's your mental health going?*

Some TMs regarded this as the most significant barrier to the success of the Farmers' Trial. There were different ideas as to how this connection might happen, depending on whether or not the host organisation felt that the Trusted Advocates model was an 'outreach' service where TAs actively sought out connections in the community through "door-knocking", networking or casual contacts, or whether it was a service that members of the community accessed based on word-of-mouth, promotion or referral. The novelty of the Trusted Advocates model will take time to become established and accepted in communities.

> *This is something that's completely new to the industry. So it's coming from a base of fairly much nothing. So I think the biggest challenge will be navigating this whole new way of thinking and this whole new way of responding as well.*

> *I wish that I knew the answer, I wish I had a magic wand that I could just get out there to those farmers and find out how we can connect with them.*

This outcome was to some extent foreseeable by referring to the literature on first responses to psychological distress. For example, systematic reviews and meta-analyses of the effectiveness of MHFA have demonstrated that the training equips people with high levels of mental health literacy but it is less clear whether it leads to changes in helping behaviours (Maslowski et al. 2019; Morgan et al. 2018). Impacts on people who receive support from MHFA trainees have not yet been demonstrated (Mei & McGorry 2020). A recently published evaluation of a MHFA course that was tailored for community pharmacists revealed a number of challenges involved in putting the training into practice during every day, public interactions (Witry et al. 2020).

Unforeseeable events have also contributed to the outcome. The whole process of engaging with farmers was hampered by the impact of COVID and resulting travel restrictions and social isolation measures. Most significantly this caused the cancellation of local networking events instigated by the TAs and, on a larger scale, rural events such as agricultural shows. As a consequence, levels of contact between TAs and the local farming community were restricted and there were fewer opportunities to promote the availability of the Trial.

> *Well, COVID-19 has had a huge impact. Because we haven't been able to have any functions. So we haven't been able to get to the farmers.*

7. Possible improvements

In this chapter we present lessons learned and ideas for improvement around connections with primary health care providers; marketing and communications; data collection to demonstrate outcomes; and sustainability. These supplement relevant findings already highlighted earlier in this report, namely:

- The potential value of a needs analysis and earlier stakeholder consultation, specifically around the targeting of the Farmers' Trial (Section 4.1.1);
- The desirability of clearer program guidelines around implementation, to guide the TMs and ensure greater fidelity to a consistent model (Section 4.1.2 and Section 4.1.3);
- The ongoing responsibility of the host organisations to the volunteers recruited for the Trials (various sections, particularly Section 3.1.4 and Section 3.2.2).

7.1 Connections with primary health care

One of the tasks for the TMs was to equip TAs with knowledge of a variety of mental health and emotional wellbeing supports to promote self-help and improve referral pathways to professional services. This applied across all Trial sites. However, the Fishers' Trial had additional components around communications and active engagement with local primary health care providers around the specific mental and physical health needs of commercial fishers. The Trial has made contact with clinics at each of the three target communities and has left education materials with the GPs to bolster their understanding of the particular issues facing the seafood industry and how this might affect health care needs. The rationale for this arose from research that showed commercial fishers would prefer to talk to a GP who understood their situation. As the TM explained, the strategy aimed to create:

> *... potentially this immediate rapport and trust building mechanism that lowers the risk of that not being the right relationship, and lowers the risk of a person not returning to that practitioner to take the next step.*

There is potential for this kind of additional activity to add considerable value to the Farmers' Trial as well. Access to suitable services can be limited in rural areas, as several TMs noted. Nevertheless, the TAs could make an important contribution by making people more aware of the services that are available and how to access them. Further, the program could leverage the PHNs' connections with the primary health care sector in order to provide "warm introduction" to service providers who have been provided with relevant knowledge and skills, so that help seeking is positively reinforced.

> *When you're in crisis or you're traumatised … if you have a negative experience with that service you will be very disinclined to try again because you're already feeling desperate and then you feel let down.*

7.2 Effective communication

At some sites, the TM had previous experience in marketing and communication which has proven valuable. They have been able to devise clever ways to attract positive attention, for instance using humour or visual imagery or by creating anticipation and suspense. Given the lack of a marketing budget for the program, doing these activities at a low cost required specialised skills and knowledge which were not available to the majority of the sites.

> *I feel like that's the downfall of a lot of mental health programs is their lack of expertise in the communications space. It's probably a junior person who's trying to communicate … a publicity officer as opposed to a high-level communications expert … developing a strategy to deliver it.*

> *We were trying to infect people with wellbeing; just flip it and turn it into a positive. So that gave us a good opportunity to engage the community by having a bit fun and creating some humour around it.*

Some sites felt the program should be publicised to help normalise conversations around mental health and encourage help seeking, but stigma proved a barrier to communication. For example, one TM observed that Facebook posts about the program appeared to have less traction with followers than general posts about the value of farming or other positively focused messages. Another TM commented that social media posts about wellbeing or mental health can come across as "awkward, uncomfortable" unless done skilfully. If used well, however, social media platforms:

> *… can influence people to lead healthier, more fulfilling lives, and there is a skill behind that … which is much more challenging than it appears.*

When TAs were asked for suggestions as to how the Farmers' Trial could be improved, the most common theme related to marketing. Several TAs commented that the local community was not aware of the existence of the Trial: "people don't know who we are or what we're doing".

7.3 Data collection and reporting

TMs were acutely aware the program was publicly funded and needed to be rigorously managed. Most set up systems to keep track of implementation, timelines and communications. These ranged from the usual mechanisms for Department of Health funded programs (e.g., submitting activity work plans) to the use of project management software. There appeared to be a link between the use of more sophisticated approaches to project management and strong organisational interest or investment in the sustainability and replicability of the Trusted Advocates model.

> *I actually quite enjoy being able to set it up and document the progress in the hope that if we get it right here, that we could potentially roll it out [elsewhere]…*

Unfortunately, there has been less effort devoted to monitoring and evaluation of the program. One TM noted that there was little information available to the Trial sites about the reporting guidelines or evaluation requirements, at least initially, and this had been the subject of discussion at EOC network meetings for the participating PHNs. According to this TM, the lack of clear guidance contributed to the program's "slow start" as Trial sites were unsure how to proceed.

> *We still hadn't seen any reporting guidelines on it. There was no evaluation at that point or even how it was going to be evaluated.*

> *To be honest, I thought we were going to get some more parameters about that [data collection and reporting].*

Some Trial sites have initiated evaluation activities out of a desire to demonstrate their outcomes, with a view to obtaining further funding. The Fishers' Trial program manager and steering committee have planned an internal evaluation which will be reported to the Department in May 2022. One Farmers' Trial site also planned to conduct an internal evaluation of the program led from the PHN. At the time of the initial interviews, the site had an evaluation plan and data collection methods

(which were not shared with the evaluation team); it had collected baseline data from volunteers via a focus group. There is interest from another Farmers' Trial site in conducting a rigorous evaluation to inform a possible wider rollout of the model within that region.

Where record keeping is taking place, methods vary across sites and tend to be rudimentary. A basic template to record the activities of the TAs was created by one site and shared with some of the others. At another site, TAs were asked to keep a handwritten diary noting some general characteristics of the person they had spoken to (e.g., age group) and the topic of the conversation, so that they could pass this information on to the TM during their regular phone chats. The TM noted that this system would allow some level of tracking of the extent to which TAs were "reaching in" to community, but not the number of people who had "reached out" to the TAs.

One TM pointed out that the TAs may not see the benefit of tracking their contacts. Another said it would not be possible to demonstrate any outcomes from the Trial "until you're a bit further on down the track". Indeed, some Farmers' Trial sites made a conscious decision not to ask volunteers to keep records of their activities, as they felt this was too much to ask.

Consequently, there was no consistent mechanism across the Trial sites for monitoring the activities of the TAs or quantifying the extent of their interactions with community members. Later interviews confirmed the interim findings that the program's key deliverables and reporting requirements were not well understood by TMs.

This has limited the ability of the current evaluation to demonstrate the reach and spread of the program at Trial sites. Without this information it is impossible to know what "dose" of the TA model a Trial community has received, and thus to predict what outcomes might reasonably be expected. If this information were available, it could facilitate the definition and collection of outcomes data and enable a future evaluator to make evaluative judgements (e.g., about the plausibility of links between any observed outcomes and Trial activities). This represents a significant missed opportunity for the Farmers' Trial in particular. More systematic data collection will be needed in future if the Trials are to contribute to the evidence base in mental health promotion.

7.4 Sustainability and spread

The evaluation finding that the program requires some ongoing input to support the volunteers (Section 3.1.6, Section 3.2.2) has implications for its sustainability. Host organisations will not be able to continue contacting the volunteers regularly, refreshing their training and information, or providing adequate supervision, without dedicated resources. A few TMs are hopeful that partner organisations or other community groups will have the capacity to continue supporting the TAs by keeping in touch occasionally. Nevertheless, there is a level of concern about what will happen once the short-term funding for the program ceases.

> *There's this idea that volunteers will somehow just keep on plugging away, but actually who plugs away at making sure they're still okay and actually what they're doing is okay and that the people on the receiving end are okay with it?*

One issue highlighted by TMs was the perceived danger of expending the limited social capital in these communities – most of which are under chronic strain, some with shrinking populations – through short-term initiatives. They would prefer to see a longer-term strategy designed to build on, rather than deplete, the existing resources in the targeted towns.

> *What we're asking people to do is to position themselves in the community, when they were already a trusted person in their community, to position themselves more so and to*

> *give them a bit of money to – you know, to allow them to drive to places and to talk to people. But actually, we'll cut that off at the end of the financial year and you'll have to start doing it off your own back.*
>
> *They may be a bit over outsiders coming in, giving them training, and then disappearing again.*
>
> *The last thing we want to do is get communities on board with something and then stop it. And that's something I think we have to be very wary of in small communities as well.*

These concerns echo the observation by Jabeen (2018) that unintended consequences may occur in the future, whether or not the intervention itself succeeds. At one site where the Trial was implemented successfully, the TM expressed disappointment that failure to implement at other sites could lead to a decision not to continue or extend funding for the program.

Volunteers themselves are "nervous", according to one TM, and starting to ask questions about "what happens from here?" In this case, the host organisation is grappling with the question and how it will be answered. Other TMs also expressed worries about how to maintain momentum:

> *That's my fear at the moment is that there's so much momentum around it and then if we just cut it off cold turkey what happens then?*
>
> *Major problem with the short term funding and it's not ideal because it does take considerable time to establish your service … you're just getting traction and getting it established well and the funding dries up.*

Insights into the future of the program are also apparent in the data from the TA interviews. For example, without regular opportunities to meet as a group, several Farmers' Trial TAs said that they did not feel part of a team with a common goal, they felt "fragmented". Meeting more regularly as a group would remind individuals about their shared goals and would also facilitate peer-to-peer learning, "because everybody's got different experiences of what they're dealing with". One TA said:

> *Even if it was just sort of over a casual dinner sometime, once a month or something like that. I think you could sort of discuss … some people might have a person that they feel needs help but they don't feel confident in speaking with them for personal reasons maybe. Whereas another one of us could do that … and I think that's where it needs to be a networking of people working with even one individual.*

Several Fishers' Trial TAs also commented that they felt isolated performing their role with limited local support. While the role of the program manager was highly valued by the TAs there was a feeling that each pilot site would benefit from a local person to refer to in times of crisis.

Further, Fishers' Trial TAs expressed a concern about the lack of activity data collected in the Trial, recognising that this would make it difficult to demonstrate success. This was complicated by the fact that it was usually impossible for the TA to know whether or not their conversations ended up in a referral to an individual or agency that could offer assistance.

There was also a feeling that it would take time for the Trial to establish itself in an environment where a lot of similar local services and programs were offering mental health support. This made it difficult for the program to attract attention.

> *Just that it's a great thing. I know fortunately, or unfortunately, mental health is now the flavour of the month, and there's that many programs going on, so the benefit is that it's front and centre I suppose. The downside of that is that we're not exclusive, so we're going to have to fight hard to keep our head, our face in front of the page, and not get swamped by bigger programs.*

TAs recommended that the Trial be continued into the future but with more of a focus on raising the profile of the initiative through marketing.

A few of the TMs broached the subject of adapting and extending the model to other parts of their regions or to sub-groups of the population, in response to community needs and changes in the wider context (for example, the drought breaking, the COVID-19 pandemic). Again, this would inevitably require further resources to boost the capacity for recruitment and training, coordination, organisation and the creation of background resources such as safety policies. Background work would also be needed to ensure it was targeted for maximum advantage:

> *So just putting that research in at the start is quite critical; so understanding what makes the town tick. How do people connect, who are the movers and shakers in town; all those sorts of things.*

Program participants (both TAs and TMs) at a few sites had been approached by others wanting to get involved or wanting to expand the program into their own towns. There was no capacity to provide this opportunity, although TMs were happy to give advice to people with the resources to set it up. One TM noted that the target community did not have a lot of resources, so it would be difficult to sustain, let alone expand, the program:

> *In the end it's up to the local community to get behind it and continue it.*

Interesting questions arose around equipment purchases. Three of the Farmers' Trial sites used program funds to buy iPads for use by the TAs when facilitating discussions around mental health using the Weathering Well app. These were managed assets of the PHNs with written agreements in place for their use. However, feedback from the volunteers was that people preferred not to use the iPads, they would rather "have a chat to them one on one". Another Farmers' Trial site approved the purchase of mobile phones and plans (without a data allowance) for the volunteers to keep in touch with people they were supporting. Given the short-term nature of the program, the TM was not convinced this was a worthwhile use of funds. They had spoken to the volunteers, who did not want to carry a second phone with them for occasional use. The TM was also unsure what would happen with the phones once the program funding ended: "We're just building an obsolescence." At the time of the interview, the TM had not spent the allocated funds.

8. Discussion

This chapter is structured around the five evaluation questions, drawing together the data presented in earlier chapters and summing up the evaluative judgements that can be made, based on the data. Recommendations are provided as part of the section on possible improvements to the Trusted Advocates Network model.

8.1 How well have the Trials been implemented?

The nine Farmers' Trial sites have reported variable success in implementing the Trusted Advocates program.

There was no implementation at three of the Farmers' Trial sites, despite evident efforts by the PHNs to engage with stakeholders and recruit volunteers. Two used some of the program funding to sponsor additional MHFA or Accidental Counsellor training which was made available to the broader community, thus contributing to mental health literacy in those areas. One is investigating the possibility of redesigning the program around a specific sub-group of the population in particular need of formal and informal mental health support.

Two of the Farmers' Trial sites had partial success in implementation. In partnership with their local branches of Lifeline, each recruited and trained a small number of volunteers. At one of these sites, program activities came to an end in October 2020. At the other site, volunteers remain involved and are actively supported by the TM. The delivery model does not allow for proactive contact with community members by the volunteers; instead they wait for people in need of support to contact them. This approach seems to have limited the reach and effectiveness of the program at that site.

Four of the Farmers' Trial sites have implemented the program fully. One PHN elected to deliver the program directly, one engaged early with an external partner, and two began with direct delivery (after initially struggling to find a partner) and have since sought and/or engaged an external provider to provide additional training, support and supervision for the volunteers. Of the 52 TAs currently involved in the program, 40 are from these four sites. They have received a variety of training including MHFA, Accidental Counsellor and several other types of courses. At all four of these sites, TAs are actively engaging with the target communities and it is reasonable to conclude that implementation has been ultimately successful, although not without challenges along the way.

Implementation of the Fishers' Trial has proceeded smoothly. The Trusted Advocates Network component is well advanced, helped by the availability of local industry groups in each of the three target communities. These local stakeholders have assisted the Trial in various ways, perhaps most importantly by helping in the search for suitable TAs by identifying key people suited to the role. The project steering committee has contributed to implementation through project planning, strategic guidance, and the establishment of governance frameworks. All the TAs have received accredited MHFA training and ongoing education and there are mechanisms in place for clinical and personal support. Group and individual activities are taking place in the target communities to raise awareness of mental health and reduce stigma.

In relation to the other three components of the Fishers' Trial, the approach to implementation has been well planned and systematic. At the time of this report, plans were in place to deliver about 15 MHFA courses in fishing communities around Australia, 26 applications had been received for the Community Resilience Grants scheme, and various marketing and communication activities were underway (for example, providing information to primary health care providers about the mental health needs of fishing communities and how these could be met by GPs).

Analysis of the interviews with TMs highlighted factors which facilitated or created barriers to the smooth implementation of the Trials, discussed below.

8.1.1 Facilitators

Facilitators included: strong stakeholder engagement utilising existing resources and networks; partnerships with local organisations experienced in managing a volunteer workforce; systematic project planning and management processes; and the commitment and enthusiasm of volunteers and project officers.

In general, PHNs that took a commissioning approach to delivery have had greater success in implementation than those that attempted direct delivery, although there were exceptions. Direct delivery was more feasible where there was a staff member in the PHN who could take on the carriage of the project, with support from managers. Key informants emphasised that it was not a program that could "run itself", but required ongoing input of time and effort to stay in contact with volunteers and provide supervision, support, and educational resources. Consistency in staffing helped to keep implementation on track. PHNs that succeeded with direct delivery were also able to draw on extensive stakeholder networks in the target communities; less successful PHNs encountered difficulties due to remoteness and scarcity of local contacts. Extended drought and chronic financial stress had depleted social capital in some of the target communities to the extent that PHNs were unable to locate organisations or individuals willing or able to participate in the Trial. Ironically, a major barrier was supporter overload in communities where there was already a great deal of drought- and bushfire-relief activity taking place.

For the Farmers' Trial, partnership with a well-established, community-facing local organisation was a major facilitator of program implementation. Suitable partners had the infrastructure and systems to train, deploy, monitor and supervise volunteers in the mental health promotion space. Their experience in managing the logistics, legal issues and risks associated with a volunteer workforce – such as Work, Health & Safety, role definition/boundaries, and reimbursement – was particularly valued.

Across the program, Trial sites with a clearer view of project goals were better able to scope the role of the Trusted Advocates and provide guidance to volunteers around the limitations and boundaries of that role. Other facilitators include the intentional adoption of a strategy to build on previous or existing programs, including the broader Empowering Our Communities initiative, the NSW Rural Adversity Mental Health program, and the Stay Afloat name originated by the Tasmanian Seafood Industry Association, through which the Fishers' Trial hopes to benefit from links with two initiatives already associated with that recognised brand. Trial sites have drawn on established training models such as MHFA, psychological first aid, Accidental Counsellor, and Gatekeeper Training.

Finally, an essential facilitator of the success of the Trusted Advocates Trials has been the commitment and enthusiasm of the volunteers, many of whom brought to the program their pre-existing skills and personal qualities, reputations and community networks, and lived experience of mental health issues.

8.1.2 Barriers

Barriers included the absence of these facilitators, plus issues around the design of the program (selection of target communities, lack of clarity around program goals and deliverables) which are discussed in the next section. Difficulties in stakeholder engagement had a significant impact, especially at three Farmers' Trial sites where the PHN was unable to establish a functional partnership with another organisation to deliver the program or to recruit and train volunteers

directly, with the consequence that the Trial was not implemented. One Farmers' Trial site which originally delivered the program directly has now contracted with an external organisation to provide extra training, support and supervision, and another site is seeking to do so. In part, these issue arose because managing a volunteer workforce requires specialised skills and resources that are not generally available within PHNs.

The impacts of the COVID-19 pandemic on implementation were felt across the program. Again and again, in our interviews with key informants, we heard the words, "And then COVID hit". The impact of the pandemic on the two Trials should not be underestimated. It has restricted travel to remote sites and limited opportunities for face-to-face training, which is a problem because internet connections and familiarity with the technology required for online learning may not be available in rural areas or among those who choose to serve as Trusted Advocates. It has created additional financial strain and contributed to social isolation, as people avoid contact to avoid catching the disease. Most importantly, it has curtailed the ability of Trusted Advocates to promote mental health and wellbeing through casual and planned conversations with members of their communities.

8.2 How appropriate were the Trials' designs for the identified needs?

Within each of the nine participating PHNs, a specific target community was selected by the Department and funding was tied to this community. This had various impacts on the Farmers' Trial. In some cases, the PHNs found that there was already a considerable amount of mental health promotion activity happening in these communities and therefore organisations and individuals who may have otherwise have been willing to participate in the Trial were already at capacity and reluctant or unable to take on additional work. In others, the drought had eased, although its effects were still being felt.

The prescriptive nature of the targeted grants affected attempts to engage with partner organisations to deliver the Trusted Advocates model, and also had impacts on recruitment of TA volunteers. In contrast, the selection process for the Fishers' Trial ensured that target communities had a demonstrated need for and interest in mental health promotion activities, and the infrastructure to support program roll-out. This suggests that greater opportunity to engage with Farmers' Trial stakeholders across the PHNs at the inception of the program, and involvement of those stakeholders in the selection of the target communities, might have been beneficial. Greater flexibility around the choice of community or population – particularly after difficulties in implementation at certain Trial sites became apparent - may have helped ensure that program funds could be expended for the benefit of those most in need.

Although the selection of Farmers' Trial target communities was quite prescriptive, the Trusted Advocates Network model itself was not defined in detail in the four-page guidance document and there was no information about how PHNs should go about identifying, recruiting or supporting Trusted Advocates (although there were recommended training programs). Interviews with TMs revealed inconsistencies in the understanding of program goals and definitions of success. The perceived lack of written guidance or an evidence-based model had impacts on the progress of implementation at some sites. It is likely that this has also contributed to the observed divergence among sites in the way the model has been interpreted and operationalised.

8.3 What difference are the Trials making?

It has been difficult to judge the extent to which the Trials have achieved their intended outcomes of improving the provision of mental health support for target communities. In part, this is because there were different ways of conceptualising the goals of the Farmers Trial across the sites. These were focused around four themes, listed in order from most common to least common:

- **Building volunteers' knowledge and skills**, to benefit the Trusted Advocates and their existing community networks;
- **Reducing distress and promoting wellbeing** by reducing stigma and encouraging discussion of mental health and help seeking;
- **Improving health service access and use** through appropriate referrals and links to care providers and self-help resources;
- **Prevention of mental illness and suicide**.

The first theme identifies the upskilling and support of TAs as an end in itself - indeed, as the primary goal of the program. TMs at most of the Farmers' Trial sites and the Fishers' Trial emphasised this as an important aim and the focus for much of the work of implementation. Outcome measures would therefore focus on the volunteers' competence and confidence following the training, in a similar fashion to most evaluations of first responder programs such as MHFA.

Many TMs went beyond this basic goal to suggest that another important aim was to get the TAs actively engaging with others in their communities, discussing mental health and encouraging self-care. In this view, the Trials were mental health promotion activities with the TAs as the means of delivery. They would provide a "listening ear" for private discussions and, in some cases, also be the program's public face, helping raise awareness and promoting wellbeing.

The third and fourth themes are logical extensions of the first two (Figure 11). They are based on the assumption that training and supporting the volunteers will in turn enable them to engage in the community more effectively and to identify those in need of professional help. Then, those at risk will act on the volunteers' referrals and receive appropriate treatment, thus preventing serious mental illness and suicide.

Figure 11 Flow chart of Trial outputs and outcomes

It should be noted that this is a very simplified model of how the program might work and the kinds of outcomes that might be measured. If the Farmers' Trial were to be extended or replicated, a fully developed program logic would be essential to guide future evaluation activities[4]. This could build on the draft logic model prepared by the evaluation team for the Fishers' Trial, but should also include stakeholder consultation with the Farmers' Trial sites that have implemented the program.

For this report, there is information available on the first link in the chain of logic, and some limited information on the second. By necessity, therefore, the outcomes reported here relate to TA capacity and activities. Achievement of these goals is a necessary but not sufficient step towards achieving the subsequent program goals relating to downstream impacts on service use or mental health outcomes.

[4] Development of program logic was not part of this evaluation; it was understood from program documents (e.g., RFQ) that this would be provided to the evaluation team by the Department.

8.3.1 Capacity to deliver mental health support

Overall, the survey data indicated that most TAs felt reasonably well supported and were confident in their roles. Response to the online survey showed that TAs particularly enjoyed the self-development aspects of the training and would like ongoing or top-up training. They had high levels of confidence, particularly in their ability to listen non-judgmentally (72% strongly agreed, 22% agreed), encourage a person to seek professional help (56%, 39%), and offer reassurance (50%, 44%) or basic "first aid" level information to someone experiencing a mental health crisis (56%, 28%). All said they were able to recognise signs that a person might need mental health support (39%, 61%). These levels of confidence following training compare favourably with those reported recently from a sample of community pharmacists who completed MHFA training (Witry et al., 2020).

The majority of TAs who responded to the survey indicated that the support they received met their needs: 68% agreed or strongly agreed that they felt totally supported in the role of TA, and 63% agreed or strongly agreed that they had all the resources required for the role. Over 70% agreed or strongly agreed that their awareness of mental health services and resources had increased since the training, and half felt they were valued and listened to as Trusted Advocates.

Additional insights are available from the interviews with TAs in both Trials. Interactive training environments were preferred; online training was generally less popular than face-to-face sessions. Many TAs said they would like more training, more in-depth training, and training that addressed practical issues such as how to approach people. Regular refresher courses were also suggested. In the Farmers' Trial, some TAs were unsure how to translate the training into practice. Fishers' Trial TAs benefitted from comprehensive, online orientation training.

Perceptions of support from the host organisation were very mixed, depending on the Trial site. Regular communication between the TAs and TMs were highly valued, along with availability and responsiveness to any questions or concerns. Some of the Farmers' Trial TAs would have preferred more communication with, and encouragement from, the host organisation. Fishers' Trial TAs were very satisfied with the support they received, both from the TM and the monthly group sessions with a clinical psychologist/MHFA master trainer. Peer-to-peer support was crucial in building morale and preventing a sense of isolation in both Trials.

In summary, there is sufficient evidence to conclude that the program has increased the capacity of TAs to deliver mental health support. This has occurred in nine of the 12 target communities: six Farmers' Trial sites and three Fishers' Trial sites. A total of 56 TAs were recruited and trained, of the (maximum) 99 volunteers anticipated. The reach of the training has extended beyond Trusted Advocates because of particular training and education strategies employed at some of the Trial sites. A variety of clinical supervision and support models are in place; the most effective strategies are proactive, regular, and involve both personal and professional supports.

8.3.2 Delivery of individual support and mental health promotion

It is difficult to gauge the extent of TA activities in the target communities as there is no consistent data collection mechanism across the program. Interviews with key informants in the Farmers' Trial indicated that the requirements for reporting and evaluation were not well understood. In contrast, the Fishers' Trial has a system for tracking TA activities and thus demonstrating the program's reach and potential impact.

Of the original 56 TAs, 52 were actively involved in the program at the time of the final evaluation interviews, across five Farmers' Trial sites and three Fishers' Trial sites. There is, therefore, potential for delivery of support and mental health promotion across eight rural and coastal communities

resulting from the program. The potential level of activity can be illustrated by the Fishers' Trial which reported 330 interactions between nine TAs and others in three communities over a five-month period. This included 72 one-to-one conversations, all of which took place in person. From the survey data, it is apparent that the activity levels in both Trials were not evenly spread but varied considerably between individual volunteers. While all but two of the TAs who responded to the survey had initiated conversations about mental health, the total number of conversations reported by an individual ranged from one to more than 20. About half of the respondents reported having at least ten conversations about mental health since the program began. These findings suggest that TAs can and do deliver first response mental health support and promotion in their communities.

The effectiveness of this support is unknown, even to the TAs themselves. Only half of the survey respondents agreed with the statement that "I am satisfied with the level of mental health support I have been able to offer people in my community in my role as a Trusted Advocate"; the others strongly disagreed or chose a neutral response.

Some explanation for this ambivalence can be found in the interview data. Making contact with potential "clients" was surprisingly challenging at some of the Farmers' Trial sites, and was made more difficult by the pandemic lockdowns and social distancing requirements. Many TAs were unsure how they were supposed to engage with people and initiate meaningful discussions about mental health. Making referrals was also challenging because of the lack of services (or long waiting lists) in small rural towns. Other challenges included lack of time and a perceived lack of public awareness of the program (which the TAs believed could be addressed with increased marketing).

Nevertheless, when they did make contact and have conversations, TAs felt they were effective in the role. They understood the importance of being good listeners and building rapport. For some, their activities were enhanced by the insights and personal experiences they could share from their own struggles with mental health. There were several specific examples of actions by TAs which had immediate, positive impacts on the people they were trying to help, such as encouraging a person who had suicidal thoughts to seek professional treatment. There has been very positive feedback from the public at a few of the Trial sites. TMs pointed out that it was likely some TAs were underestimating their own activities and effectiveness, because they were performing the role "naturally" as they had done for a long time prior to the program.

The strong interest in sustainability and spread from the TMs at some of the Farmers' Trial sites is a positive sign that the Trusted Advocates model has demonstrated feasibility and potential benefits under certain circumstances.

8.4 Were there unintended consequences?

Through a review of documents and inductive analysis of the interview data, the evaluation was able to document several unintended consequences, which were then categorised according to knowability, value, distribution and temporality (Jabeen 2018).

One unintended, negative outcome – the risk of volunteers experiencing vicarious trauma – was foreseen and addressed in the design of the program. Impacts can be ameliorated through the provision of ongoing support and supervision for the TAs, however this has implications for TM workloads and program sustainability.

Two unintended, negative outcomes were potentially foreseeable but unforeseen by those who designed the program. The first related to concerns around the risks involved in managing volunteers, which were expressed by TMs across the Farmers' Trial sites. These TMs argued that

PHNs were not set up to manage volunteers, and that by deliberately recruiting and training TAs, the PHNs assumed a duty of care for which they were not necessarily well equipped. This unintended outcome affects both TMs and TAs and potentially extends beyond the Trial period. The most effective solution appears to be partnership with an external provider with expertise in managing volunteers, to ensure that TAs understood and continued to operate within the scope of the role.

The second in this category of unexpected outcome was the unexpected level of difficulty in engaging with the public that occurred at some of the Farmers' Trial sites. TMs and TAs at these sites questioned the basic premise of the program that the volunteers would easily be able to identify and connect with farmers who needed help, because this had not been their experience to date. Some TMs regarded this issue as a significant barrier to the success of the Farmers' Trial. Their concerns are consistent with systematic reviews of the academic literature which show that more research is needed to understand how MHFA training can be translated into effective helping behaviour and positive outcomes for recipients of support (e.g., Maslowski et al., 2019; Morgan et al., 2018).

The final unexpected outcome was genuinely unforeseeable. At one of the Farmers' Trial sites, the program landed in a community with long-standing tensions among groups of people. Inadvertently, the presence of the program aggravated pre-existing mistrust and trauma. Program activities at the site were suspended for several months until the PHN was able to engage an external partner that could provide volunteers with training, support, and ongoing supervision. The selection of this site, although justified by need, was unfortunate for various reasons, including from the perspective of giving the program a fair trial. While there was no way the Department could have known this might happen, it could be viewed as a cautionary tale illustrating the value of drawing on local knowledge when choosing a target community.

8.5 Recommendations on improving the Trials

To address the fifth evaluation question, all stakeholders were asked about the lessons learned from the Trials and what, if anything, they thought could have been improved. Potential improvements were identified from their replies, as well as by examining the data around the challenges of implementing the program. Relevant findings were presented in Chapter 7 and in earlier sections of this report and provide a basis for these recommendations.

8.5.1 Selection of target communities or sub-groups

The Fishers' Trial demonstrated the benefits of a structured needs assessment and consultation process in selecting target communities. The key advantage of the Fishers' Trial was that it was supported by a tight group of lead stakeholders that clearly understood the mental health challenges of commercial fishers. The TAs were "tapped on the shoulder" based on experience of the industry and their connectedness to the community and the three locations were selected based on need and local knowledge.

In contrast, Farmers' Trial sites – with the exception of one site which had an established steering committee – faced serious challenges in stakeholder engagement and volunteer recruitment unless they were able to partner with a local, community facing organisation. For these reasons, implementation did not occur at three Farmers' Trial sites. Flexibility to move the program funding across to other towns in the PHNs' regions could have avoided this situation.

> ***Recommendation 1***
> *The Department could reconsider the way in which the program is targeted; for example, by providing guidance rather than mandating the choice of target communities, and allowing*

flexibility to change target locations within a certain period of time if implementation initially proves unfeasible.

Another key difference is that the Fishers' Trial is an industry-based initiative, rather than a response to the drought. Consequently, it has been established with a longer term view to build mental health literacy and capacity across the seafood industry to withstand shocks (e.g., changes in access to resources) that affect mental health. There may be good reasons to adopt a similar approach in rural communities, rather than waiting until they are challenged by a crisis such as a drought, flood or bushfire. A longer term capacity building approach would have the additional advantage of enabling continued support for the volunteer workforce and the potential for expansion to the point that the "dose" of the intervention is sufficient to create measurable outcomes. The Fishers' Trial includes a component of education for GPs around the specific mental health needs of the target community; this may be a valuable addition to the program in rural communities to ensure that help seeking is positively reinforced and effective.

Recommendation 2
The Department could consider developing and evaluating Trusted Advocates Networks that target particular locations, sub-populations or industry groups, with a longer term view to building mental health literacy and community resilience (rather than short-term crisis support). Stakeholder consultations and requests for expressions of interest from representative, community-facing organisations may provide a foundation for selection of program targets.

8.5.2 Implementation guidelines

A clearer definition of the Trusted Advocates Network model would have been helpful in guiding implementation. Some Trial sites have developed a detailed project plan, with specific objectives, timed deliverables, and methodical record keeping. Sites that have such documentation appear to be more focused on sustainability and also more advanced with implementation.

Recommendation 3
Future efforts to implement the Trusted Advocates Network model should draw on the academic and grey literature around MHFA and other first responder training programs, including what is known about enabling trainees to make meaningful connections with those who might need mental health support. This information should be provided to all Trial sites at the outset of the program, along with the implementation guidance.

The centralised management model of the Fishers' Trial appeared to work better than localised management models where the host organisation was either a PHN or a NFP. There are efficiencies in having one program manager undertaking project planning and delivery over a number of sites, with the support of an expert steering committee. Such a delivery model would promote consistency and fidelity across sites and may make it more feasible to offer regular, professional supervision for the volunteers. However, the TAs did express a desire for more locally available training and support in addition to the personal and professional supervision provided centrally. Specialised input into communications and marketing would also be a worthwhile investment for more effective messaging around mental health and wellbeing, to reduce stigma and to promote awareness of the Trusted Advocates Networks.

Recommendation 4
Rather than funding single communities, the Department could consider establishing centralised planning, implementation, marketing, communications and management of Trusted Advocate Networks at a regional or industry-specific level, with access to expert

advice/governance (i.e., steering committees or advisory groups) and a systematic approach to providing ongoing, proactive support and supervision of the volunteers.

8.5.3 Program goals and outcomes data collection

There was a great deal of variability among TMs in their definitions of program goals and indicators of success. The Trusted Advocates model requires further conceptual development and Trial sites would have benefitted from access to information about the evidence base for the program. There was no consistent mechanism for data collection, seriously limiting the information available to the evaluation. Measuring program outcomes will be essential to build an evidence base but also for maintaining the motivation of the TAs, knowing whether they are making a difference. Both quantitative and qualitative data collection will be required to understand perceived effectiveness and challenges.

Recommendation 5
Any expansion or extension of the Trials should include early development of program logic, linked with consistent data collection and reporting requirements across Trial sites.

8.6 Limitations of the evaluation

The evaluation began approximately 18 months after program inception and concluded before the program ended. This necessarily limited the baseline and outcomes data available to the evaluation. We interviewed TAs at five of the six Farmers' Trial sites where implementation has been accomplished; there was one other Farmers' Trial site which reported partial success with recruitment (two TAs) but the evaluation team was unable to obtain contact details for these volunteers, despite several requests.

The program guidelines did not require consistent mechanisms across the Trial sites for monitoring the activities of the TAs or quantifying the extent of their interactions with community members. Due to the timing of the evaluation, there was no opportunity to establish a data collection system or to obtain baseline data. This made it challenging to measure and demonstrate outcomes such as the extent and types of activities of the TAs, referrals to health services, or changes in patterns of help seeking behaviours. The first round of interviews established that only three PHNs and SIA had a system in place for documenting the Trusted Advocates' activities. Consequently, there was limited quantitative data available on the reach of the program in target communities. The survey of TAs across all sites was designed to address this limitation. Although the response rate (22/52, 42%) was reasonable for this type of survey, it did not provide complete data on TA activities and may not be representative of implementation sites, so findings should be interpreted with caution.

The diversity of the target communities' resources and needs, combined with the lack of guidance around the model and its implementation, means that there was considerable variation in the way the model was interpreted and operationalised across the Farmers' Trial. In addition, unforeseen events such as COVID-19 (across the sites) and community tensions (at one site) created barriers and delays which had significant impacts on implementation and the ability to demonstrate outcomes, given the short-term nature of the program. The major implication is that the Farmers' Trial was not able to demonstrate the effectiveness of the Trusted Advocates Network model. There is potential, however, for the Fishers' Trial and some Farmers' Trial sites to do so in the future, if funding is continued and data collection mechanisms, supported by a program logic model, are put in place.

8.7 Conclusions

Trusted Advocates Networks have been implemented fully at the three Fishers' Trial sites and four of the nine Farmers' Trial sites, with partial implementation at another two Farmers' Trial sites. The program has improved the capacity of 56 volunteers to act as Trusted Advocates in their communities; 52 Trusted Advocates across eight communities are currently active in providing mental health support through individual, private conversations and planned, group events to promote wellbeing and reduce stigma. Activity data are limited but indicate that most Trusted Advocates are having conversations, suggesting self-help strategies and making referrals for professional help as needed. It was not feasible for the Trials (or the evaluation) to demonstrate impacts on service use or mental health outcomes for the recipients of the mental health support provided by Trusted Advocates.

The Fishers' Trial has several advantages over the Farmers' Trial, largely because it is better resourced and planned, has access to expert advice and influential stakeholder groups, and is centrally managed with efficiencies of scale. The major difference, however, is that it is conceptualised as an industry-based, capacity building response to identified community needs rather than a short term response to a crisis. However, some of the Farmers' Trial sites are also using the program as an opportunity to build mental health literacy and are considering sustainability and possible expansion. There is potential to improve the program by engaging stakeholders in the selection of target communities or sub-populations, developing a clearly articulated, evidence-based Trusted Advocates model, issuing more informative implementation guidelines, and establishing requirements for minimum data collection and outcome reporting across sites.

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Appendix 1 Farmers' and Fishers' Trial Manager Interview Questions (Baseline)

Introduction and consent

Hello, my name is [name] from the Centre for Health Service Development, University of Wollongong. I understand that as part of your work for [name] Primary Health Network you are involved with the Trusted Advocates Farmers' and Fishers' Trial. We are evaluating the program and would like to ask some questions about the way the program has implemented in your area, including the training and support provided to volunteers.

This interview will take about 45-60 minutes. All your answers will be confidential and we won't share your information with anyone at the [name] Primary Health Network or elsewhere. We will make sure that we don't identify any individuals in our report to the Department of Health. The interview will be confidentially transcribed and stored with an ID number. If possible, we'd like to interview you again in about March next year to see whether things have changed at all.

There are no risks to taking part in the interview, apart from the time that it takes, which we appreciate. We are not judging or comparing the performance of individuals or PHNs across the program. The information you provide will help us understand what has worked and what could be learned from Trusted Advocates to inform future policy and practice. However, you are free to decline to answer any question or to stop the interview at any time.

Are you willing to take part in this interview? Are you happy for the interview to be recorded? (Record yes/no)

Role in, and understanding of, Trusted Advocates Farmers' and Fishers' Trial

1. First, could you describe your role in the Farmers' and Fishers' Trial of the Trusted Advocates program?
2. What do you think the Trusted Advocates program is trying to achieve?
3. How do you think the Trusted Advocates program fits with existing mental health supports and services in your area? (Prompt: What, if anything, does it add?)

Recruitment, training and support of volunteers

4. How many volunteers are involved in the Trusted Advocates Farmers' and Fishers' Trial in your area?
5. How were they recruited? (Prompt: Can you describe anything that helped or hindered recruitment of volunteers?)
6. How were they trained? (Prompt: when, where, size of group, type of program – MHFA, Accidental Counsellor, other)
7. What kinds of challenges have the volunteers encountered in their roles?
8. What supports are available to the volunteers in your area, and to what extent are they using those supports? (Prompt: counselling services, group work, other)

Administering the program

9. What have been the challenges (for the PHN) of implementing the Trial?
10. What resources have been required, and have they been sufficient? (Prompt: resources, time, community networks)
11. Have there been any activities or events to promote public awareness of the Trusted Advocates?
12. To what extent are you able to monitor and record what the Trusted Advocates volunteers are doing? (Prompt: Are there systems in place for regular reporting or data collection?)
13. What has been learned so far and have any changes been made as a result of those key learnings?
14. At this stage of the program, how would you say it is working? (Prompt: Why do you say that?)
15. Do you have any additional questions or comments?

Thank you very much for your time today. I hope to talk to you again next March.

Appendix 2 Farmers' and Fishers' Trial Manager Interview Questions (Follow-up)

Introduction and consent

Hello, my name is [name] from the Centre for Health Service Development, University of Wollongong. I understand that as part of your work for [name] Primary Health Network you are involved with the Trusted Advocates program. We are evaluating the program and would like to ask some questions about the way the program has implemented in your area, including the training and support provided to volunteers.

This interview will take about 45-60 minutes. All your answers will be confidential and we won't share your information with anyone at the [name] Primary Health Network or elsewhere. We will make sure that we don't identify any individuals in our report to the Department of Health. The interview will be confidentially transcribed and stored with an ID number. If possible, we'd like to interview you again in about March next year to see whether things have changed at all.

There are no risks to taking part in the interview, apart from the time that it takes, which we appreciate. We are not judging or comparing the performance of individuals or PHNs across the program. The information you provide will help us understand what has worked and what could be learned from Trusted Advocates to inform future policy and practice. However, you are free to decline to answer any question or to stop the interview at any time.

Are you willing to take part in this interview? Are you happy for the interview to be recorded? (Record yes/no)

Role in, and understanding of, Trusted Advocates Farmers' and Fishers' Trial

If the person was interviewed at baseline, skip to Question 3.

1. First, could you describe your role in the Farmers' and Fishers' Trial of the Trusted Advocates program?
2. What do you think the Trusted Advocates program is trying to achieve?
3. How do you think the Trusted Advocates program fits with existing mental health supports and services in your area? (Prompt: What, if anything, does it add?)

Recruitment, training and support

4. How many volunteers are involved in the Trusted Advocates Farmers' and Fishers' Trial in your area?
5. Has there been any attrition from the volunteer work force since the start of the program? Have new people joined the program? (Prompt: What has led to people joining or dropping out?)
6. What kinds of challenges have the volunteers encountered in their roles?
7. In your view, what are the most effective ways to support volunteers in the role of Trusted Advocates?
8. Have you had any feedback from Trusted Advocates volunteers about the role? (Prompt: Can you tell me more about that?)

Administering the program

9. What have been the challenges (for the PHN) of implementing the Trial?
10. What resources have been required, and have they been sufficient? (Prompt: resources, time, community networks)
11. Have there been any activities or events to promote public awareness of the Trusted Advocates?
12. To what extent are you able to monitor and record what the Trusted Advocates volunteers are doing? (Prompt: Are there systems in place for regular reporting or data collection?)
13. Have you had any feedback from the public regarding the activities of the Trusted Advocates?

Impacts and improvements

14. Were there any positive impacts having a Trusted Advocates Network locally?
15. Do you think the program has resulted in an increase in the number of people accessing mental wellbeing and support services in your area?
16. Were there any negative impacts or unexpected consequences?
17. Do you think that the provision of informal peer support through this program was a sensible improvement for mental health services in this area?
18. What do you think are the key learnings from being involved in the Farmers' and Fishers' Trial and supporting the mental health needs of your local community? (Prompt: What would you do differently, what should be strengthened?)
19. Do you have any additional questions or comments?

Thank you very much for your time today and for sharing your insights into the program.

Appendix 3 Farmers' and Fishers' Trial Volunteer Interview Questions

Introduction and consent

Hello, my name is [name] from the Centre for Health Service Development, University of Wollongong. I understand that you are a volunteer recruited and trained to offer mental health first aid to people in your community through the Trusted Advocates Farmers' and Fishers' Trial. We are evaluating the program and would like to ask some questions about the training, the support you have received and your experiences of being a Trusted Advocate.

This interview will take about an hour. All your answers will be confidential and we won't share your information with anyone at the [name] Primary Health Network or elsewhere. We will make sure that we don't identify any individuals in our report to the Department of Health. The interview will be confidentially transcribed and stored with an ID number. If possible, we'd like to interview you again in about March next year to see whether things have changed at all.

There is a small risk that in taking part in the interview you might have to talk about topics that upset you. If this happens, feel free not to answer. You can stop the interview at any time. Please talk to your contact in the Trusted Advocates program if you need support later.

Are you willing to take part in this interview? Are you happy for the interview to be recorded? (Record yes/no)

Recruitment and training

1. How did you become involved in this program? (Prompt: What led you to volunteer?)
2. Did you have any previous experience of this sort of role? (Prompt: Can you tell me about it?)
3. Did you have any previous mental health training? (Prompt: Details)
4. Can you tell me about the training you received for this role? (Prompt: When, where, size of group, type of training - MHFA/Accidental Counsellor/other.)

   If no training yet, ask whether/when training is planned, and skip to Question 9.
5. *This is a yes/no question.* Do you feel like you received adequate training?

   ☐ 1 Yes ☐ 2 No
6. What were the most useful aspects of the training for you?
7. How could the training could be improved?
8. *This is another yes/no question.* Did the training make you feel more comfortable talking to people about mental health to try to reduce stigma associated with mental health?

☐ 1 Yes ☐ 2 No

9. How confident do you feel in helping someone with a mental health problem? (read out options)

☐ 1 Not at all
☐ 2 A little bit
☐ 3 Moderately
☐ 4 Quite a bit
☐ 5 Extremely

Activities as a Trusted Advocate

10. When you started the role, what did you think you would be doing?
11. Did it turn out like you expected? (Prompt: In what way?)
12. *This is another yes/no question.* In the past six months have you had contact with anyone with a mental health problem? (read options)

☐ 1 Yes
☐ 2 No (go to Question 16)
☐ 3 Don't know (go to Question 16)

13. How many people? Number: .....
14. Did you offer any help? *This is a yes/no question.*

☐ 1 Yes
☐ 2 No

15. What type of help? (Prompt: Can you describe how you tried to help?)
16. Have you initiated any conversations about mental health with people since you started in the role? (Prompt: Can you tell me about that?)
17. Do you feel like these kinds of casual conversations help to reduce stigma about mental illness in the community? (Prompt: In what way? OR What would be a better way to reduce stigma?)

Support in your role

18. What are the challenges of being a Trusted Advocate?
19. Overall, have you felt supported by the Primary Health Network in performing your role?
20. Can you describe the support provided by the Primary Health Network in performing your role?
21. Did you find that support sufficient? (Prompt: Why is that?)

Appendix 4 Questionnaire – Online Survey

Information about you

What is your gender?

- ○ Male
- ○ Female
- ○ Other, please specify _____

What is the main language you speak at home?

- ○ English
- ○ Other, please specify _____

Are you of Aboriginal or Torres Strait Islander origin?

- ○ Neither Aboriginal or Torres Strait Islander
- ○ Yes - Aboriginal
- ○ Yes - Torres Strait Islander
- ○ Yes - Aboriginal and Torres Strait Islander

What is your age group?

- ○ 18-24
- ○ 25-34
- ○ 35-44
- ○ 45-54
- ○ 55-64
- ○ 65-74
- ○ Over 74

The following questions relate to the services or support you provided as a Trusted Advocate

How long have you been a Trusted Advocate?

- ○ Under 6 months
- ○ 6 months to 1 year
- ○ 1 year to 18 months
- ○ Over 18 months

Has anyone in your community approached you to talk about mental health since you started in the role?

- ○ Yes
- ○ No

Have you initiated any conversations about mental health with people in your community?

- ○ Yes
- ○ No

Approximately how many conversations about mental health have you had since being trained as a Trusted Advocate?

- ○ None
- ○ 1-4
- ○ 5-9
- ○ 10-15
- ○ 16-20
- ○ Over 20

Please describe the types of help you provided as a Trusted Advocate.

_____

Please indicate your level of agreement or disagreement with the following statements

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
My awareness of mental health care services and mental health resources has increased as a result of my role as a Trusted Advocate	○	○	○	○	○
I am satisfied with the level of mental health support I have been able to offer people in my community in my role as a Trusted Advocate	○	○	○	○	○
People in my community value and listen to me in my role as Trusted Advocate	○	○	○	○	○

The following questions relate to your level of confidence in performing your role as a Trusted Advocate

I am confident I can:	Strongly disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Strongly agree
Recognise the signs that someone may need mental health support	○	○	○	○	○
Ask someone if they are thinking about suicide	○	○	○	○	○
Listen non-judgmentally to someone experiencing a mental health crisis	○	○	○	○	○
Offer basic "first aid" level information to someone experiencing a mental health crisis	○	○	○	○	○

I am confident I can:	Strongly disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Strongly agree
Offer reassurance to someone experiencing a mental health crisis	○	○	○	○	○
Encourage someone experiencing a mental health crisis to seek professional help	○	○	○	○	○
Encourage self-help strategies for someone experiencing a mental health crisis	○	○	○	○	○

The next questions relate to how often you have used your mental health skills and knowledge

Have you:	**Yes**	**No**	**Not applicable**
Thought someone's behaviour might indicate they are having a mental health crisis	○	○	○
Thought someone's behaviour might indicate they are having suicidal thoughts	○	○	○
Asked someone about their distressed mood	○	○	○
Asked someone if they are considering suicide	○	○	○
Listened non-judgmentally to someone experiencing a mental health crisis	○	○	○
Referred someone to appropriate resources because you were concerned they might be experiencing a mental health crisis	○	○	○
Referred someone to appropriate resources because you were concerned they were considering suicide	○	○	○
Engaged with a mental health crisis resource on behalf of someone	○	○	○
Engaged with emergency medical or police services because of someone experiencing a mental health crisis	○	○	○

The next questions ask about the level of support you received from the lead agency (e.g. Primary Health Network or Lifeline)

Please indicate your level of agreement with the following statements

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I have felt totally supported in my role as a Trusted Advocate	○	○	○	○	○
I have all the resources I need to perform my role as a Trusted Advocate	○	○	○	○	○

The following questions relate to you overall experience as a Trusted Advocate

Based on your experience, would you volunteer for a similar role in the future?

○ Yes

○ No

What are the reasons for this?

_____

What do you like most about being a Trusted Advocate?

_____

What improvements could be made to the Trusted Advocate role?

_____

Do you have any other comments about the Trusted Advocate initiative?

_____

Appendix 5 Participant Information Sheet – Online Survey

Project Evaluation of the Trusted Advocates Farmers' Trial and Fishers' Trial

What is this evaluation about?
The Trusted Advocates program provides training to volunteers (Farmers' Trial) or counsellors (Fishers' Trial) to equip them for a supportive role in their communities, offering mental health first aid and, when appropriate, suggesting that contacts seek professional help through health services and other relevant services, such as financial counselling.

The evaluation will examine and document the processes of implementation at each of the trial sites, delivery of informal mental health support by the Trusted Advocates, and outcomes for communities in terms of help seeking behaviour, linkages to mental health services, and community resilience.

Please read this Participant Information Sheet in full before deciding whether or not to participate in this evaluation. If you would like further information regarding any aspect of this project, please speak with a member of the evaluation team.

Who is conducting this evaluation?
This evaluation is being conducted by researchers from the Centre for Health Service Development at the University of Wollongong who have been engaged by the NSW Ministry of Health. Research team members include:

Dr Kate Williams, Centre for Health Service Development, University of Wollongong, (02) 4221 4411, kathrynw@uow.edu.au

Dave Fildes, Centre for Health Service Development, University of Wollongong, (02) 4221 4411 dfildes@uow.edu.au

What will you be asked to do?
You are invited to participate as you have been involved as a Trusted Advocate at one of the Farmers' or Fishers' pilot sites. If you agree to contribute you will be asked to complete a short online survey, which will take approximately 20 minutes. The survey will explore your views about the implementation, impact and sustainability of the pilot. We recognise that individuals will be expressing their own views and not necessarily the views of the organisation that they work for.

Are there any risks?
We do not foresee any potential personal risks or burdens associated with the survey, apart from the estimated 20 minutes of your time taken to participate.

Why should I take part?
There is no direct benefit to you by taking part in the evaluation. However, it is anticipated that this evaluation may inform policy development and future decisions by the Australian Government Department of Health relating to future national roll out of the Farmers' and Fishers' project. The findings may ultimately contribute to improvements in services delivered by agencies and organisations working in this field.

What happens with the results?
Data will only be accessible to members of the evaluation team. Individual responses will be confidential and will not be provided to anyone outside the evaluation team. Your privacy rights will

be protected. Confidentiality will be maintained at all times. The survey responses will remain the property of the CHSD. They will be stored electronically on a password-protected server and hard copies of any data kept in locked filing cabinets in a building with a robust security system.

Information from all survey participants will be analysed together and presented in summary form. It will be used in combination with evidence from several other sources to inform an evaluation report on the pilot. The evaluation team may also publish in peer-reviewed journals or via conference presentations. No personal details that could identify you as an individual will be included in any reports, publications or presentations.

How to participate?
Your consent will be implied if you complete the online survey. Your involvement in this evaluation is voluntary and you are under no obligation to participate. Refusal to participate will not in any way affect your relationship with your employer, the Australian Government Department of Health or with the University of Wollongong.

What if I have concerns about the research or have a complaint?
This research has been approved by the University of Wollongong Human Research Ethics Committee (Ref. 2020/ETH02980). If you have any concerns or complaints please contact the University of Wollongong Ethics Officer on (02) 4221 3386 or email rso-ethics@uow.edu.au.
If you would like further information regarding any aspect of this evaluation, please contact the Chief Investigator, Dr Kate Williams (02) 4221 4411 kathrynw@uow.edu.au.

Thank you for your interest in this evaluation.