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ORIGINAL ARTICLE

Rural health workers' perspectives and experience with an online educational program in behavioural activation: A thematic analysis

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Abstract

Cognitive behavioural therapy (CBT) is an effective treatment for depression. There are established education programmes which prepare specialist mental health workers to practice CBT. CBT is a complex treatment requiring intensive preparation and clinical skill to deliver. An alternative and simpler psychological treatment, behavioural activation (BA), may be as effective as CBT. An advantage of BA over CBT is that you do not need to be a specialist mental health worker nor require lots of training to deliver it. The relative simplicity of BA and the brief education required for workers to deliver it may increase access to psychological treatments for depression. In 2020, we developed an online educational programme in BA targeting non-specialist healthcare workers. In this paper, we wanted to understand healthcare workers' perceptions and experiences of completing a professional certificate programme which prepares them to deliver BA for people living with depression. We report the feedback from seven non-specialist mental health workers who completed the online education programme in BA. Twelve workers were invited to enrol on the programme, of which four declined. All but one of the eight participants lived and worked in rural South Australia. A thematic analysis of the interview data identified three themes: Course was simple to follow, Ease of integration into clinical practice and Ongoing support and supervision. The overall meta-theme was 'Easy to train and easy to apply'. Participants reported that the online training prepared them to practice BA and they were able to apply the skills in their clinical practice. Future work needs to examine if online training for healthcare workers in BA translates to clinical outcomes for people living with depression.

KEYWORDS
behavioural activation, depression, non-specialist mental health workers, online education programmes, qualitative study

1 | INTRODUCTION

There is good evidence that training health workers in the use of psychological therapies such as cognitive behavioural therapy (CBT) and behavioural activation (BA) prepares them to effectively treat people with depression (Ekers et al., 2014; Orgeta et al., 2017). Unlike CBT which requires lengthy training and high-level clinical skill, BA is a much simpler treatment to use when supporting people with depression (Ekers et al., 2014; Richards et al., 2016). Typically, it takes about 1–2 years of intensive education to prepare specialist mental health workers (psychotherapists/psychologists) to practice CBT (Ekers et al., 2014). Richards et al. (2016) reported an equivalence trial, in which CBT was tested against a comparable dose of BA in 221 people with moderate to severe depression. Both treatments were shown to be as equally effective. The trial reported that workers received 5 days of training in BA (Richards et al., 2016). We are speculating that BA may be a solution to improve access to psychological treatments for depression in communities which struggle to recruit and retain specialist mental health workers. We were wondering, if BA is just as effective as CBT for depression, could training programmes in BA be transferred to an online platform to increase their reach and scope? Jones et al. (2021) proposed that preparing non-specialist mental health workers to practice BA could increase access to psychological treatments for depression in communities which cannot access specialist mental health workers (Jones et al., 2021). In 2020, we developed an online programme aimed at developing the capacities of non-specialist mental health workers to practice BA competently and acquire a clinical qualification in the third-wave behaviour therapy.

To the best of our knowledge, there has been no evaluation of online training programmes aimed at preparing non-specialist mental health workers to practice BA. Interviewing people who have completed such training could help us better understand as to how these could be further developed and refined.

1.1 | Aim

Understand healthcare workers' perceptions and experiences of completing an online programme and use the feedback to develop a professional certificate programme which prepares them to deliver BA for people living with depression.

1.2 | Intervention

1.2.1 | Online professional certificate in BA

The Online Professional Certificate in BA is offered by the University of South Australia. The education programme was developed using principles of adult education (Chinnasamy, 2013; Merriam, 2001) and a flipped-classroom approach for self-directed learning (Ceylaner & Karakus, 2018; Liu et al., 2018; Tawfik & Lilly, 2015). The Professional Certificate in BA comprises five modules designed to equip participants with the skills to practice BA. The core elements of the training included (a) Building therapeutic relationships (b) BA assessment (c) Mood monitoring and (d) Activity scheduling (Table 1).

What is known about this topic?

- Mental health outcomes in communities which experience challenges in accessing mental health services are usually poorer as evidenced by the higher rates of suicide in these settings.
- CBT and BA are both recognised as effective psychological treatments for depression although the latter is relatively more cost-effective, does not require lengthy education programmes and can be delivered by non-specialist mental health workers.
- Educating healthcare workers to deliver BA via an online education may increase the availability of evidence-based psychological treatment for depression.

What this paper adds?

- Online training programmes may be an acceptable method to prepare healthcare workers to deliver BA.
- Participants told us they were able to practice BA after completing the online training.
- Participants reported that BA was easy to integrate into their clinical practice after completing the online training.

The development of the BA training incorporated the core components of BA described by Martell et al. (2010), namely mood monitoring and activity scheduling. In addition, again informed by the work done by the same authors, there was a focus on the role of rumination and avoidance behaviours in maintaining depression (Martell et al., 2010). To deliver this training, the course team clinically modelled the full application of BA such as Conducting or structuring a Session, Conducting a Behavioural Activation Assessment, Mood Monitoring and Activity Scheduling via online videos. Each online video lasted approximately 3–5 min and was carefully edited before it was posted online. The videos were not live to maximise the experience and also due to the original intention to make this an online programme. The clinical modelling was supplemented by the course team recording several expert discussion forums such as prevalence, causes, course and outcome of depression. Online presentations were posted online describing the strength of the evidence underpinning BA and its potential application for other conditions.

Student engagement was facilitated by inviting students to post questions to the course team which were answered through weekly podcasts. Each podcast covered a specific aspect of BA, for example developing the skills to monitor your mental health. Additional podcasts were provided to address student requests, for example we provided podcasts on living in a pandemic and the role of BA to

TABLE 1 BA course content

Session	Module	Training content
I	Introduction to BA	• Presentation, Course, Outcome and Treatments for people with depression • The role of the environment in causing or maintaining or lifting depression • Core skills to establish a therapeutic relationship • The depression trap • How activity can be used to overcome the depression trap • The role of BA in helping people to monitor mood and schedule activity • The role of the PHQ2 in screening people for depression
II	BA Assessment	• Active ingredients of BA, namely mood monitoring and activity scheduling • The purpose of the BA for Depression Scale in assessing activation, avoidance, rumination and social impairment • The purpose of a PHQ2 assessment in assessing mood
III	Mood monitoring	• Describe the role of a mood diary in helping both the worker and the person notice fluctuations in mood • Understand how a mood diary can help the worker and the person notice fluctuations between mood and activity
IV	Activity scheduling	• Describe the therapeutic value of an activity schedule namely, an activity that introduces behaviours that are categorised as routine, essential and enhance mastery • Practice introducing the concept of an activity schedule with a colleague • Acquire an understanding of the environmental triggers that may impact behaviours/activities which lower or lift mood namely TRAP or TRAC. • Understand how supporting the person to engage in activity underpinned by values may sustain a mood.
V & VI	Competency assessment	In this final module participants upload videos demonstrating the competencies to deliver BA via three conversations encapsulating: • Ten steps to structure a session • Completing a BA Assessment and a PHQ2 Assessment • Reviewing a mood diary • Exploring the link between fluctuation in mood and activities • Developing an Activity Schedule • Exploring activities that both lift and lower mood • Using TRAP and TRAC to identify alternative coping behaviours which have a mood-lifting effect

Abbreviations: BA, behavioural activation; PHQ2, patient health questionnaire 2-iteam; TRAC, trigger, response, action, coping; TRAP, triggers, response, action, pattern.

manage your mood. All participants were provided with a printable online BA workbook and recommended reading list.

We undertook a layered approach to assessing competency. Participants had to pass a multiple-choice questionnaire (MCQ) relevant to each module. The assessment in each module was based on a weighting of 80%. Participants could attempt another (different) MCQ if they did not meet the threshold. They were unable to progress to the next module until the 80% threshold was obtained. All modules need to be successfully completed, sequentially, in order to progress to the competency assessment. For this final assessment, participants were required to submit three taped conversations of a maximum of 30 min duration. The conversations were scaffolded to incrementally introduce a key component of BA: Structuring a Session, BA Assessment and Mood Monitoring and Activity Scheduling. That is if tape one was Structuring a Session, tape two was BA Assessment and Mood Monitoring and the final tape was all three elements. The taped conversations comprised the Observed Structured Clinical Examination component of the course. Two assessors reviewed the tapes to determine competency. Within each of the components, several tasks were marked on a scale of 'fully

achieved', 'partially achieved' or 'not achieved'. Participants needed to achieve 70% on each component to be deemed competent in that area and needed to demonstrate competency on all components to be considered competent in BA. Participants were able to submit new conversations if they did not achieve competency. The course ran for 157 hours over 12 weeks to align with the University study periods.

1.2.2 | Initial pilot

For the initial pilot, participants had to complete all MCQs, however they were not required to submit tapes. Two participants chose to submit tapes. In this pilot of the online BA programme, we were concerned with the experience and feedback from participants enrolled in the course, rather than the overall performance through the programme. The intention is to use this feedback for the next iteration of the programme, which will incorporate determinations of competency. Future work will consider whether competency influences participant feedback.

2 | METHODS

2.1 | Data collection

The study used a qualitative approach, with semi-structured interviews as the primary method for data collection. We perceived that the semi-structured interviews would allow for open-ended responses from participants and enable us to access in-depth, rich data and introduce follow-up questions, as necessary. Of the 12 participants that initially agreed to trial the course, eight registered to complete the programme, four did not enrol. Reasons for non-enrolment included retirement, acquiring a new position and that online training was too complex. Only participants that completed the training were eligible to participate in the study. We sent a text message to the eight participants that completed the training inviting them to contribute to this study. The text message requested addressees to respond YES if they were willing to participate. Participants who responded positively were sent a Participant Information Sheet explaining the purpose and nature of the study. A Consent form and Interview topic guide were included as part of the study package (DeJonckheere & Vaughn, 2019). Martin Jones, Richard Gray, Shaun Dennis, Nayana Parange, Lee Martinez, Kate Gunn and Kuda Muyambi designed and pilot tested the interview protocol (Kallio et al., 2016). The interview protocol comprised three domains: course quality, implementation and sustainability and demographic information. We wanted to understand what participants felt about the modules delivered and how they might be improved. We also wanted to understand how the participants translated the knowledge in their health practice, the challenges being experienced and any additional support required to apply BA in a workplace setting. The demographic section of the interview protocol collected general information including gender, educational attainments and employment details.

One invitee declined to participate in the interview. We asked this participant for the reasons they chose not to be interviewed. We were advised it was because they perceived that they did not have much to contribute. Seven interviews (88% of the eligible participants) were conducted; six via telephone and one through Zoom, a cloud-based videoconferencing service (Zoom Video Communications Inc., 2016). Interviews lasted approximately 40 min and were audio-recorded to ensure information shared by the interviewees was accurately captured (DeJonckheere & Vaughn, 2019). Kuda Muyambi conducted all of the interviews. There were no repeat interviews. All audio recordings were transcribed verbatim by an independent transcribing service that is contracted to the University of South Australia (DeJonckheere & Vaughn, 2019). Transcripts were sent to interviewees asking if they would like to provide further information. No participants provided further information.

Ethical approval was provided by the Human Research Ethics Committee at the University of South Australia (Application ID: 202673).

2.2 | Data analysis

We used thematic analysis to help us make sense of the de-identified audio-recorded data from the interviews (Braun et al., 2019; Clarke & Braun, 2014). Following the approach developed by Braun et al. (2019), Kuda Muyambi engaged with the data, performed manual coding to identify patterns, make interpretations of the identified patterns and developed initial themes. The derivation of themes was inductive (Vaismoradi et al., 2013). Martin Jones and Kuda Muyambi discussed the preliminary coding and salient themes and consensus was reached about the key findings. In this study, we did not use multiple coders, Kuda Muyambi solely performed this task. We acknowledge not using multiple coders was a limitation in our study. Four provisional themes were agreed upon. Martin Jones presented the draft themes to two participants. The themes were shared with the wider team, and following discussion, the four themes were reduced to three. Martin Jones communicated the reduction of the themes from four to three and their rationale to the same two participants. We have described our findings using the language of the participants with minimal inference interpretation (Neergaard et al., 2009).

2.3 | Reflexivity

Martin Jones, Richard Gray, Shaun Dennis, Lee Martinez, Kate Gunn and Nayana Parange have mental health clinical academic backgrounds and are interested in increasing access to health services for people who live in rural communities. All believe BA may offer an opportunity to increase access to mental health services in communities that experience significant disadvantages in accessing services. Martin Jones, Richard Gray, Shaun Dennis, Nayana Parange, Kate Gunn and Lee Martinez developed the teaching resources. Martin Jones, Richard Gray, Shaun Dennis and Lee Martinez delivered the

course. To ensure that the data collection and analysis were objective, an author (Kuda Muyambi) not involved in programme development or delivery was responsible for collecting and analysing data. Kuda Muyambi was the lead in the preparation of the manuscript. Kuda Muyambi has expertise in health programme and service evaluation and does not have a clinical or mental health background. This was done to minimise potential bias and/or conflict of interest. None of the other authors could exert control or influence during data collection and analysis. The preliminary themes were discussed with Martin Jones and Sandra Walsh, however, they could not exert control beyond the data. Furthermore, the influence other authors could exert during manuscript writing did not extend to the interpretation of the themes. Kuda Muyambi's background in evaluation ensured a level of objectivity in this process.

3 | STUDY FINDINGS

We followed the COREQ guidelines for reporting the results of qualitative studies (Tong et al., 2007).

3.1 | Characteristics of sample

We interviewed one General Practitioner, three Allied Health professionals, two Academics and one Aboriginal Project Worker, all from rural South Australia. Two of the participants were females and five were male. The mean age was 41 with a range of 23–63 years. The educational qualifications included Ph.D., Medicine, Occupational Therapy, Aboriginal Health, Mental Health, Programme Evaluation and Psychology. Participants worked in primary and secondary healthcare settings, and the academic sector.

3.2 | Key themes

The overarching theme was:

3.2.1 | Easy to train and easy to apply

The key themes include (a) Course was simple to follow (b) Ease of integration into clinical practice and (c) Ongoing support and supervision. Ten sub-themes were identified across the three key themes (Table 2).

TABLE 2 Key themes and sub-themes

Key themes	Sub-themes
Key theme 1: Course was simple to follow	• Use of a cascading structure • Use of blended delivery modalities • Flexible and easy to understand • Ease of navigation

Key theme 2: Ease of integration into clinical practice	• Confidence in applying BA in a clinical setting
	• Transferability across different healthcare settings:
	  ○ Acute and community health settings
	  ○ Transferability in cross-cultural settings

Key theme 3: Ongoing support and supervision	• Having access to printable resources • Encourage student interaction during the course • Ongoing supervision during the course • Community of practice

3.3 | Theme 1: Course was simple to follow

3.3.1 | Use of a scaffolded structure

Participants commented on the scaffolded structure of the modules. They reported the sequencing of the modules made the course easy to follow, providing a balance between theory and skill development.

> I liked the way all of the modules are structured because they flowed into each other nicely.
> (Participant 4, Allied Health professional, Female)

> I think they kind of set things out well in terms of balancing the content with regards to the how-to of doing … behavioural activation. They gave us a lot of rich content about that but then also focused on the skills that are kind of hard to teach … things like our communication style, the importance of trust and having that open relationship with clients.
> (Participant 4, Allied Health professional, Female)

> I thought the course overall was very useful. It was a scaffolded kind of approach, so the first module introduced you to BA, and then you were stepped through how to do BA with a client. So, I found all of the modules useful … it broke up the reading.
> (Participant 6, Academic, Female)

3.4 | Use of blended delivery modalities

Participants consistently commented upon the course using a blended approach encompassing lectures and modelling the application of BA. They reported that they found the blended mode of course delivery engaging.

> …the behavioural activation course is set up in a beautiful way that kind of had … lecture-style type things

because it was necessary to actually give people that information. '...but then it also had some reading stuff that had graphics, ... like Venn diagrams and other little flow charts ... that illustrated the points that were discussed in the lecture.

(Participant 4, Allied Health professional, Female)

I think the videos ... where they were roleplaying ... seeing how it applies in the real world or a roleplay was probably the most useful thing that helped my learning throughout all of the modules.

(Participant 6, Academic, Female)

...there was a mixture of short videos, some longer videos, some reading that needed to be done. So that combination of different activities was quite engaging.

(Participant 2, Academic, Male)

3.5 | Flexible and easy to understand

Participants reported that the course was relevant to their learning and the course was simple and easy to follow.

I think all of the modules were easy to run through and quite self-explanatory. I didn't have much trouble with them at all, to be honest.

(Participant 3, General Practitioner, Male)

I think the language used was great because it was easy to understand for someone new to the topic.

(Participant 1, Allied Health professional, Male)

...a tool that is pretty darn cheap because it's free ... you don't have to buy expensive tests or anything and it's easy to implement, it is a low resource programme that you can use with clients and I think regardless of what field you're in ... I think that it's quite a good universal tool.

(Participant 6, Academic, Female)

3.6 | Ease of navigation

Participants reported finding navigation through the web pages and the modules user-friendly. The aesthetics were engaging.

It was really beautiful looking, really easy to navigate. I think it was a good balance between words and images...

(Participant 4, Allied Health professional, Female)

I think for someone who hasn't studied online or done this type of learning, they'd be able to log in and work through that without having any issues.

(Participant 5, Aboriginal Project Worker, Male)

However, one participant noted that having a clear overview of the entire programme could improve navigation.

It might be useful to have at the start of the course, how to navigate this website or ... how the website works and what you should be doing ... so it's about making the learner feel comfortable with the platform. Take me on that journey ... I started here, how am I going to end up at the end, what are we going to do in between, what should I be looking for, what should I be thinking about? So, it primes the learner as they're working through it...

(Participant 6, Academic, Female)

3.7 | Theme 2: Ease of integration into clinical practice

3.7.1 | Confidence in applying BA in a clinical setting

Participants reported that the course provided them with confidence, knowledge and skills in applying the BA skills in the clinical setting. They reported the importance of practicing BA to increase their confidence to use it in practice. Four participants reported an immediate impact of the training reporting using BA with people in their care. Two participants commented that BA could be adapted to suit the individual circumstances of people in their care.

I think it was helpful because it's something that I can use in my practice. And I can use it right away.

(Participant 1, Allied Health professional, Male)

...it just has opened more options for me to work with my clients ... I don't have to refer the client to another programme or another agency if they present with complex needs or multiple needs, including depression. Now I know I can do a bit more of that work myself ... then there is one referral less for the client.

(Participant 1, Allied Health professional, Male)

I used it recently with people who are struggling with mild depression ... who need something they can take away. So, doing a diary, talking about positive things ... gives them something to focus on ... so that they come back and see me again ... having done some homework. And people find it easy to do. I only have

to tell them once how to do it. They seem to pick it up really quickly.

(Participant 3, General Practitioner, Male)

3.8 | Transferability across different healthcare settings

Some participants reported using BA across both acute and community health settings. One participant reported that BA was like an 'additional tool for my toolbox'. The participant talked about how they could choose tools to apply in other environments such as working with children. In these instances, the adaptations of BA skills relating to Structuring a session or Activity scheduling were said to help assist changes when working with families. The tools were said to help provide a structure to guide conversations with the whole family.

I think implementing the whole thing in a community setting would be a lot easier than in an acute setting … it's probably not as easy to do the whole thing, because people are there for two weeks. You can in that 2 weeks do things like activity scheduling … but because it's in the acute settings in the hospital, it's not as applicable.

(Participant 7, Allied Health professional, Male)

Well, I've definitely used it. So, things like mood monitoring and activity scheduling, I've used several times with people … in an acute setting for an in-patient unit and … in a community setting. And I've used things like activity scheduling and mood monitoring a fair bit across those two settings.

(Participant 7, Allied Health professional, Male)

…structuring or building rapport and structuring a good session is something that transferred into my current work (children with developmental challenges).

(Participant 4, Allied Health professional, Female)

One participant reported that BA may be transferable in cross-cultural settings including Aboriginal mental health and social and emotional well-being.

…I think this would also be really valuable to Aboriginal staff for Aboriginal clients… it wouldn't require any adaptions to it… would be culturally safe and appropriate…

(Participant 5, Aboriginal Project Worker, Male)

3.9 | Theme 3: Ongoing support and supervision

3.9.1 | Having access to printable resources

Participants indicated their preference for accessing printable resources including training modules. The participants asked for training modules that were available in a printable format that could be bound into a single reference manual. In this way, participants felt they would not need to continually log onto the webpage each time they wanted to refresh their memories about aspects of the training.

Making it printable chapters… so that it creates a book. Not everybody likes to learn on the computer…

(Participant 6, Academic, Female)

I think some resources online would be a really good thing… information sheets and probably even a podcast for patients to listen to as well, about BA.

(Participant 3, General Practitioner, Male)

3.10 | Encourage student interaction during the course

Participants indicated that distance, online learning can be socially isolating. The participants felt that having access to a discussion forum or some team activity on Zoom would help promote social interaction and enable peer learning.

I was fortunate enough to be able to go speak to (Course coordinators) if I had a question, but if I didn't have them and I didn't know anyone else who was doing the course, there was no one I could just bounce ideas or questions off.

(Participant 5, Aboriginal Project Worker, Male)

… opportunities of how to get your students to interact online in … a real-time conversation online… because you do feel quite isolated as an online learner… So, get people to be interactive together, whether that's some kind of peer learning… If it can be done, that would enhance what's already there now.

(Participant 6, Academic, Female)

… so, I think if there was ever an opportunity to do a group Zoom or a group face-to-face thing… I think would have enhanced some of the relationships I could have developed with my co-students… just so everyone can see each other.

(Participant 4, Allied Health professional, Female)

3.11 | Ongoing supervision during the course

Some participants suggested having the course supervisors observe some of the assessments. They felt this would provide an opportunity for the supervisors to provide instant feedback.

> … doing a little video conference, a Zoom meeting, just a bit of a catch-up, "How are you going? What was meaningful for you in that? Have you been able to practice something or do you think that that would work with your clients?" have that kind of conversation…
>
> (Participant 6, Academic, Female)

> … having a tutor that would come and attend a couple of sessions… would be beneficial, you know, just to make sure that things are being done exactly how they should… and to provide some feedback as well on the practice. I suppose it can be done online too … using Zoom or Skype or one of the video supports… if the client was okay with that.
>
> (Participant 1, Allied Health professional, Male)

3.12 | Community of practice

Some participants suggested the establishment of a BA community of practice. The community of practice would create a platform for ongoing peer learning and information sharing among the alumni.

> … if there's a post-Moodle group kind of thing. I think it… probably would help build people's confidence knowing that there is a bit of a safety net because they're engaging in something different.
>
> (Participant 6, Academic, Female)

> … having somewhere, a safe format, to discuss the successes… some of the more difficult aspects of it, I think will be helpful. Not just necessarily with an expert practitioner, but perhaps with peers that are using it, so that you can share experiences and successes and difficulties.
>
> (Participant 2, Academic, Male)

> … there might also be an option there that if you were practicing it within a couple of months following your participation in the course, just having some support available - almost like alumni of the course… to discuss an issue but also build up that community of practice.
>
> (Participant 6, Academic, Female)

4 | DISCUSSION

We aimed to understand participants' experiences and any changes in knowledge, skills and clinical practice as a result of completing an online programme. All the participants we interviewed reported that the training was helpful. They reported an increase in their knowledge about BA and reported using BA in their clinical practice.

4.1 | Transferability to other settings

Participants commented that they felt the knowledge and skills obtained through the course were transferable across different health settings, especially in acute and community healthcare. This suggests that it may be worthwhile to expand and replicate the BA training programme in other areas to reach more health workers and broaden its impact. The finding is similar to others from a previous study in rural Australia which used traditional training approaches to educate non-specialist mental workers to recognise and treat depression (Muyambi et al., 2021). Muyambi et al. (2021) used a repeated measures design to assess the effectiveness of a training workshop on depression recognition and management. Seventy-two primary health workers in rural South Australia completed the training. The same authors reported improvements in workers' confidence and optimism in working with people with depression (Muyambi et al., 2021). We are speculating that this online education programme in BA for non-specialist mental health workers may increase access to psychological treatments for depression in people in under-served rural and regional communities.

4.2 | Enhancing the quality of the learning experience

One of the invited participants chose not to participate citing the complexity of studying in an online environment. We also received feedback on how we could enhance the online learning experience. This suggests we need to consider the needs of some workers to help them engage more fully in online learning. The course experience could be enhanced with Zoom face-to-face group sessions to build relationships across the participants, provide clinical supervision and provide an opportunity for the participants to ask questions to the course team. The point was also made regarding the participants' readiness for online learning with comments being made that not all participants enjoy reading from the computer screen. In this regard, a suggestion was made to have the modules and other online resources formatted to permit printing. The finding suggests the importance of preparing students for online learning (Widodo et al., 2020).

4.3 | Building a community of practice for BA practitioners

Transferring and sustaining new clinical skills into routine service delivery is challenging. Participants talked about several different structures to sustain the application of BA in their communities. The establishment of a community of practice for graduates could encourage ongoing peer learning, mentoring and continuing professional development post-training. A virtual community of practice might help connect health workers in geographically isolated rural areas and promote a sense of friendship and belonging to group membership (Herrington et al., 2006; Rees & Shaw, 2014). This would be important as it would encourage participants to apply and embed new learnings and approaches in a supported way, overcoming the familiar scenario of completing training without practice benefit. Given the paucity of the specialist mental health workforce in rural Australia (Australian Psychology Society, 2019; Commonwealth of Australia, 2020), building a community of practice around a non-specialist mental health workforce may be a sustainable option. This may improve access to support for people with mental health concerns and overcome the uneven distribution of mental health workers in Australia.

4.4 | Strengths and limitations

We chose to interview participants to gain a deep understanding of their experience of completing the course and how they have used BA in their practice. We interviewed seven of the eight participants who completed the course. The findings represent the views of the majority of participants who completed the course, however, they may not be generalisable to future participants. Therefore, further evaluation is required. Although the training was helpful and insightful for the participants, we cannot make any conclusions as to the transferability of these findings. We did not involve people with a lived experience of depression in the design of the study; thus, an important insight was lost. The competency of the participants to use BA was not assessed in this group of participants. So, we cannot make a judgement as to their competency in BA, apart from the two participants who chose to submit the three tapes. We did not investigate the effects of the online training programme on patient outcomes and this is an area in which further research is required. A strength of our approach to minimise the risk of bias in the analysis of the data, an academic not involved in the design or delivery of the programme conducted the interviews, coding and thematic analysis.

5 | CONCLUSION

This study has shown that it may be feasible to prepare workers to practice BA via an online training programme. However, more iterations of the programme, with more participants, need to be delivered to provide assurance that this is an effective way to prepare health workers to practice BA. It will also be important to consider whether participation in the programme translates to clinical outcomes for patients/clients. Building a community of practice may support participants to incorporate BA skills into their work practice. An online BA programme may be of relevance for communities that experience barriers in accessing psychological treatments for depression.

AUTHORS' CONTRIBUTIONS

Martin Jones, Shaun Dennis, Richard Gray, Lee Martinez and Kate Gunn conceived the study, delivered the online training and critically reviewed earlier versions of this paper. Nayana Parange and Kat Kenyon were responsible for managing the web material and adding important intellectual content to draft versions of this paper. Kuda Muyambi collected and analysed all data before preparing draft versions of this paper. All authors read and approved the final manuscript.

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CONFLICT OF INTEREST

Martin Jones/Shaun Dennis/Nayana Parange/Kate Gunn/Lee Martinez designed the course which students pay the University of South Australia a course fee to complete. The academic team do not receive any additional payment from these fees in addition to their salary.

DATA AVAILABILITY STATEMENT

The authors declare that data supporting the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

This study was authorised by the University of South Australia Human Research Ethics Committee, ethics protocol number 202673. All identifiers were removed from the transcripts to ensure the confidentiality and anonymity of the process.

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