Seeking help for mental health issues in rural South Australia: A mixed methods approach.

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Thesis submitted in fulfilment of the requirements

for the Degree of Doctor of Philosophy

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December 10

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Declaration

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Collins, J. E., Winefield, H., Ward, L., & Turnbull, D. (2009). Understanding helpseeking for mental health in rural South Australia: thematic analytical study. *Australian Journal of Primary Health, 15*, 159-165.

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Acknowledgements

There are many people I wish to thank for their help in getting me through this long journey.

First, I would like to thank all my supervisors for their support over the last four years. Special thanks to Deb for all her help and support particularly in the final stages of the write up. Also, special thanks to Lynn Ward who has believed in me and my ability to become a researcher since supervising me in my honours year in 2004. Your encouragement and faith in me has meant more than I can possibly say.

To my office mates Phillip J and Amy who have been on this journey with me from the beginning. Phillip J, thank you for the many encouraging words over the four years, our chats about life and research were always extremely helpful to me. Amy, what a pleasure it has been to share the office with you (just the two of us most of the time too), your encouraging words and just your company in the office have meant a lot to me throughout this journey. Also to Skye for keeping me company in the basement on many a Sunday.

Katie, Ang, Chrisi and Vic, I'm not sure how I will ever thank you for your support through this journey. You four special people have shared with me fun, laughter, encouragement and the occasional bottle of wine when required (!) I feel lucky to have had such a wonderful support crew around me.

All the admin staff especially Jess, Lynda, and Wanda for their support with my many IT and admin questions, and sometimes just a friendly face or encouraging word, all of which have helped to make the journey that little bit easier.

Thank you to Ian Zajac for his help with my many statistical questions, I am forever grateful for your patience and assistance.

Thanks also to the many other people I call friends who also reside in the bowels of the Hughes building, Stuart, Fiona, Ryan, Anthony, Suzie, Brooke, Kathy, Jordan and Victoria, who have all provided moral support, a friendly face, or a lunch date and all of whom have helped to make the PhD experience not only bearable but on many, many occasions, fun!

Also, thanks to Denis, you came into this journey near the end (perhaps the craziest time), but your constant encouragement to keep persevering and to finish this PhD has meant more than you will ever know.

Finally, I would like to thank my wonderful family, Mum, Dad and Emma, who have put up with me unconditionally throughout this roller coaster PhD adventure. You have all been there for me on the good days and the bad, congratulated me on every achievement and encouraged me to keep going on those days when I thought I might never get there (and there have been a few of those!). There are not enough words to describe my thanks.

Abstract

The aim of this thesis was to investigate access to and utilisation of mental health care services in rural areas. Given the drought in Australia and the unique stressors it brings to people living in country areas this research is timely. Specifically, the research aimed to explore how the individual, psycho-social and cultural aspects of rural people and rural locations interact with or influence help seeking behaviours, and more specifically, how aspects of the culture where people live may impact on or impede their seeking help for mental health issues. The aims were addressed using a mixed methodological approach with three separate but related studies: one quantitative and two qualitative. Bradley"s (2002) adaptation of the Andersen behavioural model provided the theoretical model that drove the research questions and its utility in this context was tested.

Study one used sixteen semi structured interviews to address the aims of the study. Participants were recruited via general practice surgeries and via snowballing techniques. Data was analysed using prior-research driven (Boyatzis, 1998) thematic analysis techniques following Braun and Clarke (2006). The second study was a population survey using a representative sample derived from one rural South Australian electorate (N=259). Study three used qualitative data also collected via the population survey. Respondents were asked to comment further on mental health and mental health services in their area, this question was open-ended and respondents could answer in their own words. Ninety nine of the survey respondents (38%) made a written comment, these data were analysed using thematic analysis techniques.

Results of study one revealed that psycho social factors such as stigma were the most important barriers to seeking help. Seven main themes were found: stigma, self-reliance, lack of services, awareness, lack of psychological mindedness, General

Practitioners (GPs) and need for change. Some evidence of psychological mindedness was found but this was not confirmed in study two or three. Indeed study two revealed a negative relationship between psychological mindedness and attitudes towards seeking professional help. Attitudes towards seeking help were the most important factor in help seeking intentions and actual help seeking behaviours. Intentions were predicted by being female and having more positive attitudes towards help seeking. Poor mental health and more positive attitudes were associated with having ever sought help for a mental health issue and those respondents with more positive mental health and more positive attitudes towards seeking help were less likely to have ever wanted or needed to seek help and not done so. More positive attitudes were predicted by being older, perceiving less stigma and having lower psychological mindedness. Study three had some similar themes to study one, awareness of services, stigma, and non-professional care. Other themes to emerge were locality issues and systemic disgruntlement.

The results of this thesis have shown that attitudes towards help seeking and systemic disgruntlement are the most important and salient issues to rural help seeking behaviour. Stigma is still an important influence on help seeking and psychological mindedness should be further investigated to confirm its impact on help seeking behaviour. The lack of (adequate) services available, as reported by rural people themselves, inevitably contributes to the existing unmet need and has important implications for government policy and service delivery.

Chapter 1- Introduction and Methodological Rationale

1.1 Introduction

This chapter will provide the background for the in-depth review of the literature that will follow in chapter two. It will give a general overview of the literature in the area, provide the rationale for the methodology and an outline of the thesis format.

The current research program aimed to investigate help seeking for mental health issues in rural South Australia, which is timely given the current drought that has affected these areas for many years now, causing a plethora of unique stressors for those affected. More specifically, research has shown that rural people receive fewer specialist mental health services than their urban counter parts (Judd et al., 2006c). It is this phenomenon that the current research is interested in investigating: specifically, what are the barriers that rural people experience in seeking help for mental health issues? This thesis has a two phase mixed methods design to address the issues and includes two qualitative studies and one large scale quantitative study.

1.2 Background

Mental health is the foundation for the well-being and effective functioning of individuals. More than the absence of a mental disorder, mental health is the ability to think and learn, and the ability to understand and live with one's emotions and the reactions of others. It is a state of balance within a person and between a person and the environment. Physical, psychological, social, cultural, spiritual and other interrelated factors participate in producing this balance (World Health Organization, 2006).

The World Health Organisation (WHO) has identified mental health as a global priority. The Regional Strategy for Mental Health, endorsed by the 52nd Regional Committee Meeting, has set three basic goals:

1. To reduce the human, social and economic burden produced by mental and neurological disorders including intellectual disability and substance abuse and dependence;

2. To promote mental health; and

3. To give appropriate attention to psychosocial aspects of health care and the improvement of quality of life (World Health Organization, 2006).

In accordance with the goals of the World Health Organisation, in particular, reducing the burden of mental health disorders and giving appropriate attention to the psychosocial aspects of health care, the main aim of this thesis is to investigate help seeking for mental health issues by rural people.

Access to mental health services has long been documented as a significant problem, particularly in rural areas. Over the last ten years numerous studies have investigated prevalence rates of mental health issues in rural areas, with mixed results. According to the 2008 report disseminated by the Australian Institute of Health and Wellbeing entitled "Australia"s Health", people living in rural and remote areas generally have poorer health than their metropolitan counterparts reflected in more health risk factors and higher levels of disease and mortality (Australian Institute of Health and Welfare, 2008). In terms of mental health, males in rural areas are the worst off with middle aged men 1.4 times more likely to report depression than males the same age in metropolitan areas and males in outer regional and remote areas 1.2 times more likely to report high to very high levels of psychological distress (Australian Institute of Health and Welfare, 2008). Consistent with this other studies have found supportive evidence of this conclusion, for example Kilkkinen et al. (2007) found that one third of the rural Australian population surveyed reported psychological distress, with the highest prevalence in middle

aged men and women. Similarly, a study conducted in Western Australia found nearly one quarter of people surveyed reported mild to severe depressive symptoms (Day, Kane, & Roberts, 2000). Other recent studies have found that rural residents access general practitioners less frequently than metropolitan residents (Caldwell et al., 2004a), and that suicide rates are higher in rural and remote regions than in metropolitan areas (Caldwell, Jorm, & Dear, 2004b).

However, there have also been studies that argue the prevalence of mental illness is not in fact higher in rural and remote areas. Goldney, Taylor and Bain (2007) for example, found that prevalence of depression was not higher in rural areas when compared to metropolitan residents in a population survey. Whilst there have been mixed prevalence results, it has also been suggested that simply residing in a rural location will considerably "influence people"s behaviour with respect to how they address their needs for health care services" (Judd et al., 2002a, p. 112). For the purposes of the current research study, this is an important consideration, particularly because rural people access services for mental health notably less often than their urban counterparts (Caldwell et al., 2004a; Komiti, Judd, & Jackson, 2006).

Recent research suggests that the most significant barriers to seeking help are not nearly as frequently based on issues of proximity to facilities as previously thought. In fact many of the barriers are said to be related to the social and cultural environment found in rural areas (Judd et al., 2002b). This includes the psychosocial factors involved, such as the general attitude people in rural areas have towards mental illness and mental health services, stigma and issues of confidentiality (or lack thereof), and the self-reliant culture said to exist in rural culture. This research program aims to investigate the potential factors underlying the rural reluctance to seek help for mental health issues (Helflinger & Christens, 2006), and the factors that are central in predicting help seeking behaviours. In

addition the nature of rural mental health systems as perceived by rural people themselves will be investigated to help achieve this aim.

1.3 Mental health help seeking

The definition of help seeking used in this thesis refers to the search for professional help (Gourash, 1978), although it can also refer to seeking help from non-professional people (Rickwood, Deane, Wilson, & Ciarrochi, 2005). In rural communities help seeking for mental health is most often from a local general practitioner (Aoun, Underwood, & Rouse, 1997), although seeking help from friends and neighbours is also not uncommon. It is very common for residents in rural towns to be very familiar with each other. This can function as either a positive, such that the local shop owner or hairdresser is almost used in a counselling role, or a negative, such that residents might be reluctant to seek help from any source, including professionals for fear that they might be ridiculed or treated differently if people in their community know they are suffering from a mental health issue (Wrigley, Jackson, Judd, & Komiti, 2005).

Previous research in the area of help seeking for mental health in rural areas has been predominantly quantitative particularly those studies using a theoretical framework in which to explain the findings. For example, two Australian studies investigated attitudes and stoicism (Judd et al., 2006c; Parslow & Jorm, 2001) and used the Australian National Survey of Health and Wellbeing to investigate unmet need by consumers of mental health services. More of this literature will be critically reviewed in chapter two. The small numbers of qualitative studies that have been done in this area, have predominantly engaged service providers (Beel, Gringart, & Edwards, 2008; Sweeney & Kisely, 2003) rather than service users, and have not incorporated any theoretical framework to help explain the findings. Therefore, there is a real need to engage this population in the

research questions and give them a voice on the topic, rather than having the issues defined for them by those interested in measuring them (i.e. the researchers).

Help seeking for mental health issues, particularly in rural areas, is dependent on several factors. Traditionally, help seeking was thought to be solely dependent on whether there was a service within the help seeker"s local vicinity. However as previously noted, more recent research has suggested that in rural areas there are more factors contributing to whether help for mental health issues are sought than just where the service is physically located, including cultural and community factors as well as individual factors. The paucity of research investigating these factors is one of the gaps that this research program intends to fill.

1.4 Theoretical perspective

There are a number of theoretical perspectives from which this research could be approached, and many models of health behaviour that could be applied. This section will outline some of these as well as briefly introducing the model that was used in this research program and why it was chosen in favour of others.

One model that is commonly used in health research, that has been applied to mental health help seeking research (i.e. Bayer & Peay, 1997; Westerhof, Maessen, de Bruijn, & Smets, 2008) is, what was formally known as The Theory of Reasoned Action; now known as the Theory of Planned Behaviour (Ajzen, 1991). Essentially, the Theory of Planned Behaviour is a motivational model of health behaviour (Armitage & Conner, 2000). It postulates that behavioural intention indicates how motivated a person is to engage in a certain behaviour, and that intention to engage in a (health) behaviour is the "proximal determinant of volitional behaviour" (Conner & Sparks, 1996, p. 122).There are three factors that determine the strength of the behavioural intention: first, attitude, which refers to the person"s evaluation of the favourability of the planned behaviour; second, the

subjective norm which describes the perceived social pressure to carry out the behaviour or not to carry out the behaviour, and third; perceived behavioural control which refers to the perceived level of difficulty in performing the behaviour (Westerhof et al., 2008). Intention to carry out the behaviour is strongest when the person has more favourable attitudes and subjective norms, and perceives a greater amount of control (Westerhof et al., 2008). This theory has been successfully applied to many different behaviours including seeking help for mental health issues (Bayer & Peay, 1997; Schomerus, Matschinger, & Angermeyer, 2009). However, an understanding of whether an individual has the intention to seek help does not necessarily predict behavioural outcome, as intentions to perform a behaviour do not necessarily convert to behavioural action. One meta-analysis of condom use, for example, reported that intention accounted for approximately 19% of the variability in use, suggesting that intention only partially accounts for how motivation is translated into actual behaviour (Armitage & Conner, 2000). Therefore, investigating only the predictors of behavioural intentions would miss some important part of the behavioural continuum, as the predictors of intentions could be different to the factors that influence actual help seeking behaviour. Some have argued that "intentions are not a sufficient impetus for action" (Bagozzi, 1992, p. 178).

Another model that has also been used in health research is the self regulation model of illness cognition and behaviour (Leventhal, Nerenz, & Steele, 1984). This model posits that "patients hold cognitive representations of their illness which include beliefs about the identity, cause, time-line, consequences and cure/controllability of their conditions" (Cameron & Moss-Morris, 2004, p. 84). These five key factors guide the selection and use of coping mechanisms for the illness-related experience and also determine the emotional responses of those experiences (Cameron & Moss-Morris, 2004). This model has been applied to understanding patients" illness related experiences and also adherence to treatment regimes for a number of different health conditions (Leventhal,

Diefenbach, & Leventhal, 1992), amongst other things. However, this model does not appear to provide the scope to investigate help seeking as it concentrates more on the representations people have of their illness in guiding their response (both emotional and coping). Therefore the scope to investigate psycho-social and cultural factors associated with help seeking particularly in rural areas is somewhat limited by this model making it unsuitable for the current research where psycho-social and cultural factors are critical for the investigation of help seeking.

Behavioural enaction models (Armitage & Conner, 2000) can also be applied to health and help seeking behaviours. These models extend other models such as the theory of planned behaviour, to elaborate on the processes that follow intention formation (Armitage & Conner, 2000). One example is Bagozzi's goal theory (Bagozzi, 1992), where goal intentions are formed, the means by which they are attained are chosen with reference to three appraisals: self confidence, likelihood of goal attainment and the perception of pleasantness/unpleasantness, these appraisals are then translated into "trying" which refers to the initiation of goal pursuit and they are then translated into action (Armitage & Conner, 2000). Although this model has potential in health research, it has not been widely used in this field and its potential for help seeking research may be limited by only allowing certain appraisals to be considered in the development of intentions. It may also be difficult to ascertain someone's 'trying' to pursue a goal without actually following them in their pursuit.

The expanded version of the Anderson Behavioural Model (Bradley et al., 2002) was chosen as the theoretical context under which the current research will be placed, because it provides the most scope for investigating the factors that predict both, intentions to seek help and also behavioural outcomes. The literature reviewed in chapter two will discuss the Andersen Behavioural model in greater detail. In summary though, the model was first developed to assess health service usage (Andersen & Newman, 1973), but has

since been applied to all manner of other services. The model posits that service usage is dependent on a person‟s predisposition to use services, factors which enable or impede service use and the person‟s need for the service (Andersen, 1995). The expanded version also includes psychosocial factors and intention (Bradley et al., 2002). Within these categories, there is scope for investigating the many aspects of service use that may or may not be influencing whether or not a mental health service is sought. Therefore, although there are many theories that can and have been successfully applied to health research and also to research investigating help seeking and mental health, for the purposes of the current research the expanded Andersen Behavioural Model (Bradley et al., 2002) appears to provide the most flexibility in investigating the factors influencing help seeking behaviour and the most scope for including as many variables as is necessary to thoroughly investigate and understand help seeking for mental health issues in rural areas. Therefore, Bradley‟s (2002) version of the model is used as the framework for this research program.

1.5 Rationale for the research

The rationale for this research comes from a local imperative, a global priority and theoretical perspectives. The state of mental health and mental health services in rural parts of Australia and research exploring this is particularly important in light of the goals outlined by the WHO making mental health a global priority. Rural people have more limited access to required services of health care, in terms of the number of services that are physically available (McGovern & Hodgins, 2007), and in terms of social barriers to accessing the services that are available. These include, stigma (Halter, 2004), (negative) attitudes towards seeking help for mental health issues (Judd, Cooper, Fraser, & Davis, 2006b) and even psychological mindedness which refers to a person‟s willingness and ability to get in touch with, and discuss their feelings (Appelbaum, 1973). This construct has never been investigated in this context but will be included in the current research and

discussed in more depth in the following chapter. Therefore, investigations into the factors that impact rural residents" help seeking behaviours and outcomes will address the World Health Organisation"s global priority, and the under utilisation of mental health services in rural areas.

Theory based study on this topic is also lacking. In fifty recent studies looking at mental health service use in rural people, approximately ten (all quantitative studies) have presented some form of theory to frame their findings (this was by no means a systematic review of the literature, but gives some indication of the lack of theory based studies conducted in this area). Further, research that incorporates qualitative and quantitative data under a theoretical framework is virtually non-existent. The current research therefore aims to address the lack of mixed method, theory based studies.

1.6 Methodological framework/rationale for mixed methodology

The methodology adopted for this thesis was a mixed methods approach, whereby the research questions are investigated using both qualitative and quantitative methodology in a sequential manner (Adamson, 2005). The following section will discuss the current debate surrounding the qualitative-quantitative dichotomy (Adamson, 2005), the methodological paradigm that best suits this research, the relevance for using mixed methodology in the context of health service research, and outline the settings and context for this thesis.

A mixed methodology was chosen for this research because it offered the best way of gaining multiple insights into the reasons people may or may not seek help for mental health issues. Using a qualitative investigation in the first instance allowed rural people to not only define but also to describe what they believe the barriers to seeking help may be. Following up with quantitative surveys to a larger portion of a similar population, allows

for comparison of the results as well as incorporating triangulation. Triangulation refers to checking the findings from one research design against the findings of another and can enhance the validity of the findings (Adamson, 2005). The survey study also included an open ended question for participants to textually comment further about mental health and mental health services if they wished. This extra qualitative data allowed for cross checking of reliability and consistency across the two qualitative methods (interviews and free text) as well as checking the external validity across methods (qualitative and quantitative).

1.6.1 Rationale for using a mixed methodology and debate surrounding the qualitative-quantitative dichotomy

The idea of combining qualitative and quantitative research techniques has a long history, with many nineteenth century researchers actually treating the two methods as complementary (Adamson, 2005). However, with the rapid development of statistical methods, the two came to be looked upon as a methodological dichotomy (Adamson, 2005). More recently, and particularly in the area of health service research, the concept of merging qualitative and quantitative methodology has become more popular again (Adamson, 2005). However there still exists some degree of debate about whether mixing methods is a good research tool or not.

Methodological purists (both qualitative and quantitative) have argued in favour of the "incompatibility thesis" (Howe, 1988), which suggests that "qualitative and quantitative research paradigms, including their associated methods cannot and should not be mixed" (Johnson & Onwuegbuzie, 2004, p. 14). Howe (1988) posits that methodological purists who adhere to the incompatibility thesis believe that problems of compatibility arise more at the level of epistemological paradigms. They argue that the paradigms underlying quantitative and qualitative methods (i.e. positivist and

interpretivist) are incompatible, making the two methods incompatible (Howe, 1988). One feature of the paradigm war between the methodological purists is the focus on the differences between the two paradigms, causing two research cultures to emerge, one that claims to have "superiority in deep, rich observational data (Qualitative), and the other that claims superiority in hard, generalisable data (Quantitative)" (Sieber, 1973, p. 1335). However, some researchers have suggested that mixed methods research should be thought of as a third research paradigm, and that the focus should be on the compatibility of qualitative and quantitative methods (Adamson, 2005; Johnson & Onwuegbuzie, 2004). The paradigm associated with the „compatibility" thinking of mixed methodologists is pragmatism, and it has been argued that pragmatism is the best paradigm for justifying the use of mixed methodology in research (Tashakkori & Teddlie, 1998). Pragmatism draws on many ideas including using „what works"(Howe, 1988), and making the research question most important in driving the methods used (Tashakkori & Teddlie, 1998). Pragmatism also allows for the use of diverse approaches and values objective and subjective knowledge (Cherryholmes, 1992). The pragmatic paradigm may have greater resonance with more applied areas of research such as health services research (Adamson, 2005) as it has an appealing, and very practical and applied research philosophy, that emphasises "researching what is of interest and value to you, to study it in the different ways you deem appropriate and to use the results in ways that can bring about positive consequences within your value system" (Tashakkori & Teddlie, 1998, p. 30). Pragmatism is said to provide a balanced or pluralist position to research methodology and helps in the decision about how to mix the approaches in a way that offers the best opportunity for answering the research questions (Johnson & Onwuegbuzie, 2004).

It is the "strengths and weaknesses of both approaches that lies behind the rationale for their integration" (Bryman, 1992 as cited in Adamson, 2005, p. 231). One method is not necessarily superior to the other and to think so simply "perpetuates the existing

qualitative-quantitative dichotomy, but having a range of methods available is imperative to understanding the complexities of modern health services" (Pope & Mays, 1995, p. 45). Further, it has been suggested that the research world today, particularly health services research, is becoming increasingly more interdisciplinary, complex and dynamic, and it is therefore vital for researchers across disciplines to have a solid understanding of the multiple methods used by other scholars, as well as which methods complement each other (Greene & Caracelli, 1997; Johnson & Onwuegbuzie, 2004). This knowledge and understanding of multiple methods and how to mix them effectively will facilitate communication and promote collaboration across disciplines and ultimately provide superior research that offers the best chance of holistically answering specific research questions (Johnson & Onwuegbuzie, 2004). Therefore the qualitative-quantitative dichotomy that currently exists need not be perpetuated: qualitative research can and does complement quantitative research very well, the two techniques can provide differing but non-competing representations (Adamson, 2005) of the "ever-increasing complexity and intractability" (Greene & Caracelli, 1997, p. 15) of social phenomena.

Pope and Mays (1995) also suggested that qualitative methods should be an essential part of health services research not only because they allow a more in depth discussion of either lay or professional health beliefs but also because in depth qualitative discussions can provide an important prerequisite for good quantitative research. Qualitative research as an essential preliminary to quantitative research can provide a description and understanding of situations and behaviour, and a starting off point for quantitative investigation (Pope & Mays, 1995). This is the basic rationale for using mixed methods in health services research in general, and particularly in the current research. In order to investigate the barriers to help seeking for mental health in rural areas, it is pertinent to first, ask the people who live in rural areas what they believe the barriers to be.

Second, to then supplement this with a population survey of a randomly selected rural sample to allow for close comparison (Johnson & Onwuegbuzie, 2004).

1.6.2 Triangulation

Triangulation can be used so that the findings from one type of study can be checked against the findings of the other, therefore enhancing the validity of both methods (Adamson, 2005). The concept of triangulation refers to the combining of data sources to study the same social phenomenon (Denzin, 1978). Jick (1979) discussed mixed methodology in terms of within methods triangulation, involving multiple quantitative or multiple qualitative approaches and useable as a cross check for internal consistency, and across methods triangulation, involving both qualitative and quantitative methods and can be used to test external validity. In his discussion of mixed methods Jick (1979) also suggested that triangulation may be used not only to examine the same phenomenon from different perspectives, but also to "enrich our understanding of the phenomena by allowing for new or deeper dimensions to emerge" (p. 604).

More recently in the mixed method literature a new type of mixed method design, referred to as Mixed Model studies has been suggested (Tashakkori & Teddlie, 1998). The definitions of these methods are that they are "studies that are products of the pragmatist paradigm that combine the qualitative and quantitative approaches within different phases of the research process" (Tashakkori & Teddlie, 1998, p. 19). This could involve single applications of either quantitative or qualitative methods within phases of the study, or it could involve multiple applications of qualitative and quantitative methods within phases of the study, such as data collection that includes closed-ended items as well as open-ended items on the same survey (Tashakkori & Teddlie, 1998).

After all the discussions and debate in the literature about whether mixing methods and paradigms is a good research tool, Tashakorri (1998) has pointed out that most

researchers committed to the thorough study of a research problem, consider the research question to be more important than either the method used or the paradigm supposedly underlying the method. This view is the one taken by the current research: that the research question should dictate the methods used, and that the use of mixed methods allows for a thorough investigation of the research problem, and that methods have complementary strengths and weaknesses that do not overlap (Brewer & Hunter, 1989).

In summary, the use of mixed methodology makes the most sense when doing applied research such as health services research as it provides a richer, deeper understanding of a particular topic. Knowing from a qualitative point of view what works and what does not in terms of health services, as well as what the people who use the services have to say about them is an important investigation on its own or can help shape any subsequent studies, either qualitative or quantitative. In addition, using quantitative data to investigate on a larger scale who uses services (and who does not) and why is also important in giving a „bigger picture" perspective. If the findings are corroborated across the different approaches then a greater confidence can be held in the overall conclusion that is drawn, and even if the findings conflict then the researcher gains a greater knowledge of the studied phenomena and can modify interpretations and conclusions appropriately (Johnson & Onwuegbuzie, 2004).

1.6.3 Assessing quality in qualitative research

The current thesis makes extensive use of qualitative methods. One of the main criticisms that qualitative research receives within the traditionally bio-medical/quantitative health field, is that it lacks scientific rigour (Mays & Pope, 1995). However, in qualitative research, as in quantitative it is possible to ensure scientific rigour by applying as per the previous section, "systematic and self conscious research design

and, data collection, interpretation and communication" (Mays & Pope, 1995, p. 109).

Mays and Pope (1995) have suggested that qualitative research should aim to do two things; first, "to create an account of method and data which can stand independently so that another trained researcher could analyse the same data in the same way and come to essentially the same conclusions" (p. 109), and second, "to produce a plausible and coherent explanation of the phenomenon under scrutiny" (p. 109).

There are several ways that validity in qualitative research can be improved, although there is no hard and fast rule to ensure there are absolutely no errors. The first is triangulation which has already been discussed previously in this chapter and will be used in this thesis. Second, respondent validation, whereby the researchers" accounts are checked by the research participants to establish what level of correspondence there is between the two, and then participant reactions to the analyses are incorporated into the findings (Mays & Pope, 2000). This form of validation whilst considered the strongest form of checking the credibility of qualitative research, creates the need for more interpretation as the process creates more original data (Mays & Pope, 2000). Further, the accounts produced by the researcher are designed for a wide audience and will inevitably be different to those of the respondents simply because of the different roles they play in the research process (Mays & Pope, 2000). Therefore, whilst this form of validation is strong, it is also difficult to employ due to the aforementioned limitations. Third, searching for and discussing negative cases, or as they are otherwise referred, "deviant cases" (Mays & Pope, 2000, p. 51) or exploring the cases that seem to contradict the emerging explanations of the findings will also improve the quality and validity of qualitative research (Mays & Pope, 2000) . Last, Mays and Pope (2000) also suggest reflexivity as a means of improving validity. Reflexivity refers to researchers being sensitive to the ways in which their experience and prior assumptions can shape the research, and to ensure that personal and intellectual biases are made plain at the outset of the research report to

enhance credibility of the research (Mays & Pope, 2000, p. 51). These are a few ways of demonstrating validity in qualitative research and they go some way in arguing that qualitative research can be just as scientifically rigorous as quantitative research.

1.7 Summary and Research Context

The research in this thesis is of a theoretical and applied nature. From a theoretical perspective the questions asked by the current research are useful in addressing what the most significant barriers to seeking help are for rural people. This will be achieved by using qualitative and quantitative methods and by applying the expanded version of the Andersen behavioural model (Bradley et al., 2002) in the mental health help seeking context at the interpretative phase to assist in cross checking, validating and reconciling the findings across methods. This research will expand the knowledge base around the model and how it fits for help seeking for mental health. In addition, and most novel, is the use of the Andersen model to provide a framework on which to make interpretations about both the *qualitative* and *quantitative* data together.

From an applied perspective, it is in primary health care that this kind of mixed methodology health services research will be best utilised. Research is vital for the uptake and continued usage of mental health services, particularly in rural areas where mental illness is more prevalent and usage appears to be lower. Mixed methodology provides the research with the most scope for investigating the barriers to service usage. Qualitative methodology is used to find out what people actually say about what they believe the barriers to be and quantitative methodology is utilised to expand on the qualitative research and further investigate the barriers using a population sample. In addition, another qualitative element will be added to the quantitative survey using an open ended item that allows respondents to freely write down anything further. This information will then add to

the generalisability of the interview study and triangulation utilised in the interpretative phase to discuss any convergences or indeed divergent findings. Triangulation allows for cross validation within methods and across methods. Mixing methods will allow for explanations of divergent findings also within and across methods which provides an opportunity for enriching the explanation of the issues.

It is not the intention of the thesis to contrast the rural findings with other populations. Therefore it should be noted at the outset that the generalisability of findings from this thesis to non-rural populations would need further research.

1.8 Overview of the thesis format

This thesis is a combination of text written in manuscript format (Chapter four), and papers that have either been published (Chapter three) or have been submitted for publication (Chapter five).

The following diagram (*Figure 1*) gives simplistic visual representation of the schematics of the research program.
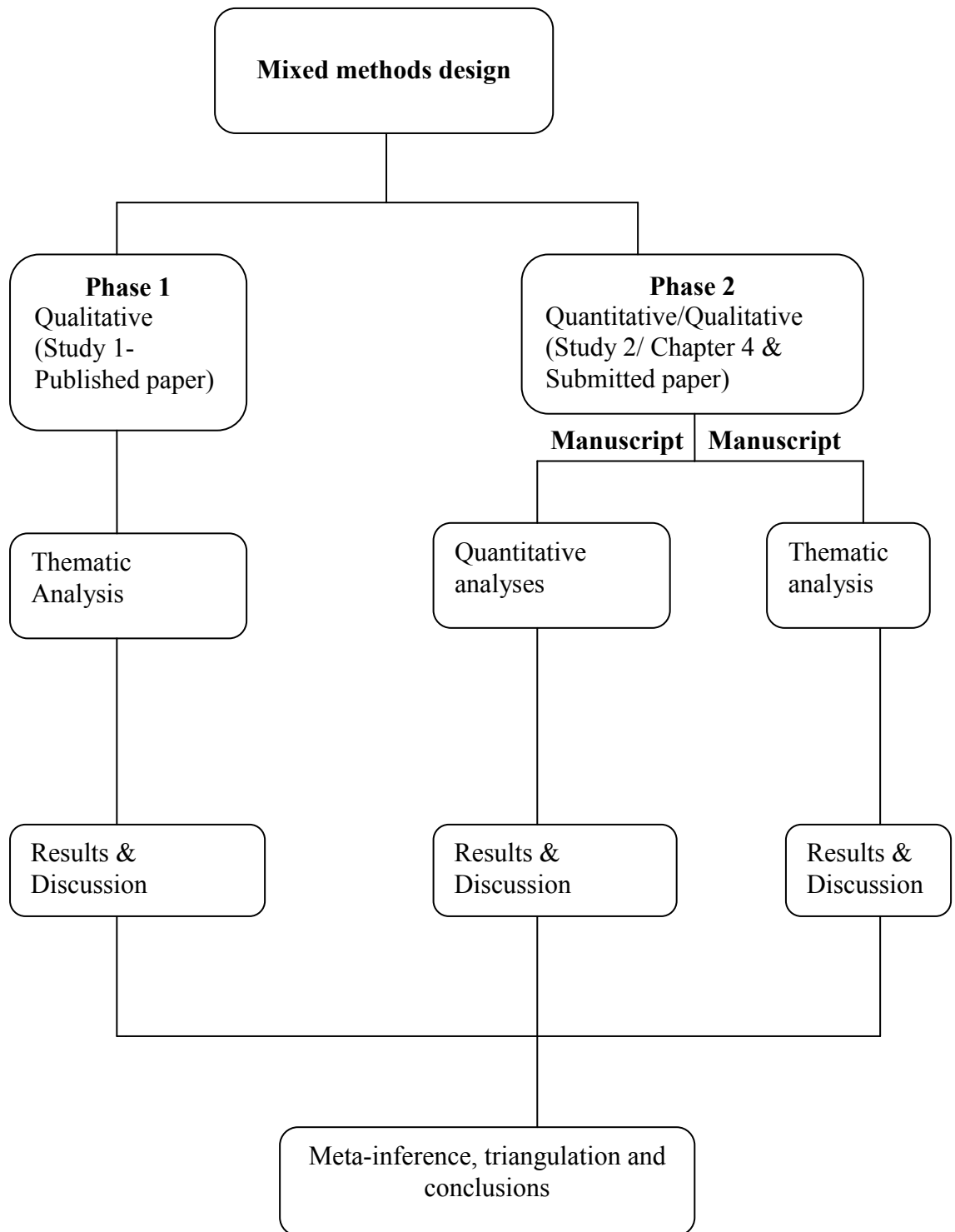
Figure 1. Schematics of the mixed methods design used in this thesis.

The present chapter: chapter one, provides the background information, overview, rationale and format of the thesis.

Chapter two will provide a critical commentary of the existing literature relevant to this area of research and includes a review of rurality, help seeking, the Andersen behavioural model, and help seeking barriers and facilitators including stigma, self reliance and psychological mindedness. An overview of the gaps the thesis will address and specific research questions of the thesis will also be included.

Chapters three, four and five contain the three empirical studies, one of which has been published in the Australian Journal of Primary Health, and another that was under review at Rural and Remote Health at the time of submission of this thesis. The two papers have with them a statement of contribution and the format has been changed to match the current typeset (with the proofs of the published paper presented as an appendix). Chapter six provides the overall discussion of the research findings, with specific reference to how all the findings fit within the Andersen behavioural model framework, as well as a critical commentary of the utility of the Andersen behavioural model in rural mental health research.

Chapter 2- Literature Review

2.1 Introduction and descriptive epidemiology

This chapter provides an in depth literature review of the research into help seeking for mental health issues in rural areas. It includes the epidemiology literature around mental illness in rural areas, defining rurality and help seeking, consideration of current policies and services, the theoretical framework used to drive the research and some of the factors that may enable of impede help seeking. It concludes with the gaps in the literature and the specific objectives and hypotheses of the thesis.

Given the significance recently placed on mental health globally, by the World Health Organisation (World Health Organization, 2006) as already stated in chapter one, research investigating aspects of mental health is both critically important and timely. From a more local perspective, the ongoing drought that has been affecting rural communities over more than ten years has left Australian rural and remote communities in a state of financial and emotional crisis (Roufeil & Lipzker, 2007; Sartore, Kelly, Stain, Albrecht, & Higginbotham, 2008b), making the current research all the more pertinent. Despite this and statistics that draw our attention to rural mental health issues, such as the high suicide rate among young males in rural Australia, rural mental health and the needs of rural communities remain largely neglected areas of study (Fraser et al., 2002; Fuller, Edwards, Procter, & Moss, 2000).

Research focussing on prevalence rates of mental illness in rural Australia has provided mixed results. One prevalence study retrospectively analysed the 1997-2000 national mortality data and the National Survey of Health and Wellbeing (a national population survey with approximately 8,800 respondents) using the rural, remote and metropolitan (RRMA) index (Caldwell et al., 2004b). Higher suicide rates were found for

men in rural (24 per 100 000) and remote regions (25.7 per 100 000), and young male (aged 20 -29) suicide rates being particularly high (40.4 per 100 000), compared to their urban counterparts (overall male suicide rates 20.2 in 100 000) (Caldwell et al., 2004b). Furthermore, this study found that young males with mental health disorders from rural and remote areas were significantly less likely to seek professional help for their disorder than young metropolitan males (11.4% v 25.2%) (Caldwell et al., 2004b) Consistent with this, the most recent mortality atlas released by the Australian Bureau of Statistics in 2002 showed that compared to those in densely populated areas, people living in remote parts of Australia have higher death rates overall, from a number of different causes particularly intentional self harm or suicide (Australian Bureau of Statistics, 2002). Prevalence rates of psychological distress, anxiety and depression have also been found to be high in rural areas. One large scale population study (N=1563) found almost one third of the rural South Australian and Victorian population (aged between 25-74 years) sampled reported psychological distress with a reported prevalence of anxiety and depression of approximately 10% (Kilkkinen et al., 2007). The highest rates of psychological distress and depression and anxiety was found in the middle age group for both men and women (Kilkkinen et al., 2007). Consistent with this, an epidemiological study conducted in the US (n=30,801) also found a slight but significantly higher prevalence of depression in rural areas (6.1%) compared to urban areas (5.2%) (Probst et al., 2006). However, after adjusting for health and resource factors, prevalence rates were no longer significantly different in rural areas compared to urban (Probst et al., 2006). In their South Australian telephone population study (n=3015) Goldney, Taylor and Bain (2007) found that the prevalence of major depression in areas where services were moderately accessible was 15.7% (12.1% in remote areas), which was no higher than areas where service were more accessible. Similarly, an epidemiological study in Canada (n=801) found prevalence of major depression in one large rural region to be 3.8%; lower than a nearby urban centre

(Patten, Stuart, Russell, Maxwell, & Arboleda-Florez, 2003). Prevalence rates, however, do not provide enough information to start the process of reducing the burden that mental illness causes in rural areas of Australia. Mixed results have been found across prevalence studies comparing rural and urban areas, some that have found significantly different prevalence rates and some that have found prevalence rates not to be significantly different across rural and metropolitan regions. Therefore the question still remains: what other factors are contributing to the burden of mental health issues in rural areas, such as elevated suicide rates (ABS, 2002). If it is the case that prevalence of commonly occurring illnesses such as depression do not to correspond with the elevated suicide rates, it is important to ask why this is so.

Very little research has examined the relationship between factors within rural lifestyles that influence seeking help for mental health issues (Fraser et al., 2002), and there remains a need to look beyond epidemiological differences between rural and metropolitan rates of mental illness, suicide and depression, and to consider the underlying nature of the differences and those factors that might be specific to rural areas (Judd et al., 2006b). Rural mental health and access to services in these communities remains a significant problem, despite there being more awareness particularly from media sources of the impact of poor mental health. Some recent studies have investigated these issues by asking service providers what they believe to be the most important issues. Beel et al. (2008), for example, found that GPs did not refer their patients to mental health services because they were dissatisfied with professional communication between themselves and psychologists and also with a mental health system that does not offer enough funding for patients in need of mental health care. Similarly, Sweeney and Kisely (2003) found that community health professionals were also dissatisfied with communication between professionals and were in fact confused about the role of mental health services. Further, they were dissatisfied with the limited after hours care being provided for mental health

care (Sweeney & Kisely, 2003). Presumably health care professionals are targeted for research in this area because they are thought to have the most valuable insight into what is and is not available. However only getting the opinion of service providers does not give a full and accurate account of the true service needs and beliefs of the community, as the beliefs of the service providers may be different to or even conflict with those of service users. Talking to those that actually use the services or could potentially use the service is crucial, particularly to ascertain whether those that actually need the services know what is available to them. A full understanding of the barriers that keep rural people from seeking help for these issues would allow mental health professionals and policy makers to design facilities, interventions and education programs to reduce the barriers and promote greater access for those who are currently in need (Vogel, Wade, Wester, Larson, & Hackler, 2007). These measures will also promote greater access to those rural residents who are currently unwilling to access existing services.

Recent research has suggested that although mental illness is a significant issue for rural people, they access professional services significantly less than their urban counterparts (Komiti et al., 2006). According to data reported from the National Survey of Mental Health and Wellbeing, overall rates of service utilisation by individuals with psychological disorders were lowest in rural areas with a population size of less than 10,000 (Judd, Jackson, Komiti, Murray, & Fraser, 2007). Similarly, Caldwell et al"s. (2004a) study using data from the BEACH program (a continuous national study of Australian general practice activity), found that, on average, rural and remote residents visited GPs far less frequently than metropolitan residents. The rates of GP visits for psychological problems were also lower for large rural (586.4 per 1000 residents) small rural (529.9 per 1000) and remote (288.3 per 1000) than non metropolitan residents (656.8 per 1000 population) (Caldwell et al., 2004a). Prescriptions for mental health medications

were also made at half the rate for remote residents compared to metropolitan residents (Caldwell et al., 2004a).

In rural areas the lack of specialist mental health services means that residents rely most heavily on GP services for assessment and treatment (Komiti et al., 2006). For most rural residents, any ailment or health issue is treated with a trip to their local GP, and for most, this will also be the first point of call for any mental health issues they may be experiencing.

Traditionally, low utilisation of mental health services in rural areas was thought to be due solely to the lack of facilities available in their immediate area and the distance they would have to travel in order to seek professional help (Judd & Humphreys, 2001). However researchers have discovered that this is not the entire story. Indeed proximity to services has some influence on whether rural residents seek help and having to travel long distances to visit specialist practitioners certainly adds further to the disadvantage (Judd & Humphreys, 2001), but social and cultural issues within rural communities also play a significant role in the process (Judd et al., 2002b).

2.2 Rurality

A major challenge for rural research is how to measure rurality. There are a number of ways to determine whether a community or indeed a person is considered rural. The first is primarily based on population numbers and an index of remoteness. The Rural, Remote and Metropolitan Areas (RRMA) classification, developed in 1994 by the Department of Primary Industries and Energy and the then Department of Human Services and Health. This index is used as the framework by which the various data sources could be analysed for metropolitan, rural and remote zones (Rural Doctors Workforce Agency, 2006). This classification is based on Statistical Local Areas (SLA) and allocates each SLA in

Australia to a category based mainly on population numbers (Rural Doctors Workforce Agency, 2006). More recently the Australian Standard Geographical Classification-Remoteness Areas (ASGC-RA) system, developed by the Australian Bureau of Statistics based on the ARIA method was introduced (Australian Government, 2010). The categories range from RA1; the major cities of Australia through to RA5; the very remote areas of Australia. This system is now the most widely used as it "defines the least remote areas more tightly than the ARIA system because it has a lower cut off index value than the ARIA system" (Australian Government, 2010). This is an advantage because it acknowledges that outer suburban areas of Australia would have lower access to goods and services than the inner city (Australian Institute of Health and Welfare, 2004).

The second is a more socio-psychological way of conceptualising rurality. Conventionally being from a „rural‟ community means being a certain distance from a main city, or determined by the population being under a certain figure, as in ASGC-RA, and traditionally the main issue with regard to access to mental health services for residents in a rural location was this distance. The distance to physically get to the service was thought to be the main reason for the underutilisation of mental health services by rural residents (Komiti et al., 2006), but the geographical distance to a service is only a relatively small part of the reason for the underutilisation of mental health services in rural communities. Being from a rural area comes with its own cultural attitudes and influences, and it has been suggested that because of the distinctive features of rural and remote life, the provision of mental health services in rural and remote communities presents a difficult challenge as it is not possible to provide the full range of mental health services in the same way they are provided in the cities (Fuller, Edwards, Martinez, Edwards, & Reid, 2004). In addition, the needs and issues of rural people are somewhat different to those of urban people such as the impact of the widespread and prolonged drought that has affected large areas of agricultural land for more than ten years (Sartore et al., 2008a). Although

most Australians are affected by the drought in some way, it is the rural people who really experience the full brunt of the financial and emotional hardship brought on by the drought as they are the most reliant on the agricultural industry (Sartore et al., 2008a). The cultural attitudes and influences are the attitudes of the general population of a rural community and how they might influence the behaviours and practices of those within that community. The attitudes of rural people are unique from the attitudes and beliefs of their urban counterparts in some important ways. First, the lack of anonymity in rural areas means rural people are acutely aware of any scrutiny their behaviours and practices may be under and in the case of mental illness the probability of being labelled "crazy" is somewhat increased (Rost, Smith, & Taylor, 1993). One study found that because of this, rural people who have had previous experience with depressive symptoms were more likely to label those who sought professional help more negatively than their urban counterparts (Rost et al., 1993). On the other hand, the tight knit rural communities can provide mutually supportive relationships or social capital (Sartorius, 2004) resulting in more support for those in need compared to more anonymous urban areas. The uniqueness of rural communities and the needs of rural residents must be taken into account, however, much of the research and training in behavioural health services is what has been referred to as "urbancentric" (Stamm, 2003), meaning that theories developed and findings from research are often based on metropolitan populations (Helflinger & Christens, 2006), and therefore not readily generalisable to the rural context, given its established uniqueness.

2.3 Help-seeking

The definition of help seeking that drove this research is the search for professional assistance, this can also encompass informal (non-professional) sources such as friends and family (Gourash, 1978). More recently, this definition has been extended and describes

help seeking as a behaviour of "actively seeking help from other people" (Rickwood et al., 2005, p. 4). In the context of mental health, help seeking behaviour refers the process by which individuals acknowledge the need for help with a mental health issue, and their subsequent behaviour, ultimately leading them to seek professional help for their mental health issue (Gourash, 1978). Rickwood et al. (2005) suggested that help seeking is a form of coping that relies on other people and is therefore based on social relationships and interpersonal skills. They also suggested that help seeking for mental health issues is a "social transaction between the personal domain of thoughts and feelings and the interpersonal domain of social relationships" (Rickwood et al., 2005, p. 1).

Although patterns of help seeking are not always consistent, there are a number of general trends that can be taken from the existing research. First, age and gender are said to influence help seeking patterns. Women were found to access professional psychological services more often than men in a study surveying 204 males and females about their help seeking attitudes, prior help seeking psychiatric symptomatology and intentions to seek help (Mackenzie, Gekoski, & Knox, 2006). Similarly, women were also found to have more favourable intentions to seek help in the first instance (Mackenzie et al., 2006). Older adults were also found to exhibit more favourable intentions to seek help from primary care physicians (Mackenzie et al., 2006).Young people, however, were found to be unlikely to seek help at all, but if they do they are more likely to seek help from informal sources such as family, but more often from friends (Rickwood et al., 2005).

Other forms of help seeking particularly in rural areas also come from informal sources such as family, friends, neighbours and even local business people and clergy (Rickwood et al., 2005). One study investigated the strategy of mental health first aid (MHFA), for ensuring rural people are getting the care they need emotionally from people in their social network (Sartore et al., 2008a). Mental health first aid involves training people who have close regular contact with rural people such as rural support workers and

rural financial counsellors to provide basic help and appropriate referral (Sartore et al., 2008a). The rationale behind this was to ensure that people with mental health problems can be assisted by other people in their social network , and those people can feel confident in giving advice and referral (Sartore et al., 2008a). The implementation of such strategies may also help to reduce the stigma attached to seeking help (which will be discussed in more detail later in this chapter) for mental health issues that exists in rural areas particularly if help is given by people considered friends in their own environment in a non threatening manner.

2.4 Access and Utilisation

Access and utilisation of mental health services in rural areas has most commonly been studied in a way that only takes into account distance from services and the overall lack of mental health services and indeed health services in these areas. It has only been in recent studies that researchers have considered the uniqueness of the rural situation and the way factors within it can impact on the way rural people think about health services and particularly mental health services. Research has only begun to understand the rural psyche and how important it is to take this into account when considering how to improve access to services. As Judd, Cooper, Fraser and Davis (2006b) found in their study investigating rural suicide, there are what they termed ‚place" factors to be considered when investigating rural mental health and access to services, including rural culture and community attitudes towards mental health.

2.4.1 Policy and Services

In recent years, utilisation of mental health services has come to the attention of policy makers at the highest level. This has led to a number of government initiatives to

help improve „accessibility" of psychological services in both rural and metropolitan areas. The most recent of these is the Fourth National Mental Health plan (Australian Government, 2009a). This government initiative takes a population health approach with a focus on social inclusion. Recognition of the social, biological, cultural and economic situation of consumers is taken into account. Further, this plan will attempt to delivery services equitably, taking into account the barriers that people suffering from mental health issues face in accessing care (Australian Government, 2009a). For rural residents the GP is the first point of call for most illness", physical or mental, and for many the GP is their only treating physician (Judd & Humphreys, 2001).Many rural people experience significant difficulties in accessing GP services in the first instance (Judd & Humphreys, 2001), which in turn makes the timeline for any treatment or referral to psychological services more extensive. As one researcher suggested in a review of mental health issues for rural Australia, "for many rural communities, access even to GPs is limited due to workforce shortages and misdistribution and the fact that the supply of GPs per head of population falls abruptly in rural areas" (Judd & Humphreys, 2001, p. 256). Further, it is argued that even if a referral is made or the suggestion of referral is made, this does not necessarily mean the patient will accept the referral. One study asked GPs in one rural West Australian community to collect information concerning demographics of chronicity of their illness and treatment and referral information on patients (n=428) with mental health problems. The study found that, although the referral rate was one in four patients, some patients had refused to be referred (Aoun et al., 1997). Therefore referral rates are not necessarily reflective of compliance and there are probably many more that accept the referral from the GP but never actually follow through on seeking the referred service.

One initiative run through the Australian General Practice Network is the Better Outcomes in Mental Health Care Initiative (BOIMHC). This initiative was implemented because one in five Australians have a mental health disorder, less than 40% will seek help

and for those that do seek help 75% will do so from a general practitioner, further, 85% of the population will see a GP in any given year, and mental health is the second most common general practice co-morbidity (Australian Government, 2009b). Given these statistics, and the historical barriers faced by GPs in the delivery of quality mental health care such as inadequate training and education and limited referral pathways (Australian General Practice Network, 2007), the BOIMHC initiative was implemented. Funded through the Australian Government Department of Health and Ageing, BOIMHC provides GPs with education and training in mental health. A service incentive payment is given as part of the initiative to encourage more effective management of mental health problems through a three step mental health process (Australian Government, 2009b). The process includes assessment, plan and review, focussed psychological strategies, access to Allied Psychological Services to support their patients, and access to psychiatrist support (Australian Government, 2009b). These kinds of initiatives are most necessary in rural areas where the GP is the first point of call for many patients with a mental health problem. If the GPs can be more educated in these issues they are more likely to detect them in the short time they have with patients and ensure the patient receives care in the systematic way set out by the BOIMHC initiative. More recently this initiative has changed to the Better Access to Mental Health services. This initiative facilitates equivalent access to mental health care providers including psychologists thorough a series of Medicare Benefits Schedule (MBS) items. This is different to the Better Outcomes version that was based within the Divisions of General Practice and aimed only at GPs. In a recent evaluation of this initiative Pirkis et al (2010) found a dramatic improvement in patients who had severe symptomatology before treatment, suggesting the initiative was reaching those with the most severe symptoms. However, it is more difficult to know whether patients with more mild symptoms are being reached by this initiative as all participants in Pirkis‟ evaluation had severe symptoms.

There have also been a number of initiatives implemented by *beyondblue*, the Australian national depression initiative. In particular, *beyondblue* has a programme specifically targeted at rural communities to raise awareness about depression and in particular how the drought could be contributing to mental health problems in rural areas. This initiative, named D*on't beat around the bush! - beyondblue's* national drought campaign, has a number of activities such as the drought buses that tour drought affected areas, and resources available through their website specifically designed to provide information about depression and other mental illnesses. Including a list of rural GPs that have special expertise (such as the better outcomes training) in mental health and information about other available resources such as Lifeline and Lifeline's "just ask" (rural mental health information) telephone service (beyondblue, 2009). Lifelines "just ask" initiative, is another government funded initiative to provide urgent information and referrals using a telephone number specifically for rural people in crisis (Lifeline Australia, 2010).

The following section will discuss the theoretical framework used to drive this research. Each of the elements contained within the Andersen behavioural model will be discussed, followed by the mental health help seeking factors to be included in the model.

2.5 Theoretical Framework/ Andersen Model

Some researchers have suggested that some of the gaps in knowledge around the mental health of rural Australians could be best addressed by developing or employing an inclusive framework built around sound clinical methodology (Fraser et al., 2002). The current study aims to address this gap in knowledge by employing such a theoretical framework. The current research will be positioned under the theoretical framework developed by research conducted extensively by Ronald Andersen and colleagues starting in the 1960s into access and utilisation of medical health care. Andersen's Behavioural

Model of Health Services Use, also referred to as the Socio-behavioural Model or just the Behavioural model was developed over forty years ago and has provided a systematic conceptual definition of access to health care that has permitted policy makers and consumers to "monitor the effectiveness of various programs within the health care system to meet the inherent goal of providing equal access to the medical care system" (Aday & Andersen, 1974, p. 208). The model proposes that people"s use of health services is a "function of their predisposition to use services, factors which enable or impede use and their need for care" (Andersen, 1995, p. 1). The framework has been successfully applied to help describe, predict and explain population based health behaviours and health outcomes (Andersen & Davidson, 1997). The initial model set out to predict and explain the use of acute health care services and has since been modified to explain access and utilisation of various other services, such as, long term care in the elderly (Bradley et al., 2002), oral hygiene (Andersen & Davidson, 1997), and mental health care (Parslow & Jorm, 2000, 2001).

The model, first proposed by Andersen and Newman (1973) refer *Figure 2* has three sets of factors: predisposing factors, enabling factors and need factors. These function together in a recursive rather than sequential manner, to predict health service (Andersen, 1995; Andersen & Davidson, 1997).
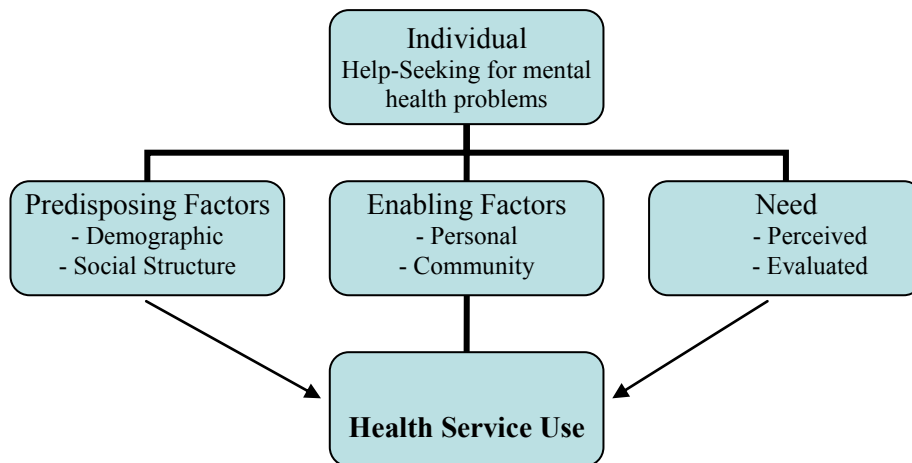
Figure 2. Andersen and Newman‶s Original Behavioural Model (1995).

Predisposing factors as described by Andersen (1995; 1973) include demographic

information such as age and gender which represent biological constraints on the

likelihood that people will need health services (Hulka and Wheat, 1985 as cited in

Andersen, 1995). Predisposing factors also include the social structure that was

traditionally thought of only in terms of education, occupation, socio-economic status and

ethnicity (Andersen, 1995). However, there has been some degree of debate within the

literature regarding psychosocial factors and whether the original model overlooked these

factors as being predisposing factors (Bradley et al., 2002). Furthermore, previous research

using the Behavioural model has given limited attention to these psycho-social factors that

can ultimately have a profound impact on whether or not someone will seek professional

help (Bradley et al., 2002). More recent attention has been given to social networks, social

interactions and cultural aspects as part of social structure and, now characterised as

predisposing factors are health beliefs, which Andersen (1995) describes as attitudes,

values and knowledge that people have about health and health services, that may

ultimately influence their perceptions of need and use of health services. These health

beliefs are thought to provide one explanation for how social structure might influence

enabling resources, perceived need and subsequent use (Andersen, 1995). It is suggested

that if we examine beliefs about a particular disease, measure need associated with that

particular disease and observe the services received to cope specifically with the disease, the relationships will be stronger than if we try to relate general health beliefs to global measures of need and a summary of services received in a given period (Andersen, 1995). This is why the behavioural model is most appropriate when assessing service utilisation.

Enabling factors refer to attributes specific to the individual or the community in which the individual lives (Andersen & Davidson, 1997). Both personal and community factors, need to be present for utilisation of care services to occur (Andersen, 1995). Enabling factors are "the resources available to an individual that encourage or alternatively, discourage a person from using services" (Keysor, Desai, & Mutran, 1999, p.335) Health personnel and facilities must be available where people live and work, and then, people must have the means and know how to get to and make use of those services (Andersen, 1995). People must also know of the availability of facilities and services in their area in order for them to access and utilise them. Social relationships can also serve as an enabling resource to either facilitate or impede help seeking behaviour and health services" use (Andersen, 1995). Thus enabling factors can be understood as the „means" and „know how" in accessing services. In the current research, enabling factors may also include impeding factors and in fact, the current research posits that one factor could act as both and enabling and an impeding factor depending on the direction of the relationship. It is also important to note that there seems to be some degree of overlap between predisposing factors and enabling factors, as some predisposing (or psychosocial) factors may also act as enabling factors in this context.

Need is also an important consideration within a model for service utilisation and it is the final descriptor in Andersen"s behavioural model. How people view their own health and functional state as well as how they experience symptoms, and whether or not they judge their problem to be of sufficient importance and magnitude to require professional help is regarded as perceived need (Andersen, 1995). Andersen also considered what he

termed „evaluated need" in the model. This refers to the situation where the need for care is determined by a professional"s judgement (Andersen, 1995). Previous research using Andersen"s behavioural model to investigate utilisation care services in the elderly has shown that need factors tend to be the strongest determinants of service use (Wolinsky, 1990). However, other studies using the model to assess preferences of short and long term care facilities have shown that enabling factors such as personal stress and family strain as well as attitudes towards the services were the most important factors in determining service utilisation (Keysor et al., 1999).

The model was initially used to assess utilisation of acute health care services the Andersen behavioural model has since been applied in a number of other contexts. Bradley et al. (2002) used the behavioural model to investigate access and utilisation of long term care services in the elderly, and also expanded the model to include psychosocial factors such as attitudes and knowledge as predisposing factors in service use, as well as including help seeking intentions. Andersen and Davidson (1997) used the behavioural model to explain access and utilisation of oral hygiene services using standardised population questionnaires across diverse age and ethnic groups. The model has also been used previously to investigate access and utilisation of mental health services. Kimerling and Baumrind (2005) used data from the population based Women"s Health Survey to investigate access to specialty mental health services for women in California. This study used the behavioural model to help drive their study and explain their findings of significant ethnical and racial variation in need factors and decisions to seek services (Kimerling & Baumrind, 2005). The model has been used with data from the Australian National Survey of Mental Health and Wellbeing to assess who uses mental health services in Australia (Parslow & Jorm, 2000) and to determine predictors of reported unmet need (Parslow & Jorm, 2001). However, Parslow and Jorm"s (2001) study included only people who had received some form of help from the formal health care system, and did not

explore the determinants of health care seeking for people who had not yet received any health services. In addition, all the previous research using the Andersen behavioural model as a framework has used a questionnaire style methodology. However, qualitative research has never been considered in any studies using the Andersen model as a framework, this is a notable gap in the knowledge around the Andersen model.

Some degree of debate exists within the literature about the fact that the original model has only included demographics as predisposing factors, suggesting that people‟s predisposition to use services was based only on biological, and systemic attributes such as education and financial issues. However others such as Bradley, McGraw, Curry, Buckser, King, Kasl and Andersen (2002), have argued that there are also psychosocial factors that contribute to a person‟s predisposition to use services. Therefore Bradley et al. (2002) who investigated long term care usage, identified a set of psychosocial factors to add to the model, including attitudes and knowledge, social norms, and perceived control, and suggested that these constituted an extended component of predisposing factors. It was suggested that psychosocial factors contribute to a wide range of decisions and subsequent behaviours related to long-term care decisions, and identified them as determinants of service use in long term care (Bradley et al., 2002), thus expanding the original Andersen Model (1995). Andersen and Davidson (1997) also expanded on the original Behavioural model when using it to frame research into oral health outcomes and also by including ethnicity as a determining factor in dental health service utilisation (Andersen & Davidson, 1997; Davidson & Andersen, 1997). Andersen and Davidson‟s (1997) suggested that their expanded version of the Behavioural model conceptualised "oral hygiene practices and dental services utilisation as intermediate dependent variables, which in turn influence oral health outcomes" (p.203), and was more focussed on the "effects of race-ethnicity and age cohort" (p.203).

Various researchers have investigated utilisation of mental health services using the Behavioural model as a framework for their investigation, two such studies were both conducted by Parslow and Jorm (2000, 2001). Using data from the National Survey of Mental Health and Wellbeing, their first study found that the factors most strongly related to use of mental health services were having a diagnosed affective, anxiety or substance-abuse disorder and their self identifying as having depression or anxiety, both of which were described as need factors (Parslow & Jorm, 2000). Three sociodemographic variables described by the authors as predisposing and enabling factors, were also found to be related to utilisation of mental health services. They were being female, being separated and having a higher education (Parslow & Jorm, 2000). In their 2001 investigation also using data from the National Survey of Mental Health and Wellbeing, Parslow and Jorm (2001) used the model as a framework for investigating met or unmet need for consumers of mental health services. This study revealed the enabling factors associated with reporting unmet need for consumers of mental health services included individuals with lower levels of education who had more expectation of receiving medication for their mental health problems, and also unmet need for individuals whose main income was a government pension, and most importantly that living in a rural location was significantly associated with reporting unmet need for psychological therapy (Parslow & Jorm, 2001).

The current study will use the expanded version of the model put forward by Bradley et al. (2002). This decision was based on the fact that this version of the model considers psychosocial variables within the predisposing, as opposed to enabling factors, and intended use is also taken into account. This is more amenable to mental health help seeking as, particularly in rural areas, health service use would not necessarily be the only possible outcome. Another possible outcome particularly in this context, may be not receiving the appropriate care or, wanting to seek help and not getting it. Further, it is important to acknowledge that help seeking intentions may also have some influence on

actual behavioural outcomes even though they are not the only factor to predict it. Whist it can be argued that intentions do not necessarily predict actual behaviour, it is important to at least consider them within a model of help seeking in order to fully understand the mechanisms and factors that are most impacting help seeking behaviour.

| Need and Enabling/impeding factors | → | Psychosocial factors (including predisposing factors) | → | Intended use | → | Help seeking outcomes |
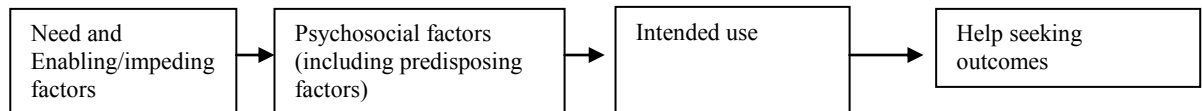
Figure 3. Andersen"s model (adaptation put forward by Bradley et al. (2002).

Other additions to the Andersen model include the concepts of mutability and discretion. Mutability refers to the extent to which a factor within the model is changeable (Andersen, 1995) and includes levels of low, medium and high mutability. Andersen argues that mutability is important to know when using the model in order to promote equitable access for a variable or factor that influences utilisation of services to be considered useful for promoting access it must also be considered mutable, or changeable. If the factor is mutable then it has more chance of highlighting policy changes that might bring about behavioural change (Andersen, 1995). Factors such as demographics are considered to have low mutability since age or gender cannot be changed to alter utilisation patterns; health beliefs are considered by Andersen to have medium mutability since they can be altered and sometimes effect behavioural change; enabling factors and some predisposing factors are seen to have high mutability as they are often easily changed and are often strongly related to utilisation (Andersen, 1995). In the current research we would argue that some predisposing/psychosocial factors also have high mutability as they are also easily changed and appear to impact service utilisation, although this will not be known for certain until the studies are conducted, and this concept will be explored further

in the final discussion in relation to the factors found to impact on help seeking behaviour and therefore service utilisation.

Discretion in this context refers to whether services are sought because of a "medical or mental condition that cannot, from the perspective of the individual, be resolved by other means" (Mitchell & Krout, 1998, p. 160). In other words discretionary services refer to whether entry into the service is "more or less controlled by formal agencies or health care providers in terms of eligibility and reimbursement" (Mitchell & Krout, 1998, p. 160), such services are less discretionary, and services that are more or less chosen and sought by the patient themselves with more choice and power in the decision are seen as more discretionary. For example, services such as aged care facilities may be seen as less discretionary as the person often feels there is no choice and are often seeking the services at the request or referral of a physician, where as for some mental health issues, services are sought solely at the patient"s own discretion, which often makes mental health services more discretionary.

2.6 Variables to explain under utilisation

Within the research literature there have been numerous suggestions about what factors could possibly influence help seeking behaviours, both positively (facilitating factors) and negatively (impeding factors). Some of these variables have been included previously using the Andersen model and some have not.

Several researchers investigating barriers to care in rural areas have suggested factors such as stigma and self reliance as significant barriers to seeking help for mental health issues.

2.6.1 Stigma

An important social factor said to impede access and utilisation of mental health services, particularly in rural areas is the issue of social stigma (Sweeney & Kisely, 2003). Stigma is a term that does not have one clear cut definition, however, it can be seen as an "amalgamation of three related problems: a lack of knowledge (ignorance), negative attitudes (prejudice) and excluding or avoiding behaviours (discrimination)" (Rose, Thornicroft, Pinfold, & Kassam, 2007, p. 2). Stigma can come in the form of perceived (social) stigma where there is a feeling of external stigmatisation or it can come in the form or self stigma where the individual stigmatises themselves. The concept of social stigma (stereotype awareness) (Corrigan, Watson, & Barr, 2006) in relation to mental illness is said to be derived from a socio-ethical association whereby according to the values of Western culture, persons with psychological problems are seen as depraved and immoral (Angier, 1984). This creates a sense of guilt and embarrassment around seeking help for psychological problems which can extend from the individual themselves to include their families, and no matter how great the need, the guilt and embarrassment associated with psychological disorder can prevent them from ever seeking help for their symptoms (Angier, 1984). Self stigma is distinguished from perceived or social stigma and is presented by one researcher as having a three level model: stereotype agreement, self-concurrence, and self esteem decrement (Corrigan et al., 2006). Self stigma occurs when the individual internalises the stigma and as a result experience diminished self esteem and self efficacy (Corrigan et al., 2006). One study comparing the two types of stigma specifically as it refers to depression in the Australian context (Griffiths, Christensen, & Jorm, 2008) found some important differences that should inform any future anti-stigma campaigns. First, personal stigma was consistently higher among men, those with less education, and older people. Personal stigma was also associated with greater current psychological stress, lower prior contact with depression, not being aware of national

awareness initiatives and lower depression literacy (Griffiths et al., 2008). Although perceived stigma was also associated with higher current psychological distress, it was not associated with lower depression literacy, and was not higher in men or older people (Griffiths et al., 2008). These differences have implications for how anti stigma campaigns should be developed and implemented, such as developing specific programs targeted at each of the at risk groups.

The issue of stigma has long been grappled with within the mental health community, and it has been an issue that has recently gained momentum and interest (Halter, 2004). In the United States, the New Freedom Commission on Mental Health in 2003 recommended that decisive action to reduce the stigma of seeking help for mental health needed to be taken, suggesting that no matter how good the services are, they are pointless if people will not use them (Halter, 2004). This suggests that stigma is still a significant issue, and is being recognised as such at the highest level of Western Governments.

Mental illness has traditionally elicited negative attitudes among the general public (Barney, Griffiths, Christensen, & Jorm, 2009) and it would seem that this continues and is somewhat more obvious in rural and remote areas where residents still tend to equate mental health issues with "insanity" (Fuller et al., 2000; Wrigley et al., 2005). It has been claimed that this stigmatisation of mental illness not only refers to unjust and discriminatory behaviour, but that it also affects aspects of personal identity and is responsible for reluctance among members of the community to disclose the presence of distressing psychological symptoms not only to each other but more importantly to health professionals (Jorm et al., 2000b). This presents an significant barrier to seeking and receiving adequate care for their symptoms (Jorm et al., 2000b). As one author suggested, in rural communities there is nothing inherently suspicious about visiting a solicitor, accountant, or even a GP, but the same cannot be said for visiting a psychologist or

psychiatrist (Harvey & Hodgson, 1995). It has also been suggested that the range of culturally acceptable strategies for coping with mental health issues is more varied than for physical distress, and given the ever present stigma surrounding mental illness, it is suggested that most people would work their way through most if not all of those strategies before seeking help from a mental health professional (Aoun, Pennebaker, & Wood, 2004).

Negative perceptions regarding mental illness can be understood by Weiner‟s (2000, as cited in Halter, 2004) attribution model, whereby stigmas are the result of negative perceptions regarding whole categories of people, whom people categorise to enhance a sense of order, to provide explanations for others behaviour and to emphasise the difference between the afflicted and themselves (Halter, 2004). Halter (2004) used patients from the waiting rooms of two healthcare facilities (n=117).Patients were asked to complete a battery of questionnaires including an attitudes towards seeking professional psychological help questionnaire (Fischer & Farina, 1995) and a vignette (depression) style questionnaire that measured emotional responses to the person with depression. The results suggested that many respondents still had the perception that depression is a sign of weakness, and all that is needed to overcome the illness is the exertion of willpower (Halter, 2004). This study also found that these attitudes were negatively impacting the use of effective treatments leading to needless suffering and even suicide in depressed patients (Halter, 2004). Further, a study utilising focus group discussions with rural mental health service users and mental healthcare workers conducted by Crawford and Brown (2002), suggested that it is the responsibility of the mental health service providers to empower clients and enhance workers‟ sensitivity to clients awareness and feelings of stigma, in order for the client‟s visit to a mental health worker to feel more "like a friend going round" (Crawford & Brown, 2002, p. 237).

Using a qualitative analysis, Sweeney & Kisely (2003) explored the views of service providers in one rural community regarding what they perceived to be barriers to

the management of mental health care in their rural area. All service providers agreed that the most significant barrier, was the stigma associated with mental illness, and that stigmatised attitudes were more pronounced in the elderly, who even saw the word „mental" as being stigmatising in itself (Sweeney & Kisely, 2003). Fuller et al. (2000), interviewed rural health and mental health professionals and mental health consumers, and found that every participant concluded that mental health problems in rural communities were associated with a high degree of stigma. Also, that the conventional understanding of mental health problems is that they imply irreversible insanity leading to a fear about what might happen if they enter the mental health care system (Fuller et al., 2000). The implication here is that even when they do recognise their distress they may actually avoid formal mental health services (Fuller et al., 2000) based on their stigmatised and ignorant views of what might occur if they do seek out formal help. This also suggests a degree of confusion about what mental health services and professionals do and how patients in the mental health system might be treated. Wrigley et al. (2005) used a cross sectional survey study (n=142) and found perceived stigma was related to more negative attitudes towards seeking help for distressing psychological symptoms. Similarly, in a qualitative study interviewing adolescents about the barriers they perceive to seeking help for mental health problems, Aisbett , Boyd, Francis, Newnham and Newnham (2007) found participants described the "presence of rural gossiping networks and how these are perpetuated by social stigma" (p. 8). Dinos, Stevens, Serfaty, Weich, & King (2004) suggested that issues around stigma are often what they referred to as subjective stigma, whereby there are feelings of stigmatisation even in the absence of any overt discrimination. According to the outcomes of this study, stigma in the context of overt discrimination was largely experienced by those with psychosis or drug dependence, and those with anxiety and depression were more likely to perceive stigma in the absence of overt discrimination, or to feel subjective stigma (Dinos et al., 2004). The issue of stigma and its apparent impeding

role in help seeking behaviours would position it in the socio-behavioural model as a psycho-social predisposing factor as described by Bradley et al. (2002). However, it has not been described within the Andersen model previously.

Although the effects of stigma in the context of mental illness have been generally explored, there still remains some degree of disparity as to the adequacy of stigma in completely or even partially explaining the apparent reluctance of rural people to disclose symptoms of mental illness or emotional problems (Prior, Wood, Lewis, & Pill, 2003). One study using college students found that perceptions of public stigma did not appear to pose a substantial barrier to seeking mental health care (Golberstein, Eisenberg, & Gollust, 2009). Similarly, another recent study found that stigma was not a primary barrier to seeking help for mental health issues among both younger and older adults (Pepin, Segal, & Coolidge, 2009), although this study did not use a rural sample. The phenomenology of stigma is not yet fully understood, particularly with respect to rural people and communities, as it remains unclear whether stigma is more prevalent in rural communities or whether the experience of stigma is more profound in rural settings as a result of social proximity, therefore it is suggested that further research investigating this phenomenon is warranted (Boyd et al., 2006). One survey study found that within the one sample of members of several rural communities, 70% believed that people in their communities would gossip about a person with a mental illness, and at the same time most participants believed that their communities would be supportive and caring towards someone with a mental illness (Komiti et al., 2006). Another study using survey data found quite benign community attitudes towards people with common mental disorders (Jorm et al., 2000b). Therefore, further investigation, especially using qualitative methods to really get an understanding of what rural people say about stigma and to explore the extent to which stigma is really apparent in rural areas as well as the extent to which it can explain non-

disclosure of symptoms of emotional distress, is required in order to help close the gap or disparity surrounding this construct.

2.6.2 Self Reliance

Another aspect of rural culture said to impact on or hinder the help-seeking process for mental health issues, is the existence of a self reliant or „stoic‟ culture in rural communities (Fuller et al., 2000; Judd et al., 2006c; Wrigley et al., 2005). Stoicism has been defined as having three main characteristics: "lacking in emotional involvement, lacking in emotional expression and exercising emotional control or endurance" (Wagstaff & Rowledge, 1995, p. 181). Research in the US using qualitative and quantitative data has suggested that rural people rely less on professional health services and more heavily on family and friends than their urban counterparts, and place more importance on self responsibility for health (Weinert & Ann Long, 1987). Similarly, Australian research has suggested that the self-reliant, stoic attitudes found in rural settings make it difficult for people to even acknowledge they are experiencing distress, let alone seek help for their distress (Fuller et al., 2000). The cultural tradition of self reliance was found to create a sense of reluctance to seek help, as rural residents are used to meeting their own needs without outside help, and to seek help from outside is regarded as a personal weakness (Fuller et al., 2000). One recent study using mail-out surveys (N=467 and 567) found that stoicism was higher in males, was correlated with lower wellbeing but was unrelated to psychological distress (Murray et al., 2008). Further, this study found that the relationship between stoicism and lower quality of life was mediated by negative attitudes towards seeking psychological help (Murray et al., 2008).

Other recent research has suggested that although in many cases, self reliance can be seen as having a negative impact on help seeking in that people (particularly men)

believe that seeking professional help is a sign of weakness and should only be a last resort (Gorman et al., 2007; Jorm et al., 2006b), self reliance could be a positive feature too (Caldwell & Boyd, 2009). One study suggested that self reliance, or more specifically, reliance on non-professionals such as neighbours, friends and family, could reflect aspects of resilience and social capital within rural communities (Caldwell & Boyd, 2009). This study used interviews with farming families to investigate coping strategies employed by families affected by the drought, and found that reliance on social capital, i.e. support from family, friends and other members of their communities was an adaptive resource (Caldwell & Boyd, 2009). Further investigation into the existence of and influence of this stoic culture on help seeking for mental health problems is required to more fully understand the impact of this culture on help seeking.

2.6.3 Lack of knowledge/Information

Another potential barrier, although much less researched, is the lack of knowledge about what services are available, or a lack of information about what is available. Previous literature has found a lack of knowledge to be an important barrier to seeking help for mental health issues in rural areas. One such study was an investigation of stress and help seeking in citrus growers in the Riverland of South Australia. It was conducted by Staniford, Dollard, and Guerin (2009) who found in the analysis of interview data with drought stricken farmers that a lack of knowledge, specifically, not knowing what is available and difficulty recognising problems created a significant barrier to seeking help for mental health problems. This finding makes intuitive sense, if a person is lacking the information they need to recognise their problem as important or serious enough to seek help, and they are not aware of what would be available even if they did want to seek help, then the likelihood of them receiving the help they need would indeed

be very slim. Mental health literacy is one construct discussed in previous research (Jorm, 2000) that may explain a lack of awareness of services in rural areas. Mental health literacy is been defined as "knowledge and beliefs about mental disorders which aid their recognition, management and prevention" (Jorm et al., 1997, p. 182). A person"s management of their own or another"s mental health symptoms will be influenced by their mental health literacy, which includes their ability to recognise types of psychological distress, knowledge and beliefs about risk factors and causes, knowledge and beliefs about available self help and professional interventions, attitudes that facilitate (or indeed form a barrier) to recognition of the disorder and help seeking, and knowledge of how to seek mental health information (Jorm, 2000). One study comparing rural and urban mental health literacy found similar scores across remoteness categories, with inner regional residents more likely to identify suicidal ideation and chronic schizophrenia vignettes and more likely to have heard of the Australian national depression health promotion campaign (Griffiths, Christensen, & Jorm, 2009). However rural groups were more likely to rate evidence based treatment of psychotherapy helpful for depression, and were more likely to rate, painkillers and drinking as helpful for depression (Griffiths et al., 2009). Further, outer remote participants were more likely to endorse antipsychotics for the treatment of early schizophrenia and less likely to endorse psychiatrists, psychologists and other allied health staff as helpful (Griffiths et al., 2009, p. 1). Goldney et al. (2007) also found that their rural South Australian population were also less positive about the use of psychologists for treatment of depression and were more likely to endorse drinking and painkillers as treatment options. This may suggest that rural people are lacking in knowledge not only about what treatments are helpful for mental disorders, but also what psychologists, psychiatrists and other mental health workers offer in terms of treatment, both creating a barrier to help seeking.

More research is needed to uncover whether a lack of information about and knowledge of services (or perhaps a lack of mental health literacy) consistently arises as a potential barrier to seeking help for mental health services in rural communities. It is anticipated that, the qualitative investigations within this research program will be most likely to uncover more information about this issue being a significant barrier in the rural context.

2.6.4 Psychological Mindedness

One construct that has not been investigated in the context of mental health help seeking and appears to be of particular relevance and potential, is the Psychological Mindedness (PM) construct. Psychological mindedness refers to a person''s ability and openness to the psychological processes by their ability to see relationships between thoughts and feelings and looks to learn the meanings and motivations behind behaviour (Appelbaum, 1973). It is this processes that gives the construct potential relevance in the context of help seeking, particularly in rural areas where the factors that underpin their reluctance to seek help are not yet fully understood.

Previously applied within the realm of clinical psychology, psychological mindedness was largely used in clinical settings to investigate individuals'' suitability for psychotherapy. It is a construct thought to be a prerequisite for effective psychotherapy (Hall, 1992). There has been limited empirical research on the construct and therefore a clear cut definition is also somewhat limited (Hall, 1992). Research investigating the applicability of this construct in contexts outside the clinical realm is also severely limited if non-existent. Knowledge of how this construct operates outside of this realm could provide researchers with a more thorough understanding of psychological mindedness, and a more clear definition of the construct. The most preferred definition in the literature (Hall, 1992; Shill & Lumley, 2002) is Appelbaum''s (1973): "A person''s ability to see

relationships among thoughts, feelings, and actions, with the goal of learning the meanings and causes of his experience and behaviour" (p.36). This definition proposes that psychological mindedness includes a person"s interest in expanding self awareness through reflection, and it encompasses the person"s interest in, and ability to reflect on affects, thoughts and behaviours in an integrated way (Shill & Lumley, 2002), thus it has cognitive, affective and motivational components (Hall, 1992).

Specifically, the cognitive component refers to "the ability to see relationships and to learn meanings and causes" (Appelbaum, 1973, p. 36), more specifically, that individuals high on psychological mindedness, posses a basic science for psychological thinking, a necessary minimal presence for psychological mindedness. Another element of the cognition component of Appelbaum"s (1973) definition is "intuition and empathy" (p. 36) referring in this instance to the "easily observed talent that some people have and others lack, to „see", „know", „feel" covert and inexplicit psychological events" (p.36). The second part of this definition is, "the goal of learning the meanings and causes of behaviour" (p. 36), meaning that someone may have the cognitive abilities and intuitive talents but they do not have the goal of using them to learn psychological meanings or causes, and also, that they can be interested in themselves and others in humanistic terms (Appelbaum, 1973). The third part of this definition is "self-directedness of psychological thinking" (p.37) whereby the direction of their thinking for treatment purposes is towards themselves, often referred to as being more self aware or more introspective (Appelbaum, 1973). The fourth component of Appelbaum"s (1973) definition is ability; which is said to be an "estimate of a person"s present and future ability to put their capacities for psychological thinking at the service of the psychoanalytic process" (p.37). One study assessing psychological mindedness and expectations of the counselling process, found that people reporting higher levels of psychological mindedness reported greater expectations of self-involvement in counselling and greater expectations of positive

outcome (Beitel et al., 2009).This suggests that highly psychological minded individuals have high expectations of themselves and their involvement within the counselling process and also have high expectations of success of using the service.

Another proposed definition suggests psychological mindedness is, "a degree of access to one"s feelings, a willingness to try to understand oneself and others, a belief in the benefit of discussing one"s problems, and interest in the meaning and motivation of one"s own and others thoughts, feelings and behaviour, and a capacity for change" (Conte, Ratto, & Byram Karasu, 1996, p. 254). This definition has some particular relevance for the construct in the context of help-seeking behaviour for mental health issues. One study suggested that Psychological openness, one aspect of the psychological mindedness construct, is an important factor in predicting help-seeking (Mackenzie et al., 2006). Psychological openness seems to be most important for females who tend to be more open to acknowledging mental health problems and more open to seeking help for such problems (Mackenzie et al., 2006). This supports the current study"s theoretical claim that psychological mindedness may be a significant factor in predicting mental health help seeking. Another study by Beitel and Cecero (2003) also found that the psychological mindedness construct was highly correlated with openness to experience. Mackenzie et al. (2006) even suggested that initiatives aimed at increasing use of mental health services particularly by men, who were found to be less psychologically open, should be more focussed on increasing their psychological openness rather than on stigma and attitudes towards help-seeking. This suggests that help-seeking behaviour may be better predicted in the first instance, by traits within the individual such as their level of psychological mindedness, rather than outside or community influences. Beitel et al. (2009) suggested that the construct of psychological mindedness is in fact a clinically relevant personality construct. This would suggest that if individuals are highly psychologically minded then not only would it be reflected in their outcomes of psychotherapy, it should also be an

important contributing factor to the preceding help seeking behaviour. Also according to Beitel and Cecero (2003) psychological mindedness is positively related to healthy rather than pathological personal and interpersonal constructs (p 163).

Therefore the main barriers to be investigated in the current research were stigma, self reliance, lack of information and knowledge, and psychological mindedness. They were all thought to be responsible for the lack of utilisation of mental health services in rural areas and the reluctance of rural residents to seek out help for mental health problems.

2.7 Gaps in the literature

Significant gaps in the literature that this research aims to fill include (1) the paucity in research investigating psychosocial and cultural factors influencing mental health help seeking, and (2) the shortage of qualitative investigations giving rural people a voice and engaging them in the research process by asking them what *they* believe the most important factors are in creating barriers or indeed facilitating help seeking behaviour for mental health issues in their rural communities. Another gap is (3) investigations of the psychological mindedness construct in context of help seeking. This novel line of investigation into this construct has the potential to give further insight into what other individual factors are important in either impeding or facilitating help seeking behaviour. Psychological mindedness has never been investigated in this context before so whether or not it acts as a facilitator or indeed a barrier remains an empirical question that this thesis aims to investigate.

It is vital to investigate these barriers and facilitators using qualitative methods because in order to provide services that are applicable, accessible and acceptable, we need to know what the people who will be using the services or potentially using the services say about what impacts on their help seeking behaviour; they need to be given a voice. Qualitative research provides the opportunity to directly obtain information in some detail

from actual and potential service users, about what the barriers (facilitators) are and what issues most affect their help seeking behaviour. Further, mixed methods research provides an even more in depth opportunity to uncover what issues are salient both across methods, and within methods on help seeking behaviour, and therefore what issues, social phenomena and systemic resources would be best suited for increasing the level of help seeking that occurs for those who are in need.

There is also a lack of studies that have used the Andersen model as a framework for both driving and explaining studies conducted using both qualitative and quantitative methods. Therefore, qualitative and quantitative results have not been combined and explained under the Andersen model. This thesis aims to address this gap.

2.8 Objectives

The aim of this thesis is to investigate access and utilisation of mental health care services in rural areas. Specifically, the research aims to explore how the individual, psycho-social and cultural aspects of rural people and rural locations interact with or influence behaviours that effect help seeking, and more specifically, how aspects of the culture where people live may impact on or impede their seeking help for mental health issues. The study also aims to investigate and identify possible predictors of mental health help seeking in rural settings.

The specific research questions of the thesis are:

1. What do rural people themselves say about access to mental health services in rural areas ?

2. What do rural people themselves say the barriers to and facilitators of access are?

3. In the context of the theory of the Andersen behavioural model:

- What are the independent contributions of psychosocial factors to help seeking behaviour?

- What is the utility of the model in the rural help seeking context?

4. What contribution to help seeking in rural areas does psychological mindedness make?

Chapter 3- Study One- Understanding help seeking for mental health in rural South Australia: A thematic analytical study

This study was published in the Australian Journal of Primary Health and is presented here in its manuscript format in the same typeset as the rest of the thesis. The published journal formatted version can be found as Appendix A.

Collins, J.E., Winefield, H., Ward, L., &Turnbull, D (2009) Understanding help seeking for mental health in rural South Australia: A thematic analytical study. *Australian Journal of Primary Health, 15,* 159-165.

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Collected data, performed analysis on data, interpreted data, wrote manuscript and acted as corresponding author.

I hereby certify that the statement of contribution is accurate

Signed *Date........................*

Professor Helen Winefield

Supervised development of the work, and manuscript evaluation.

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Supervised development of the work, helped in data interpretation and manuscript evaluation.

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Manuscript evaluation.

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3.1 Preface

The following study is the first empirical study in this research program. It is a qualitative investigation that gives voice to rural people, allowing them to describe and discuss what they believe are the main issues and barriers to seeking help for mental health.

As discussed in the previous chapter, the research makes use of and builds on the Andersen model to explain help seeking for mental health by rural people. In addition to incorporating the established variables of stigma and self reliance, the research adds to the literature by examining the notion of psychological mindedness, as well as other variables to emerge via semi structured interviews.

While it has been established that the concept of psychological mindedness may have some merit, it has not been investigated previously in the context of help seeking for mental health by rural people and this study makes use of probe interview questions specifically related to the concept to test its potential utility for subsequent studies in the research program.

In summary then, the study seeks to set the foundations for subsequent quantitative research that investigates the influences on help seeking behaviour as well as adding to the theory that informs the issue.

3.2 Abstract

This study investigated barriers to help-seeking for mental health concerns and explored the role of psychological mindedness using semi-structured interviews with sixteen adults in a South Australian rural centre. Prior research-driven thematic analysis identified themes of stigma, self-reliance and lack of services. Additional emergent themes were awareness of mental illness and mental health services, the role of GPs and the need for change. Lack of psychological mindedness was related to reluctance to seek help. Campaigns, interventions and services promoting mental health in rural communities need to be compatible with rural cultural context, and presented in a way that is congruent with rural values.

3.3 Introduction

Research into effective delivery of mental health services to rural communities is timely given the negative impact of the current Australian drought on the physical and mental health of rural dwellers (Roufeil & Lipzker, 2007). Research has focused predominantly on the prevalence of mental health concerns; the question of how rural attitudes impact on help-seeking behaviour remains largely unanswered (Fraser et al., 2002). Access to care in rural areas is likely to be influenced by psychosocial factors, as well as the availability and proximity of services. The aim of this study was to investigate what rural South Australians believe to be the main barriers to seeking help for mental health issues and to investigate the role of Psychological Mindedness (PM) in help seeking.

Help seeking refers here to seeking help from mental health professionals. However, it is not limited to this form of professional help as it is duly acknowledged that in rural areas in particular, General Practitioners are usually the first and sometimes the only point of contact for such issues (Judd et al., 2007), and that there are also many other forms of help and care that may be available in the wider community.

Australians living in rural and remote communities score lower on a range of health indices and display higher overall disability and mortality rates than their urban counterparts (Australian Institute of Health and Welfare, 2006). Death rates, particularly from suicide, are higher in rural and remote parts of Australia than in more densely populated areas (Australian Bureau of Statistics, 2002). Despite increasing need, most rural communities have limited access to professional services for mental health concerns, and what is available may not be accessible in a way that takes account of belief systems in rural communities (Roufeil & Lipzker, 2007).

Psychological openness predicts help-seeking behaviour, particularly in men (Mackenzie et al., 2006; Mackenzie, Knox, Gekoski, & Macaulay, 2004). Psychological openness, as well as, belief in the benefits of discussing problems and ability to access

feelings are components of Psychological Mindedness (Conte et al., 1996). Psychological mindedness has been typically used to assess suitability for psychotherapy among those who have sought help (Hall, 1992), however it may also contribute to whether someone seeks help in the first instance. Previous research suggests that higher levels of psychological mindedness leads to better therapeutic outcomes (Hall, 1992), therefore it is relevant to investigate whether this construct has any influence on help seeking itself. Although previous research has not directly investigated the link between psychological mindedness and help-seeking, the finding that low psychological openness predicts less help-seeking for mental health problems among men (Mackenzie et al., 2006) suggests that further investigation of this relationship is warranted.

Widespread stigma attached to mental illness and those experiencing it, affects the type of help (if any) that is sought and may also adversely affect adherence to interventions (Jorm, Angermeyer, & Katschnig, 2000a). Despite this, the extent to which stigma impacts help-seeking in rural areas, is still a point of some contention. Segal, Coolidge, Mincic, and O'Riley (2005), for example, found lack of knowledge of the mental health system, confusion about services available, concerns about cost and lack of coordination with primary care were more important than stigma in the under-utilisation of mental health services, particularly among older rural adults. Further, Komiti, Judd and Jackson (2006) found high level of stigma among rural adults that was not related to help-seeking.

The importance of self-reliance or stoicism in rural culture may also explain under utilisation of mental health services (Fuller et al., 2000; Judd et al., 2006c; Komiti et al., 2006). Fuller et al. (2000) found that the rural culture of self reliance led to a ‚mistrust of outsiders‟ suggesting that help-seeking would be seen as personal weakness that would not be endorsed except in cases of dire necessity. Depression, in particular, is seen as personal weakness (Jorm et al., 2006b).

Provision of services that are appropriate and well utilised by rural people requires an understanding of the inherent belief systems and culture within rural communities. The current study used qualitative, semi-structured interviews, analysed using a prior research-driven thematic analysis (Boyatzis, 1998) to investigate what rural South Australians believe to be the most important barriers to seeking help for mental health issues. The role of psychological mindedness in rural help seeking was also considered.

3.4 Method

General practitioners (GPs) from five Barossa region surgeries in South Australia were invited to assist in recruiting participants; GPs in two practices participated. The Barossa is a distinctive, wine-producing region with a German-speaking heritage within a two hour drive of South Australia"s capital city, Adelaide. General Practitioners are the first point of reference in the region where there are no permanent psychiatrists and only limited psychological services.

Practice receptionists canvassed patients" interest in participation, provided information sheets, and obtained patient"s permission to release contact details to the researcher. The researcher conducted face-to-face interviews with participants at the surgery.

3.4.1 Sampling Frame

Recruitment used maximum variation sampling (Grbich, 1999): individuals were recruited to provide an even spread of males and females, and a range of experiences with mental health services, from those who had never accessed services to those accessing them on a regular basis. Six of the sixteen participants were recruited via snowball sampling (Grbich, 1999); where previous participants recruited other potential participants fitting the aforementioned criteria. Sample size was determined when saturation (i.e., no

additional information was derived) of interviews was achieved (Rennie, Phillips, &

Quartaro, 1988).

3.4.2 Participants

Residents from one rural centre (11 females, 5 males) aged between 36 and 75

years participated. Seven (44%) had accessed mental health services in the previous 12

months (Table 1).

Table 1

Sample Description, Services Accessed and Method of Recruitment

Participant	Gender	Age	Previous service accessed	Method of attainment	Reason for seeking help
1	F	38	GP	Practice Receptionist	Depression
2	F	39	Nil	Snowball	
3	F	58	Nil	Snowball	
4	M	64	Nil	Snowball	
5	M	36	Nil	Snowball	
6	F	36	Counsellor	Practice Receptionist	Depression
7	M	63	Nil	Snowball	

8	M	56	Nil	Snowball	
9	F	63	Psychologist	Practice Receptionist	Depression
10	F	37	Counsellor	Practice receptionist	Psychosis
11	F	73	Nil	Practice receptionist	
12	F	45	GP, Psychiatrist, Mental health Nurse	Practice Receptionist	Psychosis
13	F	75	Nil	Practice Receptionist	
14	F	46	GP, Psychiatrist, Mental health nurse	Practice receptionist	Depression
15	F	43	GP	Practice Receptionist	Depression, Anxiety
16	M	47	Nil	Practice Receptionist	

3.4.3 Procedure

The study received ethical clearance from the University of Adelaide Human Ethics Sub-Committee. Participants were given an explanation of the objectives of the interview and an assurance of confidentiality. Consent included permission for the interview to be taped. Interviews lasted between 10 minutes and one hour.

All questions in the interview schedule were asked with order varying to assist flow. Questions were asked about participants" use of mental health services, how they did or would go about accessing services should they need to, reasons why people might not access services even if they needed or wanted to, and openness to discussing problems and talking about their feelings (interview questions are available from the authors upon request). Voice recordings were transcribed verbatim.

3.4.4 Data Analysis

Prior research-driven thematic analysis was used to identify and develop predetermined themes based on previous research and thought prior to data collection to be imperative to the research question (Boyatzis, 1998). Emergent themes were also considered. After transcription, the analytic process followed guidelines for thematic analysis of Braun and Clarke (2006) involving, first, reading and re-reading transcripts, second, generating initial codes, whereby specific features of the data were coded in a systematic way across all transcripts, and third, collating, naming and defining themes.

3.5 Results

Results have been structured according to the prominence of themes with predetermined themes presented before emergent themes (Table 2 *Predetermined and Emergent Themes*). Direct quotes are identified by gender and age of participant (I4, M, 64 indicates a quote from the fourth participant, a 64 year old male).

Table 2

Predetermined and Emergent Themes

Predetermined themes	Emergent themes
Stigma	GPs
Lack of Services	Awareness/Education
Self reliance	Need for change
Lack of Psychological mindedness	

3.5.1 Stigma

Stigma surrounding mental health was raised by every participant. It was one of the most common answers to why people might not seek help for mental health even if they needed or wanted to. It was also an important barrier to even discussing mental health concerns with others.

> ―*There is still that stigma about mental health and I think that would stop a lot of people using the services"* (I13, F, 45)

> ―*people aren't gonna openly go searching for that sort of thing (mental health information) they got people watching them in the surgery that's what they'd be thinking ohh someone's watching me take this mental health brochure they think I'm weird"*(I1, F, 38)

―The problem there of course is, there's a little bit of the embarrassment of you know everybody knows everybody else so you've got to be careful" (I16, F, 43)

Stigma directly affects choice to access services, extending even to the collection of information. Some people indicated they would not openly search for mental health information and were concerned about what others in the GP surgery might think.

3.5.2 Lack of services

Lack of mental health services was raised in all interviews. Participant indicated that there were not enough services and those available and the procedures in place were not adequate in meeting their needs.

―There is nothing, we need help up here, there is a lot of people up here that need it and there is no support here, none at all" (I15, F, 46)

―I don't think we've got anything up here in like Angaston Hospital or our hospitals available like sort of for mental health………… and I was sent down to Glenside" (I11, F, 37)

―There's no one there that can come and see you on a permanent basis so that makes it really difficult so I chose to opt out of using the mental health services here mainly for that reason" (I13, F, 45)

3.5.3 Self-reliance

Self-reliance was raised by seven participants, reflecting a preference for dealing with problems alone or for using alternative sources of help. This was particularly salient for men. Participants considered self-reliant culture to be part of the German heritage of the area, suggesting that it is an engrained cultural trait.

―You can sort it (emotional problem) out yourself without needing any help" (I8, M, 63)

―It's a very strong German place up here and men don't do things like that and that's taking a long time to change" (I15, F, 46)

"They'll be right, tough it out, I was brought up on a farm and I was in the shearing sheds for years and around men who pretty much punish themselves instead of, and I was one to, 'work it out' is the belief, work it out of your system or drink it out or, and you'll be alright, you'll pull through" (I17, M, 47)

"Well too proud to admit there's something wrong with them" (I8, M, 63)

Preference for using alternative help sources included:

"sometimes if you've got a problem like that you might go to or talk to someone about it but not necessarily a professional, you might just talk about it to a friend or something like that you know" (I4, M, 64)

"I've got a really good friend who I e-mail with regularly who knows everything. One of my best friends from you know twenty years ago" (I1, F, 38)

Nine participants suggested that dealing with problems alone was entrenched in the culture of rural men, and that it creates negative outcomes including substance abuse. This may also represent hegemonic masculinity at play within rural men.

"it's a bit Aussie you know it's real ocker kind of mentality especially around males to just 'deal', and if you can't 'deal' then you're not discussing it you know you find some alternative, so we see the drinking and the pub violence and the fighting and that kind of stuff as a result" (I7, F, 36)

"And a lot of men don't like, don't believe they're crook too. Like they sort of keep fobbing it off and say I'm alright sort of thing you know" (I8, M, 63)

"a lot of men around here that have got mental health issues, they self medicate with drugs and alcohol" (I11, F 37)

3.5.4 Lack of Psychological mindedness

Psychological mindedness includes willingness and ability to get in touch with one's feelings, belief in the benefits of discussing one's problems and an openness and

willingness to change (Beitel & Cecero, 2003). Unwillingness to talk openly about problems was raised by 13 participants.

> ―*No one talks openly about that sort of stuff*‖ (I1, F, 38)

> ―*People around here are very closed about these issues*‖ (I3, F, 58)

> ―*There's that country pride stuff, in a way it's a bit Aussie you know it's real occer kind of mentality especially around males to just _deal'*‖ (I7, F, 36)

> ―*It's just I get the feeling that they are not too willing to try anything new and things like that*‖ (I14, F, 75)

In response to how people in their community might perceive the idea of getting in touch with feelings:

> ―*People have a notion of, _that's a bit alternative or, that's a bit…..Yeah new age, um a bit soft, with the propensity in the country is to be tough, physical, work hard……. maybe now it's not so much a sign of a weakness but more of a lot of ―hoo haa*‖, *for want of a better term, like, a lot of bullshit you know*‖ (I17, M, 47)

The basic premises of psychological mindedness, namely talking about problems, getting in touch with feelings and being open to new experiences, are not well received or practiced in this particular community. For these participants, openly talking about problems is in direct opposition to self reliant culture; help-seeking is seen as a sign of weakness and causes embarrassment. Discussing feelings is seen as "soft" and the idea of getting in touch with one‖s feelings is seen as "new age" or "a lot of bullshit".

Emergent themes included the role of GPs, awareness of mental health services and need for change.

3.5.5 Awareness

Awareness manifested itself in discussions about the lack of education, knowledge and information about mental health problems, as well as the frequent misconceptions in rural areas of what mental illness is and what mental health services do. At least one of

these issues was discussed in every interview. Lack of education was raised by 11 of the 16 participants:

—‖Definitely a lack of education in the general community‖ (I1, F, 38)

—‖I think education, educating people would be a really good step………...I think they need to be educated that the psychologists and psychiatrists aren‗t going to judge them and you know tell them what to do and what not to do and stuff like that they‗re just there for guidance‖ (I13, F, 45)

—‖So I think there needs to be more that way for people to be educated up here more about the mental health too‖ (I15, F, 46).

Examples of discussions about lack of knowledge and information included:

—‖If you‗re not told about how to go about getting that help you just don‗t know where to go obviously. You don‗t know that it‗s even available that‗s the hard part‖ (I3, F, 58)

—‖You never see anything advertised‖ (I1, F, 38)

—‖As far as mental health around the area I wouldn‗t have a clue I wouldn‗t even know where to go‖ (I4, M, 64)

Eight participants suggested that there are considerable misconceptions around mental illness in their community and these are a significant barrier to seeking help for mental health problems.

—‖Yeah coz most people don‗t understand mental illness…. Well you see people and you think that there‗s nothing really major wrong with them and just build a bridge kind of thing and cross it, you know what‗s wrong with you‖ (I3, F, 58)

—‖To be mentally ill I really don‗t know what that is. You know if I run down the street naked singing am I mentally ill?‖ (I9, M, 56)

—‖You‗re always going to get those people that look at it and think —‖yeah they‗re batty‖ because they go through a mental health (problem), they‗ve gotta be batty they‗ve gotta be mad‖ (I10, F, 63)

3.5.6 General Practitioners

Issues around General Practitioners were raised by 12 of the 16 participants. General Practitioners were identified as the first point of call for all ailments including mental health issues, in country areas. Participants suggested that many rural GPs are over-burdened and that this may affect their ability to recognise and detect mental health problems.

> ―They (the GPs) have got to sort out your physical stuff first coz if you can‘t get into see them then you‘re not gonna get to see them about your mental health either‖ (I3, F, 58)

> ―it can be a six week wait, to see that doctor and he could be on the ball because they are looking out for depression now more than before, but my life experiences tells me that I need to actually say, you know‖ (I17, M, 47)

> ―I think they (GP‘s) can probably understand depression and anxiety maybe, but not so much psychosis which is what I suffer from‖ (I13, F, 45)

Some participants also suggested that GPs are not adequately aware of services available to someone with mental health issues.

> ―If you get a new GP here who doesn‘t actually come from the Barossa and it‘ll take him or her a while to learn what is available‖ (I14, F, 75)

3.5.7 Need for change

Fifteen out of the 16 participants suggested the need for change to both the system (i.e. the number of services available) and to rural attitudes towards mental illness and the seeking of treatment.

> ―There definitely needs something up here, something better, a better mental system than what they‘ve go up here definitely‖ (I15, F, 46)

*―I think ultimately a lack of resources within the services in order
to be proactive and instead they've got no choice but to be
reactive and at the end of the day what we see then is we see a
continued increase in service demand"* (I7, F, 36)

In contrast, one person suggested there was no need for change in services but that people should be responsible for their own health and be prepared search for the help that is available.

*―I don't think anything needs to change……… I just really think
you've gotta find out for yourself, unless you're on your own or
something like that, there's usually someone around"* (I9, M, 56)

This participant had never needed or tried to seek help for mental health issues. It may be that people who have never had to deal with or seek help consider the system is working well and that help would be easily accessible if they needed it. In contrast, participants who have sought services suggest that the system is not working as well as it should, some services are not available, and those that exist are not as accessible as one might hope.

3.6 Discussion

This study considered what rural residents perceive to be the most important barriers to seeking help for mental health problems in their community. Four predetermined and three emergent themes were extracted and evidence that psychological mindedness is important in initial help-seeking of rural-dwellers was found. Previous research on psychological mindedness has focused on its link to psychotherapy outcomes (Beitel, Ferrer, & Cecero, 2004) rather than initial help-seeking behaviour. The current study thus makes a novel contribution to understanding help-seeking in the rural community.

This study revealed that many rural people are unwilling to talk about problems or feelings. Participants suggested that men in their community were particularly lacking in

openness. These findings are consistent with Mackenzie et al. (2006) who also found that lack of openness contributes to under utilisation of mental health services. Judd (2006a) argues that it is essential to identify groups at risk of illness as well as those whose willingness or opportunity to access care is reduced. Psychological mindedness may provide a tool to assist this process. One implication for practice in primary care is understanding, either formally or informally, how psychologically minded a person is. This would almost certainly help in deciding what services, if required, to suggest to a patient suffering any form of mental health issue that would be congruent with their attitudes and beliefs.

One of the most prominent themes concerned stigma. Many participants considered it to be one of the most important barriers to seeking help for mental health issues in their community. Given the prior research-driven nature of this study, this finding was not unexpected. The intensity of comments and the extent to which it was raised, however, were surprising. No distinction was made between stigmatisation of different mental health disorders and many people indicated they would feel stigmatised simply for collecting an information leaflet from the GP. Further, some participants suggested that mental illness is often assumed to reflect conditions such as schizophrenia or psychosis and the belief that mental illness equates to insanity persists. Although some participants suggested that stigmatised attitudes may be changing and as Gorman (2007) suggested, health promotion strategies are currently focussing on destigmatisation of mental illness, however, acceptance in rural areas is still a long way off. The theme of stigma may also be understood as "small town syndrome", or the idea that everyone knows what everyone else is doing, this has been noted in previous research as affecting health seeking behaviour in rural same sex attracted young people (Hillier, Warr, & Haste, 1996). However it is difficult to know whether knowing what everyone else is doing is problematic only when something is perceived negatively, i.e stigmatised, or whether it is problematic in itself.

The lack of services and inadequacy of available services was highlighted by participants who needed care for highly prevalent psychological disorders such as depression through to participants suffering from severe mental illnesses such as psychosis and schizophrenia. One participant indicated that, because there is no psychiatrist who can be seen on a permanent and regular basis, she had opted out of mental health care in her area in favour of driving an hour and a half to the city for treatment. This finding could have serious implications for the health care system in rural areas, where people are choosing not to access services, as well as in metropolitan areas where mental health care services may be carrying the burden of both metropolitan and rural patients.

People in rural communities often do not have a good understanding of what psychologists can offer, due to their under exposure to their services. Services equate to 0.83 psychologists per 10,000 head of population in very remote areas, 3.44 in inner regional centres and 5.92 in major capital cities (Gorman et al., 2007). This was certainly evident in the results of this study, where participants expressed uncertainty around what mental illness actually is, and many still equate mental illness with the most serious psychoses, and therefore may perceive the role of psychologists as limited to the most serious (and more stigmatised) mental health issues. Judd et al.(2006c) argue that rural people are likely to report less mental health symptoms because they do not define such symptoms as illness and therefore only get help when the symptoms become severe or disabling. Further, rural people are unlikely to seek the help of psychologists if they are unaware of the range of symptoms that can constitute mental illness and if they do not have any real understanding of the variety or benefits of the services offered (Roufeil & Lipzker, 2007). Therefore there is a strong need to raise awareness among rural people about what constitutes mental illness and psychological services as well as building the mental health workforce in rural areas (Roufeil & Lipzker, 2007).

Self-reliance or dealing with problems alone was raised with particular reference to men. Participants suggested that men in their community have a culture of „dealing alone‟. Participants saw this as an „ocker Aussie stereotype‟: reflecting an „I‟ll be right, tough it out‟ attitude. These attitudes and beliefs may make rural people reluctant to admit they have a problem or need help (Roufeil & Lipzker, 2007). Some participants suggested that this self-reliant culture is somewhat responsible for substance abuse in men when they are no longer able to „deal alone‟. This is consistent with Judd, Komiti and Jackson (2008) who found rural Australian men were higher on scores of stoicism and personal stigma, than women. The culture of self-reliance is an important barrier to seeking help for mental health issues in this rural community. Participants believed these attitudes to be an engrained part of their „Barossa heritage‟ and more broadly, rural Australian culture. This type of self-reliance specifically relating to males may also be representative of hegemonic masculinity (dominant masculine cultures) at play (Seymour-Smith, Wetherell, & Phoenix, 2002). Hegemonic masculinity is idealised and valorised by Australian men, and in this case rural men, particularly in relation to health seeking where previous research has suggested that being bad at talking about emotional problems is a taken-for-granted fact that „everyone knows‟ about men (Seymour-Smith et al., 2002). It is important to note however, that the self-reliance analysis also suggests possible high levels of resilience in the participants (and even the communities). Excerpts from participants concerning preference for using other help sources are also representative of community connections and social capital; two phenomena underpinning resilience (Sonn & Fisher, 1998). Therefore the culture of self-reliance may also be a positive influence for some rural people.

An important emergent theme from this study is that rural people do see a real need for change, not only to the mental health system in rural areas, but also to the seemingly engrained and ever present stigmatising and self reliant attitudes and beliefs of rural

residents. Understanding the need for change in rural communities is an important step in working towards lessening the influence these attitudes and beliefs have on help-seeking behaviour.

Limitations of the current study include the self-selected nature of the sample. Participants were interested in and willing to discuss mental health issues, so those who do not normally discuss such issues were therefore under-represented. However, the mix of those who had and had not accessed mental health services, and males and females was well balanced, and the use of both GP surgery recruitment and snowballing meant that people with a wide range of backgrounds and opinions were interviewed. Second, the study was conducted in one South Australian rural centre. Findings may not be generalisable to other rural centres or indeed more remote areas of Australia or internationally. However, given the support these findings have with past research there is some ability to generalise the findings, which could be enhanced by replication of the study. Last, it is important to consider whether there may be some overlap in themes. Psychological mindedness, for example, may be on a continuum with self-reliance and might even overlap with stigma somewhat. Psychological mindedness may also have some overlap with the awareness theme. In order to have a high level of psychological mindedness there needs to be a level of awareness of psychological services and practices which seemed to be lacking in this sample, and may therefore account for the lack of psychological mindedness expressed by participants. Further, the „lack of awareness of services" and „lack of services" themes may be suggestive of a need for change, making the „need for change" theme itself obsolete. However the participants" dialogue in their interviews about need for change was often raised as a separate issue, usually as an overall comment at the conclusion of their interview. Therefore, the „need for change" theme has its place as a separate theme in order to reflect this. This possible overlap in themes could

not be resolved in the current analysis, but provides the impetus for further research into the role of these constructs.

The results of this study provide some critical insight into the barriers faced by rural residents in accessing mental health services. Cultural factors and attitudes are contributing to help-seeking behaviour. Policy makers must address the need for mental health services in rural areas by recognising distinctive rural attitudes and the way these may differ from those of urban Australians. Further, recognising and understanding these realities will help build a psychological workforce that can ensure services are provided in ways congruent with local values and that the most is made out of services provided.

Chapter 4- Study Two- Help seeking for mental health issues in rural South Australia- Survey study

4.1 Preface

This is the second empirical study in this research program. It is a quantitative investigation that follows up the previous qualitative study by making use of its findings as the impetus for the measures included. The study focuses on a large sample of rural people using a survey that has been designed on the basis of, and informed by the stakeholders and service users themselves.

The issue of utilisation of mental health services in rural areas could be investigated in a number of ways. Satisfaction with services for example, would allow an assessment of how well services are working within rural communities and the level of satisfaction with these services amongst those who use them. However, this study is focussed on help seeking, it is focussed on understanding what factors drive rural people to seek help or not. Therefore the study investigates what factors are most influential to those who have accessed services and those that have not. The novel line of investigation into the psychological mindedness construct (unpublished shortened version of the scale available as Appendix B) is undertaken following from the previous qualitative chapter that showed some utility for the construct in this context. What rural people themselves said (in the previous study) about what the important issues are, drove the decision about what measures to include.

The study also uses and develops the Andersen Behavioural Model (Bradley et al., 2002) to inform and drive the research questions, concentrating on investigating the population characteristics, i.e. predisposing characteristics, enabling resources, need, behavioural outcomes and also includes intentions to seek help. This framework is effectively utilised to explain the findings of this study.

The main aim of the current study was to investigate the factors, including the psychosocial factors that influence help seeking. A population based survey was used to gather follow up on information given by rural residents in semi-structured interviews about the barriers they believe are most important in seeking help. This information was followed up in a similar but larger geographic population group using a different methodology, to ensure what has been said by rural people is consistent with the measurements used to tap into these issues.

This chapter has been prepared in manuscript form for submission to the Australian New Zealand Journal of Public Health.

4.2 Abstract

Background

Under utilisation of mental health services in rural areas is a complex issue with many factors thought to contribute, including stigma and mental health status as well as attitudes towards seeking professional help. Previous research has also indicated the utility of the psychological mindedness construct in contributing to help seeking for mental health in rural areas (Collins, Winefield, Ward, & Turnbull, 2009) and this novel relationship is further scrutinised here. The revised version of the Andersen behavioural model (Bradley et al., 2002) can provide a framework under which to thoroughly investigate the most important factors underlying help seeking for mental health in rural areas, and it will be utilised in this study to both drive the research questions and to frame the results.

Method

This study used a mail out survey methodology with a random sample of the population selected from the rural South Australian electorate of Barker. The survey package was sent to 583 people with 259 surveys returned (43.6%). Respondents answered a battery of questionnaires including information about their attitudes towards seeking professional psychological help, perceived stigma, psychological mindedness, help seeking behaviour and their current mental health status.

Results

The results showed that gender and attitudes towards seeking help were the two most important variables in predicting help seeking intentions and actual help seeking behaviours. Psychological mindedness had a significant negative impact on attitudes towards seeking help, and whether a respondent knew someone with a mental health issue

or knew someone who had sought help for a mental health issue made no difference to their help seeking behaviours.

Conclusions

Policy and the introduction of services in rural areas need to take into account the attitudes and beliefs of the people that live in rural areas. Having a positive attitude towards seeking professional help for a mental health issues appears to be of critical importance for whether a person intends to seek help and whether they do in fact seek help. Psychological mindedness requires further investigation in the help seeking context to establish the utility of the measure in this context. The revised Andersen Behavioural model (Bradley et al., 2002) provided an effective framework from which to drive this research and within which to assess the findings.

4.3 Introduction

Research investigating help seeking in rural areas has thus far failed to provide a thorough investigation of the factors that influence the decision to seek help for a mental health issue, specifically, using a theoretical framework to both drive the research and frame the results has not been realised. The current study has adopted the expanded Andersen model of Bradley et al. (2002) to drive the research. This version of the model includes population characteristics: need, predisposing and enabling factors, intentions to seek help and behavioural outcomes. This version provides the most scope for the inclusion of all possible factors that may influence whether rural people seek help for a mental health problem. Although this framework has been used in some previous rural help seeking research (e.g. Parslow & Jorm, 2000; Smith, 2003), the revised version put forward by Bradley et al. (2002) has not been utilised in this context. The current study sought to fill this gap.

Previous research using the Theory of Planned Behaviour has suggested that attitudes towards seeking professional psychological help can have an extensive impact on help seeking intentions (Ajzen & Fishbein, 2005), and are also key determinants of actual help seeking behaviour and whether or not someone will use mental health services (Mackenzie, Scott, Mather, & Sareen, 2008). The current research therefore investigated attitudes towards seeking help as a possible predictor of help seeking.

Previous research also suggested that stigma is an important factor in the underutilisation of mental health services (e.g. Collins et al., 2009; Corrigan, 2004; Komiti et al., 2006; Sweeney & Kisely, 2003). Other research including work by Halter (2004) found that mental health problems were associated with a high degree of stigma. However, other studies have found quite benign attitudes amongst rural people towards people with mental health problems (Jorm et al., 2000a). Given the mixed results with this construct, its continued inclusion in help seeking research is warranted in order to fully understand its

impact. Further, the aspect of stigma related to embarrassment and confidentiality was emphasised by interviewees in a study by the authors (Collins et al., 2009), and it was thought that this was worthy of being followed up using a larger scale population sample. It was for these reasons that the current study included stigma as a possible influencing factor on help seeking behaviour in rural areas.

Psychological mindedness involves "a person"s ability to see relationships among thoughts, feelings, and actions, with the goal of learning the meanings and causes of their experience and behaviour" (Appelbaum, 1973, p. 36). Investigations into this construct in the help seeking context were somewhat novel. The construct has traditionally been used in psychotherapy research to investigate patients" suitability for psychotherapy (Conte et al., 1990). However, there is some evidence to suggest that psychological mindedness may affect help seeking for mental health issues (Collins et al., 2009). Mackenzie, Gekoski and Knox (2006) suggested that psychological openness (one aspect of the psychological mindedness construct) had a positive impact on help seeking behaviour, whereby willingness to acknowledge psychological problems and being open to seeking help for them, particularly in women, encouraged more help seeking to occur. Further, they suggested that a lack of psychological openness created a barrier to seeking help, particularly for men (Mackenzie et al., 2006). Additionally, previous research (Collins et al., 2009) found some suggestion that a lack of psychological mindedness may actually be an inhibiting factor on help seeking among rural people, and therefore worthy of further investigation, particularly using quantitative methods. Given the number of topics to be covered by the questionnaire, it was decided that a shortened version of the psychological mindedness scale would be used for the sake of brevity. The role of psychological mindedness in the help seeking context and what impact the construct has on help seeking intentions and behaviour was examined. Mental health status using the MHI-5 (Veit & Ware, 1983) was also examined to elucidate respondents" current level of mental health

distress and wellbeing as this may also contribute to decisions around whether or not to seek help.

The current study had a three variable approach to outcome measurement: **First,** investigating respondents *help seeking intentions*, **second,** investigating those who indicated that they *have sought help*, and **third,** investigating the factors influencing those who said that they have *wanted or needed to seek professional help but have not done so*. Intentions are often used as a proxy for behaviour and actual behaviour is most important when investigating help seeking. However, intentions were included here because the Bradley (2002) version of the Andersen model included intentions as an important step in the help seeking sequence and this is the framework used for this research. The role of both demographic factors, particularly age and gender, and psychosocial factors including stigma, attitudes towards seeking mental health services, mental health status and psychological mindedness, in influencing rural residents" help seeking intentions and behaviour were examined. Help seeking was operationalised as, help seeking intentions, and two behavioural outcomes; "**ever having sought help**", and, "**ever wanting or needing help and not seeking it**".

The aim of this study was to investigate the independent contributions that each of the demographic, individual and psychosocial variables, including age, gender, mental health status, stigma, mental health status and psychological mindedness made to attitudes towards seeking help, intentions to seek help and actual behavioural outcomes. Therefore the specific hypotheses associated with this aim were:

1. Psychological mindedness is positively related to the likelihood of help seeking behaviour and makes an independent contribution to help seeking behaviour in the rural help seeking context.

2. Contact and/or experience with mental illness is related to positive attitudes towards seeking help and the likelihood of help seeking behaviour.

3. Psychosocial variables impact on attitudes towards seeking help:

- perceptions of stigma impacting negatively

- psychological mindedness impacting positively

4. Psychosocial variables have an impact on help seeking intentions and outcomes:

- Perceptions of stigma impact negatively

- Attitudes towards seeking mental health services impacts positively

- Better mental health status impacts positively

4.4 Method

4.4.1 Sampling frame

A random sample of the population aged 18-70 from the Barker electorate was selected for participation in this study. The Barker electorate covers 64015 square kilometres (Australian Electoral Commission, 2010) and encompasses many small rural communities and a few rural centres such as the Barossa, Riverland and Mt Gambier in South Australia. All towns and rural centres encompassed within the Barker electorate are classified by the RRMA in the rural zone, mostly as small rural centres (Population 10,000-24,999) or other rural areas (population <10,000) (Rural Doctors Workforce Agency, 2006).

4.4.2 Participants

Participants were a randomly selected sample of 600 electors (1500 originally extracted and 600 randomly selected from this). Seven people opted out of the study after the forewarning letter and before the survey package was sent, 10 were no longer living at their given address, as indicated by the return of the forewarning letter. Thus, 583 residents

were sent the survey package and invited to participate, 259 (43.6%) responded.[1]
Participants included 106 males (40.9%) and 153 females (59.1%), aged between 18 and 70 years (M=46, SD=13.9).

4.4.3 Materials

4.4.3.1 Demographic information:

Age, sex, marital status, occupation, highest level of education, and duration of residence in the area (defining the extent of their rural experience) were assessed.

4.4.3.2 Inventory of Attitudes toward Seeking Mental Health Services (IASMHS):

The Inventory of Attitudes Towards Seeking Mental Health Services is a 24 item scale developed by Mackenzie et al. (2004) as a revised version of the Attitudes Towards Seeking Professional Psychological Help Questionnaire, that assesses people‟s attitudes towards mental illness, and seeking mental health services. Each of the 24 items contains a statement that the participant rates on five point Likert scale from Disagree (0) to agree (4), with a possible range of scores from 0- 96. Test retest reliability for the IASMHS was *r=* .85. In the current study, the Cronbach alpha coefficient was .87. Some sample items from the scale include, "I would not want my significant other (spouse, partner etc) to know if I were suffering from psychological problems", "having been mentally ill carries with it a burden of shame", and "psychological problems, like many things, tend to work out by themselves". Higher scores indicated more positive attitudes towards seeking professional help.

4.4.3.3 The Perceived Stigma Scale (PSS):

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[1] The ten people who were no longer at their given address were not included in the response rate calculation as they were not considered non-respondents.

The Perceived Stigma Scale, developed by Wrigley et al. (2005) is based on the Devaluation and Discrimination Scale (Link, 1987; Link, Mirotznik, & Cullen, 1991; as cited in Wrigley et al., 2005) to assess the extent to which respondents believe that most people will devalue or discriminate against a person with a history of mental illness (Wrigley et al., 2005). The 16 items in the scale present statements that are assessed on a four point Likert scale ranging from „strongly agree" to „strongly disagree", possible range of scores was 16- 64. In the present study higher scores indicate higher perceived stigma. In the current study, the Cronbach alpha coefficient was .92. Some sample items from the scale include "most people believe that a person who has been treated for a mental illness is dangerous", and "most people look down on people who have been hospitalised for mental illness".

4.4.3.4 The Psychological Mindedness Scale: Shortened Version:

The original scale developed by Conte and Ratto (1997) is a 45 item scale with each item rated on a four point likert scale from „strongly agree" to „strongly disagree". Conte et al. (1990) reported good internal reliability (Cronbach"s alpha 0.86) for the 45 item scale. The original 45 item scale, factor analysed by Conte et al (1996) revealed a five factor structure that accounted for 38% of the total variance onto which 27 of the 45 items loaded (18 of the 45 items did not load saliently on any factor). The five factors were: (1) Willingness to try to understand oneself and others; (2) Openness to new ideas and capacity to change; (3) Access to feelings; (4) Belief in the benefit of discussing ones problems; and (5) Interest in meaning and motivation of own and others behaviour. The shortened version has 25 items assessed on a four point likert scale from „strongly agree" to „strongly disagree", with higher scores indicating higher psychological mindedness, and a possible range of scores from 25- 100. Good internal consistency for the shortened version has been found (Cronbach"s alpha 0.84) and the correlation between total scores on the

shortened scale and the full 45 item version was r=.94 (p= < .01) (Shill, Unpublished). In the current study, the Cronbach alpha coefficient was .88. Some sample items from the scale include "letting off steam by talking to someone often makes you feel a lot better", "talking about your worries to another person helps you understand problems better", "I am always curious about the reasons people behave as they do" and "Often I don't know what I'm feeling".

4.4.3.5 General Help-seeking Questionnaire (GHSQ):

This questionnaire developed by Wilson, Deane, Ciarochi and Rickwood (2005) assesses respondents future help seeking intentions for mental health problems and past help-seeking experience. Future help seeking intentions are measured by listing a number of potential help sources and asking respondents how likely it is, on a 7 point likert scale, that they would seek help from that source. Help seeking intentions are reported as three subscales: level of intention to seek informal help; level of intention to seek formal help; and level of intention to seek help from no-one (Rickwood et al., 2005).

Past help-seeking experience is operationalised by asking whether professional help has been sought in the past and if it has how many times it has been sought and what specific sources of help were sought, and whether the help obtained was evaluated as worthwhile on a 5 point likert scale. Past help-seeking experience can be reported in several different ways: as a dichotomy indicating whether professional help was sought in the past; as a scale indicating the amount of professional help sought in the past; or as a weighted scale whereby the amount of help is multiplied by its perceived helpfulness (Rickwood et al., 2005).

4.4.3.6 Actual Help-seeking Questionnaire (AHSQ):

This questionnaire developed by Wilson et al. (2005) can be used in conjunction with the General Help-seeking Questionnaire to determine recent help-seeking behaviour. This measure asks respondents whether or not they have sought help from a list of potential help sources during a specified period of time for a specified problem. The help sources and problems listed can be modified to be appropriate for the research objectives, and if used in conjunction with the GHSQ help sources and problem types can be matched across the measures. Recent help-seeking behaviour can be reported in three subscales: Whether or not informal help has been sought; whether or not formal help has been sought; and whether no help has been sought.

4.4.3.7 Contact and Experience Questionnaire (CEQ):

Contact with mental illness, and help-seeking behaviour and preferences are assessed by this questionnaire. Some sample items include, "have you **ever** sought help for a psychological problem or mental health issue, and if yes from whom did you seek help?", "Have you ever wanted to, or felt that you needed to seek help for a psychological or mental health issue but have not done so? Each item in the scale represents an independent datum and there is no summary score. Each independent datum could be used as an outcome variable for analysis. This study will use the example "Have you ever wanted to, or felt that you needed to seek help for a psychological or mental health issue but have not done so?" in this manner.

4.4.3.8 The Mental Health Inventory-5:

This measure is a five item self report inventory designed to assess the level of mental health among psychiatrically healthy samples (Veit & Ware Jr, 2000). Possible range of scores was 5-25. This measure has reportedly good internal reliability with a reported Cronbach alpha of .89 (Veit & Ware Jr, 2000). In the current study, the Cronbach alpha coefficient was also .89. Some sample items from the scale are "during the past month how much of the time were you a happy person?", and "how much of the time,

during the last month, have you been a very nervous person?" Higher scores indicate better mental health.

4.4.4 Procedure

The questionnaire was piloted using a convenience sample of 10 participants known to the researcher. They were asked to complete all questionnaires then comment on ease of understanding of each measure and time taken to complete the questionnaire.

Fifteen hundred electors from the Barker electorate were then randomly extracted from the electoral role by the Australian Electoral Commission. Power analysis for this study indicated that approximately 200 responses were required for an alpha level of 0.01, up to 12 predictors, medium effect size and statistical power of 0.8. Therefore, 600 electors were randomly extracted by the researcher from the initial 1,500 and invited to participate using the multi mail-out methodology following Dillman (2000). This involved multiple contacts being made with participants to ensure the best possible response rate. First, a forewarning letter was sent to all randomly selected participants explaining that they would be receiving a survey in the next few days regarding mental health services in their area. Second, the survey package was sent including a cover letter informing them about the study, how they were selected and that their answers would be kept confidential. An information sheet was also provided for further information about the study and the details of services participants could contact should the need arise. To increase the participants" perceived importance of the study, a profile of the researcher was included in the package outlining the researchers" rural background and therefore vested interest in the study. The third and final contact was a reminder letter asking all those who had not yet replied to please consider doing so, and thanking those who had replied. The reminder letter was printed on green paper to make it notably different from the forewarning letter, according to Dillman (2000) this is important for ensuring the letter is read by the participant. It is

also said that just the green paper itself can help to boost response rates (Fox, Crask, &

Kim, 1988). The final overall response rate for this mail out survey was 44.4%. Prior to the

reminder the response was approx 35.8%; therefore the additional contact via the reminder

letter increased the response by 8.6%.

4.5 Results

Variables used to operationalise help seeking behaviour were taken from the

Contact and Experience questionnaire, first "have you ever sought help for a mental health

issue", and second, "have you ever wanted to, or felt that you needed to seek help for a

psychological or mental health issue but have not done so?"

4.5.1 Descriptive statistics

Table 3

Descriptive Statistics

Descriptives	N	Minimum	Maximum	Mean	SD
Age	259	18	70	**45.8**	14.14
Years lived in rural areas (cumulative)		< 1Year	70	**33.5**	17.5
Attitudes towards seeking MH services	247	26	96	**64.5**	14.7
Perceived Stigma	246	16	61	**38.4**	7.5
Psychological mindedness	247	25	89	**52.5**	9.5
Mental health Inventory	255	6	30	**22**	4.7
Overall help seeking intentions (all sources)	155	9	59	**27.5**	11.5
	Yes		No		
Ever accessed mental health services	40.2%		59.8%		
Ever wanted or needed to seek MH services and have not done so	26.1%		73.9%		

Table 3 shows the descriptive statistics associated with each of the measures and includes the percentage of those who had ever sought help for mental health issues from a mental health service and also those who have ever needed or wanted to and have not done so (over ¼ of the sample).

Of those who had accessed mental health services their GP was the most common person from whom they have sought help (27.4%), followed by counsellors (17.4%) and psychologists (13.9%). When asked from whom they have actually sought help for emotional problems in the last two weeks, participants most commonly said they had sought help from informal sources such as partner (31.7%), friend (23.2%), or parent (15.1%), rather than formal sources such as their GP (9.7%), mental health professional (3.5%) or phone help lines (1.9%).

Of those who had wanted to seek professional help but had not done so, 10.8% said it was too difficult, 10.4% said they were embarrassed and 9.7% said they didn‟t know who to ask for help (for full list see table 11 in research note).

When asked whether they would feel comfortable discussing mental health issues with their General Practitioner, 74.9% of respondents said they would feel comfortable whilst just over a quarter (25.1%) said they wouldn‟t feel comfortable discussing such issues with their GP (for reasons given for not feeling comfortable discussing these issues with the GP see table 10 in research note).

4.5.2 Analysis Design

Help seeking was operationalised for the purposes of analysis in three ways: **first**, help seeking intentions, **second**, ever having sought help, and **third**, having ever wanted to seek help and not doing so.

The steps taken to determine the predictors of **help seeking intentions** and the two help seeking behavioural out comes; **ever having sought help**, and **ever wanted to seek help and have not**, are as follows:

1. Preliminary analysis:

    - Correlations were conducted to determine any relationships between the psychosocial variables, age and help seeking intentions.

    - Univariate analyses (t-test and chi square) were conducted on each of the two behavioural outcomes **ever having sought help** and **ever wanting to seek help and not doing so**, to determine what variables were significantly associated.

2. All variables that were significantly associated with the three help seeking outcome variables (intentions, ever having sought help & ever wanting to seek help and not doing so) either by correlation, t-test or chi-square, were put into multivariate analyses (multiple regression or logistic regression) to determine the most important predictors of help seeking behaviours.

4.5.3 Preliminary Analyses

Preliminary analysis of the data showed the following correlations (see Table 4) between the psychosocial variables, age and help seeking intentions:

Table 4

Psychosocial and Descriptive Variables Correlation Matrix

	Psychological mindedness	Perceived stigma	Attitudes towards seeking professional MH services	Mental health score	Help seeking intentions	Years lived in rural areas
Age	-.01	-.03	.17**	.19**	-.060	.460**
Psychological mindedness	1	.322**	-.585**	-.428**	-.288**	-.019
Perceived stigma		1	-.386**	-.288**	-.088	-.079
Attitudes towards seeking professional MH services			1	.279**	.297**	.027
Mental health score				1	-.011	.152*
Help seeking intentions					1	.011

*p<0.05 ** p<0.001

4.5.3.1 Univariate analyses

<u>Help seeking intentions</u>

A t-test was conducted to investigate the relationship between sex and help seeking intentions. A significant difference in scores was found for males (*M*=24.6, *SD*=10.8) and females (*M*=30.1, *SD*= 11.5; t (153)= -3.05, *p*<0.01).Therefore sex, along with the other variables correlated with help seeking intentions will be entered into a multiple regression.

<u>Help seeking behavioural outcomes</u>

t-tests (and chi square for sex, and contact and experience) were conducted to investigate the relationships between the all the variables that were significantly correlated with those who have ever sought help for mental health issue and also, those who have wanted to/needed to seek help but have not done so.

Table 5 shows that from the t-tests, the factors significantly associated with ever having sought help were, attitudes towards seeking help and mental health status. The factors significantly associated with ever wanting to or needing to seek help and not doing so were, age, perceived stigma, mental health, psychological mindedness, and attitudes towards seeking help. These variables were entered into a multivariate analysis to investigate the most important predictors.

Table 5

T-tests to Indicate Significant Predictors of, ‗Ever Sought Help' and For ‗Ever Wanted or Needed to Seek Help and Have Not Done So'

Ever sought help for mental health problems?

Predictors	Yes		No					
	M	SD	M	SD	t	df	p	Cohens d (effect size)
Positive attitudes to seeking services	67.75	14.83	62.23	14.38	2.90	241	<.01	.38
Mental health inventory	20.94	5.34	24.43	3.62	-5.76	162.6	<.001	-.79

Ever wanted/needed to seek help and have not done so?

Predictors	Yes		No					
Age	40.5	14	47.2	13.7	-3.4	247	.001	-0.49
Perceived stigma	41.2	8.7	37.3	6.8	3.2	90.6	<.01	0.53
Mental health inventory	18.7	5.4	24.6	3.3	-8.3	82	<.001	-1.49
Psychological mindedness	55.9	10.4	51.2	8.9	3.4	237	.001	0.50
Positive attitudes to seeking services	57.3	14.2	66.7	14.2	-4.5	236	<.001	-0.66

A Chi-square test for independence (with Yates Continuity Correction) indicated a significant difference in ever having sought help and sex χ^2 (1, n=254) = 7.14, p<.01, phi = -.18. Therefore, sex was also entered in the multivariate test for "ever sought help".

A Chi-square test for independence (with Yates Continuity Correction) did not indicate a significant difference for sex in ever wanting/needing to seek help and not doing so χ^2 (1, $n=249$) = .04, $p=.85$, phi= -.02.

4.5.3.2 Contact & experience and ever having sought help

Chi square analyses were also conducted to investigate whether contact and experience with mental illness made any difference to whether someone had ever sought help for a mental health issue.

Chi-square test for independence (with Yates continuity correction) indicated a significant association between ever having sought help for a mental health issue and having known someone who has experienced a mental health issue χ^2 (1, $n=252$) = 7.27, $p=<.01$, phi=.181 and knowing someone who has ever sought help for a mental health issue χ^2 (1, $n=250$) = 4.89, $p=<.05$, phi=.15. Results from the cross tabulation showed that 91.2% of respondents who had ever sought help for a mental health issue knew someone experiencing a psychological or mental health issue, and 87% knew someone who had sought help for a psychological or mental health issue. Therefore both these contact and experience variables were entered into the multivariate analysis for the "ever sought help" variable.

Chi-square test for independence (with Yates continuity correction) indicated no significant association between ever wanting or needing to seek help and not doing so, and both, having known someone with mental illness χ^2 (1, $n=248$) = 1.12, $p=.29$, phi=.08, and having known someone who has sought help for a mental health issue χ^2 (1, $n=247$) = 2.86, $p=.09$, phi=.119. Therefore, for this outcome variable, contact and experience variables were not entered into the multivariate analyses.

4.5.4 Multivariate Analyses

Multiple regression

Using the variables found to be significantly correlated with help seeking intentions, a multiple regression analysis using the forward method was conducted. Attitudes towards seeking mental health services, psychological mindedness and sex were entered into the model.

Table 6

Variables Significantly Predicting Help Seeking Intentions

Predictor variable	Standardised coefficients B (95%CI)	*p*
Sex	.19 (.71, 8.0)	<.05
Positive attitudes towards seeking help	.26 (.08, .32)	.001

The total variance explained by the model was 35% $F(2, 146)= 10.14$, p<.001. Table 6 showed that the two variables that were significantly predicting help seeking intentions were sex (female) and having more positive attitudes towards seeking mental health services. Psychological mindedness was not a significant predictor and was therefore excluded from the model.

4.5.4.1 Logistic regression.

Logistic regressions were conducted with all variables found to be significant in the univariate analyses (t-tests and Chi-square).

Logistic Regression: **Ever having sought help for mental health issue**

The full model containing all variables was statistically significant χ^2 (3, *N*=240)= 61.8, *p*< .001, indicating the model was able to distinguish between respondents who

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reported having ever sought help for a mental health issue and those who had not. The model explained 24% (Cox & Snell R Square) of the variance in _ever having sought help', and correctly classified 60% of cases. As shown in Table 7only two of the independent variables made a unique statistically significant contribution to the model (attitudes towards seeking help for mental health issues and mental health status). The strongest predictor was mental health status, indicating that, as mental health status improves, the likelihood of ever having sought help decreases. This was followed by attitudes towards seeking professional mental health services, where, as attitudes towards seeking help become more positive the likelihood of ever having sought help also increases.

Logistic regression: **Ever WANTED or needed to seek help and have NOT done so**

The full model containing all variables was statistically significant χ^2 (7, N=222)= 75.83, p< .001, indicating the model was able to distinguish between respondents who reported having ever having wanted to seek help for a mental health issue and have not done so and those who said no to this question. As a whole, the model explained 28.9% (Cox & Snell R Square) of the variance in ever having wanted to seek help but have not done so, and correctly classified 73.9% of cases. As shown in table 7 two of the independent variables made a unique statistically significant contribution to the model (attitudes towards seeking help for mental health issues and mental health status). The strongest predictor of ever having wanted to seek help and not doing so was mental health status. Better mental health status decreased the likelihood of ever wanting or needing help and not getting it. Similarly, more positive attitudes towards seeking help decreased the likelihood of ever wanting help and not getting it.

Table 7

Logistic Regression: Predicting ‗Ever Sought Help' & ‗Ever Wanted to Seek Help and Have Not Done So'

Variables predicting ever having sought help for a mental health issue						
	B	**S.E**	**Wald**	***df***	***p***	**Odds ratio (95% CI)**
Sex	.6	.32	3.17	1	.075	1.76 (.94, 3.3)
Mental health Inventory	-.23	.04	32.9	1	**<.001**	.79 (.73, .86)
Positive attitudes towards seeking help	.05	.01	15.4	1	**<.001**	1.05 (1.02, 1.07)
Know someone who has experience a MI	-1.08	.77	1.98	1	.16	.34 (.07, 1.53)
Know someone who has sought help for MH	.35	.68	.26	1	.61	1.41 (.37, 5.35)
Variables predicting ever wanting to seek help and not doing so						
Positive attitudes towards seeking help	-.04	.02	4.67	1	**<.05**	.96 (.93, .1.0)
Mental health inventory	-.29	.05	33.1	1	**<.001**	.75 (.68, .83)
Perceived stigma	.02	.03	.55	1	.46	1.02 (.97, 1.1)
Psychological mindedness	-.05	.03	3.1	1	.08	.96 (.91, 1.0)
Age	-0.3	0.1	4.0	1	.06	.97 (.95, 1.0)

4.5.4.2 Attitudes towards seeking professional help

Given that attitudes towards seeking mental health services appears to be the most consistently reliable predictor of both help seeking intentions and help seeking behaviour, it was decided that a multiple regression (forward method) using the significant correlates

of this variable would be conducted to investigate what predicts attitudes towards seeking

professional mental health services.

Table 8

Variables Predicting Positive Attitudes Towards Seeking Professional Help for Mental Health Issues

Predictor variable	Standardised coefficients B (95% CI)	*p*
Age	.162 (.06, .28)	**<.01**
Sex	.07 (-1.1, 5.2)	.193
Stigma	-.214 (-.64, -2.1)	**<.001**
Psychological Mindedness	-.512 (-.98, -.62)	**<.001**
Mental health inventory	-.03 (-.46, .27)	.62

The total variance explained by the model was 40%, $F(5,229=32.5, p<0.001)$.

Table 8 shows that of the significant correlates of attitudes towards seeking help, the ones

that predicted attitudes towards seeking professional mental health services were; age,

stigma and psychological mindedness. As age increased the more positive the help seeking

attitudes got. As levels of perceived stigma increased the more negative help seeking

attitudes got, and similarly, as levels of psychological mindedness increased the more

negative help seeking attitudes got.

4.6 Discussion

This study quantitatively investigated the predictors of help seeking intentions, and

two behavioural outcomes; ever having sought help and wanting to or needing to seek help

and not doing so. Predictors of attitudes towards seeking professional psychological help

were also investigated as they were found to be crucial in influencing help seeking

intentions and behaviour in this context. Further, the study investigated the psychological mindedness construct in the rural help seeking context. The results of the study identified some of the barriers that exist for rural people in seeking help for mental health concerns.

4.6.1 Main findings

The main findings of this study were that sex and attitudes towards seeking professional help for mental health were the two most crucial predictors of intentions to seek help for mental health. Attitudes towards seeking help for mental health issues and mental health status (levels of mental health as measured by the Mental Health Inventory) appeared to act as facilitators to ever having sought help for mental health and the same two variables also appear to act as barriers given that they also predict whether someone has ever wanted or needed to seek help and has not done so.

Being female and having more positive attitudes towards seeking help predicted higher help seeking intentions in this rural population. This is consistent with previous research that found females were more likely to have more favourable intentions to seek professional psychological help (Mackenzie et al., 2006) and those that have found a disparity between males and females on actual help seeking behaviour (Caldwell et al., 2004b).

People with poorer mental health status but more positive attitudes towards seeking help were more likely to have actually sought help, and those with better mental health status and more positive attitudes towards seeking help were less likely to have ever wanted help and not sought it. This suggests that those requiring help with their mental health (i.e. those with a poorer mental health status) are seeking the help they need as long as they have a positive attitude to doing so. Similarly, people with an increased mental health status and more positive attitudes towards seeking help are also less likely to have ever wanted help and not gotten it. However, this finding could also imply that those

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people who are unwell and actually do need and perhaps even want help, but have more negative attitudes to seeking help are therefore not getting it. This is a worrisome finding given the unique stresses faced by some of these rural communities that are unlikely to subside while the drought continues in these regions (Staniford et al., 2009).

In accordance with the hypothesis, attitudes towards seeking professional mental health services were crucial in predicting both intentions and actual help seeking behaviour in this rural population, therefore the predictors underlying these attitudes were also investigated. The results showed that older people have more positive attitudes, people who perceive more stigma have more negative attitudes, as do individuals who are higher on psychological mindedness. Therefore, stigma did not have a direct impact on help seeking intentions or outcomes as hypothesised, but was an important factor influencing attitudes towards seeking help.

A previous study suggested that older people are less likely than younger adults to seek help (Klap, Unroe, & Unutzer, 2003). However, other studies have found older adults to exhibit positive help seeking attitudes. The current study also found older people exhibited more positive attitudes towards seeking help. Previous research using population data, found that more than 80% of their older adult participants had positive help seeking attitudes and were two to three times more likely to report positive help seeking attitudes than younger adults (Mackenzie et al., 2008).

The results of this study indicate that attitudes towards seeking professional psychological help are crucial determinants of both help seeking intentions and actual help seeking behaviour. This finding gives credence to the influence of attitudes and beliefs on behaviour (Mackenzie et al., 2008) as set out by theoretical frameworks including the Andersen behavioural model (Andersen, 1995; Andersen & Newman, 1973). This is consistent with previous research that has found health care seeking-related attitudes to heavily influence access to care (Goodwin, Koenen, Hellman, Guardino, & Struening,

2002; Judd et al., 2006c). Using the Andersen model as a framework for the current study findings, it would appear that predisposing factors, help seeking attitudes and mental health status have the most influence over not only intentions to seek help but also and most importantly on behavioural outcomes. It would also appear that they are potentially acting as both barriers and facilitators. Therefore these factors could be considered both predisposing and enabling factors within the Andersen behavioural model. The results showed that particularly for rural people who have wanted to seek help and have not done so, the most important barriers fell within the predisposing factors category of the Andersen behavioural model. Predisposing factors in the Andersen behavioural model include sex, attitudes towards seeking mental health services and mental health status, also included as predisposing factors would be some of the predictors of attitudes towards seeking mental health services such as age and psychological mindedness. An enabling factor is stigma and lower mental health status was associated with greater likelihood of having sought help and therefore establishes need as outlined by the model. This is consistent with previous studies that have also found mental health to influence help seeking behaviour (i.e. Judd et al., 2006c). These (potentially overlapping) predisposing and enabling factors along with need all contribute to help seeking behavioural outcomes, whether actually seeking help or wanting/needing help and not seeking it. See *Figure 4* for a diagrammatical representation of this.
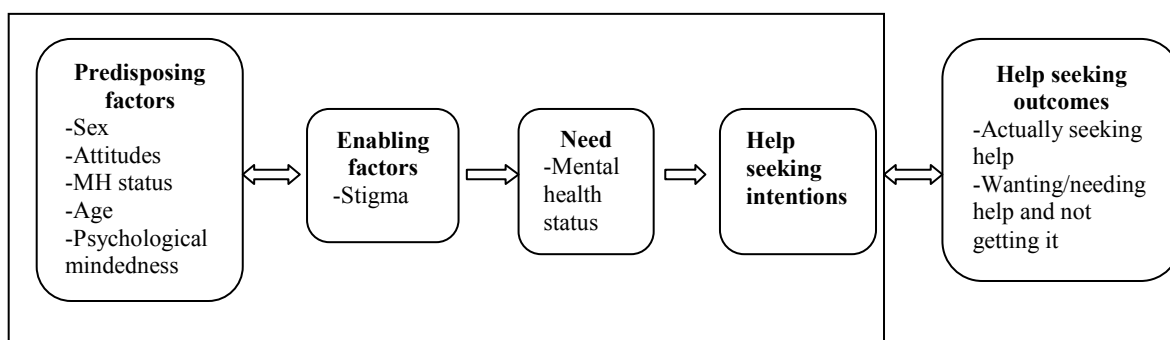
Figure 4. Results represented using the framework of Andersen's behavioural model.

4.6.2 Psychological mindedness: A novel finding

The psychological mindedness measure used in this study was an unpublished shortened version of the original 45 item scale. A factor analysis was conducted and found that as with the original 45 item scale, this measure also had five factors similarly labelled to those of the Shill and Lumley (2002) in their investigation of the psychometric properties of the 45 item scale (N.B. for full factor analysis results please see section 4.7 of the research note).

Although psychological mindedness did not have direct influence on help seeking behaviour, it contributed to predicting attitudes towards seeking mental health care, which played an important role in both help seeking intention and behaviour. What is interesting is that contrary to the hypothesis, given the previous research that posits psychological mindedness as a positive trait, those with higher psychological mindedness were more likely to have negative attitudes towards seeking professional mental health services. At first glance this result seems somewhat counter intuitive, however upon further consideration, a possible explanation for this has become evident. According to Beitel and Cecero (2003) psychological mindedness is positively related to healthy rather than pathological personal and interpersonal constructs (p 163), but it does not appear to be the case in the present study. One possible explanation for the result found in this study may be that people who are psychologically minded may also be ruminators. If this is the case then psychological mindedness may not necessarily be linked to healthy personal constructs in every context. In the case of this study, psychological mindedness is correlated significantly with low mental health status (see Table 4). Further, one researcher found that highly psychologically minded individuals also had lower self esteem than those who are less psychologically minded (Farber, 1989). Therefore one possible explanation

for psychological mindedness acting as a negative influence on help seeking attitudes could be found in the construct of rumination. In particular, self focussed rumination, is an unhealthy trait associated with poor mental health outcomes (Lyubomirsky & Nolen-Hoeksema, 1995). The factors within psychological mindedness: access to feelings and interest in meaning and motivation of own and others behaviour suggest high levels of thinking which may lead to over thinking, or, rumination. People who use this particular ruminative coping style are said to "not only experience more prolonged dysphoric reactions to problems but may also be more negatively biased in their interpretations of these problems and more impaired in their ability to solve them (Lyubomirsky & Nolen-Hoeksema, 1995, p. 188). Another study similarly found rumination to have a detrimental effect on problem solving (Donaldson & Lam, 2004). This is significant for the results of the current study because if highly psychologically minded people tend towards rumination, and rumination impairs a person"s ability to problem solve, then this would have a detrimental effect on their ability to make a decision about whether or not to seek help.

A study by Beitel et al. (2009) found that individuals with higher levels of psychological mindedness had higher expectations of self involvement in counselling and greater expectations of positive outcome. Given this and the fact that there are limited and/or inadequate services available in rural areas (Collins et al., 2009), another possible explanation for psychological mindedness acting as a negative influence may be that highly psychologically minded people feel that lack of services and probably more likely, inadequate services, means that their expectations of the counselling process may not be met and therefore they are not willing to seek any help at all, preferring to just cope alone waiting until the situation gets to the point where they can no longer cope alone and then have no other choice but to seek help. This explanation would make sense in the rural context where rural people are known for their self reliance (eg. Collins et al., 2009; Judd

et al., 2006c) which often leads to them holding off on seeking help until their situation reaches crisis point.

It is important to note that the psychological mindedness construct has not ever been investigated in any other context besides outcomes of psychotherapy, so the finding that the construct impacts negatively on attitudes towards help seeking, whilst perhaps somewhat counter intuitive, is important because it expands the knowledge base of this construct and expands the contexts in which it has been applied. It should be interpreted with some caution, and provides an impetus for future research on this construct. Further research using this construct in different contexts is required to find out in which, if any, other contexts besides psychotherapy outcome, this construct can be reliably applied.

4.6.3 Contact and Experience with mental illness: Does it make a difference?

Contrary to the hypothesis, people who had contact with or experience with mental illness, either by knowing someone who has had a mental illness or knowing someone who has sought help for a mental health issue, did not differ from those who had not in either help seeking intentions or on their actual help seeking behaviour. Further, those who had known someone with a mental illness or known someone who has sought help for a mental illness did not have significantly more positive attitudes towards seeking help than those who have had no contact with or experience of mental illness. This is similar to the findings of Wrigley et al. (2005) who also found that contact and experience was not a significant predictor of help seeking.

4.6.4 Limitations

The results of this study should be considered in light of several limitations. First, the self selected nature of the respondents, meaning that the thoughts of those who chose not to respond to the survey has been missed. This means that the results should be

interpreted with some caution. Second, the use of self-report data in this study means that the data could be subject to uncertain validity. Third, the Barker electorate from which these respondents were derived included mostly rural towns with fewer very remote areas, therefore the results cannot be generalised to the most remote locations, as their needs may be different. Fourth, the current study was a cross sectional population study, so whilst causal relationships can be inferred they cannot be assumed as definitive. Fifth, the association between stigma and attitudes may reflect some overlap between the two scales. The attitudes towards seeking professional psychological help scale contained several questions related to perceived stigma and as such the relationship between the two scales may be due to this overlap. However, Wrigley et al. (2005) using these two measures also suggested there may be some overlap, but concluded that it is still reasonable to assume that people who perceive their community to hold stigmatising attitudes about mental health issues, are more likely to be hesitant to seek professional help for such issues. Similarly, there may have been some overlap in some of the aspects of psychological mindedness and attitudes towards seeking professional help such as openness.

4.6.5 Implications for service delivery and policy

The results of this study have several implications both for practice, service delivery, and for policy makers. Given what is known about the lack of help seeking that occurs in rural areas, and the high levels of need that exist especially during this time of drought and extreme stress for rural residents, knowing and having an understanding of the factors that have the most influence on help seeking behaviours for mental health issues is vital to ensuring people are getting the help they need in a manner compatible with their values, thoughts and beliefs. The knowledge that attitudes towards seeking professional mental health services can act as both a barrier and a facilitator to seeking help and that such things as stigma and age impacts on attitudes means that policy makers and especially

people on the forefront of service delivery can target these specific aspects of rural people and their culture. Some recommendations would be for interventions or policies to target younger rural people and males, and making some real changes to target reducing stigma. Although in this instance stigma did not have a direct impact on help seeking behaviour it is still clearly an important issue to target in creating more positive attitudes towards seeking help which will then help to increase use of services.

4.6.6 Conclusions

This study has added some critical findings to the research literature around help seeking for mental health problems in rural areas. This study has revealed that the factors impacting most importantly on help seeking in the rural context are, people's overall attitudes towards seeking professional help and their mental wellbeing. Further, this study has contributed to the knowledge base around psychological mindedness as a potentially influencing factor on help seeking. This is a novel contribution, albeit a counterintuitive one, however further research should follow up and investigate this finding further.

4.7 Research note and additional findings

The purpose of this research note is to show the additional work that was conducted using the survey data but was not included in the prepared manuscript for the sake of brevity.

Included are the factor analysis of the shortened psychological mindedness measure, and some additional descriptive analyses that were conducted but not pertinent to the research paper manuscript.

4.7.1 Factor analysis of Psychological Mindedness measure

The shortened version of the Psychological Mindedness scale used in this study was an unpublished version created by Shill (Unpublished) and had not been factor analysed previously, nor had it been tested in the rural help seeking context. It was therefore decided that investigating the psychometric properties of the measure should be the first step in the analysis process to ensure the measure was performing in a manner consistent with the 45 item scale. The purpose was to test whether there were indeed five factors within the scale, as described by Shill and Lumley (2002) for the 45 item scale. Therefore the 25 items of the Shortened Psychological Mindedness scale were subjected to principle components analysis using SPSS version 17 (SPSSInc., 2008). Suitability for factor analysis was assessed using The Kaiser-Meyer-Olkin measure of sampling adequacy (KMO= .84), which exceeded the recommended value of .6 (Tabachnick & Fidell, 2007), and Bartlett"s Test of Sphericity which reached statistical significance supporting the factorability of the correlation matrix.

Even though the presence of 5 factors based on past research was assumed, a scree plot of eigenvalues was generated for confirmation. There was a distinct levelling off of the scree from the 5th factor which supports that 5 factors should be extracted. The eigenvalues were 6.92, 2.31, 2.11, 1.53, and 1.37 respectively.

Following this, an exploratory factor analysis using Maximum Likelihood estimation was conducted. The factors of the Psychological Mindedness Scale are most likely to correlate given the interrelatedness of the items in the scale and the factors that are said to exist according to previous research, and therefore Promax rotation of the components was specified. Factor loadings of ≤.30 were suppressed to assist in factor interpretation (Pallant, 2007).

This solution fitted the data and the interpretation of factors follows that of Shill and Lumley (2002) in their analysis of the 45 item psychological mindedness scale. For factor loadings, items relating to each factor, and correlations between factors refer to Table 9.

Table 9

Item Loadings for Exploratory Factor Solution Using Promax rotation, and correlations between factors.

Structure Matrix						
Items	Questions	Factor				
		1	2	3	4	5
Rpms10	Letting off steam by talking to someone often makes you feel a lot better.	.837				
Rpms19	Talking about your worries to another person helps you understand problems better.	.798				
Rpms2	When I have a problem, if I talk about it with a friend, I feel a lot better.	.784				
Rpms16	I've found that when I talk about my problems to someone else, I come up with ways to solve them that I hadn't thought of.	.710				
Rpms11	I've never found that talking to other people about my worries helps much	.602				
Rpms23	When you have troubles, talking about them to someone else just makes you more confused	.521				
Rpms6	When you have troubles, talking about them to someone else just makes them worse	.478				
Rpms17	When I learn a new way of doing something, I like to try it out to see if it would work better than what I had been doing before.		.804			
Rpms15	At work if someone suggested a different way of doing a job that might be better, I'd give it a try.		.690			
Rpms4	I am willing to change old habits to try a new way of doing things.		.561			
Rpms21	I like to try new things, even if it involves taking risks.		.511			
Rpms25	Fear of embarrassment or failure doesn't stop me from trying something new.		.458			
Rpms22	It would be very difficult for me to			.771		

Item	Description					
	discuss upsetting or embarrassing aspects of my personal life with people even if I trust them					
Rpms14	There are some things in my life that I would not discuss with anyone.			.758		
Rpms13	I like doing things the way I've done them in the past. I don't like to try to change my behaviour much.			.611		
Rpms5	There are certain problems which I could not discuss with people outside my immediate family.			.461		
Rpms24	I don't like doing things if there is a chance they won't work out		.314	.352		
Rpms8						
Rpms12	Often even though I know I'm having an emotion, I don't know what it is.				.866	
Rpms20	I'm usually in touch with my feelings.				.712	
Rpms7	Usually, if I feel an emotion I can identify it.				.693	
Rpms3	Often I don't know what I'm feeling.				.629	
Rpms9	I find that once I develop a habit, that it is hard to change, even if I know there might be another way of doing things that might be better.				.351	
Rpms1	I am always curious about the reasons people behave as they do.					.725
Rpms18	I really enjoy trying to figure other people out.					.618

Factor Correlations					
F2	.457				
F3	.402	.284			
F4	.434	.543	.480		
F5	.204	.320	-.104	.077	

*Loadings ≤.30 are omitted

These factors are interpreted as representing the following. Factor one is named "outcomes of discussing ones problems" (this is a deviation from Shill and Lumley's (2002) naming of this factor. In the current study, items on this factor included those relating to both benefits and difficulties of discussing ones problems, where in previous studies this factor was named "benefits of discussing ones problems" and had items only relating to benefits). Factor two represents openness to change, factor three represents willingness to discuss problems, factor four, access to feelings and factor five represents interest in meaning and motivation of own and other's behaviour.

Table 9 also shows that all items load on single factor except for item 24 that loads on both factor two and factor three. This makes intuitive sense as this item could fit into either openness to change (factor 2) or willingness to discuss problems, because an

unwillingness to discuss your problems would be intensified by fear of doing something in case it did not work out. Some other items such as item nine in factor four may have been more appropriate to factor two and item thirteen in factor three, which may also have been more appropriate to factor two. The fact that there are some items that have loaded on factors that may not be appropriate was also found in the original 45 item scales as analysed by Conte et al (1996). It was suggested that there may be a number of inconsistent or extraneous items that were not central to the factor structure and could be dropped to create a shorter version. As the shortened version was created by another research study (Shill, Unpublished), it may be that some of the items that were dropped should not have been and some that were kept should not have been. More research using the original 45 item scale and the shortened version are required to more fully understand this construct and its scale.

The factor analysis was conducted on the shortened version of the psychological mindedness measure was carried out to ensure the measure had a similar factor structure to the longer version. This had never been previously done and in this sample it did indeed have a very similar factor structure to the longer versions; further follow up studies and exploration of the scale are needed to confirm it.

4.7.2 Additional descriptive results

When asked if they would feel comfortable discussing mental health problems with their GP 74.9% said they would feel comfortable and 25.1% said they wouldn't (*N*=247). Table 10 represents reasons respondents who said they would <u>not</u> feel comfortable discussing mental health issues with their GP gave (respondents could give more than one response).

Table 10

Reasons for Not Feeling Comfortable Discussing Mental Health Issues With GPs

Reasons given for those who would not feel comfortable (*N*=107)	% who cited this reason for why they would not feel comfortable discussing MH issues with their GP
I don't have a regular GP	10.8
Embarrassment	6.6
Other	5.4
GPs don't deal with such issues	5.0
Such issues are none of their business	3.1
I don't like/trust my GP	3.1
Frightened	2.3

The most common reasons cited in the "other" category were that GPs were too busy (30.8%), that GPs are not trained in this area (23.1%), and that GPs are only there to prescribe drugs (15.4%).

When asked if they have ever wanted or needed to seek help for a mental health issue but have not done so, 26.1% said yes and 73.9% said no. Reasons that respondents who answered yes to this question gave, are shown in Table 11.

Table 11

Reasons for Not Seeking Help When Needed or Wanted

Reason for not accessing help if wanted or needed (*N*=159)	% who cited this reason for why they did not seek help when they needed or wanted to
Too difficult	10.8
Embarrassment	10.4
Didn't know who to ask for help	9.7
Too costly	8.9
Frightened	6.2
People will think I am crazy	4.6
Other	5.4

Some of the reasons cited in the "Other" category were, feeling unsure about seeking help (21.4%), and that their problems were solved before needing to attend a professional (14.3%), however, the most common reason cited (35.7%) was that respondents felt they could handle it alone.

4.7.3 Contact and experience as related to attitudes towards help seeking

To compare attitudes towards seeking professional psychological help, of people who have or have not known anyone who have experienced a psychological or mental health issue and people who have and have not known someone who has sought help for a psychological or mental health issue, t-tests were conducted. However they did not make a significant difference to peoples" attitudes towards seeking professional help for a mental health issue, and were therefore not included in the multivariate analysis.

Chapter 5- Study Three- Qualitative investigation of open ended survey question

5.1 Preface

The following was the third empirical study conducted in this research program. It was a qualitative investigation using data arising from an open ended question contained in the survey of the previous empirical study. After completing the battery of questionnaires, respondents were invited to comment further on any aspect of mental health or the mental health system in their area. The purpose of this study was to allow survey participants to give any further information they believe to be pertinent to the issue of rural mental health and mental health services having just completed a battery of questionnaires covering those topics. The intention was to ensure that anything the respondent believed needed expanding on or that was missed in the questionnaires could be raised.

Collecting written text, without the researcher present, allows the respondent to be candid in their comments in a way that perhaps interview participants would not be addressing the research question about the nature of rural health systems as perceived by rural people themselves, and will also allow for triangulation between this thesis" two qualitative methodologies and the quantitative methodology used in the survey study. Further, the results will be fed into the Andersen behavioural model in the final discussion chapter with the results of the previous two studies to investigate the utility of the model in the rural help seeking context.

Preliminary analyses of the sub groups, males and females and, those that had and had not sought help for mental health issues showed no substantive differences, and therefore the group was analysed as a whole. This is important to note because the issues

raised in the study were likely to be issues that are of concern across all groups within the sample.

In summary, the study sought to ensure that all the issues related to help seeking as voiced by rural people themselves were captured, and to further inform the theory with qualitative research.

Note: This study has been prepared for submission to Rural and Remote Health and is therefore presented here as a manuscript in its entirety (including abstract).

5.2 Abstract

Written qualitative data from a population survey of 259 people in the rural electorate of Barker, South Australia were analysed to understand mental health help seeking behaviour and un-met needs experienced by rural people. Respondents were invited to provide a written response to an open-ended question that allowed them to comment on mental health or mental health services in their area after having already completed a paper and pencil survey on the topic. Of the 259 respondents to the survey, 99 (38%) responded to the open-ended question. Thematic analysis highlighted systemic disgruntlement as the main theme, with respondents reporting insufficient services and services that did not meet their needs. Other themes identified were awareness, stigma, locality issues, non-professional care and issues specific to rural people. Knowing and understanding the barriers that rural people themselves believe to exist, particularly those that are systemic in nature, will ensure that policies and services can be provided in a manner that helps to reduce the un-met need that exists for those seeking help for a mental health issue in rural Australia.

5.3 Introduction

Research investigating the mental health of rural people and their access to services has gained momentum, particularly with the financial and emotional impact of the ongoing drought in Australia (Roufeil & Lipzker, 2007). The current study was conducted as part of a large population survey, where respondents completed a series of questionnaires and were asked to comment on, or raise any issues about, mental health or mental health services in their area. Previous research on this topic used semi structured interviews with a sample of rural South Australians (n=16) to identify barriers to seeking help for mental health concerns (Collins et al., 2009). This study aimed to provide an opportunity to consider the role of stigma, and psychological mindedness with a larger population based sample, using a different data collection methodology involving unprompted, self directed written data.

Previous researchers have suggested that rural and remote communities in South Australia face difficulties in accessing appropriate mental health care (McGovern & Hodgins, 2007). The distinctive features of rural and remote life including the culture of self-reliance and stigmatising attitudes that may characterise these communities, as well as the shortage of specialist staff available to ensure early intervention means that exposure to the range of mental health services provided in the cities may not occur (Fuller et al., 2004). Roufeil and Lipzker (2007) suggested that although the concept of „rural culture‟ could raise concerns about stereotyping, an awareness of common belief systems in rural cultures can be critical in working with this population. Rural Australian communities also face unique stressors, for example, following the current drought.

Current strategies in place for rural and remote mental health include the Better Outcomes for Mental Health Initiative. This initiative is run through the Divisions of General Practice that provides training to general practitioners in mental health, focussed psychological strategies and they are also informed about local referral options for mental

health (Australian General Practice Network, 2007). The Australian General Practice Network was also funded for two years (2008-09) to provide the „mental health support for drought affected communities initiative" which provided community support people, raised awareness and provided education to health workers and community leaders in recognising the signs of emotional distress (Australian General Practice Network, 2009). Despite these initiatives, one study from New South Wales found that the Better Outcomes initiative served to highlight the challenges of mental health care in rural regions: workforce retention, stigma and strong demand for services (McGovern & Hodgins, 2007). In spite of this the Divisions of General Practice have made no variations to address these challenges (McGovern & Hodgins, 2007), therefore these challenges still exist in spite of specific interventions.

Further, a search of the Australian Psychological Society"s „search for a psychologist" website, an examination of The University of Adelaide"s directory of mental health services and an examination of some of the rural South Australian Yellow Pages, provided evidence of the short supply of registered psychologists even in some of the main regional towns within the Barker electorate (the setting for this study). For example, the town of Mount Gambier on the South East coast of South Australia (from which some of the participants from this study have come) had only one psychologist registered within a 50km radius, on the APS find a psychologist website who specialises in mental illness including depression and anxiety (it should be noted that registration on this website, and indeed in the yellow pages is not compulsory and therefore may not be fully comprehensive).

Qualitative investigations provide in depth descriptions of what rural people consider to be the barriers to seeking mental health services. One recent qualitative study investigating help seeking within a farming group in the Riverland, South Australia (Staniford et al., 2009) found that financial hardship as a result of the drought adversely

affected health and wellbeing and alleviation of strain by mental health professionals was uncommon because of five barriers: self reliance, social image, lack of knowledge, negative perceptions of health professionals" efficacy, and restrictive lifestyle factors. Similarly, Collins et al."s (2009) thematic analysis identified awareness, including a lack of knowledge, and self reliance as important barriers to seeking help for mental health in one rural South Australian area. An interview study with stakeholders in another rural area of South Australia revealed that the central difficulties were with service access, especially the availability of specialist mental health supports to ensure early intervention, acceptability of services, and teamwork amongst GPs and allied health workers such as mental health teams, drug and alcohol services, aboriginal health workers and so on (Fuller et al., 2004).

The aim of this study was to collect written data about what rural people believe about mental health and mental health services in their area from survey respondents, using a broad question as the only prompt. The current study added to the literature because it allowed survey respondents the opportunity to add anything further after having answered forced choice questions in relation to help seeking and various topics known to be salient to the issues of mental health help seeking in rural areas. This approach provides a vehicle for respondents to comment from their own frame of reference without being constrained by having to respond in terms of fixed choices. Thus the data provided by this technique is likely to reflect issues of true importance and meaning to the respondents. In addition to adding these different data collection methods, the current study furthers previous work (Collins et al., 2009) by including a larger, representative sample.

5.4 Method

5.4.1 Participants and Sampling Frame

Participants of the survey were a randomly selected sample of 600 electors from the South Australian electorate of Barker. Seven people declined to consent and ten were no longer at their given address, leaving 583 residents who were invited to participate from these 259 responded. The open-ended question was completed by 99 (38%) of the 259 survey respondents: 66 females and 33 males with an age range from 19 years to 70 years and mean age 46.5 years. Of the 99 respondents, 52.5% had accessed mental health services in the past. A further 32.3% of the 99 respondents indicated that they had wanted to, or felt they needed to access mental health services in the past but had not done so. The remainder had not accessed services and did not feel the need to do so.

5.4.2 Procedure

The study received ethical clearance from The University of Adelaide Human Ethics Subcommittee. Data were collected via a mail out to a random population sample using an extract from the Australian Electoral Commission. The open-ended question used for analysis in this study was one section of a larger survey containing Likert scale questionnaires including, a perceived stigma scale, a mental health status scale, and an attitudes towards seeking professional mental health services scale.

The question itself asked respondents to "please comment on any other aspects of mental health and mental health services in your community that you think are important". The question was devised in consultation with an advisory panel to allow respondents the opportunity to comment further after completing forced answer questions. It was decided that based on the depth of information gleaned from previous qualitative work (Collins et al., 2009), that it was important to allow survey respondents an opportunity to comment

further on any of the issues raised in the survey or add anything they felt was imperative to the topic and may have been missed in the survey. As with the rest of the questionnaire, this question was also piloted using a convenience sample of seven rural residents, during this process one pilot participant responded to the open ended question.

5.4.3 Data Analysis

Data were analysed following the guidelines for thematic analysis of Braun and Clarke (2006). This involved reading and re-reading the responses, generating initial codes, and then collating, naming and defining themes (Braun & Clarke, 2006). Those who had and had not accessed services were analysed together after it was determined by the researcher and two other independent researchers that participants in the subgroups were raising similar issues. Inter-rater reliability was assessed by having two other independent researchers involved in the coding and analysis of themes. They analysed a random sample of the questionnaires looking for themes, then these were then compared to the researchers themes. Any minor discrepancies were discussed and resolved after all three coders completed the coding process on their random sample and the researcher completed the analysis of the remaining questionnaires searching for the themes devised with the help of the additional researchers, and for any emerging themes.

5.5 Results

The quantity written by each participant varied quite considerably from one sentence to a whole page, the average was approximately four to five lines of written text.

Table 12 shows how respondents and non-respondents compared on a number of measures. These included, Attitudes Towards Seeking Mental Health Services (Mackenzie et al., 2004), Perceived Stigma (Wrigley et al., 2005) and a measure of mental health using the

Mental Health Inventory-5 (Veit & Ware Jr, 2000). Measures are scored so that higher

scores indicate higher presence of the construct i.e. higher scores on mental health

inventory equals more positive mental health, higher scores on the attitudes towards

seeking mental health services indicate a more positive attitude and higher scores on the

perceived stigma scale indicate more stigma is perceived.

Mean mental health inventory scores were high, attitudes towards seeking mental

health services and on the amount of stigma they perceived were approximately mid range.

Results on the measures for those who responded to the open-ended question did not differ

considerably from those who did not respond (

Table 12).

Table 12

Descriptive Statistics for Respondents Versus Non-Respondents

Respondent Descriptives (Non-respondent)	N	Possible Range	Minimum	Maximum	Mean	SD
Age	99(160)	18-70	19(18)	70(70)	46.5(45.3)	14.2(14.1)
Attitudes towards seeking MH services	94(153)	0-96	33(26)	96(96)	66.5(63.3)	15.2(14.4)
Mental health Inventory	99(156)	5-30	7(6)	29(30)	22.1(23.6)	5.1(4.3)
Perceived stigma	93(153)	16-64	17(16)	58(61)	38.5(38.3)	5.1(7.5)

5.5.1 Thematic analysis

Results have been structured according to the prominence of themes with extracts

from the data used to illustrate each theme. Direct quotes are identified by gender, age and

whether or not they have sought help for mental health issues (F, 36, Y indicates a quote

from a 36 year old female who has sought help for a MH issue). Themes will now be

discussed in greater detail.

5.5.1.1 Systemic disgruntlement

Systemic Disgruntlement was named so because of the strength of the language used to describe services. It was the most prominent theme (*Figure 5*), raised by 64 of the 99 respondents including those who had and had not sought help. Respondents raised disgruntlement in one (or both) of two subthemes: lack of services and inadequate services. Many people interpreted the question to   comment on mental health services to include General Practitioners (GPs), and this was often raised in the context of there being inadequate services available.
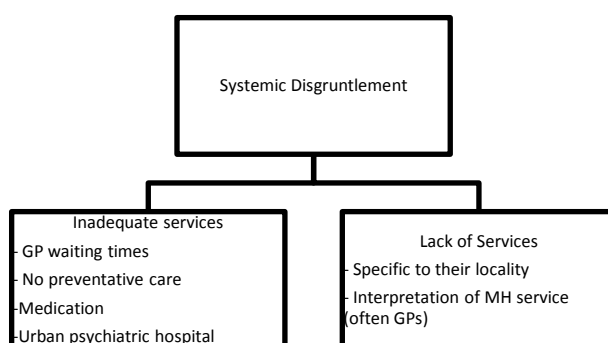
Figure 5. Systemic disgruntlement theme and subthemes.

5.5.1.2 Lack of Services

Thirty respondents, who suggested there is a serious lack of available services, raised this sub theme:

"Mental health supports are very limited in our area....and there are not

enough mental health workers to be employed in our area" (F, 45, N)

"Not enough services....very difficult to access due to number of

patients" (F, 58, N)

"Being a nurse in a country hospital, our mental health patients are

grossly neglected by the system" (F, 50, N)

Many respondents, made specific reference to either their exact locality, or to „rural areas"

more broadly, emphasising that lack of services is specific to their rural area or ‚rural

areas" in general.

"I feel strongly mental health in rural S.A is very hard for people to get

access to" (F, 69, N)

"Mental health services in rural South Australia are poor to non-

existent" (M, 30, Y)

"Our mental health system appears to be in tatters, we urgently need

more regional mental health assistance in regional areas" (F, 70, N)

"Working in the health care industry (nurse) in a country area has been a

big eye opener in recognising the shortages of mental health services

and professionals" (F, 28, N)

5.5.1.3 Inadequate services

This sub-theme differs from lack of services in that respondents did not necessarily

refer to there being a lack of services, but suggested that what is available is not meeting

their needs. 34 respondents raised this sub theme, and GPs were often raised within this

context.

Comments about inadequate services were manifest in four ways: GP waiting times, no preventative care, medication, and the system of sending patients to the urban psychiatric hospital as an unsatisfactory option.

The most common issues raised concerned GPs and particularly, GP waiting times.

"Things aren't addressed soon enough. There's currently a 5 week wait to see a GP" (M, 32, Y).

"A disadvantage, I guess everywhere, is to get an appointment with a doctor to even get a referral for counselling" (F, 33, N)

"Everything is slow to happen. Takes ages to get an appointment (with GP) and referral and then another appointment. For some this slow process could mean it's all too late" (F, 40, Y)

Respondents also commented on lack of preventative care.

"There is no preventative help for „mild" illnesses" (F, 45, N)

"Had a friend almost kill himself, once he tried it was possible to get major help. Without attempted suicide it was pretty hard. Access to major help before something happens seems hard!" (M, 34, N)

"Accessing psychological support is difficult in country areas particularly urgent assessment for crises i.e. suicidal people and young people with mental health issues" (F, 58, Y)

Respondents also commented that medication is used in favour of other alternatives.

"One thing I have found when consulting help is that the first thing they offer is medication when I feel counselling would serve better" (F, 32, Y)

"I feel not enough is done to allow people to work through their problems rather than offer them a quick fix in terms of medication" (M, 50, Y)

"I believe that when a GP gives out medication for depression it should be compulsory that the patient should then attend counselling" (F, 42, Y)

Although over two-thirds of respondents raised their concern over the lack of services and inadequacy of existing services, it is important to note that some respondents suggested it is not all bad and there are some good services in place.

"There are excellent mental health services in my community. Anyone who has a problem can talk to a clinical counsellor" (F, 60, N)

"It is good that we have counsellors in our community" (F, 51, Y)

"The town I live in has had a number of seminars re mental health and

has recently opened a counselling centre" (F, 61, N)

5.5.1.4 Awareness

Two sub themes were identified within the theme of awareness: lack of information and advertising, and being unsure of where to go.
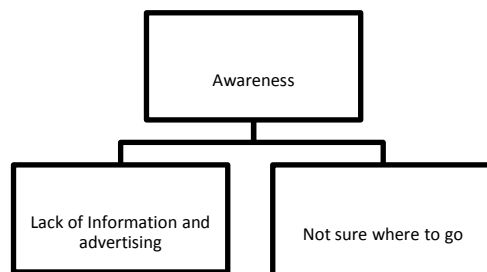
Figure 6. Awareness theme and sub themes.

5.5.1.4.1 Lack of information and advertising

This sub theme manifested itself in comments about the lack of readily accessible information and advertising about available services.

"Mental health services in these areas should be advertised so that

people are aware of the services available" (F, 21, Y)

"There is not enough general information for people seeking help,

its needs to be publicised more particularly in the doctor"s surgery"

(F, 65, Y)

"Help for issues need to be advertised in local papers etc so people are

aware of them" (F, 32, Y)

5.5.1.4.2 Not sure where to go

This sub theme differs from that of the above in that it focuses more on a lack of

awareness of where to go for help.

"I believe that many people in the country don't know how to find

help" (M, 21, N)

"The main concern is not knowing who to go to for your

problems/who deals with different problems" (F, 19, Y)

"It would be very helpful to talk to someone and to seek help but I

wouldn't know where to start or how to do it" (F, 60, Y)

5.5.1.5 Stigma

Stigma was the third most common theme to emerge. This theme was raised by 10

respondents in comments about embarrassment and gossip, and travelling elsewhere to

receive treatment for mental health issues to avoid such reactions. Stigma can be

experienced as either perceived stigma, where the stigma comes from others, or it can be

self-directed where the stigma comes from within the individual. The following participant

quotes represent both these forms of stigma.

"In the Riverland we are a close community, I would not trust anyone with personal information regarding my health- This place thrives on gossip" (M, 47, N)

"In a small town it is hard to be private and for people to not find out things you may not want them to know. I think people probably hold off seeking help until they have nearly hit bottom" (F, 28, N)

"When I did have a problem I didn't feel confident seeking help within the community as I didn't want local people to know I was having problems. I travelled to Adelaide to see a psychologist at least four times" (F, 32, Y)

"Privacy-first point of call [is] GP or clinic-Always open to gossip" (M, 54, N)

5.5.1.6 Locality Issues

This broad theme includes three sub themes representing some of the more traditional barriers thought to hinder help seeking in rural people, including distance, cost. The drought that has been affecting rural Australia for much of the 21st century was also raised as something that contributes to the stress of rural people, increasing their need for services. Each of the sub themes were raised fewer than 10 times each.
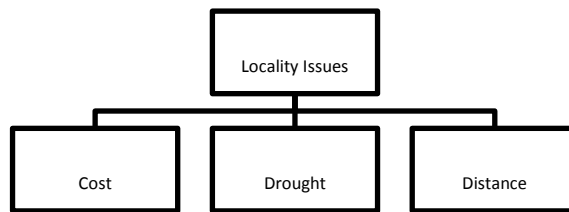
Figure 7. Locality Issues theme and subthemes.

5.5.1.6.1 Cost

"It would be very helpful to talk to someone........but feel I probably

could not afford it anyway" (F, 60, Y)

"It seems that to access a lot of the mental health services you need to be

referred through a GP for it to be affordable. If you access anything

privately it"s a higher cost" (F, 42, Y)

"..... cost in the country is prohibitive" (M, 60, Y).

5.5.1.6.2 Drought

"Being a citrus grower relying on water, interest rates, no income as a

result of the drought.... is enough to cause a multitude of mental health

problems" (M, 65, N)

"The drought and ongoing water problems have a dramatic effect on

country areas, both on farming families and in townships" (F, 52, N)

5.5.1.6.3Distance

"I had to travel one and a half hours to see a psychologist" (F, 44, Y)

"I believe it"s very difficult to access a psychologist and there isn"t a resident psychiatrist in this area" (F, 51, Y)

"Distance......... in the country is prohibitive" (M, 60, Y).

5.5.1.7 Non-professional care (Alternative care)

This theme was presented in two distinct sub themes either as positive, where using family, friends and others in the community as a help source can be good, which has been labelled as „social capital", or as negative, labelled here as „self reliance", whereby respondents suggest that dealing with problems alone is commonplace in rural areas but is not looked upon as a particularly good or healthy thing.
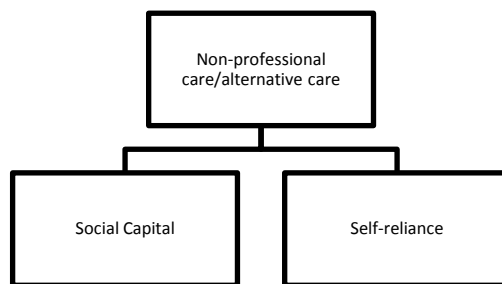
Figure 8. Non-professional care/alternative care theme and subthemes.

5.5.1.7.1 Social capital

Comments within this subtheme suggest a certain resilience amongst rural communities and that they consider this caring for one another a powerful asset.

"Mentors are very important to me also i.e. elders that have "been there done that" can offer very good insight and advice for problems that can put you back on track" (M, 33, Y)

"A kind word or a friendly smile by acquaintances is important when you feel flat or down e.g. local shop owner or hairdresser. These are people who are at your elbow in your times of stress and need" (M, 61, Y)

"Farmers need support from their friends and neighbours, so a decreased population (in the country) has a huge influence on their mental health" (F, 52, N)

5.5.1.7.2 Self-reliance

Self-reliance on the other hand was referred to with a more negative connotation that when people do not seek help for mental health issues, it is often because they think it reflects weakness. Self-reliance was also raised with specific reference to men:

"Had a friend almost kill himself; once he tried he was more open to getting major help" (M, 34, N)

"I think people probably hold off seeking help until they really need it and have nearly hit bottom" (F, 28, N)

5.5.1.8 Specific categories of affected people

Some respondents drew attention to problems specific to sub groups within the larger rural group. These included males, particularly young males, Aboriginal people, and carers of mentally ill people.

5.5.1.8.1 Men

"Many males in the country think it"s weak to seek mental health professionals" (M, 21, N)

"Rural towns need more services available.....especially for our youth......I see too many young men with too much pressure on them and not enough support for them" (M, 41, Y)

5.5.1.8.2 Carers

"I feel for people who are carers for mentally ill or disabled people and feel they should get more help for long term cases" (F, 67, Y)

"The mental health of carers is overlooked or not understood in small communities" (F, 61, N)

5.5.1.8.3 Aboriginal people

Although there was only one reference to issues around Aboriginal mental health (made by a woman who is both Aboriginal herself and an Aboriginal health worker), it is important to note this group with specific, and seemingly unmet needs.

" I am an Aboriginal health worker, and I find that there is only

a very limited number of social and emotional wellbeing

counsellors in SA for Aboriginal people to have access to" (F,

45, N)

5.5.1.9 Drugs

The issue of drugs was also raised as an important issue facing rural people,

some examples are shown below.

"... The drug problem locally is out of control" (F, 70, N)

"More professional workers in the field to cope with the ever alarming

number of people suffering mental illness.......especially now drugs are

controlling our young" (F, 55, Y)

A number of self professed health professionals were amongst those who took the

opportunity to add further comments to the survey and their answers were analysed

compared to those who were not health professionals. However this analysis revealed no

comparable differences between the two groups in terms of their responses.

5.6 Discussion

Respondents and non-respondents to the open ended question in this study were

compared on the various psycho social measures, and these findings are important to keep

in mind when considering the results of the thematic analysis. Specifically, those that

chose to answer the open ended question and those that did not answer it had similar

mental health scores and similarly positive attitudes, so there does not appear to be any selection bias.

This study utilised written textual data collected via an open-ended question that was part of a large population survey. The aim was to allow an opportunity for survey respondents to make additional comments about mental health and mental health services that they felt important to raise, after having filled out a survey about these issues. The strength of the language used by respondents to describe services revealed the existence of considerable disgruntlement with the current mental health system. Approximately two thirds of the respondents noted that there were not enough services available or that what is available (generally GPs) are often inadequate. More specifically, respondents suggested that waiting times are long, and that GP''s don''t have specific training in mental health or are unaware of services available for referral. Respondents made many comments about the long process of firstly seeing a GP for a referral (and the waiting times involved in that), and then the waiting times involved in seeing the limited number of specialist mental health professionals available. A search of some of the towns and surrounding areas from which participants were sampled on the Australian Psychological Society''s „search for a psychologist" page of their website (Australian Psychological Society, 2010) shows that for some centres such as Mount Gambier there is only one APS-listed psychologist dealing with anxiety, depression and mental illness, or the Barossa Valley region where there are only two psychologists listed within a 50km radius of one of the central regional towns (however, as noted previously, this website list is not compulsory for all psychologists and therefore would not be fully comprehensive). One respondent even raised concern about the fact that this slow arduous process can and has been too late for some people in need of help, and resulted in an attempted suicide. Others raised concern about the time it takes to get an appointment with the GP at any time for any reason. This slow process of getting any form of help especially from a GP could be indicative of the workforce shortage of

GP''s in rural areas (Judd & Humphreys, 2001) and therefore the overburdening of those that are available. This also suggests that rural people feel that the mental health care system is failing to meet their needs in a number of ways, especially because GP''s are very often the first stop for patients with mental health issues, and referral is often the only way for patients to get access to the (often limited) specialist mental health care in these areas (Australian General Practice Network, 2007). This in turn could raise concerns that if it takes a long period of time to get to see a GP then other services would have as long or longer waiting times. This in itself creates a barrier to the seeking of mental health services, particularly because rural people may then be less inclined to even broach their mental health with their GP when they feel a very short time limit is being placed on their visits. This finding is consistent with previous research that suggested that doctors also see themselves as too busy to question patients about such things as depression, anxiety and other life problems that might complicate and lengthen the patient''s visit (Mechanic, 2007).

Awareness of services was an important theme raised by many respondents, with the sub-themes being, lack of information and advertising, and lack of knowledge in terms of where to go for help. Similar issues have been identified amongst citrus growers in rural South Australia, where not knowing what services were available was a barrier to seeking help (Staniford et al., 2009). Previous research has suggested that general practitioners are the main provider of mental healthcare in rural areas (Komiti et al., 2006), however it may be the case that they have not always been adequately trained in recognising mental health problems, and have often worked in isolation from the wider human service systems available in metropolitan areas, which means they do not have the referral options of this nature available (Fuller et al., 2004). This may also contribute to the lack of awareness about available services that the results of this study have demonstrated, because if their first point of reference for these issues is their GP, but the GP is not familiar with the

services, then this provides a barrier for the patient following up further treatment. A number of respondents also suggested that medication is the only treatment option offered in rural areas. The lack of awareness of available services and referral options may be a contributing factor to this as both patient and GP are unaware of the other options available to them. It is interesting to note that other than one or two comments made in relation to offering counselling instead of medication for mental health problems, respondents did not make any suggestions about what changes would make the system better. Again, lack of knowledge and awareness of mental health services may have limited respondents" knowledge of what could (or should) be available.

Systemic disgruntlement such as the lack of, and inadequacy of services, as well as awareness of services were categorically the most important barriers to seeking help raised by respondents in this study. Psycho social influences such as stigma were also raised but to a lesser extent. This is an important and novel finding, as previous recent research, have found cultural issues such as stigma to be the most influential factor in help seeking behaviour in rural areas (Barney et al., 2009; Collins et al., 2009; Sweeney & Kisely, 2003).

Notably, within the theme of non-professional help alternatives, there was the suggestion that self-reliance was a negative influence on seeking help, as men in particular believed this reflected weakness. Previous research has also found that rural people and males in particular, believe seeking professional help for a mental illness is a sign of personal weakness (Murray et al., 2008). Help seeking as a sign of weakness amongst rural males may also reflect the hegemonic masculinity (dominant male cultures) at play in these communities (Collins et al., 2009) and investigations directed specifically at rural men are needed to confirm this. However, a sub-theme within the non-professional help seeking alternatives theme was that of social capital. Social capital refers to "the public good that results from mutually supportive social relationships" (Sartorius, 2004, p. S101). In the

context of this study respondents described social capital as having close communities, and this was described as a positive. One respondent suggested that the people in her community such as the local hairdresser or shop owner can be invaluable in times of need. Social capital also suggests a certain resiliency amongst rural people. Resilience is said to represent "successful adaptations to adversity, stressful events, and oppressive systems" (Sonn & Fisher, 1998, p. 468). The notion of the competent community as described by Iscoe (1974) suggests that networks of people and groups within a community can provide opportunities and structures that may moderate the impact of stressors (Sonn & Fisher, 1998). Community resilience refers to the positive ways in which people use others in their community to respond to stressful life events (Sonn & Fisher, 1998). It may be that rural people are getting a certain amount of help from these alternate help sources referred to as "mentors" by one respondent or, as another respondent suggested even just a friendly smile or chat with the local shop owner can be enough to help in times of stress, anxiety or depression. Caldwell and Boyd (2009) suggested that this is in fact a coping mechanism used very often by rural communities in times of stress. They investigated resilience in farming families affected by the drought, and they found quite clearly that social capital was drawn upon by their participants in times of stress for social debriefing and support (Caldwell & Boyd, 2009). This study also found that family and even other townspeople such as bank managers were identified as providing indirect support simply by regularly enquiring about the participant and their families (Caldwell & Boyd, 2009).

Limitations of the current study include, first, the self selected nature of the respondents suggests an overarching motivation to respond. Those who did choose to comment in the open ended section obviously have the strongest opinions, therefore the opinions of those not willing to respond or indeed participate in the survey at all, are missed. Further, half the respondents to the open ended question had sought services in the past, this disproportionately high, too. Second, although the open ended question was very

broad and there were no prompts from the researcher as there might be in face to face interviews, in all likelihood the respondents may have been influenced by simply having filled out the questionnaires related to help seeking, attitudes towards seeking mental illness and stigma before answering the open-ended question. The act of completing these questionnaires may have coloured their thinking about the topic in some way. Conversely, the aim was have respondents make additional comments in light of the topics covered in the questionnaires, this ensured respondents could include anything that was missed or needed expanding. In addition, it is recognised that there may be some degree of overlap between the themes of self-reliance and stigma. It is recognised that self reliance for mental health issues may be borne out of a fear of being stigmatised by others (perceived stigma) or the stigma the individual puts on themselves (self-stigma).

It is important to note that some of the themes raised here are not necessarily specific to rural people; even some that rural people believe are specific to them. For example, access to adequate services can also be an issue for people living in more metropolitan areas, although they would have a larger selection of GPs for example if they were to find their current one inadequate in meeting their needs. Similarly, lack of information could also be an issue for urban dwellers, although they similarly have more resources from which to find information. In addition, drugs and lack of support for carers are also not necessarily problems that are specific to rural dwellers.

The results of this study have shown that the biggest concern amongst rural South Australians with regard to mental health and mental health services is both the lack of services available and the [in]adequacy of services that are available in meeting their needs. In addition, they feel that there is not enough advertising or awareness of services that are available, and that people are unsure of where to go and what to do should they need or want to access any kind of mental health service. However, it can be seen from the other themes that arose from this study that systemic issues are only one barrier within the

complexity of help seeking for mental health in rural communities. Although socio-cultural issues such as stigma were not as prominently raised in this study, it does not mean they should be discounted as crucial barriers to consider when investigating and implementing mental health services in rural areas. Particularly because of the way the question was posed to them i.e. as an opportunity to add anything further, so it is possible that after responding to a questionnaire on this topic, they did not feel the need to give additional comments.

What this study adds to the existing literature is a sense that the issues and barriers facing rural people in seeking help for mental health issues are exceptionally complex and all factors, systemic and socio-cultural, are important to consider when reviewing existing services or implementing new ones. It would be a mistake for policy makers and stakeholders to assume that by simply providing more services in these areas, the problem would be solved, because clearly there are many more issues to consider. These include, changing the stigma that is clearly still attached to mental illness and seeking help for mental health issues, as well as providing services that are tailored specifically to deal with the issues that rural people see as being particular to them. These include, the drought and the financial issues that come with the drought, and the negative issues associated with young men such as, drug abuse and their propensity to see help seeking as a sign of personal weakness. Further, addressing the apparent workforce capability in these areas should be done through the development of the primary care workforce, perhaps though more training of rural GPs in mental health strategies and perhaps more incentives for mental health specialists to reside in rural areas. Also, more emphasis on the Better Outcomes for Mental Health initiative, and more funding for the "mental health support for drought affected communities initiative" to provide training to prominent community leaders and retailers in mental health strategies in order to target those who will not seek formal mental health services. In addition, developing and encouraging better integration

and communication with specialist services within primary health care and private practice will also aid in addressing some of the issues associated with mental health services in rural areas.

Chapter 6- Overall Discussion/Meta-inference

6.1 Introduction

The impetus for this thesis originated from the researcher"s knowledge of the plight of rural residents with regard to accessing mental health services. Upon examining the literature, it was apparent that lack of access to services was a salient issue for rural people. It was not clear however, what rural residents themselves would say about what they believed to be the barriers, and qualitative research investigating the experiences and needs of rural communities was also lacking. Similarly, research into the psychosocial factors impacting on mental health help seeking had not reached any definitive conclusions, nor had any other study considered the influence of psychological mindedness in the rural help seeking context. The mixed methods approach was therefore taken to address these gaps and to ensure a comprehensive view of the issues. The qualitative methods were used to draw out what rural people believed to be the barriers, and the quantitative methods were used to follow up and investigate the impact of those barriers on intended and actual help seeking behaviour.

The contribution that this thesis has made to rural help seeking research is three fold. The first innovation was the study used mixed methodology to investigate help seeking for mental health issues in rural areas which had not been done previously. Second, Bradley"s (2002) expanded version of the Andersen behavioural model had never previously been applied to the rural mental health help seeking context, nor had a mixed methodology study been applied to it. Third, the construct of psychological mindedness was thoroughly investigated using qualitative methods, followed up with quantitative methods and also a factor analysis of the measure. It had never been previously

investigated in this context before nor had the shortened version had its psychometric properties tested.

6.2 Overview of thesis

All studies in the thesis were conducted using participants residing in the Barker electorate of South Australia. Study one used a convenience sample (N=16) recruited from General Practice surgeries and snowballing techniques. Semi structured interviews were conducted and analysed using thematic analysis. Psychological mindedness was investigated to understand the relevance in this context, and whether or not to pursue it further in subsequent studies. Results were focussed on socio cultural issues such as stigma, and some evidence for psychological mindedness was found.

Following up the interviews, study two used the themes that emerged (as well as those specified under the Andersen model) as a guide for the measures to be included in the questionnaire. A representative population sample was recruited via the electoral roll (N=259). Results were focused on attitudinal factors and offered a novel but counter intuitive finding with regard to psychological mindedness.

A second thematic analysis was conducted using data obtained from an open ended question on the survey. The question invited respondents to comment on mental health and mental health services in their area. Ninety nine (38%) survey respondents made a written comment and results revealed a distinct systemic focus.

The specific research questions addressed in this thesis were:

1. What do rural people themselves say about access to mental health services in rural areas?

2. What do rural people themselves say the barriers to and facilitators of access are?

3. In the context of the theory of the Andersen behavioural model:

- What are the independent contributions of psychosocial factors to help seeking behaviour?

- What is the utility of the model in the rural help seeking context?

4. What contribution to help seeking in rural areas does psychological mindedness make?

Research questions one and two were addressed using semi structured interviews where respondents spoke openly about access to mental health services and what they thought the barriers and facilitators to seeking help for mental health were. They acknowledged several difficulties in accessing help such as stigma, lack of awareness of services and the culture of self reliance, but they also indicated a readiness for change.

Research question three was addressed using the survey data in study two where decisions about measures to include in the survey were based on categories of the Andersen model and results were understood and explained within the model. The utility of the model is discussed later in this chapter.

Research question four asked about the contribution of psychological mindedness in the help seeking context. It was addressed in two ways. First, in the interview study, where some indication that rural people lacked psychological mindedness was found. Subsequently, in the survey this was not confirmed and indeed it found that psychological mindedness had a negative impact on attitudes towards seeking help. Attitudes were the most important factors in predicting help seeking outcomes. The final study using written data from the surveys revealed no theme related to psychological mindedness. The equivocal results found suggest the impact of this construct on help seeking is not yet known and further research is warranted to better understand the construct in the help seeking context.

The following sections of this chapter will provide the meta-inference and triangulation of qualitative and quantitative results in more detail, and discuss the utility of the Andersen behavioural model. It will discuss the overall conclusions of the thesis, the implications for service delivery and policy, and provide future directions for research in this area.

6.3 Triangulation

Triangulation refers to the comparison of two or more methods of data collection (Mays & Pope, 2000). It also refers to the combining of data sources to study the same social phenomenon (Denzin, 1978). Denzin‟s (1978) definition was most relevant for this thesis because while the three studies had the same broad aim, data collection and analysis varied. Applying triangulation to this mixed methodology thesis allowed for a cross check of the internal consistency of the two qualitative papers (also referred to as within methods triangulation), and to test the external validity by cross checking the qualitative and quantitative studies (also known as across methods triangulation) (Jick, 1979). This combining and comparing of data sources added to the validity of the findings in both data collection methods.

One of the most significant differences across the three studies was the finding about psychological mindedness. While the interview study found some evidence for the importance of psychological mindedness, this was not confirmed in study two or three. Indeed, the population survey study showed the somewhat counter intuitive finding of a negative relationship with attitudes towards helps seeking. This is a finding in direct contradiction with previous research findings that positioned psychological mindedness as a positive psycho social trait (e.g. Conte et al., 1990; Shill & Lumley, 2002). There was no strong systematic evidence for the validity of psychological mindedness in the final

qualitative study. The context of participants in the interview study compared to the respondents of the open ended survey question caused different themes to emerge. Having already answered questions in the survey about Psychological mindedness, respondents might not have felt the need to reinforce this with a follow up comment. Similarly, perhaps issues such as systemic disgruntlement were simply the most pressing when asked only to comment (unprompted by a researcher present) about mental health services in their area.

Despite the fact that the thesis confirmed the factor structure of the psychological mindedness scale, suggesting it was a valid tool in this context, it did not relate positively to help seeking. This had never previously been found, and was explained using the concept of rumination. Self focussed rumination has previously been linked to poor mental health outcomes, and has been deemed an unhealthy personal trait (Lyubomirsky & Nolen-Hoeksema, 1995). Certain aspects of psychological mindedness such as getting in touch with feelings and interest in meaning and motivation of own and others behaviour are suggestive of high levels of over thinking, or, rumination. Problem solving skills are also affected by high levels of rumination (Donaldson & Lam, 2004), impairing the ability to make a decision about seeking help. Therefore, if high levels of psychological mindedness encourage high levels of rumination impairing problem solving skills, the likelihood of help seeking would be radically reduced.

The three studies also had some similar findings. Stigma was raised in all three studies, with varying degrees of importance. The interview study saw stigma raised as a barrier by every interviewee at least once and in some cases more than once. Similarly, stigma was raised consistently in the written qualitative study but was raised with less importance than systemic factors such as lack of and inadequate services. The results of the population survey study showed that stigma did not have a direct impact on help seeking behaviour outcomes. It did however, have a direct impact on attitudes towards seeking help, and attitudes were the single most important factor for both intentions to seek help

and behavioural outcomes (always highly significant at the p <0.01 level). This finding is consistent with the existing body of rural help seeking research and may suggest that stigma is not a direct barrier to actual behaviours once the definitive decision has been made to seek help, but still significantly influences attitudes and intentions to seek help. For example, Wrigley, Jackson, Judd and Komiti (2005), found that higher perceived stigma was associated with more negative attitudes toward seeking help, but they did not find an associated lack of help seeking (i.e. willingness to discuss mental health issues with a GP). Similarly, Komiti, Judd and Jackson (2006) found stigma was not a predictor of help seeking behaviour, but that attitudes were.

The results from the studies presented in this thesis have both a socio cultural, and systemic emphasis. Themes extracted from both qualitative studies were also quite similar (with the exception of psychological mindedness), despite the method of data collection, sampling frame and size being different. This suggests that systemic factors including lack of services and inadequate services, and psychosocial factors, particularly stigma, are both salient issues in the rural help seeking context. Similarly, „awareness of services" arose in both the interviews and written data, suggesting that a lack of awareness of available services is another salient issue in this context. Systemic issues raised in both qualitative studies, may also be a product of this lack of awareness of services. As a result, if service users are unaware of the services available and do not know where to find this information, they are more likely to feel disgruntled about the system. Further, the lack of availability of services may also be associated with the lack of awareness of services. Similarly, the „lack of available services" and „issues around GPs" themes from the interview data were comparable to systemic disgruntlement from the written data, where dissatisfaction with the number and quality of services was also raised. Further, self-reliance from the interviews was similar to the non-professional care theme extracted from the written qualitative data, whereby it was suggested that rural people prefer to seek help from others

or simply cope alone. However, the written data extended on this, with the „social capital"

theme that suggested looking to other members of the community for assistance in

preference to seeking professional help, was actually a resilient trait of rural people and

indeed a positive feature of rural communities.

An additional key finding was that of gender. The interview data suggested rural

men were less likely than women to discuss mental health issues and certainly less likely to

seek help, preferring to cope alone or self medicate with drugs and alcohol. The survey

indicated that gender influenced help seeking intentions, whereby women were more likely

to intend to seek help for mental health issues. Confirming and extending this, was the

„nonprofessional help" theme and two subthemes; social capital and self reliance that

emerged from the written qualitative data. The self reliance theme suggested that men in

particular are less likely to want to seek help from professional sources, preferring to cope

alone when suffering from a mental health issue. However, as previously discussed, the

written responses also yielded the social capital theme where seeking help from and caring

for others in the community was seen as a powerful asset.

In sum, the three studies had many similarities despite differences in methodology

and recruitment. The results gave a clear indication that, systemically, there is much work

to do in rural areas, particularly from a policy and service delivery standpoint. The other

key finding across the tree studies was that attitudes towards seeking professional help

including perceived stigma were the most important barriers to help seeking for mental

health issues in rural areas.

The following section will apply the Andersen Behavioural Model to the findings

across the three studies. The results of all three studies will be integrated under one

theoretical model.

6.4 Using the Andersen behavioural model to understand the findings within a theoretical framework.

Andersen's behavioural model provided the framework for the discussion of rural help seeking behaviour for mental health services, and the result of the three studies presented in this thesis.

The Andersen model has been applied to mental health help seeking behaviour previously (i.e. Judd et al., 2006c; Kimerling & Baumrind, 2005; Parslow & Jorm, 2000). However, there have not been any studies that have incorporated qualitative and quantitative data together within the model. Bradley's adaptation of the model (Bradley et al., 2002), to the author's knowledge, has never been used to investigate rural help seeking. This adaptation of the model focuses on more of the psychosocial factors associated with help seeking behaviour (Bradley et al., 2002) and includes intended and actual use of services.

6.4.1 The present research and the Andersen Behavioural Model

The following section will describe how findings from this thesis fit into Bradley's (2002) adaptation of the model. Below (Figure 9) is a visual representation of the model as applied to the current research findings. Themes were determined sufficiently relevant if they were evident in any one of the three studies conducted. Most of the themes or issues included in the model, however, were raised in more than one of the studies. For example, stigma was raised in all three studies, psychological mindedness was found to have some impact in both the interview study and the questionnaire study, awareness was raised in both qualitative studies.

| Need and Enabling/impeding factors | Psychosocial factors (including predisposing factors) | Intended use | Help seeking outcomes |

Need
-Degree of mental health impairment
-Wanting/needing help and not seking it

Psychosocial/ Predisposing factors
-Sex
-Age
-Attitudes
-MH status
-Psychological mindedness
-Self reliance
-Social capital

-Intentions to seek help for mental health issues

Help seeking outcomes
-Actually seeking help
- Wanting/needing help and not seeking it

Enabling/impeding factors
-Perceived Stigma
-GP‟s (availability & quality of care)
-Awareness
  -Knowledge of services
-Systemic issues
  -No services
  - Lack of adequate services
-Locality issues
  -Cost
  -Drought
  -Distance

Figure 9. Andersen‟s model (adapted from the expanded version, Bradley et al. (2002) applied to main findings from all three studies, within and across methods.

6.4.2 Need and enabling factors

Need is of central importance to seeking care according the Andersen model (Bradley et al., 2002). Need in this thesis was determined by an individual‟s self assessment of having mental health problems, either by the Mental Health Inventory or by the respondents own admission (from interview or written response data). Need was also categorised by a „yes‟ answer to the survey question, "have you ever needed or wanted

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help and have not got it", and answer of yes to this question was also considered a help seeking outcome.

Enabling factors are those which make mental health services and resources available to the individual, including demographic, community and systemic factors (Andersen & Newman, 1973). Each of the three studies confirmed some enabling factors. The interviews and written data reported awareness and knowledge of available services, and systemic issues such as lack of available services and inadequate services as enabling factors. Further, as discussed in the interviews, GPs" availability, interest in, and knowledge of mental health issues were also considered enabling factors. If the GP was considered by respondents not to have the knowledge to refer, or lacked time or interest in such issues, it was considered a serious impediment to accessing appropriate services. Other enabling factors reported in the written qualitative data included those such as, issues of locality, including cost of services, and distance from appropriate services.

Perceived stigma was reported in all three studies (with personal stigma reported in the interviews), it was included as an enabling factor because perceived stigma is likely to affect a person"s ability/willingness to present their problem in a clinical setting (Parslow & Jorm, 2001). It was also included as a predisposing/psycho social factor because of its suggested (by interview and open ended question respondents) innate existence within the psyche of rural residents. Both types of stigma exist within the rural psyche: p. Perceived stigma (stereotype awareness) as shown from the survey study and interviews, as well as personal stigma, drawn mostly from the interview study. This cements the stigmatisation of mental illness for rural people as the general population endorses prejudice and discrimination against people with mental illness and people with mental illness internalise the stigma and diminish their self esteem in the process (Corrigan et al., 2006).

6.4.3 Psychosocial/Predisposing factors

Predisposing factors were described by Andersen and Newman (1973) in the original behavioural model as, "an individual's propensity toward service use that can be predicted by individual characteristics that exist prior to the onset of illness" (p. 108). In the original model predisposing factors were limited to demographic (i.e. age and sex), social structural, and attitudinal belief variables (Andersen & Newman, 1973). Bradley's expanded version (Bradley et al., 2002) suggested that predisposing factors should also include more psychosocial factors. Again, each of the three studies confirmed several psychosocial factors. Sex and age were shown in the population survey study to have an impact on help seeking behaviour. Females were more likely to have higher help seeking intentions. This was an unsurprising finding given previous research that has shown females were more likely to seek help, generally have more positive attitudes to doing so (Mackenzie et al., 2006), and are more open (Judd et al., 2008). Older adults were also found to have more positive intentions to seek help and age was also included as a predisposing factor. Importantly, attitudes towards seeking professional psychological help were also considered psychosocial/predisposing factors. One's attitude towards the help seeking process predisposes an individual to either seeking help or not.

Attitudes towards seeking help were the single most important factor influencing care seeking for mental health. These findings were similar to Bradley et al. (2002), and also the work of Keysor, Desai and Mutran (1999) who both found psychosocial variables are of great importance to the process of help seeking when applying the model to aged care. Similarly, Keysor et al. (1999) found that when attitudes towards long-term care facilities were entered into modelling strategies, no other factors (except marital status) were significantly associated with preference for long term care location (p. 342). This confirmed the strength of help seeking attitudes in predicting service use. Both stigma and

psychological mindedness were also included as psychosocial/predisposing factors because of the impact they had on attitudes towards help seeking.

6.4.4 Mutability

Another key aspect of the Andersen model that has important implications for service use is the concept of mutability. This concept was described as "the extent to which a variable or factor is changeable" (Keysor et al., 1999, p. 342). For example, demographic factors (such as age and gender) have low mutability as they cannot be altered. However, many of the enabling and psycho social/ predisposing factors strongly associated with mental health utilisation are highly changeable, and therefore highly mutable. Need in this context could also be somewhat changeable, though less so because as the current research has uncovered, need can exist without care actually being sought. However, given the right information, services, and attitudes, need for care could be changed. Therefore need had medium mutability, this could vary however, depending on the issue that help is sought for. For example, need for care in the case of psychoses or more severe mental illness would be categorised as low mutability given the nature of such illnesses and the immediacy of the help required. However, more highly prevalent disorders such as anxiety and depression may be more highly mutable, and in the rural context there is a higher likelihood that those suffering these disorders would put off seeking professional help (Staniford et al., 2009).

All significant factors in each of the three studies were categorised with medium to high mutability. Attitudes are highly changeable and therefore have high mutability. Perceived stigma, like attitudinal factors should be highly changeable and therefore highly mutable. However, from the findings of both the interviews and written qualitative study, rural people believed the stigma that exists in their communities to be particularly ingrained and therefore less changeable. So, in the context of rural mental health help

seeking, stigma is categorised as medium mutability. The systemic issues found in both qualitative studies including lack of information and knowledge, lack of available services and lack of adequate services were all categorised as highly mutable. They can all be easily changed, mostly at a service delivery or policy level. Perhaps the policy and service delivery level would be an important place to start the change process for utilisation issues in rural areas.

6.4.5 Critical evaluation of the utility of Bradley's adaptation of the Andersen behavioural model

Bradley"s adaptation of the Andersen behavioural model had good face validity in the rural mental health help seeking context. The adapted model was useful in conceptualising the research questions through to framing and understanding the results. First, the model was amenable to both qualitative and quantitative methodologies, and a combination of the two, making the model flexible for the development of research questions that are multilayered, for example, encompassing individual, systemic and cultural variables. Second, the model was useful for facilitating decisions around what measures were most important to include in a survey, or for qualitative research, the context in which to place questions for collecting qualitative data. Third, the inclusion of intentions in this version of the model, despite the debate around its utility in predicting outcomes, provides the research with an inclusive picture of all the factors that potentially play a role in help seeking for mental health in rural areas.

The current research suggested that not all variables were equally important within the model. The research highlighted attitudes as the most important variable to consider in rural help seeking and when using the Andersen model in this context. This is consistent with previous help seeking research using the model in different contexts, such as long term care (e.g. Bradley et al., 2002). Indeed Bradley et al"s. (2002) adaptation was intended

to address the importance of attitudes. Similarly, stigma should be considered within the model's psychosocial (and even enabling) category when researching help seeking in the rural context and included in the model for this purpose.

The model had some utility for contextualising new measures or constructs for help seeking both before and after analyses were conducted. Psychological mindedness, for example, was considered in the current research program. However in light of the equivocal results found for psychological mindedness in this research, it is premature to suggest it should be (always) included in the model in this context. Further research is required to establish the predictive power of psychological mindedness in the rural help seeking context, and to determine where it fits in the model.

Some of the shortcomings of the model in this context were, first, currently the model is of a descriptive nature. It was beyond the scope of this research, however, future research should consider an analysis of the weighting of each variable within the model and the factors of the model itself. This would move the utility of the model beyond being simply descriptive to giving weightings to each of the variables and factors in the model. A rural urban comparison of help seeking using the model with relative weightings for each of the variables and factors would establish whether the emphasis on attitudes found in the current research was specific only to the rural context. Second, the overlap between enabling/impeding factors and the psychosocial (predisposing) factors. However, where a variable in this research fitted in one or more of the model categories, for example stigma, the variable was simply described in both categories and reasons for this explained. Also beyond the scope of this research, but something future research and model development should consider, are two possible ways of managing this issue of overlap. First, consider how a single variable might operate differently as an enabling factor or, as a psychosocial (predisposing factor). Second, future research should consider collapsing the enabling factors and psychosocial factors into one encompassing factor. In doing this, some

explanatory power may be lost however, so a decision to do this would need to be carefully considered. Demographic variables should also be separated from predisposing and/or enabling factors. They should stand alone as separate variables despite their predisposing capacity and limited mutability. Feedback loops to indicate their overlap with the psychosocial (predisposing) factors, and the overlap between need and enabling factors, and psychosocial factors, would need to be included. In light of the current thesis" results, if these modifications were made to the model, it would look very similar to Bradley"s adaptation but with demographic variables separated, feedback loops included and enabling and psychosocial factors collapsed (*Figure 10*).
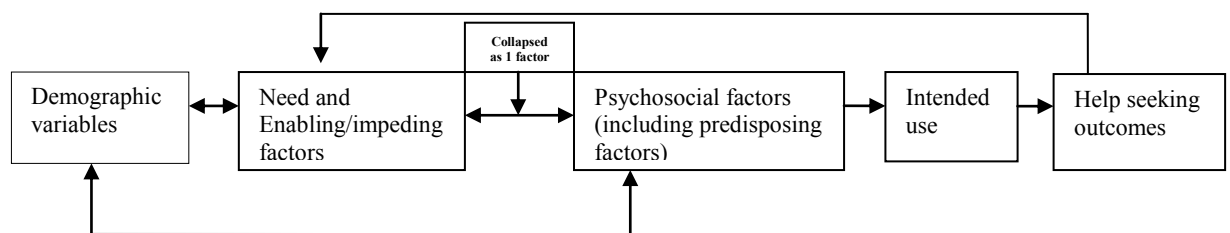
Figure 10. Andersen"s Model with demographics separated out and feedback loops included, possibility of collapsing enabling and psychosocial factors

Despite the shortcomings of the model it is still exceptionally useful for research in the rural help seeking context, and possibly the best model for research in this area. The implications that this model could have at a policy and indeed practice level would be predominantly in the development of strategies and interventions to increase mental health service usage. The model provides a clear picture of what the most important factors impacting help seeking outcomes are, and therefore the factors that should be most vigorously targeted in these strategies to increase usage, quality and quantity of services. The current research would suggest the use of Bradley"s adaptation of the Andersen model for future research in the rural help seeking context, with the recommendation that the

issues of variable overlap across the factors, and the relative weighting of variables and factors within the model be considered.

6.5 Implications for policy and service

The results from this thesis confirm that policy development, implementation and service delivery for mental health services in rural areas needs a multi-factorial approach. First, more services in rural areas need to be implemented simultaneously with the implementation of campaigns to make rural people more aware and more accepting of mental health issues and mental health services. Campaigns to help remove the stigma associated with mental health and mental health services are also required. These two interventions occurring in tandem is essential to making mental health services more available and more acceptable to rural communities and the individuals within these communities. Second, interventions and services need to be introduced in a manner that matches the cultural attitudes and belief systems of the communities. All three studies confirmed stigma as a factor in the lack of help seeking, therefore suggesting that this construct is engrained in the psyche of rural residents and should be the starting point of policy aimed at increasing acceptance of and ultimately help seeking practices. To take these findings from research to policy would include consideration of how and where mental health services are offered in rural communities. Having mental health professionals placed in rural areas for longer terms with less turnover of staff may help to reduce the stigma associated with seeking professional help. This would be particularly the case if professionals became involved in the community and the residents get to know them as a community member. This would help to build rapport and trust so that seeking them out in a professional capacity almost feels like „going round to see a friend‟ (Crawford & Brown, 2002). Further, by incorporating mental health services into other

health care services, the impact of (lack of) confidentiality (and ultimately stigma) may also be diminished and utilisation increased. Although the Better Access to Mental Health Services has made some headway into incorporating mental health assessment into GP services, the addition of psychologists, social workers and mental health nurses into GP practices may further the effort to rural acceptance of such services. Awareness of services might also be increased simply by placing regular articles in local newspapers describing the service and including testimonials from rural clients about what the service involved and how it helped them. Making the process more transparent and less elusive may go some way in encouraging help seeking without fear of stigmatisation. Given the findings of this research, in particular the qualitative studies, meeting the needs of rural males should also be a major focus for policy interventions. This may pose quite a challenge for policy makers given the stoic nature of rural men, however, policy aimed at meeting the needs of rural males should start by including rural males in the process. These might include round table discussions or focus groups conducted for men only in a casual, nonthreatening environment where they are able to speak freely about how best to meet their needs. Perhaps local people themselves could run them without researchers or policy makers present.

As demonstrated by the use of Bradley"s adaptation of the Andersen model, it has been shown that the ways in which demographic, psychosocial and systemic factors in a rural setting interact with and combine with one another, creates an environment where help seeking for mental health issues is severely impeded. Therefore approaching policy and service delivery with a multi-factorial approach would ensure all influencing factors are covered. The good news is that rural people are ready for change. The ‚need for change" theme from the interview study definitively suggests that respondents felt that a change in both the system and attitudes of the communities was essential for improving the mental health facilities available to them and indeed the mental health of rural residents.

6.6 Strengths and Limitations

The strengths of this thesis were, first, that rural people were given a voice. They were given the opportunity to talk in depth about the issues they believed to be most significant for them in relation to seeking mental health services. Second, following up with a large scale survey that used what rural people said to inform and develop it was another strength of this thesis because it involved the stakeholders in the research process. Third was the use of Bradley"s (2002) adaptation of the Andersen model with the combination of qualitative and quantitative methodologies, both of which had never been done in this context before. Last was the investigation of psychological mindedness in the rural context. It had never been investigated in this context previously and some fascinating (albeit counterintuitive) findings worthy of future investigation were made.

The results of this thesis should also be considered in light of its limitations. Recruiting rural participants was quite a challenge, particularly for the population survey. After the forewarning letter was posted, many phone calls from invited respondents were received. They were suspicious of the University contacting them and many of them were concerned that their details had been gained from their medical practitioners despite the forewarning letter indicating they were randomly chosen from the electoral roll. Therefore, the required population in itself was seen as a limitation for getting a higher response rate.

Second, self selection bias may have been a constraining factor across all three studies. The thoughts and opinions of those who declined, or who were unwilling to participate have been missed. Therefore, potentially vital information from these people was also missed.

Third, the self report measures used in the quantitative survey may have impacted on validity. Respondents may have answered in a socially desirable manner or may not

have answered truthfully or objectively. However, self report measures have been used extensively and successfully in much of the current rural help seeking research (i.e. Parslow & Jorm, 2001; Wrigley et al., 2005).

Fourth, the correlation between perceived stigma and attitudes towards help seeking may partly reflect similarities between the two scales. The attitudes towards seeking professional help scale comprised a few items about perceived stigma as well. Therefore, the association between the two scales may have been because the constructs were somewhat overlapping. However, Wrigley et al. (2005) suggested that it would still be reasonable to conclude that if stigmatised attitudes are held by individuals or they perceive their community to hold these attitudes, they are still more likely to be reluctant to seek help for mental health issues (Wrigley et al., 2005, p. 519).Therefore, it was important to include both scales separately. Similarly, there may have been some overlap with the attitudes towards seeking help scale and the psychological mindedness scale. The attitudes scale had some questions related to openness, one aspect of the psychological mindedness construct. This may have constrained the findings; however it was still important to include both measures, particularly because the thesis was investigating psychological mindedness not only certain aspects of it.

Fifth, the Barker electorate contained mostly rural towns, with few very remote areas, therefore the results cannot necessarily be considered generalisable to very remote areas across Australia, nor can they necessarily be generalised to other rural and remote areas cross culturally.

Last, the population survey contained the question, "have you ever wanted to seek help but not done so"? This question may have been problematic in that answering „yes" to this question implies that the respondent has wanted help and not sought it, and an answer of „no" covers respondents who have wanted or needed help and actually sought it. However, the question forced respondents to answer either yes or no, therefore an answer

of no could also include respondents who have never wanted help. Nonetheless, it was a valuable question to ask and an important behavioural outcome to explore in the context of rural help seeking particularly because rural residents often hold off on seeking help, or never seek it even when they want to or need to.

6.7 Future research

Gender differences in rural help seeking should be further researched. The population survey showed that gender was a significant predictor of help seeking intentions but did not influence any other outcomes. It was however, raised extensively in the interview study and should be investigated in future research, particularly the notion of hegemonic masculinity (dominant male cultures) within rural male culture. There is also a need for more in depth qualitative research into rural males more generally, and the issues surrounding their lack of help seeking. It was beyond the scope of this thesis to further investigate this topic. It would require more specifically designed qualitative research aimed specifically at males to unravel the issues that are specific to rural men, and to further investigate the influence of hegemonic masculinity (Donaldson, 1993) in this context.

Future research in this area should continue to use mixed methodology. This will ensure that an in depth understanding of all the factors influencing help seeking is made and will therefore ensure interventions, policies and practices are focussed in the right direction and targeting aspects of rural culture impacting most significantly on help seeking as reported by those affected. In particular, qualitative research is essential to truly understanding help seeking behaviour; it is impossible to know why someone behaves as they do without asking them to explain why in their own words. This method of research will ensure that rural people get the best care possible in a way that is tailored to them and their unique needs.

6.8 Conclusion

By investigating the attitudes and needs of rural communities with regard to mental health and how these impact their help seeking practices, some necessary insight was gained into the current attitudes and beliefs of these unique communities and the barriers they face in seeking help. In doing so, this thesis has arrived at a multi factorial approach for how mental health facilities can best be implemented to suit the culture and lifestyle of rural people, and most importantly, utilised by them.

6.9 Postscript

Just prior to completion of this thesis the 10 year long drought in Australia appears to have broken with widespread flooding occurring across much of the East coast of the continent. However, the susceptibility of rural people"s lives to be impacted by short or long term climactic changes leading to mental health problems remains. Drought is only one manifestation of the challenges faced by rural residents which will be felt even post the drought. Although the drought appears to have broken for the time being, the impact both emotionally and financially will be felt by rural communities for some time.

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Appendices

7.1 Appendix A: Published Paper (prepublication version)-

Full publication can be found at the Australian Journal of Primary health
http://www.publish.csiro.au/nid/261/paper/PY09019.htm.

Collins, J. E., Winefield, H., Ward, L., & Turnbull, D. (2009). Understanding helpseeking for mental health in rural South Australia: thematic analytical study. *Australian Journal of Primary Health, 15*, 159-165.

7.2 Appendix B: Psychological Mindedness scale

Shill, M. A. (Unpublished). A shortened version of the Psychological Mindedness Scale.

7.3 Appendix C: Interview Schedule

7.4 Appendix D: Questionnaire

Appendix A- Prepublication version of published paper-

Collins, J. E., Winefield, H., Ward, L., & Turnbull, D. (2009). Understanding helpseeking for mental health in rural South Australia: thematic analytical study. *Australian Journal of Primary Health, 15*, 159-165.

Understanding help-seeking for mental health in rural South Australia: A thematic analytical study

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Abstract

This study investigated barriers to help-seeking for mental health concerns and explored the role of psychological mindedness using semi-structured interviews with sixteen adults in a South Australian rural centre. Prior research-driven thematic analysis identified themes of stigma, self-reliance and lack of services. Additional emergent themes were awareness of mental illness and mental health services, the role of GPs and the need for change. Lack of psychological mindedness was related to reluctance to seek help. Campaigns, interventions and services promoting mental health in rural communities need to be compatible with rural cultural context, and presented in a way that is congruent with rural values.

Introduction

Research into effective delivery of mental health services to rural communities is timely given the negative impact of the current Australian drought on the physical and mental health of rural dwellers (Roufeil & Lipzker, 2007). Research has focused predominantly on the prevalence of mental health concerns; the question of how rural attitudes impact on help-seeking behaviour remains largely unanswered (Fraser et al., 2002). Access to care in rural areas is likely to be influenced by psychosocial factors, as well as the availability and proximity of services. The aim of this study was to investigate what rural South Australians believe to be the main barriers to seeking help for mental health issues and to investigate the role of Psychological Mindedness (PM) in help seeking.

Help seeking refers here to seeking help from mental health professionals. However, it is not limited to this form of professional help as it is duly acknowledged that in rural areas in particular, General Practitioners are usually the first and sometimes the only point of contact for such issues (Judd et al., 2007), and that there are also many other forms of help and care that may be available in the wider community.

Australians living in rural and remote communities score lower on a range of health indices and display higher overall disability and mortality rates than their urban counterparts (AIHW, 2006). Death rates, particularly from suicide, are higher in rural and remote parts of Australia than in more densely populated areas (ABS, 2002). Despite increasing need, most rural communities have limited access to professional services for mental health concerns, and what is available may not be accessible in a way that takes account of belief systems in rural communities (Roufeil & Lipzker, 2007).

Psychological openness, predicts help-seeking behaviour, particularly in men (Mackenzie et al., 2006; Mackenzie et al., 2004). Psychological openness, as well as, belief in the benefits of discussing problems and ability to access feelings are components of Psychological Mindedness (Conte et al., 1996). Psychological mindedness has been typically used to assess suitability for psychotherapy among those who have sought help (Hall, 1992), however it may also contribute to whether someone seeks help in the first instance. Previous research suggests that higher levels of psychological mindedness leads to better

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therapeutic outcomes (Hall, 1992), therefore it is relevant to investigate whether this construct has any influence on help seeking itself. Although previous research has not directly investigated the link between psychological mindedness and help-seeking, the finding that low psychological openness predicts less help-seeking for mental health problems among men (Mackenzie et al., 2006) suggests that further investigation of this relationship is warranted.

Widespread stigma attached to mental illness and those experiencing it, affects the type of help (if any) that is sought and may also adversely affect adherence to interventions (Jorm et al., 2000a). Despite this, the extent to which stigma impacts help-seeking in rural areas, is still a point of some contention. Segal, Coolidge, Mincic, and O'Riley (2005), for example, found lack of knowledge of the mental health system, confusion about services available, concerns about cost and lack of coordination with primary care were more important than stigma in the under-utilisation of mental health services, particularly among older rural adults. Further, Komiti, Judd and Jackson (2006) found high level of stigma among rural adults that was not related to help-seeking.

The importance of self-reliance or stoicism in rural culture may also explain under utilisation of mental health services (Fuller et al., 2000; Judd et al., 2006c; Komiti et al., 2006). Fuller et al., (2000) found that the rural culture of self reliance led to a ‚mistrust of outsiders‟ suggesting that help-seeking would be seen as personal weakness that would not be endorsed except in cases of dire necessity. Depression, in particular, is seen as personal weakness (Jorm et al., 2006b).

Provision of services that are appropriate and well utilised by rural people requires an understanding of the inherent belief systems and culture within rural communities. The current study used qualitative, semi-structured interviews, analysed using a prior research-driven thematic analysis (Boyatzis, 1998) to investigate what rural South Australians believe to be the most important barriers to seeking help for mental health issues. The role of psychological mindedness in rural help seeking was also considered.

Method

General practitioners (GPs) from five Barossa region surgeries in South Australia were invited to assist in recruiting participants; GPs in two practices participated. The Barossa is a distinctive, wine-producing region with a German-speaking heritage within a two hour drive of South Australia‟s capital city, Adelaide. General Practitioners are the first point of reference in the region where there are no permanent psychiatrists and only limited psychological services.

Practice receptionists canvassed patients‟ interest in participation, provided information sheets, and obtained patient‟s permission to release contact details to the researcher. The researcher conducted face-to-face interviews with participants at the surgery.

Sampling Frame

Recruitment used maximum variation sampling (Grbich, 1999): individuals were recruited to provide, an even spread of males and females, and a range of experiences with mental health services, from those who had never accessed services to those accessing them on a regular basis. Six of the sixteen participants were recruited via snowball sampling (Grbich, 1999); where previous participants recruited other potential participants fitting the aforementioned criteria. Sample size was determined when saturation (i.e., no additional information was derived) of interviews was achieved (Rennie et al., 1988).

Participants

Residents from one rural centre (11 females, 5 males) aged between 36 and 75 years participated. Seven (44%) had accessed mental health services in the previous 12 months (Table 1).

[Insert Table 1]

Procedure

The study received ethical clearance from the University of Adelaide Human Ethics Sub-Committee. Participants were given an explanation of the objectives of the interview and an assurance of confidentiality. Consent included permission for the interview to be taped. Interviews lasted between 10 minutes and one hour.

All questions in the interview schedule were asked with order varying to assist flow. Questions were asked about participants‟ use of mental health services, how they did or would go about accessing

services should they need to, reasons why people might not access services even if they needed or wanted to, and openness to discussing problems and talking about their feelings (interview questions are available from the authors upon request). Voice recordings were transcribed verbatim.

Data Analysis

Prior research-driven thematic analysis was used to identify and develop predetermined themes based on previous research and thought prior to data collection to be imperative to the research question (Boyatzis, 1998). Emergent themes were also considered. After transcription, the analytic process followed guidelines for thematic analysis of Braun and Clarke (2006) involving, first, reading and re-reading transcripts, second, generating initial codes, whereby specific features of the data were coded in a systematic way across all transcripts, and third, collating, naming and defining themes.

Results

Results have been structured according to the prominence of themes with predetermined themes presented before emergent themes (Table 2). Direct quotes are identified by gender and age of participant (I4, M, 64 indicates a quote from the fourth participant, a 64 year old male).

[Insert table 2]

Stigma

Stigma surrounding mental health was raised by every participant. It was one of the most common answers to why people might not seek help for mental health even if they needed or wanted to. It was also an important barrier to even discussing mental health concerns with others.

> *─There is still that stigma about mental health and I think that would stop a lot of people using the services"* (I13, F, 45)

> *─people aren't gonna openly go searching for that sort of thing (mental health information) they got people watching them in the surgery that's what they'd be thinking ohh someone's watching me take this mental health brochure they think I'm weird"*(I1, F, 38)

> *─The problem there of course is, there's a little bit of the embarrassment of you know everybody knows everybody else so you've got to be careful"* (I16, F, 43)

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Stigma directly affects choice to access services, extending even to the collection of information. Some people indicated they would not openly search for mental health information and were concerned about what others in the GP surgery might think.

Lack of services

Lack of mental health services was raised in all interviews. Participant indicated that there were not enough services and those available and the procedures in place were not adequate in meeting their needs.

> ―There is nothing, we need help up here, there is a lot of people up here that need it and there is no support here, none at all" (I15, F, 46)

> ―I don't think we've got anything up here in like Angaston Hospital or our hospitals available like sort of for mental health………… and I was sent down to Glenside" (I11, F, 37)

> ―There's no one there that can come and see you on a permanent basis so that makes it really difficult so I chose to opt out of using the mental health services here mainly for that reason" (I13, F, 45)

Self-reliance

Self-reliance was raised by seven participants, reflecting a preference for dealing with problems alone or for using alternative sources of help. This was particularly salient for men. Participants considered self-reliant culture to be part of the German heritage of the area, suggesting that it is an engrained cultural trait.

> ―You can sort it (emotional problem) out yourself without needing any help"
> (I8, M, 63)

> ―It's a very strong German place up here and men don't do things like that and that's taking a long time to change" (I15, F, 46)

> ―They'll be right, tough it out, I was brought up on a farm and I was in the shearing sheds for years and around men who pretty much punish themselves instead of, and I was one to, ‗work it out' is the belief, work it out of your system or drink it out or, and you'll be alright, you'll pull through" (I17, M, 47)

> ―Well too proud to admit there's something wrong with them" (I8, M, 63)

Preference for using alternative help sources included:

*―sometimes if you've got a problem like that you might go to or talk to someone
about it but not necessarily a professional, you might just talk about it to a
friend or something like that you know"* (I4, M, 64)

*―I've got a really good friend who I e-mail with regularly who knows
everything. One of my best friends from you know twenty years ago"* (I1, F, 38)

Nine participants suggested that dealing with problems alone was entrenched in the culture of rural men, and that it creates negative outcomes including substance abuse. This may also represent hegemonic masculinity at play within rural men.

*―it's a bit Aussie you know it's real ocker kind of mentality especially around
males to just ‗deal', and if you can't ‗deal' then you're not discussing it you
know you find some alternative, so we see the drinking and the pub violence and
the fighting and that kind of stuff as a result"* (I7, F, 36)

*―And a lot of men don't like, don't believe they're crook too. Like they sort of
keep fobbing it off and say I'm alright sort of thing you know"* (I8, M, 63)

*―a lot of men around here that have got mental health issues, they self medicate
with drugs and alcohol"* (I11, F 37)

Lack of Psychological mindedness

Psychological mindedness includes willingness and ability to get in touch with one"s feelings, belief in the benefits of discussing one"s problems and an openness and willingness to change(Beitel & Cecero, 2003). Unwillingness to talk openly about problems was raised by 13 participants.

―No one talks openly about that sort of stuff" (I1, F, 38)

―People around here are very closed about these issues" (I3, F, 58)

*―There's that country pride stuff, in a way it's a bit Aussie you know it's real
occer kind of mentality especially around males to just ‗deal'"* (I7, F, 36)

*―It's just I get the feeling that they are not too willing to try anything new and
things like that"* (I14, F, 75)

In response to how people in their community might perceive the idea of getting in touch with feelings:

"People have a notion of, ‗that's a bit alternative or, that's a bit…..Yeah new age, um a bit soft, with the propensity in the country is to be tough, physical, work hard……. maybe now it's not so much a sign of a weakness but more of a lot of ―hoo haa", for want of a better term, like, a lot of bullshit you know" (I17, M, 47)

The basic premises of psychological mindedness, namely talking about problems, getting in touch with feelings and being open to new experiences, are not well received or practiced in this particular community. For these participants, openly talking about problems is in direct opposition to self reliant culture; help-seeking is seen as a sign of weakness and causes embarrassment. Discussing feelings is seen as "soft" and the idea of getting in touch with one"s feelings is seen as "new age" or "a lot of bullshit".

Emergent themes included the role of GPs, awareness of mental health services and need for change.

Awareness

Awareness manifested itself in discussions about the lack of education, knowledge and information about mental health problems, as well as the frequent misconceptions in rural areas of what mental illness is and what mental health services do. At least one of these issues was discussed in every interview. Lack of education was raised by 11 of the 16 participants:

"Definitely a lack of education in the general community" (I1, F, 38)

"I think education, educating people would be a really good step…………I think they need to be educated that the psychologists and psychiatrists aren't going to judge them and you know tell them what to do and what not to do and stuff like that they're just there for guidance" (I13, F, 45)

"So I think there needs to be more that way for people to be educated up here more about the mental health too" (I15, F, 46).

Examples of discussions about lack of knowledge and information included:

"If you're not told about how to go about getting that help you just don't know where to go obviously. You don't know that it's even available that's the hard part" (I3, F, 58)

―You never see anything advertised" (I1, F, 38)

―As far as mental health around the area I wouldn't have a clue I wouldn't even know where to go" (I4, M, 64)

Eight participants suggested that there are considerable misconceptions around mental illness in their community and these are a significant barrier to seeking help for mental health problems.

―Yeah coz most people don't understand mental illness…. Well you see people and you think that there's nothing really major wrong with them and just build a bridge kind of thing and cross it, you know what's wrong with you" (I3, F, 58)

―To be mentally ill I really don't know what that is. You know if I run down the street naked singing am I mentally ill?" (I9, M, 56)

―You're always going to get those people that look at it and think ―yah they're batty" because they go through a mental health (problem), they've gotta be batty they've gotta be mad" (I10, F, 63)

General Practitioners

Issues around General Practitioners were raised by 12 of the 16 participants. General Practitioners were identified as the first point of call for all ailments including mental health issues, in country areas. Participants suggested that many rural GPs are over-burdened and that this may affect their ability to recognise and detect mental health problems.

―They (the GPs) have got to sort out your physical stuff first coz if you can't get into see them then you're not gonna get to see them about your mental health either" (I3, F, 58)

―it can be a six week wait, to see that doctor and he could be on the ball because they are looking out for depression now more than before, but my life experiences tells me that I need to actually say, you know" (I17, M, 47)

―I think they (GP's) can probably understand depression and anxiety maybe, but not so much psychosis which is what I suffer from" (I13, F, 45)

Some participants also suggested that GPs are not adequately aware of services available to someone with mental health issues.

―If you get a new GP here who doesn't actually come from the Barossa and it'll take him or her a while to learn what is available" (I14, F, 75)

Need for change

Fifteen out of the 16 participants suggested the need for change to both the system (i.e. the number of services available) and to rural attitudes towards mental illness and the seeking of treatment.

> "There definitely needs something up here, something better, a better mental system than what they've go up here definitely" (I15, F, 46)

> "I think ultimately a lack of resources within the services in order to be proactive and instead they've got no choice but to be reactive and at the end of the day what we see then is we see a continued increase in service demand" (I7, F, 36)

In contrast, one person suggested there was no need for change in services but that people should be responsible for their own health and be prepared search for the help that is available.

> "I don't think anything needs to change……… I just really think you've gotta find out for yourself, unless you're on your own or something like that, there's usually someone around" (I9, M, 56)

This participant had never needed or tried to seek help for mental health issues. It may be that people who have never had to deal with or seek help consider the system is working well and that help would be easily accessible if they needed it. In contrast, participants who have sought services suggest that the system is not working as well as it should, some services are not available, and those that exist are not as accessible as one might hope.

Discussion

This study considered what rural residents perceive to be the most important barriers to seeking help for mental health problems in their community. Four predetermined and three emergent themes were extracted and evidence that psychological mindedness is important in initial help-seeking of rural-dwellers was found. Previous research on psychological mindedness has focused on its link to psychotherapy outcomes (Beitel et al., 2004) rather than initial help-seeking behaviour. The current study thus makes a novel contribution to understanding help-seeking in the rural community.

This study revealed that many rural people are unwilling to talk about problems or feelings. Participants suggested that men in their community were particularly lacking in openness. These findings are consistent with Mackenzie et al. (2006) who also found that lack of openness contributes to under utilisation of mental health services. Judd (2006a) argues that it is essential to identify groups at risk of illness as well as those whose willingness or opportunity to access care is reduced. Psychological mindedness may provide a tool to assist this process. One implication for practice in primary care is understanding, either formally or informally, how psychologically minded a person is. This would almost certainly help in deciding what services, if required, to suggest to a patient suffering any form of mental health issue that would be congruent with their attitudes and beliefs.

One of the most prominent themes concerned stigma. Many participants considered it to be one of the most important barriers to seeking help for mental health issues in their community. Given the prior research-driven nature of this study, this finding was not unexpected. The intensity of comments and the extent to which it was raised, however, were surprising. No distinction was made between stigmatisation of different mental health disorders and many people indicated they would feel stigmatised simply for collecting an information leaflet from the GP. Further, some participants suggested that mental illness is often assumed to reflect conditions such as schizophrenia or psychosis and the belief that mental illness equates to insanity persists. Although some participants suggested that stigmatised attitudes may be changing and health promotion strategies are currently focussing on destigmatisation of mental illness, acceptance in rural areas is still a long way off (Gorman et al., 2007). The theme of stigma may also be understood as "small town syndrome", or the idea that everyone knows what everyone else is doing, this has been noted in previous research as affecting health seeking behaviour in rural same sex attracted young people (Hillier et al., 1996). However it is difficult to know whether knowing what everyone else is doing is problematic only when something is perceived negatively, i.e stigmatised, or whether it is problematic in itself.

The lack of services and inadequacy of available services was highlighted by participants who needed care for highly prevalent psychological disorders such as depression through to participants

suffering from severe mental illnesses such as psychosis and schizophrenia. One participant indicated that, because there is no psychiatrist who can be seen on a permanent and regular basis, she had opted out of mental health care in her area in favour of driving an hour and a half to the city for treatment. This finding could have serious implications for the health care system in rural areas, where people are choosing not to access services, as well as in metropolitan areas where mental health care services may be carrying the burden of both metropolitan and rural patients.

People in rural communities often do not have a good understanding of what psychologists can offer, due to their under exposure to their services. Services equate to 0.83 psychologists per 10,000 head of population in very remote areas, 3.44 in inner regional centres and 5.92 in major capital cities (Gorman et al., 2007). This was certainly evident in the results of this study, where participants expressed uncertainty around what mental illness actually is, and many still equate mental illness with the most serious psychoses, and therefore may perceive the role of psychologists as limited to the most serious (and more stigmatised) mental health issues. Judd et al.(2006c) argue that rural people are likely to report less mental health symptoms because they do not define such symptoms as illness and therefore only get help when the symptoms become severe or disabling. Further, rural people are unlikely to seek the help of psychologists if they are unaware of the range of symptoms that can constitute mental illness and if they do not have any real understanding of the variety or benefits of the services offered (Roufeil & Lipzker, 2007). Therefore there is a strong need to raise awareness among rural people about what constitutes mental illness and psychological services as well as building the mental health workforce in rural areas (Roufeil & Lipzker, 2007).

Self-reliance or dealing with problems alone was raised with particular reference to men. Participants suggested that men in their community have a culture of „dealing alone". Participants saw this as an „ocker Aussie stereotype": reflecting an „I"ll be right, tough it out" attitude. These attitudes and beliefs may make rural people reluctant to admit they have a problem or need help (Roufeil & Lipzker, 2007). Some participants suggested that this self-reliant culture is somewhat responsible for substance abuse in men when they are no longer able to „deal alone". This is consistent with Judd, Komiti and

Jackson (2008) who found rural Australian men were higher on scores of stoicism and personal stigma, than women. The culture of self-reliance is an important barrier to seeking help for mental health issues in this rural community. Participants believed these attitudes to be an engrained part of their „Barossa heritage" and more broadly, rural Australian culture. This type of self-reliance specifically relating to males may also be representative of hegemonic masculinity (dominant masculine cultures) at play (Seymour-Smith et al., 2002). Hegemonic masculinity is idealised and valorised by Australian men, and in this case rural men, particularly in relation to health seeking where previous research has suggested that being bad at talking about emotional problems is a taken-for-granted fact that „everyone knows" about men (Seymour-Smith et al., 2002). It is important to note however, that the self-reliance analysis also suggests possible high levels of resilience in the participants (and even the communities). Excerpts from participants concerning preference for using other help sources, are also representative of community connections and social capital; two phenomena underpinning resilience (Sonn & Fisher, 1998). Therefore the culture of self-reliance may also be a positive influence for some rural people.

An important emergent theme from this study is that rural people do see a real need for change, not only to the mental health system in rural areas, but also to the seemingly engrained and ever present stigmatising and self reliant attitudes and beliefs of rural residents. Understanding the need for change in rural communities is an important step in working towards lessening the influence these attitudes and beliefs have on help-seeking behaviour.

Limitations of the current study include the self-selected nature of the sample. Participants were interested in and willing to discuss mental health issues, so those who do not normally discuss such issues were therefore under-represented. However, the mix of those who had and had not accessed mental health services, and males and females was well balanced, and the use of both GP surgery recruitment and snowballing meant that people with a wide range of backgrounds and opinions were interviewed. Second, the study was conducted in one South Australian rural centre. Findings may not be generalisable to other rural centres or indeed more remote areas of Australia or internationally. However, given the support these findings have with past research there is some ability to generalise the findings,

which could be enhanced by replication of the study. Last, it is important to consider whether there may be some overlap in themes. Psychological mindedness, for example, may be on a continuum with self-reliance and might even overlap with stigma somewhat. Psychological mindedness may also have some overlap with the awareness theme. In order to have a high level of psychological mindedness there needs to be a level of awareness of psychological services and practices which seemed to be lacking in this sample, and may therefore account for the lack of psychological mindedness expressed by participants. This possible overlap could not be resolved in the current analysis, but provides the impetus for further research into the role of these constructs.

The results of this study provide some critical insight into the barriers faced by rural residents in accessing mental health services. Cultural factors and attitudes are contributing to help-seeking behaviour. Policy makers must address the need for mental health services in rural areas by recognising distinctive rural attitudes and the way these may differ from those of urban Australians. Further, recognising and understanding these realities will help build a psychological workforce that can ensure services are provided in ways congruent with local values and that the most is made out of services provided.

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Table 1

Sample Description, Services Accessed ,Method of Recruitment

Participant	Gender	Age	Previous service accessed	Method of attainment	Reason for seeking help
1	F	38	GP	Practice Receptionist	Depression
2	F	39	Nil	Snowball	
3	F	58	Nil	Snowball	
4	M	64	Nil	Snowball	
5	M	36	Nil	Snowball	
6	F	36	Counsellor	Practice Receptionist	Depression
7	M	63	Nil	Snowball	
8	M	56	Nil	Snowball	
9	F	63	Psychologist	Practice Receptionist	Depression
10	F	37	Counsellor	Practice receptionist	Psychosis

11	F	73	Nil	Practice receptionist	
12	F	45	GP, Psychiatrist, Mental health Nurse	Practice Receptionist	Psychosis
13	F	75	Nil	Practice Receptionist	
14	F	46	GP, Psychiatrist, Mental health nurse	Practice receptionist	Depression
15	F	43	GP	Practice Receptionist	Depression, Anxiety
16	M	47	Nil	Practice Receptionist	

Table 2

Predetermined and Emergent Themes

Predetermined themes	Emergent themes
Stigma	GPs
Lack of Services	Awareness/Education
Self reliance	Need for change
Lack of Psychological mindedness	

Appendix B: Psychological Mindedness Scale- Shortened version

Shill, M. A. (Unpublished). A shortened version of the Psychological Mindedness Scale.

Appendix C: Interview Schedule

<u>Interview Schedule</u>

All questions to be asked, not necessarily in the proposed order. Allow the interviewee to direct the flow of the interview whilst ensuring all topics are covered by the end of the interview (deviation from the transcript is allowed to delve further into meanings and attitudes of the individual interviewee).

1. Tell me what you know about mental health services here in the Barossa, or around this community.

2. Discuss whether you would ever consider using the services that are available if you needed to.

3. Alright so tell about the kinds of reasons people in this community or indeed other rural communities might choose not to access them even if they needed or wanted to.

4. Psychologists emphasise the importance of talking about your problems and that being a way of helping you to get over them but what do you think about that?

5. Psychologists also emphasise the importance of getting in touch with your feelings in order to talk about them, so what do you think about that?

6. Tell me your thoughts about people who deal with their problems alone?

7. Say you would consider going to see someone or seeking help what would your process be how would you go about accessing those kinds of services do you think?

8. Do you think people in country towns still have that same attitude as like 20 years ago or do you think that''s changing?

9. What, if anything, needs to happen going forward for mental health in rural areas?

Appendix D: Full Questionnaire (excluding the Psychological Mindedness scale which can be found at appendix B)

Access and Utilisation of Mental Health Services in Rural Areas Survey

*Please note that the survey is double sided

*Please complete all questions in the survey

Information about you:

Age: _____

Sex: _____

Highest level of Education:

☐ No schooling
☐ High School
☐ Trade certificate/ Diploma
☐ Degree or higher

Occupation:_____

Marital Status:_____

How long (in years) have you lived in this and/or other rural areas?_____

Have you ever accessed mental health services?_____

Please turn over to start the survey →

Joanne Collins
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5005

Perceived Stigma Scale (PSS)

We are interested to know something about your attitude to persons with a mental illness. Please circle the number that best represents your responses to the questions listed below.

1. Most people believe that people who have or have had a mental illness cannot be trusted.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly disagree

2. Most people would not marry a person who has been a patient in a mental hospital.

1	2	3	4
Strongly	Agree	Disagree	Strongly
Agree			disagree

3. Most people believe that a person who has been treated for a mental illness is dangerous.

1	2	3	4
Strongly	Agree	Disagree	Strongly
Agree			disagree

4. Most people think less of a person after he/she has been hospitalised for a mental illness.

1	2	3	4
Strongly	Agree	Disagree	Strongly
Agree			disagree

5. Most people look down on people who have been hospitalised for mental illness.

1	2	3	4
Strongly	Agree	Disagree	Strongly
Agree			disagree

6. Most people think that people with a mental illness are just as intelligent as the average person.

1	2	3	4
Strongly	Agree	Disagree	Strongly
Agree			disagree

7. Most employers would not hire a person who has been hospitalised for mental illness.

1	2	3	4
Strongly	Agree	Disagree	Strongly
Agree			disagree

8. Many people are afraid of those people who have been hospitalised for a mental illness.

1	2	3	4
Strongly	Agree	Disagree	Strongly
Agree			*disagree*

9. People who experience a mental illness would be treated differently by their friends and colleagues if they found out about their illness.

1	2	3	4
Strongly	Agree	Disagree	Strongly
Agree			disagree

10. Many people would feel uncomfortable around someone with a mental illness.

1	2	3	4
Strongly	Agree	Disagree	Strongly
Agree			disagree

11. Many people would be wary of someone who was being treated for a mental

illness.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly disagree

12. People with a mental illness should hide it from others for their own sake.

1	2	3	4
Strongly	Agree	Disagree	Strongly
Agree			disagree

13. People with a mental illness would be treated poorly in this community if people found out about it.

1	2	3	4
Strongly	Agree	Disagree	Strongly
Agree			disagree

14. This community would be supportive and caring towards someone who experienced a mental illness.

1	2	3	4
Strongly	Agree	Disagree	Strongly
Agree			disagree

15. People would gossip about a person who had a mental illness.

1	2	3	4
Strongly	Agree	Disagree	Strongly
Agree			disagree

16. Many people would be wary of someone who had been hospitalised for a mental illness.

1	2	3	4
Strongly	Agree	Disagree	Strongly
Agree			disagree

Contact with and Experience of Mental Illness

Psychological or mental health issues can include any circumstance or illness which impacts on an individual's mental health and well being. These can include: relationship difficulties, anxiety, depression, schizophrenia, psychological trauma, family problems, difficulty coping, etc. The following questions ask about such circumstances or experiences.

1. Have you **ever** sought help for a psychological problem or mental health issue?

Yes ___   No ___

If yes, whom did you seek help from: (you may tick more than one)
    a) GP   ___
    b) Counsellor   ___
    c) Psychiatrist   ___
    d) Psychologist   ___
    e) Mental health service   ___
    f) Religious worker   ___
    g) Natural healers   ___
        e.g. naturopath, homeopath.
    h) Physiotherapist/Chiropractor ___
    i) Other (please specify) _____

2. Are you currently receiving treatment for a psychological problem or mental health issue?

Yes ___   No ___

If yes, please indicate the problem/issue that you are receiving treatment for: (you may tick more than one)
    a) marital problems   ___
    b) family problems   ___
    c) depression   ___
    d) schizophrenia   ___
    e) anxiety   ___
    f) problems at work/school   ___
    g) psychological trauma   ___
    h) other (please specify):

    _____

If yes, from whom are you receiving this treatment: (you may tick more than one)
    a) GP   ___
    b) Counsellor   ___

     c) Psychiatrist   ___
     d) Psychologist   ___
     e) Mental health service   ___
     f) Religious worker   ___
     g) Natural healers   ___
         e.g. naturopath, homeopath.
     h) Physiotherapist/Chiropractor ___
     i) Other (please specify) _____

3. How satisfied are/were you with this help? (if you responded to more than one item in Q2 please write your level of satisfaction next to each item ticked e.g. „satisfied‟)

      Very satisfied ___   Satisfied ___   Unsatisfied ___   Very unsatisfied ___

4. How was/is this experience for you?

a)   Embarrassing ___ if so, why?
_____

b)   Frightening   ___ if so, why?
_____

c)   Difficult   ___ if so, why?
_____

d)   Frustrating   ___ if so, why?
_____

e)   Expensive   ___ if so, why?
_____

f)
Other:_____

5. What responses did you find **most** helpful: (you may tick more than one)

a)   understanding/empathy   ___
b)   counselling   ___
c)   psychotherapy (e.g. CBT)   ___
d)   referral to another health professional   ___
e)   lifestyle advice e.g. how to lower stress,   ___
         improve sleep patterns, etc.
f)   medication   ___
g)   sympathy   ___
h)   other (please specify):

_____

6. What responses did you find **least** helpful: (you may tick more than one)

a)   understanding/empathy   ___
b)   counselling   ___
c)   psychotherapy (e.g. CBT)   ___
d)   referral to another health professional   ___

e) lifestyle advice e.g. how to lower stress,   ___
        improve sleep patterns, etc.
f) medication   ___
g) sympathy   ___
h) other (please specify):

_____

7. Do you know anyone who has experienced a psychological or mental health issue?

Yes ___   No ___

If yes, what problems/issues did they experience? (you may tick more than one)

    a) marital problems   ___
    b) family problems   ___
    c) depression   ___
    d) schizophrenia   ___
    e) anxiety   ___
    f) problems at work/school   ___
    g) psychological trauma   ___
    h) other (please specify):

        _____

8. Do you know anyone who has sought help for a psychological or mental health issue?

Yes ___   No ___

9. What relation are they to you? (you may tick more than one)

        a) Partner   ___
        b) Sibling   ___
        c) Parent   ___
        d) Grandparent   ___
        e) Extended family member ___
        f) Close friend   ___
        g) Friend   ___
        h) Work colleague   ___
        i) Child   ___
        j) Other (please specify)   _____

10. From whom did they seek help? (you may tick more than one)

    a) GP   ___
    b) Counsellor   ___
    c) Psychiatrist   ___
    d) Psychologist   ___
    e) Mental health service   ___
    f) Religious worker   ___

g) Natural healers ___
    e.g. naturopath, homeopath.
h) Physiotherapist/Chiropractor ___
i) Other (please specify) _____

11. Have you ever wanted too, or felt that you needed to seek help for a psychological or mental health issue but have not done so?

Yes ___   No ___

If yes, what prevented you from doing so?

a)   Embarrassment   ___
b)   Frightened   ___
c)   Too difficult   ___
d)   Too costly   ___
e)   Didn't know who to ask for help ___
f)   People would think I was crazy   ___
g)   Other (please specify) _____

12. Would you feel comfortable discussing mental health issues with your General Practitioner?

Yes ___   No ___

    If no, why: (you may tick more than one)

a) GPs don't deal with such issues   ___
b) Embarrassment   ___
c) Frightened   ___
d) Such issues are none of their business   ___
e) I don't have a particular GP   ___
f) I don't like/trust my GP   ___
g) Other (please specify)

_____

13. If you did experience a psychological or mental health problem, who would you seek help from? Please rank the following people from 1 to 10 in order of preference, i.e. place a 1 next to the person you would consult first, place a 2 next to the person you would consult second, and so on.

a) Partner/Family   ___
b) Friends   ___
c) GP   ___
d) Counsellor   ___
e) Psychiatrist   ___
f) Psychologist   ___
g) Mental health service   ___

h) Religious worker   ___
i) Natural healers   ___
    e.g. naturopath, homeopath.
j) Physiotherapist/Chiropractor ___
k) Other (please specify) _____

14. Please indicate how helpful you believe the following people would be in the treatment of a psychological or mental health problem:

a) Partner/Family

1	2	3	4
Very helpful	Helpful	Unhelpful	Very Unhelpful

b) Friends

1	2	3	4
Very helpful	Helpful	Unhelpful	Very Unhelpful

c) General Practitioner

1	2	3	4
Very helpful	Helpful	Unhelpful	Very Unhelpful

d) Counsellor

1	2	3	4
Very helpful	Helpful	Unhelpful	Very Unhelpful

e) Psychiatrist   1

2	3	4	
Very helpful	Helpful	Unhelpful	Very Unhelpful

f) Psychologist

1	2	3	4
Very helpful	Helpful	Unhelpful	Very Unhelpful

g) Mental Health Service

1	2	3	4
Very helpful	Helpful	Unhelpful	Very Unhelpful

h) Religious Worker

1	2	3	4
Very helpful	Helpful	Unhelpful	Very Unhelpful

i) Natural Healer
    e.g., naturopath

1	2	3	4
Very helpful	Helpful	Unhelpful	Very Unhelpful

j) Physiotherapist/
    Chiropractor

1	2	3	4
Very helpful	Helpful	Unhelpful	Very Unhelpful

k) Other (please specify) _____

_____

1	2	3	4
Very helpful	Helpful	Unhelpful	Very Unhelpful

**Inventory of Attitudes Towards Seeking Mental Health Services (IASMHS)**

The term *professional* refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers and GP"s). The term *psychological problems* refers to reasons one might visit a professional.

For each item please **CIRCLE THE NUMBER** that best represents your response.

1. There are certain problems which should not be discussed outside of one"s immediate family.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

3. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

4. I would not want my significant other (spouse, partner etc) to know if I were suffering from psychological problems.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

5. Keeping one"s mind on the job is a good solution for avoiding personal worries and concerns.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

6. Having been mentally ill carries with it a burden of shame.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

7. It is probably best not to know *everything* about oneself.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

11. People should work out their own problems; getting professional help should be a last resort.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

10. If I were to experience psychological problems, I could get professional help if I wanted to.

0	1	2	3	4
Disagree	Somewhat	Undecided	Somewhat	Agree

11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

12. Psychological problems, like many things, tend to work out by themselves.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

13. It would be relatively easy for me to find the time to see a professional for psychological problems.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

14. There are experiences in my life I would not discuss with anyone.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

15. I would want to get professional help if I were worried or upset for a long period of time.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

17. Having been diagnosed with a mental disorder is a blot on a person''s life.

| 0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears *without* resorting to professional help.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

20. I would feel uneasy about going to a professional because of what some people would think.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

21. People with strong characters can get over psychological problems by themselves and would have little need for professional help.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

23. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up".

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

24. I would be embarrassed if my neighbour saw me going to into the office of a professional who deals with psychological problems.

0	1	2	3	4
Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree

Mental Health Inventory- (MHI-5)

Please **CIRCLE THE NUMBER** that best represents your responses to the questions listed below.

1. During the past month, how much of the time were you a happy person?

1	2	3	4	5	6
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time

6. How much of the time, during the past month, have you felt calm and peaceful?

1	2	3	4	5	6
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time

3. How much of the time, during the past month, have you been a very nervous person?

1	2	3	4	5	6
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time

4. How much of the time, during the past month, have you felt downhearted and blue?

1	2	3	4	5	6
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time

5. How much of the time, during the past month, did you fel so down in the dumps that nothing could cheer you up?

1	2	3	4	5	6
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time

*Please comment on any other aspects of mental health or mental health services in your community that you think are important for us to know

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Thank you for taking the time to complete this survey ☺