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ORIGINAL RESEARCH

Understanding barriers to mental health service utilization for adolescents in rural Australia

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ABSTRACT

Introduction: There is a general paucity of research in the area of rural adolescent mental health in Australia, and in particular a lack of data regarding the experiences of rural adolescents who seek help for mental health problems. This study used a qualitative approach to data collection and analysis in order to assist understanding of the barriers to mental health service utilization for young people in rural communities.

Method: A series of interviews were conducted with each of the study's participants, who ranged in age from 15 to 17 years. All participants were clients of the Child and Adolescent Mental Health Services in the rural cities of Horsham and Ararat, Victoria, Australia.

Results: Participants described how the lack of reliable transport to and from the mental health service affected the utilization of the service by rural young people. They also expressed concern regarding a lack of qualified professionals in their region who specialize in child and adolescent mental health. Participants reported frustration at long waiting lists and the lack of an after-hours service. One participant shared her experiences of deliberate self-harm to in order to gain access. Results also revealed that rural gossip networks and social visibility within rural communities compounded the experience of stigma and social exclusion for these young people. Furthermore, participants explained how these experiences negatively impacted on their utilization of the mental health service and their progress towards recovery.

Conclusions: There are several barriers to mental health service utilization for rural adolescents which affect both their decision to access help as well as their ability to engage effectively with mental health services over time. Clinicians who work with rural adolescents need to be mindful of the influence of rural culture on mental health service utilization by young people. The co-location of mental health services and general health services is suggested as one way to reduce the fear associated with 'being seen' entering a stand-alone mental health service. It is suggested that treatment programs for adolescents in rural areas address the

different types of stigma that these young people are likely to encounter. Furthermore, community and school-based interventions aimed at reducing the social stigma of young people with mental illness in rural areas is recommended.

Key words: access issues, child and adolescent mental health services, rural adolescent mental health, social stigma of mental illness.

Introduction

Past research suggests that as few as 25% of Australian adolescents with mental health problems seek professional help[1]. Furthermore, the delay between the onset of psychological problems and receiving effective treatment is associated with poorer outcomes[2-4]. Access issues, such as the cost of professional psychological services[5], distances needed to be traveled to access services[6] and lack of qualified mental health professionals in rural and remote areas[7] have been previously studied in Australia. However, little research is aimed specifically at understanding the experiences of adolescents with mental health problems in the context of their rural communities, and in particular the implications that this 'rurality' may have on the utilization of child and adolescent mental health services[8].

There is now a growing recognition in the field of rural mental health that any attempt to define 'rural' must incorporate a fundamental understanding of the characteristics of rural places[9,10]. For instance, international researchers have noted that while rural people are physically distant from their neighbours and friends, they are socially proximate[11]. Apart from the challenges that physical distance creates for accessibility of services for young people[12,13], this degree of social proximity means that neighbours who live several kilometres from one another may possess an intimate knowledge of each other's personal histories, family relationships, or history within the community. In socially proximate settings, the genealogy of an individual and their family is something collectively known, placed, remembered and narrated by other community members[14]. This may have particularly negative implications for a young person experiencing an emotional or behavioural problem.

Furthermore, social proximity does not always lead to caring community practices. As suggested by Parr and colleagues[11], the effects of the 'rural paradox of proximity and distance' often are the silencing of mental health difficulties, the exclusion or ostracism of people with mental illness in more overt ways than occurs in urban areas, low level expressions of support and inclusion, a general lack of confidentiality and social discrimination as well as stigma. The recent identification of issues such as these are being increasingly acknowledged as vitally important for improving the provision and utilization of mental health services in rural areas, and in promoting better therapeutic outcomes for those experiencing psychological distress[5].

The present study

Due to the qualitative nature of the present study, a set of research questions (rather than hypotheses) were formulated to guide data collection. These were:

- What is the experience of an adolescent living in a rural community after discovering that he or she has a mental health problem?
- What, if any, barriers to mental health service utilisation do young people with mental health problems experience due to living in a rural community?
- What is the experience of being treated for a mental health problem for a young person living in a rural community?
- How is the young person's progress towards recovery affected by living in a rural community?

The present study is the first of its kind in that qualitative, phenomenological research methods were utilized, and the difficulties faced by rural adolescents are assessed by going

directly to the source – the young people themselves. The motivation for this research strategy was to provide these young rural Australians with a 'voice' because, in the past, the concerns of rural Australian adolescents with mental health problems have tended to be unheard.

Method

Participants

Participants were three adolescents currently living in Horsham and Ararat who were: (i) current clients of the Child and Adolescent Mental Health Service (CAMHS) in their local area; and (ii) not currently in an active phase of a mental illness. All three participants were female, ranging in age from 15 to 17 years. Two of the participants suffered from clinical depression and the third from an anxiety-related disorder. Two of the three participants were school students, and one was in paid employment.

Horsham and Ararat are rural cities with populations of 13 000 and 11 500 people, respectively. The nearest regional centre is Ballarat with a population recently estimated at 88 000 people[15]. Horsham is approximately 200 km from Ballarat and has an ARIA (Accessibility/Remoteness Index of Australia)[16] of 2.18, indicative of some restriction in the availability of goods and services. Ararat is approximately 100 km from Ballarat and has an ARIA of 1.51, indicative of relatively unrestricted availability of goods and services, due mainly to its closer proximity to the regional centre.

Design and procedure

The methodological framework selected for use in this study was a phenomenological interpretive approach, primarily because the investigators were interested in achieving insight into the experiences of rural adolescents in accessing and receiving treatment for mental health problems in the context of their rural communities. The sampling method used for this particular study could be described as purposive[17], in that any individual's selection for participation was dependent on them having a history of mental health problems and service use, as the intention was to seek out individuals who had had contact with mental health services in the past. The small sample size is typical of phenomenological research as the longer periods of engagement lead to stronger rapport between the interviewer and participant which results in a large volume of 'useable' data[18].

This study received ethical approval to proceed from the University of Ballarat's Human Research Ethics Committee as well as the Ballarat Health Service Ethics Committee. Participants were recruited in cooperation with the CAMHS team in the Grampians region of Victoria, Australia. Prior to commencement of the study all participants were asked to read an explanatory statement and sign a consent form. As all participants were under the age of 18 years, their parents were also sent an explanatory statement and asked to co-sign the consent form prior to their child attending the first interview.

Two out of three participants completed a series of three interviews of approximately 90 min duration over the course of the research period, spaced approximately one week apart. The third participant completed two out of three interviews as she could not be reached to arrange the third. This method of repeated interviewing is consistent with a phenomenological approach to data collection[19].

All interviews were conducted on CAMHS premises apart from two interviews which were conducted by special arrangement at the school of one participant. Interviews were recorded in MP3 format using a digital recording device. Digital files were later transcribed in preparation for interpretive phenomenological analysis.

Data analysis

Once interview data were collected, all digital recordings were transcribed and any potentially identifying information was removed in an effort to protect participant anonymity prior to the reporting of results. Transcripts were then

subjected to interpretive phenomenological analysis (IPA) in accordance with the procedure outlined by Smith and Osborn[20]. As the first step, the first author 'trawled' the interview transcripts and produced a set of wide-ranging notes that reflected the initial encounter with the transcripts. Second, the first and second authors identified themes that characterized the transcripts and assigned each theme a conceptual label that characterised the quality of the theme. Third, the first and second authors brought structure to the analysis by considering each theme in relation to the other themes and organising the themes into clusters. Each cluster was then assigned a label that encapsulated its meaning. Finally, clusters were integrated across transcripts in order to identify shared master themes.

As qualitative coding strategies such as IPA have the potential to be subjective, a number of strategies were instituted to improve the rigor of the analysis[21]. One such strategy was the team approach to reflexivity[20]. Peer debriefing also served as a validity check by challenging the researchers to consider alternative ways of categorizing the data. The very nature of the phenomenological method also increases validity, because spending extended periods of engagement beyond a single interview session allows the researchers to understand the context and achieve better trust and rapport with the study participants.

Results

Three master themes emerged from the analysis and from these stemmed numerous sub-themes. The main themes were: (i) accessibility issues; (ii) stigma and social exclusion; and (iii) characteristics of rural communities. Results are presented below according to master theme. Along with each thematic description, specific quotations are included with the purpose of better illustrating each theme or area. A matrix display illustrating the extent of data saturation across the series of interviews is presented (Table 1).

Master theme: accessibility issues

Transportation difficulties: All but one participant was presently living within close proximity of mental health facilities and as such, lack of transport was not reported as a serious issue for them at the time that they were interviewed. However, participants were asked to consider what it would be like for an adolescent who lived out of town when attempting to access mental health services, and also discussed problems that they had encountered in the past when help was not so close. One participant indicated that lack of transportation had been a significant problem for her before she and her family had moved closer to psychological services. Participants also believed the need to rely on others to travel to and from appointments impacted negatively on their progress towards recovery. For instance, participants reported:

> *It's harder to get around if you don't have a car at all and you live out of town…yeah, transportation is yeah, a big problem here.*

> *That would be hard, say if I lived, even just lived* [just out of town] *that would be hard if I had to go to an appointment every week cos mum works and everything it would be a lot harder without transportation.*

Perceived lack of qualified mental health professionals who specialize in child and adolescent mental health: The most significant accessibility issue reported by participants was the lack of availability of qualified mental health professionals in their areas. Participants described a general lack of mental health professionals who specialize in the treatment of adolescent clients and negative impressions regarding the quality of the service for young people. For example:

Table 1: Thematic matrices for each participant by interview

Participant themes	Interview		
	1	2	3
Participant 1			
1. Accessibility issues			
Transport/travel	-	+	+
Availability of qualified professionals	+	+	+
Hours of operation/waiting lists	+	+	+
2. Stigma			
Social stigma	+	+	+
Self stigma	+	+	+
Fear of social stigma	+	+	+
3. Characteristics of rural communities			
Exclusionary practices/ostracism	-	+	-
Social visibility	+	+	+
Gossip networks	+	+	-
Participant 2			
1. Accessibility issues			
Transport/travel	+	+	
Availability of qualified professionals	-	-	
Hours of operation/waiting lists	-	-	
2. Stigma			
Social stigma	+	+	
Self stigma	-	+	
Fear of social stigma	+	+	
3. Characteristics of rural communities			
Exclusionary practices/ostracism	-	+	
Social visibility	-	+	
Gossip networks	-	+	
Participant 3			
1. Accessibility issues			
Transport/travel	+	+	+
Availability of qualified professionals	+	+	+
Hours of operation/waiting lists	-	-	-
2. Stigma			
Social stigma	+	+	+
Self stigma	+	-	-
Fear of social stigma	+	+	+
3. Characteristics of rural communities			
Exclusionary practices/ostracism	+	+	+
Social visibility	-	+	+
Gossip networks	+	+	+

'+' Indicates that this issue was discussed in the interview; '-' indicates that this issue was not discussed in the interview.

> *Well it's very disappointing and you just think 'Well, what's the point?' Like you think, I might as well move away if I can't get the help I need here.*

> *Because the city* [has] *got everything that they need, the country really doesn't. It would be different cos they've got all the help they need up there. We've sorta got to go up there to get the help.*

Participants also expressed feelings of guilt in regard to mental health professionals having to travel large distances to provide psychological services to adolescents in rural communities. There was also acknowledgement of the difficulties faced by professionals attempting to provide mental health services to rural adolescent populations when they did not live locally.

> *Well it would be good to have maybe one person here, I mean, yeah, it kinda sucks having to go all the way to Ballarat just to get an appointment or put* [the mental health professional] *out for an hour. I kinda feel bad like that because of the fact that she has to put herself out or the fact that we have to go up there. We should have someone here I reckon.*

Hours of operation and implications of extended waiting lists: Although hours of operation were not raised as a significant issue by these participants, concerns were expressed regarding the availability of after-hours crisis help. In particular, participants were most concerned about the lack of an after-hours service at times of feeling suicidal.

> *I know you can't expect people to be on call for you all day and work all night, but I think most attempted suicide or suicides happen at night so they do need to have people on call at night that can come around if it's really that urgent and no one else can calm the person down and they are really gonna do something stupid.*

Participants also expressed frustration regarding the long wait for mental health services and believed this delay had a negative impact on their treatment. One participant shared her experiences of deliberate self-harm in order to gain access to the service.

> *I sort of felt that you sort of had to overdose or do something to harm yourself to get in here fairly quickly cos there's such a demand for these services…I wanted to get more information about what was going on inside my head, so yeah. But I did it the hard way* [attempting suicide]*…six months waiting list otherwise, I think there's only two or three psychologists.*

Master theme: stigma and social exclusion

Social stigma and exclusion: Participants described the generally negative attitudes of members of their communities regarding mental illness. They also described past experiences of social stigma and how their utilization of the mental health services was negatively perceived by others. Participants expressed concerns regarding the 'bulk classification' of people with mental disorders by community members in rural settings, regardless of the diagnosis.

> *They probably do think I'm a nutcase cos I come to psych services, but to be a nutcase you have to be in and out of a mental institution or trying to kill yourself all the time or cutting yourself all the time. They think you're a nutcase then. It's not depression, you're a nutcase.*

All participants reported that at some stage being the victim of exclusionary practices while living in their rural community.

> *Because I told some of them* [about experiencing depression] *because I trusted them as my friends and*

when they found out they sorta told the whole group and yeah they sorta just excluded me from everything.

Some people sorta think its like really bad and you shouldn't be walking the streets if you've got a mental illness, like yeah, just stupid stuff like that. Like if you have a mental illness you're not normal, you can't live a normal life…They think that they're gonna catch it. They think, 'Oh no, if I talk to her I might catch what she's got.' Yeah they think it's sorta catchy and contagious, when it's not.

Self-stigma: A phenomenon less commonly identified by participants was self-stigma. While the experience of self-stigmatic attitudes was mentioned at some stage by all three participants, this theme only emerged in later interviews. All participants expressed negative attitudes regarding people with mental illness prior to their experiences of these types of problems. One participant reported still holding self-stigmatic views regarding her mental health problems, views that she indicated had persisted long after her first contact with mental health services. In describing an interaction with her brother, she said:

He just made a joke out of it and said that's where mental people go, my brother just goes yeah. I laughed cos it's true… the people who go to CAMHS are psycho people.

Fear of social stigma: Participants described their fear of the implications of disclosing a mental health problem to others in their community and explained that these fears had, in the past, caused them to try to hide the distress that they were experiencing. Participants also said that fear of social stigma had been a barrier to their utilization of the mental health service:

I feel that if they knew about me…knew about my depression, their opinions would drop because I'm yeah, I'm not normal. But what's normal really? …You just wouldn't tell them that you had it [depression] *because they'd be like 'Get away from me! You're a head case'.*

It sort of stopped me [utilizing mental health services]*, like I said, if they have a bad opinion of me I might as well keep it the same, it doesn't really matter. If they don't care, why should I? And I sorta didn't want to get better. Didn't want to help myself, didn't want to get help because if they thought of me like that, maybe the person I was going to see was going to think of me like that.*

Master theme: characteristics of rural communities

Rural gossip networks: The existence of rural gossiping networks was raised as an issue by all three participants. Participants explained how quickly information can travel within socially proximate rural areas where community members engage in gossip. One participant indicated that community gossip had been a significant issue for her, to the extent that she believed her progress towards recovery had been negatively affected by it. Participants believed that young people in metropolitan areas did not have to contend with this issue.

One thing gets said about someone, like just say you and me were having a conversation bagging someone out, the whole town would know about it in two minutes…it's not good.

Just the way people talk about you in this town. It's disgusting. Yeah, just the gossip and everything. I know I really shouldn't care what other people think and everything but it gets a bit hard when everyone's at school, or everyone in your group of friends start talking about you. [It's] *like you've got nowhere to go so you just stay home…That's one reason that the city is better cos you know, you don't know everyone and you can get a second chance whereas [if] everyone knows, you can't have one and people have been forced to move out of town before.*

Social visibility: Social visibility is a particular feature of rural communities whereby human movement, sounds, and behaviours are easily seen and heard with the consequence that it becomes difficult to keep any part of life private. Participants expressed concerns regarding the actual physical location of mental health facilities in their town and described the negative impact this had on their experience of treatment. In several cases, participants reported that social visibility compounded their experience of social stigma.

> *Other people look at it and say 'Well, she's going there, she's obviously like really bad', like, 'why is she let out because she has to go to psych services, isn't that where all the crazy people go? Obviously she's crazy too. She obviously has a lot of problems because she has to go there'.*

One participant shared her thoughts of ways to improve the situation and, in turn, enhance utilization of mental health services in her area:

> *It was better when it was up at the hospital, yeah because you could just be going into the hospital to see someone, like yeah, because where it was, it was sorta like you walk in the door - psych services was that way and dentist was that way so you could be going to the dentist when really you were going to psych services.*

Discussion

Summary and interpretation of findings

Consistent with past research,[6,7,8,12] participants in this study reported the existence of various 'rural' barriers to mental health service utilisation such as limited availability of mental health professionals, lack of after hours services, the lack of availability of qualified mental health professionals in the local area, and the long distances that must be travelled in order to access professional services in larger regional areas. While some of these barriers may be common to rural people of all ages with health problems, factors such as long travel distances and lack of transportation can be argued to be even more serious for rural adolescents who are under the legal age for driving and, therefore, reliant on others for transport.

Due to the qualitative nature of this research, it has been possible to get a better sense of how these rural adolescents were able to face and overcome these barriers in order to access professional help. Examples of this provided by study participants included entire families having to move so that they could be closer to services. Participants also expressed feelings of guilt because their access to suitable professional services could only be facilitated by already 'overworked clinicians' travelling large distances to provide the help. It can be seen how these factors might contribute to a negative perception of mental health services as a whole, and that these perceptions of poor service may result in extreme behaviour by young people who are in desperate need of access to services. This was confirmed by one participant who reported that she felt forced to engage in potentially fatal, self-harming behaviour to gain access to the professional help that she needed, a phenomenon that has been previously reported to occur in rural young people requiring rapid access to specialist mental health care[12].

The adolescents who participated in this study also described experiences of social exclusion and ostracism by members of their community when the existence of their mental health problems became public discourse. They described the presence of rural gossiping networks and how these are perpetuated by social stigma. Their experiences of social stigma had a profoundly negative impact on their psychological wellbeing as well as their ability to participate fully in the social lives of their communities. Fear of social stigma had been a barrier to these adolescents' first contact with the mental health service, and being socially visible in the context of their rural community had compounded their experiences of stigma and social exclusion.

Although it was not the case for these clients, it is likely that for some clients the weight of negative experiences such as those described in this study may cause them to withdraw

not only from treatment but from social participation altogether; further reinforcing stigmatic community attitudes regarding those with mental illness as different and strange. In a similar vein, the fear of being socially visible when accessing mental health services can be regarded a barrier to seeking help that is unique to the rural environment. Some rural young people may be afraid of being seen and subsequently ostracized or gossiped about on the grounds of their psychological distress. Again, this may have particularly negative implications on the rural adolescents' initial decision to seek help, continued utilization of help sources, and subsequent treatment outcomes.

Conclusions

The barriers to mental health service utilization described by adolescents in this study had been ongoing problems for them and were not associated exclusively with the decision to seek help. These barriers had also affected their ability to continue to utilize the service over a long period of time, subsequently limiting their progress towards recovery and further compromising their health.

Key stakeholders in mental health need to broaden their concept of rurality, especially in terms of its impact on mental health utilization and the experiences of young people with mental health problems. Participants in this study indicated that they would feel less anxious about accessing a mental health service if it was integrated with other more general health services at the same location, so that when they were seen entering the service it would not automatically be assumed that they were doing so to access help for a mental health issue. This would reduce the social visibility in accessing services in rural communities for others and subsequently lessen the negative impact of its after effects.

Strategies to assist rural adolescents who utilize mental health services to cope with social stigma, self-stigma, gossip and issues relating to social visibility and social exclusion should be considered by the mental health clinicians providing treatment. The inclusion of such strategies in the treatment of young people with mental health problems in rural areas would assist them to more fully participate in, and derive greater benefit from, the treatment they receive, and to achieve better long-term treatment outcomes.

In terms of primary prevention and health promotion, community development programs that emphasize mental health, as well as whole-school approaches to understanding the nature and range of mental disorder, may help to improve the situation for rural adolescents with mental health problems. It is important for members of rural communities to understand that the social stigma of mental illness is a form of active discrimination that can have a profound impact on a young person. By changing the way in which rural communities regard those with mental illness, treatment outcomes can be improved, and inroads can be made into improving the mental health of rural youth.

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