Steering Healthy Minds Transport Industry Mental Health Initiative – Pilot Program Evaluation Report

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1. Introduction to The Steering Healthy Minds Pilot Program

1.1 The Steering Healthy Minds Pilot Program (SHMPP) Project Rationale

It is estimated that poor mental health in the heavy vehicle road transport industry costs Queensland 10 million dollars every year. This includes business losses as well as workers compensation claims with return-to-work rates being 30% lower than in other industries. More alarmingly the suicide rate in male road and rail drivers was nearly 30% higher than that of other occupations from 2001-2010 (Milner, Page & LaMontagne 2015). The Steering Healthy Minds Pilot Program (SHMPP) was developed to address the mental health issues being experienced by workers in the transport industry.

Steering Healthy Minds (SHM) is a collaboration between key organisations with interests in the transport industry. All of these organisations recognise that mental health issues in the industry are on the rise and want to offer meaningful support for workers and establish programs and support for employers. Founding organisations are Transport Education Audit Compliance Health Organisation, Transport Workers Union QLD, Queensland Trucking Association, Queensland Council of Unions, Kitney OHS, WorkCover Queensland and TWU Super.

The SHM Steering Group recognises the importance of a common understanding and goal in collaborations to identify and implement programs to prevent mental health and support transport workers. The SHM Steering Group meet monthly for SHM initiative and program oversight, strategic direction, and to further collaboration and program initiatives.

1.2 The Steering Healthy Minds Pilot Program (SHMPP) Queensland Overview

The SHMPP initiative has been championed by key representatives within the transport industry. As part of this initiative a pilot program was developed in 2019 where awareness of the issue was raised, and key personnel of participating companies were trained in mental health first aid (MHFA). Mental health first aid is 'the help provided to a person who is developing a mental health problem, experiencing a worsening of a mental health problem, or in a mental health crisis … the first aid is given until appropriate professional help is received or to crisis resolves' (Mental Health First Aid Australia 2021). The mental health first aid providers (MHFAs) make themselves available to workers within their own organisations. In the longer term it is intended that this will become a peer-to-peer support program that will continue to provide support internally but will also provide support externally to other transport industry workers by making themselves easily identifiable at truck stops, pickup/drop off points, and in workplaces.

1.3 The Steering Healthy Minds Pilot Program (SHMPP) Strategy

The initial phase of the 12-month program ran from late 2020 to the end of 2021. In this initial phase a group of companies in Southeast Queensland were identified and select staff members were included in mental health first aid training. Employees of the participating companies were made aware of the availability of these staff members as mental health first aid providers and their ability to provide peer-to-peer support. The mental health first

aiders and the participating companies were to work to raise awareness of the three key pillars of the SHMPP. These being the normalisation of mental health conversations, promotion of the issues and awareness of the importance of maintaining good mental health, and the available avenues of support (Transport Industry Mental Health Initiative, 2021). Upon completion of this first phase the effectiveness of the project would be evaluated to determine if the program would be adopted nationwide and during 2021 the Transport Workers Union Western Australia (WA) joined the Steering Group and secured funding for SHM initiatives and programs in WA.

Upon completion of the first phase of the program a team of researchers from Central Queensland University (CQUniversity) was engaged to evaluate the effectiveness of the programs with the intention that the findings would be shared by the Transport Workers Union (TWU) of Queensland with the wider transport industry in Australia.

2. Program Revisions and Set Backs

Originally three organisations within the transport industry expressed interest in the pilot program evaluation study. The original plan for the data collection period was that organisational sites would be visited to allow face to face interviews with both the trained Mental Health First Aiders and Senior/Middle Managers. This was later changed to a purely online survey and the interview questions were therefore adjusted for the online survey format.

The majority of the data for the pilot program evaluation study was intended to come from organisational employees and due to the anticipated size of the study, this data collection would be done online using an online survey link. Participants would be approached through organisational distributed emails which would include a link to the survey. The other transport industry stakeholders targeted to be involved via an online survey included the SHM Steering Group members.

Another program adjustment was that organisations required the proposed generic question set to be modified to suit their organisational terminology i.e., employees/staff/workers; manager/leaders. This resulted in the need to take time to develop several tailored surveys in order to fulfil individual organisational requests for a more personalised survey.

The major setback for the evaluation study was the unforeseen world events in 2020-2021 which resulted in the onslaught of COVID-19. This resulted in the industry partners who ultimately agreed to take part in the pilot program evaluation study being reduced to only one organisation. Despite efforts being undertaken to secure industry engagement during this time, most organisation felt that they could not participate in the pilot program evaluation study due to the pressures and demands on their transport operations and staff as a result of COVID-19 disruptions.

Therefore, only one organisation took part in the pilot program evaluation study which resulted in a major reduction in the number of available participants, and therefore the data collection sample size. The final outcome of the pilot program evaluation study was that

data could only be collected using online surveys and surveys were only completed by two leaders from management (N=2), two Mental Health First Aiders (MHFAs) (N=2) and sixteen staff members (N=16). Three SHM Steering Group members (N=3) also completed surveys.

Other major staffing set backs were experienced within the research project team. The senior researcher appointed from Macquarie University who was instrumental in liaising with industry partners unfortunately passed away and another researcher from CQUniversity was made redundant due to university restructuring as a result of COVID-19 disruptions to the educational sector.

Staffing changes also occurred within the Transport Workers Union (TWU) Queensland with a new general secretary appointed as well as a change to the Chair of the SHM Steering Group.

3. Methodology

3.1 Evaluation overview

CQUniversity was initially engaged to perform the evaluation study examining the effectiveness of the MHFA pilot program across three organisations based in Queensland. This mixed methods approach would allow for both qualitative and quantitative data to be gathered from key stakeholders involved in the pilot program and ensured that the reach, efficacy, and maintenance, of the project was examined at both individual and institutional levels.

3.2 RE-Aim Evaluation Framework

Evaluation data collection was formulated around the Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) framework (RE-AIM 2021). The RE-Aim framework model (see Figure 1) has been widely used resulting in over 700 publications that explicitly used the RE-AIM framework thus ensuring evidence of its support across a wide range of settings and various populations and health issues within both clinical, community and corporate contexts (Holtrop et al. 2021).

Figure 1 – RE-AIM Framework Model

3.3 Development of data collection tools

Four separate sets of data collection surveys were developed to gather tailored feedback from the following key stakeholder groups:

- Mental Health First Aiders (MHFAs);
- Leaders -Senior/Middle Managers;
- Employees (Non MHFAs); and
- SHM Steering Group members.

The survey questions were constructed using the Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) framework. There were 25 questions in the surveys presented to the participants. This ensured that reach, efficacy, and maintenance were examined at both individual, institutional, and steering group member levels.

3.4 Participants

The survey questions were designed to be answered individually. Leaders, MHFAs and employees from the industry partner were invited to participate in the evaluation via email. In total 20 participants from one organisational site provided responses to the surveys as well as three SHM Steering Group members. Participants were provided a with an anonymous online survey using the Qualtrics web-based platform and consented to take part in the study.

3.5 Ethics Approval

CQUniversity was responsible for gaining the Ethics Approval for the research study. The project was approved by the CQUniversity Human Research Ethics Committee, approval number 0000022939.

4. Results

Results are presented for each of the five RE-AIM framework components being Reach, Effectiveness, Adoption, Implementation and Maintenance of the initiative. Results are discussed for the MHFA pilot program initiative ('the initiative') and results are presented for each participant group being employees, leaders (senior/middle managers), MHFAs and the SHM Steering Group members.

4.1 Reach

Reach relates to who is intended to benefit and who actually participates in or is exposed to the initiative. It examines how many people are exposed or have been served by the initiative and if they are representative of who the initiative was trying to serve.

4.1.1. Leaders – Senior/Middle Managers

Leaders were asked about what factors contributed to the initial idea that MHFAs should be trained and positioned within the worksite to support workers? Responses included:-

- To provide peer to peer support for employees (under the umbrellas of wellbeing and EAP programs); and
- To encourage team support and engagement.

When asked about which employees the Mental Health First Aid initiative intended to support within the organisation, the response was:-

- Employees at every level

When asked about how employees are being made aware of the MHFA initiative, both leaders reported that employees were made aware of the MHFS initiative via MHFA posters; Internal communications; word of mouth; staff meetings and to a lesser extent via email signatures and toolbox sessions.

When questioned about what might be done to get more of the target audience to participate the leaders reported:-

- Staff engagement; and
- Word of mouth - constantly discussing the program.

When asked what might be done to get more transport industry organisations to participate in a similar initiative the team leaders felt that 'industry awareness' was a key factor.

4.1.2 MHFA Officers

The MHFA officers were asked about how many people at their workplace could access support from a MHFA officers. One participant reported 1-50 people and the other reported over 101 people could access support.

When asked about how staff were being made aware of the MHFA officers with the workplace, the notion of internal communications and staff meetings were identified.

The MHFA officers were asked if they thought that the MHFA officers cover a range of roles across the workplace. They reported that there were MHFAs on most shifts as well as across all roles.

When asked if they thought that the staff who are at most risk have the opportunity to be supported by a MHFA officer, one reported they were unsure and the other reported yes.

4.1.3 Employees – Non MHFA trained

The employees were asked about how they heard about the MHFA initiative at the workplace. Employees reported that they were made aware via MHFA posters (n=2), email signatures (n=2), internal communications (n=4), word of mouth (n=1), in their initial training (n=1) or they had never heard of it and were unaware of the initiative (n=3).

When asked if they thought the initiative was reaching staff within the workplace the employees reported that they were mostly unsure (n=8), with some reporting no (n=3) and some reporting yes (n=2).

Employees were then questioned on what they through the organisation could do to further support the MHFA initiative. Employees gave a range of responses including:-

> *Employees need to identify the mental health first aid support person. This is done at our workplace, displaying photographs and contact details. As bus drivers, there is a need for that recognition of the individual committee member out in the work area, e.g., badge or MHFA motto on our uniforms approved by our company, being more visible;*
>
> *More staff meetings to keep staff abreast of the separation of depots which would include information on MHFA;*
>
> *Stop treating employees like there just a number;*
>
> *Clearly by giving us information;*
>
> *Better rostering like 8/9 day rostering so drivers can have more time away from driving allowing people to decompress;*
>
> *Be a lot more inclusive and transparent about driver issues;*
>
> *Have one on one paid meetings with employees who choose to take up the offer maximum 1 hour session before or after a shift;*
>
> *Not really sure; and*

It is a good initiative.

When asked how they thought the organisation could increase the number of MHFA trained staff some were unsure (n=6), some said break the 12 hours of training down to 4 x 3-hour sessions (n=5); having blended on-line training (n=3), having more training sessions (n=3). Free comments reported included being unsure of how many are already trained and who they were (n=2) and well as a suggestion to advertise for the positions and give the necessary training (n=1).

4.1.3 SHM Steering Group

The SHM Steering Group members were asked what factors they thought contribute to the participation or non-participation of the MHFA initiative by managers of organisations. Responses included:-

Personal interest, time and availability, organisational support, budget;
A reluctance to be involved with unions. Also, an unrealistic perception that this will not be agreed to by upper management; and
2 days training being too long for employers to release people, also material not all relevant; prevention lacking and senior management commitment necessary.

SHM Steering Group members were also asked about the factors they thought would contribute to the participation or non-participation of the MHFA initiative by employees within organisations. Reponses included:-

Personal interest, position, relationship with peers and managers/team leaders, role and availability, organisational support;
A willingness to support their co-workers as well as gaining an extra skill. Non-participation could be that they fear it will be too much work; and
2 days training is a long time and not all material is relevant.

When asked about what they thought might be done to get more management support for a MHFA initiative responses included:-

Understanding the reasons for lack of management – give voice to he is underlying issues, understand and seek to address them;
Highlight the cost saving by having a mentally healthy workforce. Show research that states peer support is beneficial; and
Co-funding, obviously COVID has impacted with other business priorities, less day of course (training).

In response to what might be done to get more workers to participate in a MHFA initiative responses included:-

Highlight the impact a mentally healthy workforce can have on employees, less sick days, meaning less pressure to take over other workers shifts;
Building good rapport amongst colleagues, building moral within an organisation, an extra skill set to add to the resume;
Shorten the course.

SHM Steering Group members were also asked about what might be done to get transport industry organisations to participate in a MHFA initiative with responses including:-

Lack to time, availability are a significant issue for small, medium sized businesses, provide relevant and real-world small business examples of how to participate and outcomes;
Highlight the benefits especially the cost saving benefits. Less unplanned leave, retaining staff, better productivity; and
Sell positive from pilots.

4.2 Effectiveness

Effectiveness relates to what is the most important benefit you are trying to achieve and what is the likelihood of negative outcomes. It examines the impact of an initiative on outcomes, including potential negative effects, heterogeneity, quality, and economic outcomes as well as the reasons why.

4.2.1 Leaders – Senior/Middle Managers

Leaders were asked if the MHFS initiative had achieved the outcomes the organisation wanted and both leaders stated it was too early to tell.

When asked if the results and outcomes were meaningful to the organisation both leaders stated 'yes' it was.

Leaders were asked if they considered the results and/or outcomes meaningful to staff, and again this was a 'yes' from both leaders.

4.2.2 Mental Health First Aiders

MHFA officers reported that they felt that the MHFA initiative provides support for staff as it was intended. However, when questioned about if the MHFA initiative reaches all staff across the workplace one reported yes, whilst the other reported no.

When asked about unanticipated consequences, one MHFA felt that there had been no unanticipated consequences to the initiative (good or bad) whilst the other was unsure. Both agreed that it was beneficial to have a MHFA program in the workplace.

4.2.3 Employees – Non MHFA trained

The employees were asked if they felt the MHFA initiative has had a positive impact on their workplace.

Some employees were Unsure (n=5), others said No (n=4) and some reported Yes (n=3) When questions if they felt that peer to peer support like the MHFA initiative is effected again some employees were Unsure (n=5), others said No (n=4) and some reported Yes (n=3).

4.2.4 SHM Steering Group

The SHM Steering Group members were asked if they thought a MHFA initiative works to affect the outcomes wanted. Responses included:-

Workers can sometime be reluctant to seek professional help;
Being able to discuss things with a work colleague first can assist, then gentle encouragement for them to seek further professional assistance if required;
Can reduce stress, anxiety, depression, suicide. Show that colleagues care for each other; and
Understanding of mental health.

When asked about what factors they thought contributed to achieving positive results from such an initiative, responses included:-

Need to firstly define the outcomes wanted – may be different in each organisation, and across different levels within the organisation;
Build team morale;
Better support for work colleagues;
Reduction of mental health issues escalating; and
Management commitment.

SHM Steering Group members were asked about if they knew if the outcomes of a MHFA initiative were delivering expected outcomes. Responses included:-

No, the take up was lower than expected;
The outcomes to this initiative have exceeded expectations, even through the challenges of the COVID lockdown of 2020; and
Yes.

When asked if they thought the results and/or outcomes were meaningful to the organisations implementing the MHFA initiative, responses included:-

Unable to answer this;

Yes they are. This has been a difficult period that is unprecedented. I would like to think that all the challenges faced by transport workers during COVUD have lessened due to this initiative; and
Yes.

Members were also asked if they thought the results and/or outcomes of the MHFA initiative were meaningful to workers, responses included:-

Unable to answer this;
Yes, but I have limited knowledge; and
Yes.

4.3 Adoption

Adoption relates to where the program was applied and who is applying it. It examines the absolute number, proportion, and representativeness of settings and agents willing to initiate the program, and the reasons why.

4.3.1 Leaders – Senior/Middle Managers

The leaders were asked about the main factors that were considered by the organisation in relation to the adoption of the MHFA initiative within the workplace. They reported both the duration of the training and the accessibility of the training course as main factors.

In examining what barriers there were for staff to take up the MHFA training course the leaders reported the accessibility of the course and other work demands had an influence.

Leaders were asked about the rate of adoption that they would like to see across all workplaces with one leader reporting 5 MHFAs per site and the other reporting that the hours of coverage and MHFA ratio to employee should be considered.

When asked about why they thought some staff would not engaged in the MHFA training, they reported it was either not suitable for all people and the availability to attend the 12-hour training course.

Leaders reported that the MHFA training had been provided either as blended on-line training or as a mix of both internal face to face training and blended on-line training.

4.3.2 Mental Health First Aiders

The MHFA officers were asked about what they thought were the main factors considered by the organisation to the adoption of the MHFA initiative within the workplace. They reported that the duration of training, accessibility of the training course and staff wellbeing were considered.

In examining barriers for staff to take up the MHFA training the officers advised the accessibility of the training course and work demands are barriers.

When asked about the number of MHFA officers in the workplace, they reported between 1 – 10 MHFA officers are currently within the workplace.

When ask about what they considered to be the barriers to staff approaching a MHFA officer, one reported time allocation was a factor whilst the other was unsure.

4.3.3 Employees – Non MHFA trained

Employees were asked how many staff members could access the MHFA initiative at their workplace. Mostly the employees were unsure (n=6) with some reporting over 101 (n=3) and one reporting between 51-100 employees.

When asked if they knew how many MHFA officers were at the workplace the majority of employees reported they did not know (n=9) whilst one thought it was one officer.

The employees were asked what they thought were the barriers to staff approaching a MHFA office and speaking to them. Reposes were varied and included:-

> *Personal embarrassment, vulnerability and looking silly;*
> *Staff knowing who the MHFA are and how to contact them. (As I don't know either?);*
> *Time - nothing is ever done in real working hours;*
> *Hours of work;*
> *Unsure who you can speak to, if they have had any training and if the talk is confidential;*
> *Gossip privacy;*
> *No trust in the employer;*
> *Lack of confidence and trust with the aider who may be unpopular with the employees. Aiders need to be carefully selected and those who have numerous years of experience with the company; and*
> *No confidence in any of the Management Process.*

A numbers of staff indicated that they were unsure of the confidentiality (n=7) whilst others thought it was a great initiative (n=2).

The employees were generally Unsure (n=5) if staff support the MHFA initiative whilst some said No (n=3), and some said Yes (n=2).

When asked if they thought that some employees would participate but others would not there was mixed responses with some saying Yes (5), some being Unsure (4) and one saying No. Comments on suggestions to improve adoption included:-

> *Building trust;*
> *Making people aware;*

More conversations around work; and
They would think it is a waste of time and a lack of trust with their friends.

4.3.4 SHM Steering Group

The SHM Steering Group members were asked about what factors they thought would contribute to an organisation adopting a MHFA initiative. Responses included time, availability, resources, management support and team work. Additionally, they thought organisations should recognise the benefits including improved workforce, better productivity, and cost savings.

When asked about what factors they thought contribute to individuals taking up the MHFA initiative they reported interest, time, support and supporting colleagues. Building skills base, team work and confidence were also mentioned.

In examining the barriers that interact with a MHFA initiative to prevent its adoption the member reported time, interest, availability, and support, as well as time away from their role. Management allowing time for staff to be training, business activities and workload was also mentioned.

SHM Steering Group members were mixed in their responses on whether they thought the MHFA initiative would be partially or fully adopted with responses on both partially and fully.

When asked if they thought some transport industry member would participate and other would not responses included:-

Unable to answer this;
Yes, there is still a stigma around mental health and the old school belief that it is not needed. But this is rapidly changing. I believe more transport industry members will participate and that further promotion is needed;
Other commitments and COVID.

4.4 Implementation

Implementation relates to how consistently is the program delivered, how it is adapted, how much did it cost, and why did the results come about. It examines the fidelity of the initiative, including adaptations, time, and costs was well as reasons why.

4.4.1 Leaders – Senior/Middle Managers

The training had been provided by an external trainer.

When asked about the combination of things that might affect the effectiveness of the MHFA initiative one leader reported the effective roll out with enough trained MHFAs and the other leader did not comment.

4.4.2 Mental Health First Aiders

The MHFA officers were asked about what actions had been used to implement the MHFA initiative at the workplace. They indicated that access to MHFA training and information on further mental health support (EAP, Beyond Blue, etc.) were the two main factors and to a lesser extent time for staff to meet MHFAs.

When asked if they felt those activities were effective one reported yes whilst the other reported being unsure.

In considering how well they thought the MHFA initiative had been accepted at the workplace on a scale from 1 (poor) to 5 (very well) one scored it a 1 whilst the other scored it a 4.

4.4.3 Employees – Non MHFA trained

Employees were asked what activities had been taken to implement the MHFA initiative at the workplace with employees able to tick multiple boxes. Results showed MHFA posters (n=4), access to training (n=2), tool box sessions (n=2), a private room to meet (n=2), MHFA logo on emails (n=1) and time for staff to meet MHFA officers (n=1) and one being Unsure. Comments included:-

> *There have been no meetings or updates on any information relating to work or MHFA's since a separation of worksites;*
> *Basically, there has been no face-to-face communication from management apart from a feel good BBQ; and*
> *No of the above activities are present.*

When asked if they felt the activities mentioned above were effected some where unsure (n=6), others said Yes (n=3) whilst one said No.

Employees were asked how well they thought the MHFA initiative had been accepted by staff on a scale of 1 to 5, where 1 is Poorly to 5 being Very Well. Responses were 1 Poorly (n=3), 2 (n=2), 3 (n=1), 4 (n=1), 5 (n=0)

4.4.4 SHM Steering Group

The SHM Steering Group members were asked if they knew how the MHFA initiative was being implemented within industry. Only one member was able to reply to this question and reported that a pilot site had a launch and awareness program that seemed to have a lot of interest. In examining this further around the who, when and where of the MFHA initiative they reported the main depot had a BBQ breakfast to launch the initiative and provide information.
When asked about what combination of implementation factors might affect the outcomes or results of the initiative the response received related to advertising on lunch notice

boards, management letting staff know about the initiative and MHFA officers having some kind of identifier.

Members were asked if they knew if the initiative was modified over time and why, it was reported that adjustments to cater for COVID were required as well as fine tuning of the message over time had occurred and further evaluation of the initiative should be ongoing.

4.5 Maintenance

Maintenance relates to when was the program operational and how long are the results sustained. It examines the extent to which a program becomes institutionalised as the setting level or sustained at an individual level as well as the reasons why.

4.5.1 Leaders – Senior/Middle Managers

The two leaders both reported that the MHFA training had been maintained after its initial core period and was ongoing.

When asked if the MHFA training had been modified they mentioned that the face-to-face training course has been supplemented with a blended on-line option due to COVID19.

Neither leader reported any perceived barriers to the continued maintenance of the MHFA initiative in the workplace.

4.5.2 Mental Health First Aiders

The MHFA officers were questioned about if the MHFA initiative produced immediate effects with one offer reporting that it could do depending on the willingness of the client whilst the other was unsure.

When asked if they felt it produced lasting effects both reported that it did.

One MHFA officer reported that there was consistent and continuing support from the organisation to the MHFA officers whilst the other did not feel supported.

When asked about perceived barriers to MHFA at the workplace one officer reported there were barriers but did not elaborate, whilst the other officer reported no barriers.

Neither MHFA officer elaborated when asked about their view of what issues were enhancing the ongoing momentum of the MHFA initiative at the workplace.

4.5.3 Employees – Non MHFA trained

Employees were asked if the MHFA initiative was still being offer at the workplace. Most were unsure (n=7) with some reporting Yes (n=3).
When asked if they thought if produced immediate effects most were Unsure (n=6), with one each report Yes and No. Comments included

It should but you need the right people to be available; and
No feedback at all in writing.

When asked if they thought the MHFA initiative would produce lasting effects again most were Unsure (n=6), some said Yes (n=3) and one said No.

Employees were asked about their view on any perceived barriers to the maintenance of the MHFA initiative with most reporting they were Unsure (n=4), some reporting Yes (n=3) and some reporting No (n=3). Further comments included:-

There is no current information being relaid to staff on what's happening in the organisation;
The TWU gets too much say and input as to who gets these positions including workplace consultative members. There should be elections for any position that involves company and employees, which does not happen and the reason for lack of trust;
No communication has been provided.

The final question for the employees was in relation to their view on what issues (if any) are enhancing or helping the ongoing momentum of the MHFA initiative within the workplace. Comments included:-

Posters in the staff rooms, accessibility to contacts when help is needed no matter how small or large the problem is;
It's not evident that it's in the workplace;
More face-to-face communication;
Didn't know anything about it. Personally, I wouldn't use it but I am sure there are people who could benefit from it but it's not for me; and
The wrong people are being appointed.

4.5.4 SHM Steering Group

SHM Steering Group members were asked if the MHFA initiative was being maintained after the initial core period. The one response received indicated that it was difficult to measure as the initiative had commenced one month prior to the big COVID lockdown of 2020 which impacted further pilots being launched. They also felt that more time for further evaluation of the initiative was warranted. What was being sustained was a willingness for colleagues to support each other.

Members were unable to say if anything was being discontinued. When asked if anything had been modified they reported that they would like to think that more and more workers are coming on board to do the MHFA training.

When asked what they thought might be the perceived barriers for maintaining the MHFA initiative they mentioned time, availability, and ongoing support. In response to being asked

what issues are enhancing the ongoing momentum of the MHFA initiative they reported that mental health is being highlighted more and more and that this is having a flow on effected to the initiative.

5. Discussion

This evaluation project used the Reach, Effectiveness, Adoption, Implementation and Maintenance (RE-AIM) Framework (RE-AIM 2020). RE-AIM has been used to translate research into practice and to help improve various programs and initiatives chances of working in "real-world" settings. The framework is also used to understand the relative strengths and weaknesses of different approaches to physical and mental health promotion initiatives.

The overall goal of the RE-AIM framework is to encourage program planners, evaluators, researchers, funders, and policymakers to pay more attention to the essential program elements that can improve the sustainable adoption and implementation of effective, generalisable, evidence-based interventions to produce individual, organisational and population impact.

Participants were therefore surveyed online through a series of questions in order to evaluate the Steering Health Minds Transport Industry Mental Health Initiative being implemented within an organisation, across the five key factors of Reach, Effectiveness, Adoption, Implementation and Maintenance (RE-AIM).

5.1 Reach

In this study 'Reach' was seen as examining how is the MHFA initiative reaching the intended participants? The RE-AIM organisation (www.re-aim.org) advises that there are a number of strategies that can be used to enhance the reach of an initiative however all of the strategies are able to be summed up in two words - advertising and outreach. Of interest then was how was the initiative being advertised and if the outreach was working.

The organisational leaders reported that the MHFA initiative was seen as an employee support system similar to the Employee Assistance Program and would be used to encourage support and engagement for all employees.

Internal communications were the main way that the MHFA initiative was being rolled out within the organisation. Leaders thought that that employees were made aware of the MHFS initiative via MHFA posters; word of mouth; staff meetings and to a lesser extent via email signatures and toolbox sessions. The MHFAs agreed that internal communications were being used to spread the word about the initiative.

The employees generally agreed that internal communication was how they heard of the initial although some staff reported that they had never heard of the initiative and were unaware of it. This indicates that the not all staff are familiar with the internal support system at this stage and more may be needed to be done to get the message out across the

workforce. A range of responses on how more employees could be reached in relation to the initiative was also offered up and included having the MHFAs more easily identified through badging or other forms of identification.

The SMH Steering Group gave some reasons as to why transport organisation may or may not consider implementing the initiative and included the availability of staff for training, recognition of mental health issues and the need to recognise the cost benefits of such a program.

5.2 Effectiveness

Within the RE-AIM framework, efficacy or effectiveness is measured at the level of the individual and is reflective of the success of an intervention when implemented as per intervention guidelines under optimal conditions or in real-world situations, respectively (www.re-aim.org).

Due to the initiative being in the early inception date, most organisational members reported that it was too early to comment on the effectiveness of the initiative at this early stage. The MHFAs indicated that they felt that staff were being supported by the initiative but were somewhat unsure if all staff who would benefit from the initiative were being supported.

Organisational responses generally indicated that everyone thought the initiative was of benefit to the organisation. Whilst some staff felt the initiative was having a positive effect some were unsure about it or indicated it was not having a positive impact which would warrant further investigation into these concerns.

The MH Steering group voiced positive feedback on the effectiveness of the initiate but also reported that the update of the initiative was lower than expected. The impact of COVID on the update of the initiative is a factor which needs to be considered as the transport industry deals with the business disruption from COVID whilst considering implementing new initiatives within organisation support systems.

5.3 Adoption

Adoption can have many (nested) levels and for this study included transport organisations, management, MHFAs, and employees. Understanding how adoption of interventions varies among settings and intervention agents (or modalities) is critical to the current and potential impact of an intervention (www.re-aim.org).

The evaluation presented here was only able to study the adoption by one organisation in Queensland. The main barriers to the adoption of the initiative were reported to be the duration of the MHFA training course (12 hours) as well as the availability of the course and the work demands for staff to attend the course in order to commence the initiative.

Employees voiced concerns that staff may not engage in the initiative due to factors including personal vulnerability and embarrassment, not knowing who to contact, time to

access MHFAs when need and confidentiality. These issues will need careful consideration and addressed at the employee level if the initiative is to be adopted by the staff who are concerned about their privacy and confidentiality.

The MH Steering group generally felt that more organisations would take up the initiative in the future with further promotion of the initiative throughout the industry.

5.4 Implementation

At the setting level, implementation refers to the intervention fidelity to the various elements of an intervention's key functions or components, including consistency of delivery as intended and the time and cost of the intervention. Importantly, it also includes adaptations made to interventions and implementation strategies. Implementation also includes examining the extent to which the intervention was delivered as intended (www.re-aim.org).

Managers reported that the MHFA training was being implemented by both face to face and blended on-line training and this was delivered via an external trainer. The MHFAs reported that implementation was being achieved through the training as well as having time to meet with staff and having further mental health information available for employees. Employees reported that the implementation of the initiative initial was happening via internal communication however they indicated that they were unsure if those activities were effective and felt there was fair poor acceptance of initiative. This indicates that more work may need to be done to get the message out about the initiative and that staff may take time to accept the initiative.

In relation to the wider transport industry the SMH Steering Group acknowledged that ongoing promotion of the MHFA initiative were taking place with a view to getting more organisations to implement the MHFA initiative within their workplaces.

5.5 Maintenance

At the setting level, maintenance is about the extent to which a program or policy becomes institutionalised or part of the routine organisational practices and policies. Within the RE-AIM framework, maintenance also applies at the individual level. At the individual level, maintenance has been defined as the long-term effects of a program on outcomes after a program is completed. The specific time frame for assessment of maintenance or sustainment varies across projects (www.re-aim.org) and due to the early stages of this pilot program roll out can only examine the maintenance of initial roll out rather than long term maintenance.

Managers reported that the there had been no modifications to the initiative at this early stage other than the MHFA training had changed to a blended mode of face to face and online due to COVID.

The MHFAs had a mixed response to the ongoing support they were receiving. Employees voiced some concern over perceived barriers to the maintenance of the initiative including a

perceived lack of communication and union involvement having an impact on the level of trust around the initiative. These issues point to identified areas of improvement for ongoing success of the program and uptake of the initiative by employees.

5.6 Study Limitations

The main limitation to this study is the low participation rate with ultimately only one organisation agreeing to take part in the pilot program evaluation study. Whilst other organisations had initially appeared keen to take part, the onslaught of COVID-19 meant that many could not rationalise surveying staff during the disruption to work from COVID lockdowns and other pressures.

6. Conclusion

This pilot evaluation study is a snap shot in time for a pilot program for one organisation in the transport industry in the early days of implementing a MHFA initiative within its workplace.

Whilst being in the early days, several key factors have been highlighted. These have included the need for ongoing and widespread dissemination of information about the initiative to employees and the need to provide psychology safety for employees accessing the service.

The training of MHFAs evolved into a blended mode of a combination of both face to face and online due to COVID-19 and some adjustments to the timing and length of the delivery of training program were noted.

Management were clearly keen to support the implementation of the initiative via committing time and money to training MHFAs to support employees across the organisation. Ongoing support to ensure the maintenance and success of the initiative will now need to also be delivered with perhaps more been done to both promote the initiative throughout the organisation and support the MHFAs themselves as they encourage employees to access this support service.

Employees reported several perceived barriers to the uptake of the initiative which will need to be addressed including a lack of knowledge about the initiative, a lack of suitable time to access help and how it works to keep confidentially assured if the service is accessed. Building trust around accessing the service will be key to both its adoption and maintenance in the future.

The MHFA initiative is continuing to be promoted widely within Australia and the SMH Steering Group's continued support of the initiative within the transport industry should see further uptake and implementation in the future which will in itself allow further evaluation on a much wider scale.

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