Connecting Mental Health Helping Capital in Rural Communities to Young People with Emergent and Early Mental Health Problems

A thesis submitted for the degree of Doctor of Philosophy of the University of New England.

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ABSTRACT

Understanding the mental health help-seeking experiences of young rural people in rural areas is important because most mental health problems emerge during adolescence. In addition, early recognition of emerging mental health problems in adolescents is linked to recovery as it is known to mitigate the long-term consequences of mental health decline. This research study aimed to better understand young people with emergent mental health problems who live in rural areas and to develop an improved theoretical perspective of rural mental health care that draws from the unique mental health helping capital that already exists within rural communities. Relevant literature was reviewed and a mixed methods case study research design selected to answer the research question: *What helps young rural people with emergent mental health problems?* A rural socio-ecological health theoretical framework was selected to explore the research topic.

A cross sectional survey was conducted and data was analysed with descriptive, comparative and content analysis techniques. A pilot study with nine respondents was compared to the actual survey results of 81 respondents to determine the reliability of the survey tool. A strong similarity in responses between the two sets of responses was detected using Pearson's correlations. The survey sample was inclusive of a broad range of rural participants from relevant backgrounds and across a full range of adult age groups. The results showed that rural people are willing to seek mental health help when it is required, and that the best people to provide mental health advice to young people are health professionals. People prefer to do nothing and hope that a mental health problem will resolve spontaneously prior to actually seeking mental health professional care. Young people prefer to seek help from their parents and friends if their mental health problems do not resolve spontaneously. In addition, the survey results described the rural nursing characteristics that are seen as helpful mental health care contributions towards the mental health care of people in rural communities.

In-depth interviews were conducted with 20 participants. Transcribed data were analysed using thematic techniques and four themes emerged. The first theme described the characteristics of the emergence of mental health problems experienced by young rural people. The second theme described the characteristics of helping and how other people help young rural people with mental health problems. The third theme outlined the lack of meaningful connection with mental health services that young people and their families

experience. Lastly, the fourth theme described the characteristics of health, welfare and social service providers.

The integrated findings of this study identify the importance of:

- Providing positive first mental health encounters for young rural people in their rural communities enables successful initial and ongoing mental health helping.
- Rural nurses are mental health capital in rural communities.
- Barriers to mental health help-seeking for young rural people persist.

Implications arising from the findings for clinical practice and interdisciplinary collaboration support the need for an innovative deployment of current health resources to places of greater convenience for young rural people. The new theoretical perspective arising from this research supports a co-location of nursing assets in rural communities to promote the early engagement of young rural people into appropriate mental health care when required. Rural nurses are ideal mental health human resource assets to deploy in co-located rural settings because nurses are able to contribute expertise by paying adequate attention, carefully listening, providing authentic care which is mindfully present and understanding the local context for young rural people. The outcomes of this study provide new insights about the emergent mental health problems of young rural people, and make recommendations to improve rural mental health services for this population.

CERTIFICATION

I certify that the substance of this thesis has not already been submitted for any degree and is not currently being submitted for any other degree or qualification.

I certify that any help received in preparing this thesis and all sources used have been acknowledged in this thesis.

Signature of Candidate

Date: 29 May 2014

DEDICATION

This PhD thesis is dedicated to my mother, *Lynne Alison Schaeffer* (12 July 1947 – 2 October 2012), who died following a fierce, but short battle with cancer midway through my candidature. My mother ignited for me a joy in reading and discovering new things at an early age. She was a creative person, with spinning and weaving fibres her favourite expression of her creativity. As a master and artisan of her craft, she undertook many large projects and saw them through to completion, never beaten by a challenge that seemed too hard. At the end of a project she would reflect on a job well done, satisfied that she had applied her skills to the best effect to create something beautiful, complete and useful. Then, most often, she would give away the item she had laboured over, joyful in the giving.

In the same spirit, I hope that I have been able to do my mother's memory justice in the way that I have created some new scholarship for rural mental health, having taken on the project of a PhD and having carefully woven it through to completion. I hope that the findings of my work make a useful contribution to knowledge about improving mental health care for young rural people. As I look back on my efforts at this time, and in this moment, I can draw satisfaction from knowing that I have applied my craft, as best I can, to better understand the needs of young rural people in regard to their mental health. At the end of this project, I remember my own rural childhood beginnings, and some of the important lessons that I learned from my mother, and I am grateful.

Thank you, Mum, for your enduring belief in me to achieve whatever I set my mind to. First Enrolled Nursing, then becoming a Registered Nurse, next a Master of Nursing (Honours). You cheered me on along the way with full confidence in my abilities, as perhaps only a mother can do. It is this belief that you had in me from the beginning that has helped to sustain me through to the completion of this project, and not to give up when the going got extremely tough when you left this world a lot earlier than we had hoped. I have finished this last work without you, in the shadow of that enduring belief, and I dedicate this Doctor of Philosophy thesis to your memory.

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IN MEMORIAM

During the course of this research, I discovered that a mental health nurse colleague, the sole mental health nurse in her community (in the study region), had herself died by suicide. I would like to acknowledge the work of Linda, a mental health nurse who gave greatly of herself to her clients and community. People in this study referred to Linda and were grateful to her for the care and compassion that she had contributed to their lives, and the lives of people they loved. People told me that Linda went over and above in her service to her community and in caring for others with mental health problems; they told me she was tireless in her advocacy for local mental health resources and carer supports; that she listened, and always had time for the most vulnerable people. Linda was clearly a remarkable mental health nurse, who is deeply missed by others in her community. It is appropriate to acknowledge her work here because her contribution to rural mental health nursing should be recorded and honoured posthumously. She was a remarkable mental health nurse and should be remembered as such. As a mental health nurse myself I salute her, and pick up her baton to advocate for more professional support for rural mental health nurses so that they are not in the lonely and desperate circumstances that Linda must have found herself in, without the care that she needed in her saddest hour. Rest in Peace.

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
CoAG	Council of Australian Governments
CTO	Compulsory Treatment Order
DIDO	Drive In Drive Out services and workforce
DoHA	(Commonwealth) Department of Health and Ageing
EPPIC	Early Psychosis Prevention and Intervention Centre
FIFO	Fly In Fly Out services and workforce
FaHCSIA	Department of Families and Housing, Community Services and Indigenous Affairs
GPs	General Practitioners
MHCA	Mental Health Council of Australia
MHNIP	Mental Health Nurse Incentive Program
NACMH	National Advisory Council on Mental Health
NMHC	National Mental Health Commission
NMHS	National Mental Health Strategy
WHO	World Health Organisation

DEFINITIONS

Biophilia	Concerned with natural systems and the relationships that people have with those systems (Kellert, 2012).
Brain	The major central nervous system organ located anatomically in the bony skull of the head. The functions of the brain include sophisticated neurochemical regulation (including implications for mood, interpretation, and cognition), memory and learning functions. The synaptic activities within the brain are responsible for learning, memory and mood quality.
Duration of untreated illness	Period of untreated mental health problem or illness.
Ecology	Concerned with systems and the relationships between those systems.
Emergent mental health problems	Prodromal - subclinical phase and early decline in mental health wellbeing.
Health	A positive state of physiological functioning within the human body.
Help	Help is used as a descriptive term to ascribe a label to the collection of strategies and actions that assist, make easier, support, provide relief, comfort, alleviate, ameliorate, improve or relieve the very early problems that are associated with the experience of emerging mental health problems for young rural people. Colloquially rural people are at ease talking about gaining or giving help, and it is because of the ease with

	which this term is used that it has been selected for use in this study.
Mental health	The optimal positive functioning of both the brain and mind resulting in both health and wellbeing.
Mental health helping capital	The collection of social capital assets that can be specifically applied to helping, supporting and promoting mental health and help-seeking, illness prevention and service provision within a human social system.
Mind	The mind has no physical location in the human body. While there is no organ or system that can be labelled as an anatomical reality, it is the collection of real life experiences, thought processes and emotional locus of a person. The mind represents the lived experiences of personhood. If the mind function is sub-optimal, poor wellbeing is experienced by a person. There is a relationship between brain organ health, and mind experiential wellbeing.
Person-centred mental health ecology	The functional ecological influences of relationships and interactions that impact on the mental health of a person. If the natural functional ecological world for a young person is resource abundant and distributed in even quantities, the outcomes for mental health are more likely to be positive. Conversely, if the ecological influences are not sufficiently available or poor, the young person's mental health may fail to thrive.
Rural social mental health helping	

capital	A subset of the social capital available in rural communities that is characterised by the way in which local rural people are able to support and resource each other towards meeting or improving the mental health and wellbeing needs of vulnerable people within their community (Allen, Inder, Lewin, Attia, & Kelly, 2012; Boyd, Hayes, R.L. Wilson, & Bearsley-Smith, 2008; Farmer et al., 2012; R. L. Wilson, Cruickshank, & Lea, 2012).
Social capital	The collection of community or personal characteristic assets, trust and cohesiveness that is available within a human social system (Boyd et al., 2008).
Social ecology	Concerned with human systems and their relationships.
Wellbeing	A person's perception of the lived experiences of positive health.
Yarni	Term for cannabis/ marijuana used frequently by Indigenous people.
Young people	18-25 years of age.

CHAPTER ONE

Introduction

1.1 Introduction

The extent of mental health problems of young people in Australia has been recognised as a national health priority (Slade et al., 2009). As a specific rural complexity related to this problem, young rural people are known to have longer durations of untreated mental illness than their urban counterparts (Fraser et al., 2002; Amminger et al., 2006; Boyd 2006; Endacott et al., 2006; Campbell et al., 2006; Catts, 2007; Hickie, 2007; Hodges, O'Brien & McGorry, 2007; Fragar et al., 2010). Mental health service delivery in rural communities is sometimes patchy in distribution and type, and young people and their families report difficulty in locating appropriate mental health help when it is needed (R. L. Wilson, Cruickshank & Lea, 2012). Communities in rural northern New South Wales (NSW), Australia, were the focus of the research reported in this thesis. It is important to understand the mental health help-seeking experiences of young rural people, because most mental health problems first emerge during adolescence and it is well known that early intervention promotes recovery and mitigates the long-term consequences of mental health decline. This research study was designed to better understand the experiences of this population and to explore ways that mental health services, and in particular nurses, might better align with the needs of young rural people in the study region. This thesis explores these issues and examines what other factors are associated with successfully accessing and providing mental health care for young rural people.

1.2 Background to the study

1.2.1 Help-seeking

The mental health help-seeking patterns of young people in rural communities have not been previously comprehensively explained in the literature. The journey towards gaining help is a variable human experience. It is vital that logical and timely pathways are established for young people to commence a help-seeking journey if the need for mental health help emerges (Boyd et al., 2008).

Rural health service providers attempt to deliver services without a strong model to capture early-entry help-seekers. Conversely, the help-seekers are looking for help, but not from the service providers who are seeking to offer help (R. L. Wilson, 2009). The narrowness of current health service delivery models limits the effectiveness of mental health prevention, promotion and early intervention aspirations and ideals.

1.2.2 Social capital and mental health helping capital

The Asset-based Community Development (ABCD) Model suggests that once local skills are identified within a community these skills, often previously unrecognised or supported, are in fact a community asset, which when harnessed usefully provide local citizens with a framework to build social capital (Mathie & Cunningham, 2003). Boyd et al. (2008) suggest that this 'bottom-up' approach is more useful than a 'top-down' approach to community development and endorse it especially when applied to the mental health of rural men. However, mental health programs in rural communities that have been underpinned by this type of modeling have not attracted renewed funding to continue their programs despite achieving clearly successful outcomes (Morrell, Page, & Taylor, 2007; Probhu & Oakley Browne, 2007).

1.2.3 Rural nurses – potential mental health helping capital

Rural nurses have a range of local dual roles and relationships that position them uniquely in relation to the early identification of emergent mental illness. As a result of their embeddedness within the rural community and their legitimate community membership of the rural community, they are in a position to notice change and to engage in informal discussions about the early identification of young rural people in need of help and early intervention. They are assets within their communities in this regard. There is a credible argument that suggests specialist-generalist nurses in rural communities add an element of community protection and community health promotion as resident community members, thus they contribute a human resource asset that cannot be replicated by visiting services or by rural people attending out-of-town specialist appointments in larger referral centres (Boyd et al., 2008).

1.2.4 Nurses – plentiful health service providers

Nurses are the most abundant population of health workers in rural areas of Australia (Rajkumar & Hoolahan, 2004), so, it is important to consider how this resource might be used

most effectively to address the needs of young rural people with emergent mental health problems. These authors also indicate in their literature review that nurses, especially generalist-specialist nurses, are well placed to assess and to intervene early in rural and remote communities (Rajkumar & Hoolahan, 2004). Generalist-specialist nurses are defined as nurses who have developed expert knowledge and practice in generalist nursing. Operationally this level of skill is recognised as specialisation in general nursing (Edwards & McGorry, 2002; R. L. Wilson, 2007). Rajkumar and Hoolahan (2004) suggest that further research should be conducted to explain why the clinical work of such nurses and its proven efficacy is not implemented on a widespread basis. Currently, state health systems and national Medicare provider rebate models of health service delivery in rural Australia do not adequately support nurses taking a more assertive role in managing youth mental health problems more actively.

1.2.5 What is *rural*?

Rural is a multidimensional concept, which includes aspects of a person's culture, place, identity, and geography, and the extent to which these align with standardised measures of rurality and remoteness (R. L. Wilson, 2014b). A range of perceptions and factors need to be considered when attempting to understand what it is to *be* a rural person. People who live in rural communities often identify closely with a deep sense of 'place'. The concept of place has a number of facets that include psychological, emotional, socio-economic and geographical factors (Campbell, Manoff, & Caffery, 2006). People in rural and regional communities may refer to themselves as being 'from the bush', or as a 'country person', or as 'rural', and all of these descriptions convey a sense of identity for people. People from within a similar geographical region usually share an interrelatedness that includes an inherent sense of connection and mutual support for each other that can also be thought of as 'mateship'. It is important that mental health professionals strive to recognise the richness of rural identity and culture, which is the real life experience of rural people generally, and to incorporate appropriate and uncontrived respect for this culture into their professional practice and therapeutic interactions with others (R. L. Wilson, 2014b).

In terms of mental health care, the rural person and the rural community are central to the concept of recovery for rural people. The cultural aspects underpinning what it is to be a rural person, and the places, people, and interconnectedness that make up an individual's rural

lifestyle, are critical to understanding the whole picture of a rural recovery system (R. L. Wilson, 2014b). Attention to these aspects of care will assist in developing a plan of mental health care that is realistic, achievable, and person-focused rather than health-service focused. If we confine our thinking to a health service focused perspective, we will discover that there are perpetual health service shortcomings that we cannot hope to address sufficiently within the bounds of usual resources. However, if we consider the strengths that are inherent within rural communities and cultures, we will discover creative ways in which the mental health of rural people can be improved (Lourey, Holland, & Green, 2012).

Government departments need to utilise more pragmatic measures to define rurality so that they can plan to distribute resources and services to populations equitably. Rurality has been defined by the Department of Health and Ageing in Australia using an equation that takes into account both the population size, and the distance required for travelling to services by road transport. The Accessibility Remoteness Index of Australia (ARIA) has been developed to describe the relative ease or difficulty that rural people are confronted with in regard to accessing services by road. This measure is used across five service sectors and is not limited to health services (Department of Health and Ageing, 2011). The ARIA scale rates from 0 (high accessibility) to a maximum of 15 (high remoteness), with five bands of remoteness identified in Australia (see Figure 1.1).

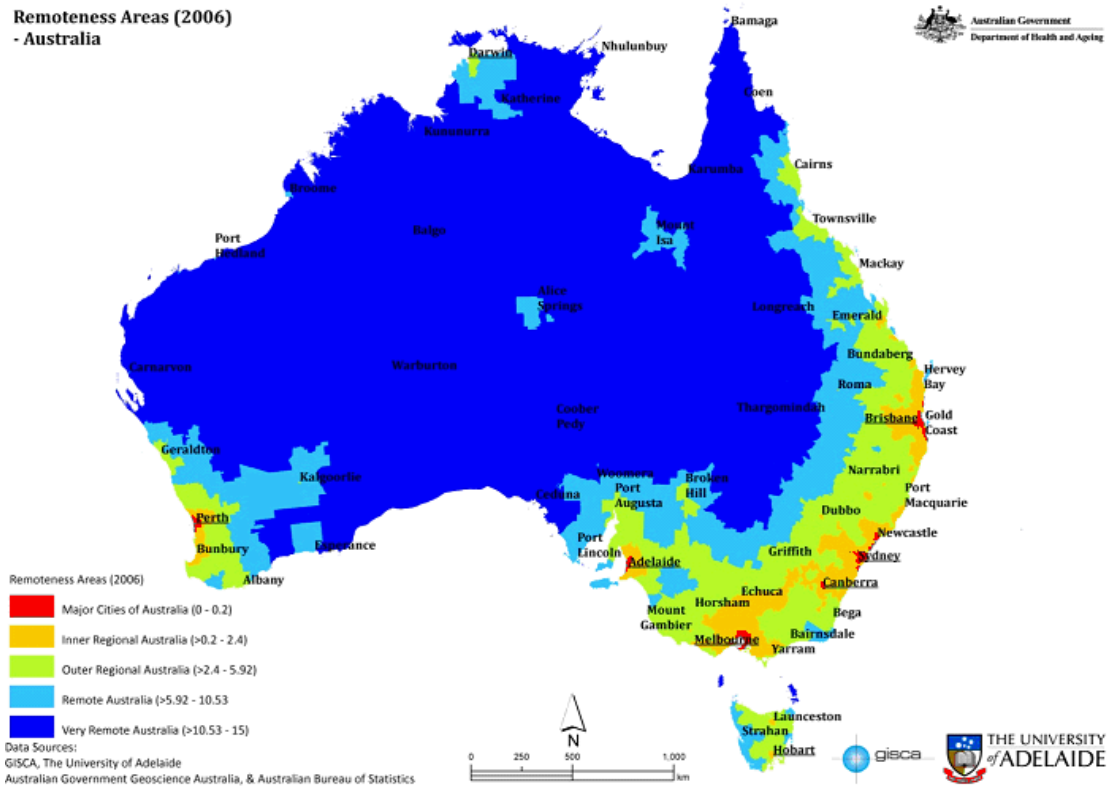


Figure 1.1: **Remoteness zones for Australia (Department of Health and Ageing, 2011).**

Thus, rurality is not a straightforward concept. In both urban and rural clinical settings, care needs to be taken by mental health clinicians, to ensure when planning for recovery in collaboration with a person who usually resides in a rural community, that therapy is conducted with a positive regard for rural cultures and circumstances (R. L. Wilson, 2014b).

1.2.6 Young rural people

The mental health problems of young people have been identified as a national health priority, with the highest prevalence of mental health problems and/or drug and alcohol problems found in the 12-24 year age group within the Australian population (Slade et al., 2009). It has been recognised that the early treatment of mental health problems promotes recovery prognosis, while conversely the lack of early treatment results in slower recovery with less promising outcomes (Amminger et al., 2006; Boyd et al., 2006; Endacott et al., 2006; Judd et al., 2006; Aisbett, Boyd, Francis, Newnham, & Newnham, 2007).

The duration of untreated mental health problems of young people in rural communities is known to be longer than for young urban people (Fraser et al., 2002; Amminger et al., 2006; Boyd 2006; Endacott et al., 2006; Campbell et al., 2006; Catts, 2007; Hickie, 2007; Hodges, O'Brien & McGorry, 2007; Fragar et al., 2010). This disparity between the treatment of rural and urban young people has significant detrimental impacts on the longer term functional capacity, wellbeing and recovery of rural individuals, resulting in delayed social, educational and vocational developmental milestones of up to ten years (Edwards & McGorry, 2002; ORYGEN Youth Health, 2004; Amminger et al., 2006; Catts, 2007).

1.2.7 Emergent mental health problems

The identification of emergent mental health problems is difficult as early signs and symptoms are often vague and easily misinterpreted as a difficult adolescent phase (ORYGEN Youth Health, 2004). While the prevalence of mental illness does not differ across gender in rural Australia, it is clear that gender does make a difference in regard to help-seeking, with females more likely than males to seek mental health services help (Judd et al., 2008; Slade et al., 2010). According to Judd et al. (2008), rural males have stoic characteristics that distance them from active help-seeking. Furthermore, while rural women are more frequent help-seekers, both young men and young women have difficulty in ascertaining suitable services that might be able to provide mental health help. Both genders report barriers to seeking mental health help including the social consequences of stigma related to mental health problems and the social exclusion that may accompany these in rural communities (Francis et al., 2006; Kelly et al., 2010).

1.2.8 Mental health rural workforce

The overall significant workforce shortage of specialist mental health professionals has meant that there is limited specialist mental health service provision in rural communities, and therefore limited access to professional help for mental health problems. However, a great deal of social capital exists in rural communities (Boyd et al., 2008). This social capital includes nurses who are the most plentiful deliverers of rural health services (Rujkumar & Hoolihan, 2004). All registered nurses in Australia are educationally and professionally prepared to provide mental health assessment and intervention to people with mental health problems. Rural nurses have been recognised as frequently operating as specialists in general care (Hegney, 1996; Edwards & McGorry, 2002; R. L. Wilson, 2007). Rural nurses represent

skilled mental health helping capital in their local communities, yet this important mental health helping resource, or helping capital, is both under-recognised and under-utilised in providing early mental health help in rural communities.

Many communities rely on the occasional visiting services by outreach mental health workers, and while this might provide a service opportunity to those consumers who have an established and enduring mental health problem, it is less likely to assist in the very early and emergent phases of mental health disorder. Visiting mental health workers are not locally embedded as rural social or helping capital and therefore are not privy to the unique networks and social structures within the local community where early detection is most likely to occur. Rural people are well known to value a close social proximity despite geographical distance (Boyd et al., 2008). Insiders within a rural community are distinctive participants within the social network of the community, while visiting outreach workers are not usually considered with the same regard as community insiders. These notions of insiders and outsiders are likely to impact on the degree of success of helping capital. This research study examines these influences and describes how helping is currently achieved, and how it might be improved in the future, based on the real life experiences of rural community participants.

1.2.9 Difficulty in seeking help

Young people and their families remain confused about where they might seek help for early mental health problems. Parents are the frequent helpers of their young adult offspring, and while they are frequently skilled in helping with the specific and unique needs of their adult or near-adult child, their helping can have the detrimental effect of containing emergent mental health problems within the family helping network for long periods of time (R. L. Wilson, Cruickshank & Lea, 2012). When parents do seek help for their son or daughter, they have trouble identifying who is available to provide suitable help. Help provision by professional mental health helpers is not immediately apparent to parents or young people, and so they continue to manage in a tenuous situation that is risk laden and escalating in terms of clinical complexity and recovery prognosis (R. L. Wilson, 2009; R. L. Wilson et al., 2012).

1.3 The aims of the study

This research study aimed to better understand the help-seeking experiences of young people with emergent mental health problems who live in a rural area and to develop an improved theoretical perspective of accessing rural mental health care that draws from the unique mental health helping capital that already exists within rural communities.

The significance of such a theoretical positioning is that it will assist in reducing the morbidity related to the long duration of untreated mental illness in rural young people. The extent of mental health problems in rural communities is well documented and is generally poorly addressed when compared with urban communities. It is extremely important to develop innovative strategies to map and utilise mental health helping capital in rural health care delivery, especially in the context of limited fiscal and human resources available for rural health care. A model that firstly describes unique mental health helping capacity and secondly mobilises that capacity to achieve mental health helping outcomes in rural communities will be beneficial to both the particular rural communities identified in this research, and more widely to rural communities nationally and internationally. This theoretical generalisation will ensure that the findings of this study will add usefully to mental health discipline knowledge generally and to rural mental health knowledge specifically.

1.4 Significance of the study

It is important to conduct further research so that the problems associated with vulnerable young rural people with long periods of untreated mental health problems can be better understood. Confusion exists from a carer and consumer perspective in regard to accessing professional mental health help. However, rural communities consist of registered nurses who are professionally qualified to provide at least basic levels of mental health care. These nurses are recognisable as mental health helping capital in their unique rural communities (Edwards & McGorry, 2002; Boyd et al., 2008). There is a clear gap between the need for early mental health help in rural communities and the current capacity to offer help in these same communities. Understanding the dynamics between these two community characteristics will inform the development of strategies to reduce this gap and make better use of the capital that exists in rural communities, thus improving the mental health outcomes for the rural communities. This research is significant because the need for improved mental health

services in rural communities is apparent. Australia has a track record of inadequate funding for mental health care, and this is not likely to improve in the short term; thus, any mental health interventions that can be applied in rural communities without the requirement of preclusive additional fiscal resources will be beneficial to the residents, and will improve the long-term mental health outcomes for vulnerable young rural people.

1.5 Description of the research methods

1.5.1 Research design

A case study research design using mixed methods (Yin, 2009) was an appropriate design to address the research problem identified. Case study research methods are useful in answering questions that seek to explore *how* and/or *why* a real life phenomenon occurs. The researcher was interested in understanding how rural communities can help young people with emergent mental health problems. It was important to understand why there is an apparent delay in accessing mental health help by young rural people despite the general availability of nurses who are professional mental health helping capital and the most abundant deliverers of health services to rural people. The research problems are expressed in such a way that to deal with them adequately, it was important to explore people's real life experiences. The qualitative paradigm was the most appropriate choice for exploring human lived experiences. The research problem does not lend itself entirely to quantitative exploration, although case study research methods do accommodate the inclusion of some quantitative data to gain a depth of understanding both within cases and/or unit of analysis, and across cases and/or units of analysis (Yin, 2009). Some quantitative data has been included in this study because it assists in describing some of the unique characteristics of rural communities such as demographical features; for example, population size, post codes, available services and their types, and gender profile of participants. These quantitative aspects of the study added descriptive depth to understanding the context in which the human experiences occur.

1.5.2 Research question

What helps young rural people with emergent mental health problems?

1.5.3 Justification for research design

While a number of research designs could be used to explore the research problem identified, they have been excluded because they will not achieve the depth and breadth of exploration

possible from using a mixed method approach within a case study framework. A mixed methods approach is appropriate when the research question/s cannot be answered fully by using only one approach: quantitative or qualitative alone (Creswell & Plano-Clark, 2011). An explanatory mixed method design was chosen as the best mixed method approach, as here the researcher is able to assess a phenomenon using a quantitative approach and then obtain in-depth qualitative information to help explain the quantitative data.

Case study research design offers a great deal of flexibility while maintaining a methodological logic that includes a chain of evidence and ensures that reliability can be achieved (Yin, 2009). Allan (2010a) and Kelly et al., (2010) have identified the need for research plans to address rural mental health problems and accommodate a flexibility whereby the variables and unique characteristics of various rural locations can be accommodated. Case study research design has the added benefit of allowing the researcher to examine simultaneously both the real life phenomenon and the context in which the phenomenon occurs, especially when the boundaries of the phenomenon and the context are not immediately clear (Yin, 2009).

1.5.4 Theoretical propositions

Case study research requires that propositions are developed, assessed and redeveloped as a response to the data analysis. The initial theoretical propositions include the following developing theory and rival theory:

Developing theory: The case study will show that mental health helping capital is contained within the unique social capital of small rural communities and is represented by registered nurses and other residents of those communities. It is important that mental health helpers develop literacy skills and community awareness that include the interpretation of life problems and emergent mental health problems of community members. Health professionals (and other professionals) should have a better understanding of the help seeking vocabulary and characteristics of young rural people and their families. In doing so, the gap between emergent mental health problem onset and appropriate professional mental health service provision might be lessened, resulting in briefer durations of untreated mental health illness and more promising recovery prognoses for this group.

Rival theory: Young rural people and their families should improve their mental health literacy so that they are more likely to be able to identify mental health disorders and

problems. In doing so, they are more likely to be able to select the most appropriate health professional or mental health service to provide them with the help they require. Programs to promote mental health awareness and mental health first aid in rural communities will help rural people to develop sufficient skills in identifying and seeking treatment for early mental health problems.

1.6 Researcher perspective

I have lived in two communities in the study region and worked at various times as a rural registered nurse and as a mental health nurse for a period of 13 years across all of the study region rural communities in northern New South Wales, Australia. Some of that nursing work included drive-in drive-out and fly-in-fly-out clinical service delivery to the people in the rural communities. There were a number of triggers that made me wonder why health services to rural regions were scant, especially for young rural people, and why the young people who were referred to me in my capacity as an early psychosis nurse clinician were frequently five to ten years older than their urban counterparts with similar problems. During my clinical practice as the sole clinician across a large geographical area, it became anecdotally evident that my attempt to provide early mental health intervention for those young people was an inadequate response considering the scale of the existing problem. However, additional funds and the strategic plans of the health service were not available for any further expansion of services for the population. I was aware that a potential consequence of limited access to services for young rural people was that people who experienced a first episode of psychosis were likely to be discovered later, and that this would adversely affect the recovery prognosis for these individuals. Thus, a professional frustration developed for me, and I was propelled towards conducting research to find new ways in which the population at risk could be better helped.

At one time, I lived and worked in a small country town in the study region with a population of approximately 5000 people. I enjoyed living and working in the town, and enjoyed the rural nursing practice opportunities available to me in that health service setting; for example, conducting mental health and drug and alcohol health consultations during the day, and responding to emergency calls in the course of my work or after hours. These included scrubbing for operating theatre, attending to triage and resuscitation in accident and emergency presentations, responding to farming accidents and providing local advanced life

support management for deteriorating patients in need of transfer to critical care settings in larger centres while waiting for Royal Flying Doctor Services. There was never a dull moment, not even when I went on maternity leave, with regular telephone calls and home visits by interdisciplinary colleagues (nurses, paramedics, police, doctors and teachers) and often friends as well, seeking health advice about specific mental health or drug and alcohol treatment matters. As a local registered nurse and loyal community resident, I was happy to contribute to the health capital of my local community. The diversity of rural nursing practice for me was exciting and vibrant, and provided me with opportunities across a specialist generalist spectrum. But career progression opportunities are often hampered at lower levels in rural communities and I found my career prospects were stunted, and the underemployment for my level of qualifications and experiences was a factor that persuaded me to relocate to gain the income commensurate with my experience and qualifications (Wilson, 2003).

These are common outcomes for small communities where experienced registered nurses are unable to advance in their careers. For some rural nurses, that means opting out of the nursing profession and developing a new profession such as farming. Whether the experienced rural nurses leave the community or move to careers outside nursing, there is a net loss for small rural communities, which results in a loss of social and mental health helping capital in the community (Wilson, 2003). This is what I did, and I have many colleagues who have relocated or changed careers. In my circle of contacts there are many excellent farmers who have had previous careers as excellent rural nurses, and allied health professionals. Thus, some under-utilised health professional capital exists in rural communities, but satisfying ways have not been found to harness such capital in small rural health services (Wilson, 2004). These personal experiences have niggled away in the background for me, and I have often thought of the lack of logic that underpins the failure to harness health professionals' services for better health outcomes for rural populations.

My own self-stigma as a rural person and a rural nurse also influenced my earlier nursing practice. As a rural person (from birth to present), I have previously held a suspicion that rural people, and therefore rural nurses, are a little lower in status than urban people in large metropolitan centres. For some time, this hampered my professional expectations for my career development. As a reflective practitioner who is also an advocate for clinical supervision, I have been able to recognise the extraordinary specialisation that is rural nursing

practice. I have moved to a position of strength in regard to my accumulated expertise as a rural nursing practitioner, and I now position my career in that light. However, the suspicion of inadequacy and the traditional invisibility of nursing work generally, may well be a factor for other rural nurses. I tucked this thinking away for future investigation as well, and this background too has influenced my research study development.

I love living in small communities and in the bush, in other words, in rural communities. I enjoy the loyalty and social proximately of rural people generally. It is my culture and a significant component of my own identity, as is my professional identity as a rural nurse. It is incorporated in my own cultural and social ecology. The relationships that rural people form and the ways they relate to people, land, community, water, health, and business sectors are all matters where I have lifelong personal real life experience. However, for many rural nurses, choosing rural practice will also eventually mean choosing under-employment as a lifestyle. The collection of these life experiences and my reflection on them, have led me to undertake research to explore some of the mental health adversities I have seen in the course of my clinical practice over a significant period of time. My hope is that the findings of my research will add new information to decision-making processes so that young rural people will have improved access to mental health care when it is required, so some of the rural disparity and inequity in regard to mental health morbidity (and mortality in the form of suicide) can be reduced.

1.7 Overview of thesis

This thesis contains five chapters. The first chapter has provided an introduction to the research; the second chapter reviews the relevant literature and presents the theoretical framework for the study; the third chapter describes the methods used in conducting this research; the fourth chapter outlines and discusses the data analysis and results; while the final fifth chapter presents the main findings and recommendations of the research. References and appendices, including the compilation of a list of book chapters, journal papers, a radio podcast and blogs that have arisen from the research described in the thesis, can be found at the end of this document.

1.8 Conclusion

This chapter has provided an introduction to the research that has been conducted to explore the ways that young rural people in northern New South Wales, Australia, can be provided with improved early access to mental health care in their rural communities when it is required. It commenced with a background to the study, and went on to outline the aim and purpose of the study and the significance of the research. An introductory description of the research methods and design was provided and the research question was identified. In keeping with the research methodology, two theoretical propositions were developed at the outset of the study; the first is a developing theory, and the second is a rival theory to assist with a thorough consideration of the research topic as a basis for the commencement of the research, and these were presented in this chapter.

The chapter explained the researcher's specific interest in mental health wellbeing, health promotion, early intervention and recovery care for young rural people, which is based on her previous practice of clinical rural and mental health nursing in all of the communities in the study site region over the past thirteen years. The limitations of the study were also identified. This chapter has provided an introduction to the thesis and to the topic under investigation for this research. In particular, it has provided background for the study and described the aim and purpose of the study, together with outlining the significance of this study in respect to the mental health needs of young rural people in the northern New South Wales region of Australia. The research design and research question has been introduced and a justification for the research design has been provided. The researcher has provided a perspective that situates her long-term interest in the mental health nursing care of young rural people in the identified study region; additionally, she has identified some personal rural practice stimuli that have influenced the instigation of this research project.

The following chapter will continue to build the story of the research process and will discuss the literature that is pertinent to this investigation.

CHAPTER TWO-SECTION ONE

Literature review

2.1 Introduction

This chapter is divided into two sections. Section one will review literature that is relevant to understanding what is already known about the emergent mental health problem context for young rural people in Australia. It commences with an introduction to the topic and continues by describing the international and Australian contexts for youth mental health. It then reviews other relevant literature that describes rural places and people and the relationship between social and environmental influences. The links between young people's experiences of mental health problems and the people and places associated with their lives, which are well demonstrated in the existing research literature, will be outlined. The rural mental health service and consumer context will be reviewed with particular attention to the experience of accessing mental health help in the study region. Additionally, the contribution that nurses make to the rural community will be reviewed. Finally, the section will conclude by summarising the main issues arising in the literature. Section two follows and it will describe the literature that informs the theoretical framework used for this study.

SECTION ONE: A critical analysis of relevant literature

A broad range of literature was searched initially using online databases (CINAHL, Medline, PsycINFO), and by searching NSW Health, the Department of Health and Ageing online databases and the Australia Bureau of Statistics online databases. Search terms included *rural, *youth, *young people, *mental health, *nursing, *early intervention, *help-seeking, *social capital, *social ecology, *health ecology. In addition, Australian nursing and rural health journals were monitored throughout out the study period for new relevant literature as it was published. Relevant literature was selected if it was published with dates between 2000-2013.

2.2 International context for youth mental health

A change in paradigm in the delivery of youth mental health has gathered some momentum in recent times. Mental health experts across Australia, the United Kingdom and Ireland have banded together to call for a new approach to the delivery of mental health care for young people, and have developed an *International Declaration on Youth Mental Health* (Coughlan et al., 2011). Traditionally there has been a division of service provision that has fallen into arbitrary age brackets; that is, that clients under the age of 18 years are seen by child and adolescent mental health service provider clinician teams and any clients older than 18 years of age are treated by an adult mental health service. Coughlan et al. (2011) challenge the traditional paradigm and have identified a need to reform youth mental health service delivery at an international level.

Age-based classifications have some limitations because human developmental phases and experiences vary considerably across the adolescent-young adult development spectrum. In particular, a gap has been identified for 16-18 year old people who do not always fit into the simplistic age-based categorisations because for some people in that age group, their lived experiences may include adult experiences, such as independent lifestyles away from their families of origin. These young people do not adequately fit into either of the arbitrary mental health service streams, and are at risk of falling through service gaps (Coughlan et al., 2013). In contrast, young adults who are older than 18 years may live in dependent circumstances where they remain at home with their parents supporting them to various extents, and they find their circumstances at odds with the traditional adult mental health service stream provisions (R. L. Wilson, 2007; R. L. Wilson et al., 2012). There is a need to adopt a young adult mental health service paradigm to better align services with the specific needs of each individual young person for appropriate mental health care provision, and not to use the traditional arbitrary age-based classification system as a criteria for service provision (Coughlan et al., 2013). Better treatment offers considerable potential for improved health later in adult life.

It is known that 75% of all adult mental health disorders have their onset prior to the age of 25 years of age (Jones, 2013; Kessler, Berglund, Demler, Jin, & Walters, 2005), and that half of all lifetime mental health problems have an onset by 14 years of age (Kessler et al., 2005). The economic and human impact of these early adult experiences leaves young people at risk

of other long-term difficulties as a result of their mental illness, such as personal, family, social, educational, financial and vocational consequences (Coughlan et al., 2013). The age-based classification systems for traditional mental health service provision is at odds with the developmental phases of adolescence and young adulthood, and this incongruence is a significant barrier for young people (Coughlan et al., 2013).

In Australia in 2007, one in four young people aged 16-24 years had experienced an anxiety, depression, or substance related disorder in the previous 12 months (National Mental Health Strategy, 2009; Slade et al., 2009; Teesson et al., 2010). This is comparable to international morbidity rates, which report that young people first encounter a mental health problem of any type during the ages of 12-25 years with approximately 20% of the world population in this age bracket affected (Kessler et al., 2005; Wei, Hayden, Kutcher, Zygmunt, & McGrath, 2013). Monitoring of the global burden of disease from 1990-2010 has shown a steady increase in the burden of mental disorders which account for 7.4% of Disability-Adjusted Life Years (DALYs) of all 291 diseases measured globally (Murray et al., 2012). Murray et al. (2012) highlights a need for additional health system and health professional education investment because mental disorders currently rank in the top six DALYs growth demands internationally, and the trend is rising in conjunction with increases in the world population. Future demands for increased mental health care can be forecast based on large-scale research and ongoing longitudinal monitoring studies, and Murray and colleagues are continuing to build a global morbidity profile to inform health planning for the future (Murray et al., 2012).

2.3 Australian mental health context for young people

In Australia, a total of 13% of the burden of disease can be attributed to mental disorders. However only 5% of the health budget is spent on mental health care, with proportionally more of that funding spent on bed-based mental health care and less on community-based care (Australian Institute of Health and Welfare, 2011; S. P. Rosenberg & Hickie, 2013). Suicide is the leading cause of death for people aged from 16-25 years, with an occurrence of almost one in four deaths (Mendoza et al., 2013). On average, in every year 12 high school class in Australia, one person will have attempted suicide (Mendoza et al., 2013), while 2% of young men report a suicide attempt within the previous year, and 20% of young men report that ‘life is not worth living’. Fifteen percent of young people experience psychological distress at high or very high levels, and 19% of young people have a lifetime prevalence of non-suicidal self-

harming behaviours (Mendoza et al., 2013). An additional concern is that 39% of young Australians binge drink at dangerously high levels (Mendoza et al., 2013). Schizophrenia is the third leading cause of disease burden and injury for Australian young men and the fifth for young women in the 15-24 year age bracket (Australian Institute of Health and Welfare, 2007). The youth population in Australia, and particularly young people who have no prior experience of mental health care, are in urgent need of more services that target emergent mental health problems (S. P. Rosenberg & Hickie, 2013). Currently only 13% of young males and 31% of young females who need mental health care services receive any services. This clearly demonstrates that there are profound major gaps in adequate mental health care provision, policy and funding, with significant under-met whole of population needs (S. P. Rosenberg & Hickie, 2013).

In Australia, young men are least likely to seek mental health help when they encounter mental health problems (Rickwood, 2012; S. P. Rosenberg & Hickie, 2013). Only 35% of all Australians with mental health disorders receive any mental health care (S. P. Rosenberg & Hickie, 2013). It is well recognised that a range of interventions will be required to address the burden of mental health need in Australia, and that mental health promotion and encouragement of early help-seeking will be increasingly more important (Rickwood, 2012). Rickwood (2012) and S. P. Rosenberg and Hickie (2013) all suggest that traditional mental health service models do not have the capacity to meet the current and future under-met need of mental health morbidity within Australia. Rickwood (2012) notes that approximately 875,000 12-25 year old people in Australia are likely to benefit from mental health interventions, while the national response to youth mental health, *headspace*, is actually only registering fewer than 30,000 clients per year (Rickwood, 2012). The mental health of young Australians is therefore grossly underserviced and new, innovative solutions to assist with all levels of mental health care need to be developed and implemented for the national long-term mental health across all ages (Coughlan et al., 2011, 2013; Mendoza et al., 2013; Rickwood, 2012; S. P. Rosenberg & Hickie, 2013).

Emerging mental health problems are difficult to detect because initially symptoms may be non-specific and vague, with a gradual development of symptoms such as perceptual difficulties, stress, depression, anxiety and/or sleep disturbances (Boydell, Volpe, Gladstone, Stasiulis, & Addington, 2013). Early psychosis is characterised by symptoms that include

perceptual problems (for example, hallucinations), disturbances of belief and interpretation of the environment (delusions), and thought disorder, which is noticed when speech patterns become disorganised (Early Psychosis Writing Group, 2010). These symptoms are not always present simultaneously, especially in the early phases of the disorder, and their gradual development can make the detection of psychosis difficult for clinicians, and therefore especially challenging to the public population, and to young people themselves, who are most likely to encounter the problems during adolescence (Early Psychosis Writing Group, 2010). One of the first problems young people develop, in regard to early psychosis, may be impairment to their social functioning. This can easily be confused with a normal spectrum of emotional ebbs and flows associated with adolescent developmental phases (Early Psychosis Writing Group, 2010).

Mental health is a priority for future health budgets to continue to address and to plan improvements on a national scale (Lourey et al., 2012; S. P. Rosenberg & Hickie, 2013). The recent National Mental Health Report Card (Lourey et al., 2012) highlights that every year 3.2 million Australians experience a mental health problem. In addition, annually there are 31.1 million mental health prescriptions filled, yet there are only 900,000 mental health individual consumers who are provided with mental health services (Lourey et al., 2012). There are thought to be about 65,000 suicide attempts every year, but despite this only somewhere between 6-8% of the population are budgeted for in regard to mental health care while the Report Card calls for a budget increase to 12% (Lourey et al., 2012; S. P. Rosenberg & Hickie, 2013). It is clearly evident that the Australian population urgently requires an increase in the capacity of mental health service delivery, both now and into the near future, and that this will require a population of skilled nurses, and other health professionals, who have an above basic knowledge of mental health (Happell, Wilson, & McNamara, 2014; S. P. Rosenberg & Hickie, 2013).

2.3.1 Public mental health services

An inaugural NSW Mental Health Commission commenced in July 2012 as an independent statutory body to oversee all NSW state mental health policy and processes (New South Wales Health, 2012). One of the first actions of the commission has been to create a policy directive that promotes a consistency of *Transfer of Care from Mental Health Inpatient Services*, which was yet to be formally released at the time of this study. However, the

preparation phase of this policy directive demonstrates the direction that the commission is taking in terms of promoting safe and supported transition of care for people who are discharged from mental health bed-based services. The objective would be to ensure that adequate community level supports are consistently and helpfully available to them (New South Wales Health, 2012). In addition, the commission has a goal to foster the development of strategies to limit hospital admissions and to promote hospital avoidance programs, which aligns with the National Mental Health Commission goals (New South Wales Health, 2012; S. P. Rosenberg & Hickie, 2013). Further, the commission is hoping to strengthen community mental health resources especially in regard to a full complement of services that include prevention, early intervention, treatment and community recovery support services, again in parallel to the National Mental Health Commission goals (New South Wales Health, 2012; S. P. Rosenberg & Hickie, 2013). Despite the concordance of goals at both state and national level, the current funding and policies continue to reinforce and foster hospital-based mental health care, leaving little room or resources for any community-based innovative models of mental health care (S. P. Rosenberg & Hickie, 2013).

NSW Health aspires to some goals that are to be achieved by 2021, one of which is to 'keep people out of hospital (Goal 11)' (New South Wales Health, 2012:16). The intention is to have an increased focus on wellness, and illness prevention in the community, by enhancing preventative health strategies so that people in 2021 and beyond can live 'healthier, happier and more fulfilling lives (Goal 11)' (New South Wales Health, 2012:17). The ideal of a happier and healthier lifestyle in the future will be brought about, in the view of the annual report authors, by improving outcomes for mental health so that there are fewer readmissions to hospital within a 28 day period. There should be an increase in the community follow-up within seven days post discharge from a bed-based unit discharge, and more young people and adults with mental illness should be diverted from law courts and into mental health treatment (New South Wales Health, 2012). A limitation for achieving these outcomes is that the ideals are proposed from a health promotion and illness prevention paradigm, while the anticipated outcomes are better suited to a traditional illness-based paradigm. The goals and outcomes do not appear ideally aligned to promote health and wellbeing, despite the appealing aspirations (S. P. Rosenberg & Hickie, 2013).

2.3.2 National brokerage model for youth mental health service

The dominant national model for youth mental health service provision in Australia is a brokerage model facilitated by a *headspace* framework (Cohen, Medlow, Kelk, & Hickie, 2009; McGorry et al., 2007; Patulny, Muir, Powell, Flaxman, & Oprea, 2013). This type of service provision has been in operation in Australia since 2006, and provides a one-stop-shop style of mental health service provision to young people in the communities where a *headspace* centre exists. The types of services available in each *headspace* service will vary according to the availability of service providers and health consultant contractors in that location, but they will in general either provide, or provide referral to, primary mental health care for young people. Ideally, every community should have access to a *headspace* centre. If this were to be achieved nationally, significant progress toward the reduction of the burden of mental ill-health for young people in Australia might be achieved.

2.3.3 Barriers to mental health service access

There are many barriers for young people in accessing mental health services. Many mental health authors have reported lack of access to appropriate services as a significant barrier, in particular for rural young people. Long travel distances make it extremely difficult and sometimes impossible to access mental health services (Aisbett, Boyd, Francis, Newnham, & Newnham, 2007; C. Black, Roberts, & Li-Leng, 2012; Boyd et al., 2006; Coughlan et al., 2013; Hoolahan, 2002; R. L. Wilson, 2009). While rural disadvantage in regard to service access has been noted at a federal level (Lourey et al., 2012), there has been slow progress in regard to developing an adequate mental health response to improve access for young rural people. Additional delays to help-seeking are common in the mainstream, and include the severity of the onset of a mental-health problem, substance use, homelessness, cultural issues, and a general reluctance to seek help, service accessibility and perceptions of stigma (Boydell et al., 2013).

2.4 Health service context in rural northern New South Wales

A range of public, private and non-government organisations provide primary, acute and recovery mental health service to people within the study region. Travel to health services is a significant factor in accessing specialist services, with regional centres acting as a hub for a range of services. Mental health services that target rural young people are extremely limited in size and distributed sparsely across the region, with clinicians providing sessions of service

by telehealth, videolink, drive-in-drive-out (DIDO) and fly-in-fly-out (FIFO) service to outlying towns.

The New South Wales health region of Hunter New England Health Service provides public mental health services to the study site region in the northern part of New England. These services are largely provided as hospital based services (bed-based, emergency department-based, and community or ambulatory based services). These services are funded by the state government of New South Wales, and administration and governance for the services are provided through the NSW Ministry of Health. A small multidisciplinary child and adolescent mental health team operates from two central hubs in two of the larger towns, Tamworth and Armidale, and this service provides outreach services to other communities in the region. A child and adolescent mental health eight person bed-based unit is available in Newcastle, which is the largest regional centre within the Hunter New England Health service region; however it lies outside of the study region reported in this thesis (http://www.hnehealth.nsw.gov.au/mh/services/mhsf/camhs). No dedicated bed-based child and adolescent mental health facilities are available in the study region, although paediatric units in some hospitals in the study region admit children and adolescents for voluntary mental health treatment when required.

2.4.1 Medicare rebated primary mental health care

Access and affordability of mental health services to rural young people and their families remains a significant barrier to mental health help-seeking. In 2006, affordability of mental health services became more achievable for people in Australia because some mental health services were added as rebate items to the national public health system (Medicare). At this time, a variety of clinicians were issued provider numbers enabling them to claim financial rebates, and thus they were able to offer services to clients at a reduced or no cost rate (Patulny et al., 2013). Mental health nurses were the last mental health professional group to be included on this rebate list, although their remit remains only to rebate services provided by them to people with enduring chronic and severe mental illness, and these problems are less likely to occur for young people (Health Management Advisors Pty Ltd, 2012; Meehan & Robertson, 2013). Thus, funding models for primary mental health nursing care for young people do not yet exist in Australia.

Headspace is the national youth mental health initiative throughout Australia relying almost exclusively upon the Medicare rebate system for funding services. That is, practitioners who are contracted to work with *headspace* centres, do so without charging a gap payment and are paid the Medicare rebate for service provision (Patulny et al., 2013). Each discipline has a different rebate allocation with mental health nurses the lowest rebate pay point in the system at an average of about AU$60 per contact hour inclusive of all expenses and overheads (Australian College of Mental Health Nurses., 2013; Health Management Advisors Pty Ltd, 2012). Despite the success of the *headspace* initiative where it has been provided, only 56 centres are currently operating throughout Australia and only one centre is operating in the study site (http://www.headspace.org.au/headspace-centres/headspace-tamworth). In a region that represents over 12% of the state's land mass and almost 200,000 people, with only one new *headspace* centre in the largest community, Tamworth, and where that community also hosts most other health care resources for the region, it can only be concluded that there are significant barriers to appropriate access for mental health care for young people, and that disparity of primary mental health services continue to be a priority for redress in the study region.

2.4.2 Mobile population of fly in fly out (FIFO) and drive in drive out (DIDO) services and host rural community perceptions

Rural Australia has an increasingly transient population of people, some of whom visit for short durations purely for employment purposes, with their main residential address in other urban locations. FIFO workforces have been very disruptive to many communities, which often find it difficult to plan services and infrastructure to accommodate the influx of larger transient populations because there has been no Australian census data collection to understand the extent of the FIFO population or their service needs (Haslam McKenzie, 2013). In addition, it is recognised that local authorities are not able to capture rate-fees from this population, so the ability of small communities to service FIFO populations lacks a financially sustainable basis. The burden then falls on the resident-wide smaller community rate-payer population to develop services that can accommodate the FIFO population in addition to their regular rural residents (Haslam McKenzie, 2013). Some communities in the research study region have experienced the challenges of a mining FIFO workforce whereby large transient populations of mining workers set up temporary housing 'camps' on the outskirts of a small town (for example in Narrabri, NSW), and these challenges have impacted

and stretched the health service delivery capacity of the local region significantly in recent times. The limited sense of host community connection among FIFO and DIDO workers is a threat to the host rural community cohesion (Haslam McKenzie, 2013). In particular, a host community where FIFO and DIDO workers are sometimes seen as unwelcome visitors because their authentic contribution to other aspects of community life is limited or non-existent (Haslam McKenzie, 2013).

Rural communities value strong community cohesion and this in part builds a community corporate sense of trust and social engagement, so when FIFO and DIDO workers only contribute to the micro economy of the local community (for example, small grocery, cigarette, alcohol, fast-food and other small personal purchases), and yet fail to contribute to local community organisations, volunteering and sporting groups, they are perceived as intruders to the community, and a lack of trust and authenticity of relationships develops between the two cohorts (Haslam McKenzie, 2013). This has implications for the whole population, and certainly the mining industry has been a significant driver of this circumstance (Haslam McKenzie, 2013). However, lessons can be learnt and applied to other services such as health and education, where workers are brought into the community to provide services, either as FIFO, DIDO or digitally by videolink or telehealth. This study investigates the real life experiences of young rural people with emerging mental health problems, some of which are influenced by mobile workforces across a range of sectors. These concepts will be discussed further in Chapter Five of this thesis.

Internationally, Dutch researchers have identified similar dynamics when they compared mobile and resident population of place using data collected in a National Travel Survey, which was then analysed using economic, environmental and social indicators to understand the performance of mobile and residential populations in the Netherlands (Zandvleit, Bertolini, & Dijst, 2008). The National Travel Survey yielded travel behaviour data of 130,000 Dutch individuals in a single day from time-logged travel journals by the participants (Zandvleit et al., 2008). During analysis Zandvliet et al. (2008) were able to track where and when people travelled during the day, including municipalities visited and the time of day or night when people travelled during the study period. The findings of the Zandvleit et al. (2008) study indicated that the traditional nocturnal measures of residence did not actually reflect the diurnal spatial mobile populations, and that with an increasing mobile population,

these have a direct impact on the performances of places and the relationships of people in those places (Zandvleit et al., 2008). Zandvleit et al. (2008) suggest that planning for populations has traditionally been based on place of residence, that is, where people reside overnight. The authors counter that this basis for planning fails to take into consideration the contribution and consequences of mobile populations within communities (Zandvleit et al., 2008). It may be that diurnal populations provide a better basis for planning services, as better reflecting local and mobile populations active within a community during its high density times (Zandvleit et al., 2008).

On the one hand, it can be seen that a contribution of a specific service is helpful, although the lack of authentic membership of the community is a significant limitation to the effectiveness and trustworthiness of these services to rural communities; especially in communities that have a high turnover of short-term community development style projects, such as short projects to address population health matters. The geographic locations of young rural people and the services that support them required significant distance of travel in the region for this study, and travel issues related to this study will be discussed in more detail in subsequent chapters of this thesis.

2.4.3 E-mental health in the context of rural settings

One mental health care innovation is likely to lie within e-health domains, and includes the use of online, social media and mobile phone mechanisms to deliver a range of interventions. This is recognised as an important direction for future mental health care development for young rural people (Christenson & Petrie, 2013a; Rickwood, 2012; R. L. Wilson, 2014c; R. L. Wilson, Ranse, Cashin, & McNamara, 2013a).

While the internet as a mechanism for the delivery of mental health intervention is an evolving area of practice for mental health professionals, it should be noted that a limitation for this type of intervention will be the extent to which it appeals to young people and the varied experiences and duration of experience young people have with internet usage (J. Smith, Skrbis, & Western, 2012). In particular, J. Smith et al. (2012) note that the quality, context, frequency, duration, and motivation for internet use will influence the usefulness of any internet-based experiences for young people, and that success will be influenced by a young person's digital literacy skills and their level of confidence using this platform. In addition, a new role is developing for knowledge brokers to assist people with low digital

literacy to access and understand online mental health information and self-help interventions, with some commentators indicating that knowledge brokers might be increasingly needed in rural areas to combat the low literacy levels experienced in some rural communities (Christenson & Petrie, 2013a).

In 2008, the national youth mental health initiative, *headspace*, developed a youth mental health website to complement its network of office locations and service options (Muir, Powell, & McDermott, 2012). This website development was accompanied by a marketing campaign on television, in print and in electronic media advertising the *headspace* concept and services. This enhanced public knowledge about youth mental health and available service options and types (Muir et al., 2012; Patulny et al., 2013).

2.4.4 Telehealth

NSW Health has signalled a commitment to enhance its future telehealth capabilities and offerings with a new Telehealth Technology Centre that it plans to base at Nepean Hospital in the Sydney region. The strategy is that a centralised metropolitan and technologically advanced digital service will improve the availability of health service provision to rural and regional communities in NSW (New South Wales Health, 2012).

The notion that specialist mental health services should be centralised and delivered by visiting specialists to rural communities is not isolated to NSW's telehealth teams. Melbourne-based early psychosis expert teams also advocate for visiting specialists to travel to rural and regional areas to deliver services (Early Psychosis Writing Group, 2010; ORYGEN Youth Health, 2004). However, there is a caution that while telehealth and other technological resources should be made available to rural clinicians and rural communities, they should not be viewed as a substitute for specialist visiting services (Early Psychosis Writing Group, 2010). In addition, the types of services that suit densely populated urban areas may not suit more sparsely populated rural areas, for a range of reasons that include the critical mass of disorders and problems to sustain the economic viability of services and specialist staff (Early Psychosis Writing Group, 2010). A difficult tension exists between ensuring equity of accessibility to appropriate mental health service types for young people, and populations and infrastructure to support these services. However, it is clear that tailoring service types to populations of rural young people is important for the adequate provision of rural mental health services to this group (Early Psychosis Writing Group, 2010).

2.4.5 Economic influences on mental health service distribution

The evidence to support the conceptualisation of telehealth mental health service provision is scant, and is based more on economic modelling and fiscal constraints than it is on aligning to the specialist mental health needs of a micro population of young rural people who are geographically scattered across vast location areas, and without a critical mass to match clinical human resourcing demands. Balancing the fiscal and human mental health constraints and demands for young rural people is difficult, and there are no easy solutions to these health service provision dilemmas. Nevertheless, they do need to be acknowledged against a background of health service and political rhetoric about the fitness of telehealth for the purpose for which is has been designed, which is to support the medical needs of rural and regional NSW. There is a need for further research regarding the effectiveness of telehealth for servicing rural populations, to better understand how it assists service administrators, clinicians, and/or the mental health help-seeking service-users. There is no literature to identify if urban, regional or rural bases for telehealth services are best matched to rural mental health service delivery. In addition, there are variations in the quality and type of telecommunication infrastructure to support telehealth service delivery in Australia, with different regions using different internet capabilities, speeds, and with varying reliabilities (see http://www.communications.gov.au/broadband/national_broadband_network). The relevance of telehealth to this study will be discussed further in subsequent chapters of this thesis.

2.4.6 Self-help with e-mental health

There have been significant developments in e-mental health, and especially with self-help e-mental health interventions such as cognitive behavioural therapy, many of which have been developed in Australia (Christenson & Petrie, 2013b). Christensen and Petrie (2013b) conducted a review of a university-controlled database that contained 62 web-based and 11 mobile applications for mental health self-help interventions listed on an open access website that addressed affective and anxiety disorders. The authors found most of the interventions available had been designed for adults and were based on cognitive behavioural therapy principles (Christenson & Petrie, 2013b). One third of the interventions had been evaluated by at least one randomised control trial, which shows some promise for the developing body of evidence emerging around the use of e-mental health in the future. However, more research

needs to be done to understand the effectiveness and implications for e-mental health delivery to rural young people (Christenson & Petrie, 2013b).

2.4.7 Mental health telephone-based triage

The 2011-2012 annual report for NSW Health (2012) described a mental health telephone service that commenced as a statewide initiative in March 2012, and reported that the 24/7 telephone service allowed people to talk to a mental health care professional and obtain referral to appropriate care by calling the *NSW Mental Health Line* (New South Wales Health, 2012). However, to date there has been no statewide communication and promotion campaign for this telephone service, so it is not well known to the public, including people within the study site for the research reported in this thesis.

A research study conducted recently in rural/regional Victoria, Australia, examined service-users' experiences of telephone-based mental health triage system in that region (Elsom, Sands, Roper, Hoppner, & Gerdtz, 2013). Over a three month sampling period, which involved purposively telephoning triage service callers and inviting them to participate in the study, 74 consumers and carers took part in structured interviews by telephone after they had first contacted the telephone-based mental health triage service seeking mental health related help (Elsom et al., 2013). Differences between consumer and carer responses in the data were analysed using x^2-tests of independence (Elsom et al., 2013). An important finding from this study was that 70% of the consumers that were interviewed indicated that they had difficulty in finding the triage telephone number, and they experienced delays in waiting for a call-back from a nurse after they had registered their call with the triage service receptionist (Elsom et al., 2013). In addition, 48% of carers reported similar difficulties in finding a pathway to triage mental health help, with some indicating that they could not find information about the service either on the internet or in printed telephone directories (Elsom et al., 2013).

There is an identified knowledge gap about the difficulties associated with telephone-based mental health triage services, particularly difficulties experienced by people with mental health problems, and to a lesser extent, their families and/or carers (Elsom et al., 2013). Public information about mental health triage access is lacking and some researchers have called for a more nationally consistent message about access to mental health triage (Elsom et al., 2013). Additionally, more research is needed to understand if there are some disabilities related to the nature of mental health problems that make it unsuitable or difficult for consumers to use

a telephone-based triage mental health service (Elsom et al., 2013). The findings from the Elsom et al. (2013) study relate to the investigation in this study because public mental health services in the study site region have a gateway for access to public mental health service via a telephone intake system. The suitability of telephone-based intake for public mental health services related to young rural people with emergent mental health problems is discussed further in Chapters Four and Five of this thesis.

2.5 Expectations of young people about mental health care

Young people need to feel that they can talk to someone and access mental health expert help, so that a great deal of unhappiness can be averted, and indeed so that suicide rates can be reduced, because at a very basic level, unhappiness underpins suicide to some extent (Coughlan et al., 2013). Young people are often considered by others to be in a happy youthful life stage, but for many young people this is not the case, and without sufficient mental health provision, promotion and prevention services, the burden of youth unhappiness cannot be adequately abated (Coughlan et al., 2013). Coughlan et al. (2013) equate poor access to mental health care with the limited potential that young people have to fully participate in society. They further state that:

> Every time a young person is overcome by the challenges they face and have no one to turn to for the support they need, an opportunity to foster their spirit of resilience and the chance of recovery from mental ill-health is lost (Coughlan et al., 2013:104).

It is important to ensure that appropriate access to mental health care for young people is equitably available. The National Mental Health Commission also identified the critical nature of a ‘no wrong door’ approach to accessing mental health care for young people (Lourey et al., 2012). The National Mental Health Commission has urged the federal government to plan to increase the funding to service providers to promote the likelihood of achieving earlier intervention for young people and their families in regard to mental health problem help-seeking (Lourey et al., 2012). This need is further underscored by the findings of a study in Canada where 86 young people were surveyed and asked about their initial mental health help-seeking pathways (Addington, van Mastrigt, Hutchinson, & Addington, 2002). Despite the occurrence of between one and four contacts by young people in an effort to obtain mental health help, only two of the 86 individuals were successful in gaining the

mental health help they needed (Addington et al., 2002). The health care provision and service dynamics between Canada and Australia are sufficiently similar to suggest that similar occurrences are likely in both countries. The pathways towards seeking mental health help by young rural people in Australia are the subject of investigation in this study.

2.5.1 Young people's expectations as recipients of mental health care

When young people are successful in achieving access to a mental health service, they bring with them a set of preconceived ideas and expectations about what being a client of a mental health service might mean for them (Watsford, Rickwood, & Vanags, 2013). Subtypes of client expectations include ideas about the roles of client and clinician, what therapeutic activity might occur and how the likely treatment outcomes might look and feel. The client expectations may differ from the expectations of the health service providers about the roles and the therapy elements of mental health care (Watsford et al., 2013).

A qualitative study was conducted in 2010 that interviewed 20 young people in Canberra, Australia, with an aim to understand the expectations that young people have of youth mental health services (Watsford et al., 2013). Watsford et al. (2013) collected and then thematically analysed data about the first-visit expectations that participants had when they attended a youth mental health centre (Watsford et al., 2013). The findings of the Watsford et al. (2013) study revealed that young people were unsure of what to expect if they attended a mental health service, and so they were not always ready to engage in therapy. This lack of understanding led to their anxiety about the experience of a first visit with a mental health clinician (Watsford et al., 2013).

Watsford et al. (2013) found that young people were not always clear about the types and roles of professionals working in a mental health setting. They considered that if they liked and were able to talk to the clinician, and things went well in the first few sessions, then they thought they would proceed with further therapy and became more hopeful that things would improve for them in the future (Watsford et al., 2013). The implications for practice that this study identified were that clinicians should consider carefully how they develop a therapeutic alliance with young people, because the quality of this exchange was a pivotal characteristic for young people in deciding whether they would continue with pursuing mental health help (Watsford et al., 2013). A further implication was the way in which clinicians conveyed the need to practice strategies for recovery outside the therapy session, because conveying that

'homework needed to be completed' can have an adverse effect on young people and repel them from a decision to engage in changing their behaviours in the future (Watsford et al., 2013). Building therapeutic relationships with young people requires that clinicians attend to their own preconceived views and beliefs about young people's behaviours, values and beliefs, and to ensure that clinicians work towards developing young person acumen as part of their professional clinical development (R. L. Wilson, 2014b). The findings of the Watsford et al. (2013) study are relevant to the study reported in this thesis, and the relationships between clinicians, nurses and young people will be discussed further in Chapters Four and Five.

2.6 Mental health and law: Limitations and conflicts

The NSW Law Reform Commission undertook a general review of criminal law and procedures that are applied to people with cognitive and mental health impairment in NSW, and reported that of all the young people under 18 years of age detained in custody in NSW, 87% have at least one mental health problem and 73% have two or more mental health diagnoses (New South Wales Law Reform Commission., 2012). Young people with mental illness are over-represented in the criminal justice system compared with the wider population, where 22% of the general population have a diagnosable mental health problem, while the total prisoner population in NSW experience mental health problems at a rate triple that of the general population (New South Wales Law Reform Commission, 2012). Ways forward to reduce this over-representation are not yet obvious and further work to address this problem has been called for by the NSW Law Reform Commission (2012). There does not appear to be a direct relationship between mental illness and crime for the young offenders. However, a number of additional ecological factors impact the full set of life circumstances for young people who offend, in particular their vulnerability is exacerbated by exposure to disrupted family backgrounds, family violence, abuse, misuse of drugs or alcohol, and unstable housing (New South Wales Law Reform Commission, 2012).

2.6.1 Police and justice preferences for diversion strategies related to young people with suspected and actual mental health problems

The stated goals of policing and justice are diversionary wherever this is possible; however, that requires a pre-existent platform of sophisticated referral mechanisms between justice, social and health services. Because of this, services are not always available or accessible, especially in rural regions, and so young people are not always able to engage with

diversional options, and therefore are detained in custody either because no other option is available to them, or because they have a history of offending (New South Wales Law Reform Commission, 2012). The average age for a young person with a mental health problem to be remanded in custody for the first time is 18 years of age and on average they will have had 15 police events recorded by that time, with the first occurring at an age of between 12-14 years, an age where the onset of mental illness is also most commonly noted (Kessler et al., 2005; New South Wales Health, 2012; New South Wales Law Reform Commission, 2012).

It is difficult for non-mental health professionals to identify emerging mental health problems, and this is especially challenging in the context of the criminal justice system. However, a mental health assessment service is available to some offenders who are fortunate enough to be dealt with by statewide Community and Court Liaison Court Locations (CCCLS).There are only 20 of these locations in NSW, with the service not available to the remaining 128 local court locations (New South Wales Law Reform Commission, 2012). The disparity of this service provision has been recognised by the Law Reform Commission, which has recommended an expansion of this program to all 148 local court locations (New South Wales Law Reform Commission, 2012).

2.6.2 Policing and health service management of unwilling young people affected by mental health issues

Police have powers to detain a person whom they believe to be mentally ill or mentally disordered, under the *Mental Health Act 2007 (NSW)*, and they can formally request that the person be admitted to an involuntary mental health facility. This mode of request for admission makes up 23% of all police requests for admissions to mental health facilities, however 26% of those do not meet medical criteria for involuntary admission to a mental health unit (New South Wales Law Reform Commission, 2012). This leaves a substantial number of people who may have a mental health problem but do not meet the extreme criteria for involuntary treatment, in the compromised position of not being able to access mental health help when it is needed, and at risk of reoffending and further complicating their offending track record (New South Wales Law Reform Commission, 2012).

Both the Law Reform Commission and NSW Health recognise that significant gaps in access to meaningful and timely mental health service provision exist for people with suspected

mental health problems and concurrent law matters (New South Wales Law Reform Commission, 2012). To date, health and law systems have been largely unable to address the gap effectively because human rights guidelines need to be adhered to in regard to involuntary care of people with mental illness. Frequently the only mechanism available to both health and law systems is to proceed with the justice process, and to deal with the offender from a legal framework without coercive mental health system measures or involvement (New South Wales Law Reform Commission, 2012). This is further complicated by a five year duration of lengthy deliberations by NSW Health, NSW Ambulance and NSW Police and their inability, to date, to agree on a memorandum of understanding in regard to the transport and request for admission to a mental health facility for people who are thought to be either mentally ill or mentally disordered (New South Wales Law Reform Commission, 2012). This state of disorganisation does nothing to progress reform of ways in which young people with mental health problems are treated in either the health or justice systems. A recommendation has been made to develop a resolution within a six-month period and to escalate the stalemate situation to the NSW Mental Health Commissioner to ensure an outcome is achieved (New South Wales Law Reform Commission, 2012). One example of an adverse event between health services and police services occurred in June, 2009, within the study region, where a young man with an acute episode of psychosis was fatally shot by police in the central business district of one community. The young man had attended the hospital earlier that day, and was not admitted to hospital as an involuntary patient under the Mental Health Act. He became of interest to police again during the day, and following a police chase on foot through the central business district, he was fatally shot by police. This incident demonstrates the vulnerability of young rural people with mental health problems in rural communities and the dilemma of mental health services and police in responding to mental health problems of young rural people.

2.6.3 Inadequacy of clinical decision-making based on risk assessment

Collaboration between the state Police, Health and Ambulance services in supporting people with a mental health problem to access appropriate care is ideal and fits neatly with the ideals of a '*no wrong door*' to seek mental health help that are aspired to by state and national Mental Health Commissions. However, there are significant limitations within clinical decision-making capabilities that need to be considered. In particular, no clinical risk assessment tools exist with adequate specificity, sensitivity and accuracy to predict harm to

self or others; for example, violence by people affected by mental health disorder or illness (Ryan, Nielssen, Paton, & Large, 2010). It is not possible to accurately conclude that commonly used current clinical assessment of risk investigations will be sensitive enough to predict which clients will need higher levels of resource-heavy interventions and restrictive care, and which people will require fewer and less expensive clinical resources and less restrictive care to achieve the desired safety outcomes (Ryan et al., 2010).

Ryan et al. (2010) reviewed the efficacy of the most commonly used risk assessment instrument, that is, the *Macarthur Violence Risk Assessment*, which is regarded widely as a valid instrument for use in the prediction of violence among people who are acutely mentally ill (Monahan, Steadman, & Robbins, 2005). Ryan et al. (2010) re-examined the data in the original study and found that the level of sensitively for accurate prediction was ambiguous and that it had very poor sensitivity in accurately detecting risk related to future violence. In fact, the sensitivity of the instrument produced 9% incidence of false-negative cases, where people were categorised as being low-risk and went on to commit violent acts to themselves or others in the 20 weeks immediately following the assessment (Ryan et al., 2010). Thus, 9% of mentally ill people who were considered to be 'low-risk' for harm to themselves or others were in fact 'high-risk'. These people will slip through gaps in service streams of all types despite having been provided with a clinical mental health risk assessment, because to date no instruments are available to sufficiently and accurately detect risk. However, they are in common use despite this paradox and despite an insufficient body of evidence to underpin the continued use of risk assessment to inform clinical decision making (Ryan et al., 2010).

Health services from an actuarial perspective are adverse to risk events and wish to be seen to be doing everything possible to reduce the risk of harm to people. The risk of homicide by a person with schizophrenia is 1 in 10,000 (Ryan et al., 2010). However, Ryan et al. (2010) have been able to demonstrate that, based on the fidelity of the most common risk assessment tool, if a usual risk assessment was conducted on every person with schizophrenia, that annually 4117 people would be detained for up to a year in mental health bed-based facilities because they would statistically achieve a 'high-risk' categorisation. Thus, in order to prevent one person committing a homicide, using the *Macarthur Violence Risk Assessment* scale, 4116 people would have to be detained perhaps needlessly (Ryan et al., 2010). However, of those people assessed as low-risk, 1 in every 22,421 people would in fact go on to commit

homicide (Ryan et al., 2010). The health resources and costs absorbed by keeping false-negative cases in hospital detract from the finances and recourses available to provide care to the low-risk cases. Some of the low-risk cases in fact require higher levels of care, but are not deemed eligible because they did not meet the 'high risk' categorisation at assessment (Ryan et al., 2010). The dispersal of health resources could be better allocated across broader mental health criterion, and improve support for the mental health care of more people if the use of clinical risk assessment was abandoned as having any role in the clinical decision-making process (Ryan et al., 2010).

Given the frequency with which young people with mental illness are involved in justice and policing matters, coupled with the lack of accuracy and sensitivity in detecting risk related to acute mental ill-health, it is evident that the difficulties related to helping young people with mental health problems who are also violent, and who do not wish to participate in mental health care, are significant and that little support is available. This perpetuates the problem of the high numbers of young people with mental health problems who are detained in custody in Australia. More research is needed to better understand how young people with emerging mental health problems can be helped earlier, so that fewer young people are subject to custody arrangements related to their mental health state. This study investigates ways in which young people with emerging mental health problems can be helped and supported with timely mental health care and this will be discussed further in subsequent chapters.

2.6.5 Parent-child violence in the context of emerging youth mental health problems

Rural mental health risk factors involving parent and adolescent relationships and the deterioration of those relationships are better understood than are the ecological factors that coexist within the family context. For example, family culture with its inherent internal attributes can either increase or inhibit mental health risk or vulnerability (Hong, Kral, Espelage, & Allen-Meares, 2012). It is important to understand the context of relationships between young people, their families and parents because an individual's behaviour is influenced by multiple environments, relationships and circumstances (Hong et al., 2012).

Hong et al. (2012) applied a socioecological framework to their review of international literature published between 1980-2010, which identified 30 studies that focused on adolescent aggression and abusive behaviour towards their parents. Their analysis found that mothers are more likely to be abused than fathers, while the risk for both was impacted by

adolescent peer influences, exposure to media violence and changes in the family structure (Hong et al., 2012). Mothers were also more likely to have their experiences minimised or dismissed by others and this discouraged them from seeking help or support about the situation (Hong et al., 2012). A limitation of the Hong et al. (2012) review was that the period of adolescence was deemed to be between 10-19 years of age; however, it is noted that mental health problems are most prevalent between 12-24 years of age and many mental health experts extend the period of developmental adolescence (or young adulthood) to a period between 10-24 years (Blows, 2011; Coughlan et al., 2013; Kessler et al., 2005).

In a qualitative research study in Taiwan about parent-child violence in the context of mental ill-health, Hsu and Tu (2013) conducted a phenomenological study that included in-depth interviews with a purposive sample of hospitalised young people who had been violent toward their parents of either gender. These authors found that in this context violence is repetitive and leads to emotional distress, and when violence is beyond controlling, danger to parents and young people increases (Hsu & Tu, 2013). They also discovered that when parents developed more experience with child violence, their management of situations improved over time, although parents reported that they did not feel as though they had sufficient knowledge or competence to either manage or resolve conflict in such a context (Hsu & Tu, 2013). These findings are congruent with the biological basis for human brain development during mid-adolescence, where emotional regulation and the identification of distress and emotion in others by adolescents has been described as ‘turned-off’ while the brain is undergoing intensive structural development in the learning and memory structural regions. Hence emotional control is less robust during this developmental phase (Blows, 2011).

2.6.6 Violence related to young people with emergent mental health problems

Internationally, and in Australia, it has been shown that there is a trend for young people with mental ill-health to occasionally become engaged in criminal and/or violent behaviour, with an onset of violent behaviour commencing as early as 13 years of age (New South Wales Law Reform Commission, 2012; Stoddard-Dare, Mallett, & Boitel, 2011). This average age of onset of violent behaviour coincides with the earlier age bracket for the onset of mental health problems for vulnerable young people (described previously in this chapter). The most common people to be subject to the violent behaviour of young people are their own parents

(Hong et al., 2012; Hsu & Tu, 2013). However, young people are also exposed to violent behaviour directed towards them in the context of their family, because of the heavy emotional burden of their distress and repetitive nature of violent outburst. Also, with parents known to respond with violence at times, the risk to both victim and perpetrator of violence in both child and parent directions will increase (Hsu & Tu, 2013). The ecological family dynamics for young rural people, and especially aspects pertaining to the mental health of young people, relate to the topic of investigation in this study. This will be further discussed in Chapter Five.

2.7 A rural context for mental health literacy and awareness

Improving mental health literacy in the general population has gained some popular and scholarly momentum. According to Wei et al. (2013) by improving the mental health literacy of the general population, health outcomes for people and communities will be improved. Wei et al. (2013) conducted a systematic review of the findings of 27 international trials of mental health literacy programs administered to 12-25 year olds. The aim of the review was to understand if mental health literacy programs enhanced knowledge of mental health, reduced stigmatising attitudes and improved help-seeking behaviours of young people (Wei et al., 2013). The results of the synthesis of the review indicated that the research designs of the studies included in the review were not sufficiently robust to demonstrate a positive effect of mental health literacy programs for this age group. However, nor were they able to demonstrate any harmful or negative effect (Wei et al., 2013). The authors of the review suggested that this was an emerging area of research that needed to be conducted more rigorously in the future to improve the level of evidence in regard to mental health literacy programs for young people. Once effectiveness is established, appropriate mental health literacy programs can be selected for evidence-based implementation for this age group (Wei et al., 2013).

2.7.1 Mental Health First Aid

Mental Health First Aid (MHFA) is a copyright licensed mental health awareness program developed in Australia to promote mental health literacy in the general population (Jorm, Kitchener, Kanowski, & Kelly, 2007). MHFA has been a successful international and national initiative, yet despite this success, only 1% of the Australian adult population have been able to complete the mental health first aid training program over the past 10 year period (Jorm &

Kitchener, 2011). It is similar to the familiar, established concept of physical first aid, whereby regular members of the public are trained to render assistance to other injured members of their community until professional help is available (Jorm & Kitchener, 2011). It is important to note that MHFA is defined as the help provided to a person developing a mental health problem or in a mental health crisis. The first aid is given until appropriate professional treatment is received or until the crisis resolves (Kitchener, Jorm, & Kelly, 2010). There are five steps to guide the implementation of MHFA and these are: (1) assess risk of suicide or harm, (2) listen non-judgementally, (3) give support and information, (4) encourage person to get appropriate professional help, and (5) encourage self-help strategies (Kitchener et al., 2010). It is anticipated that any person, regardless of vocation, once they have undertaken a 12-hour MHFA training program could render this type of assistance, in much the same way as a traditional first-aider could render basic life support assistance, until such time as professional help is available (Happell et al., 2014).

Many Australian adults and young people may have limited knowledge of how to respond if someone close to them is developing mental health problems or experiences a mental health crisis (Jorm, Blewitt, Griffiths, Kitchener, & Parslow, 2005; Jorm, Wright, & Morgan, 2007; Yap, Reavley, & Jorm, 2012; Yap, Wright, & Jorm, 2011). As a result, MHFA was developed to improve the knowledge of mental health problems in the general community, with the intention of overcoming the fear and stigma of mental illness, and to provide skills for people to initiate a response to promote the safety of individuals until professional help can be obtained (Happell et al., 2014).

Evaluations of the effects of MHFA training have produced positive findings (for example, Kelly et al., 2011; Kitchener & Jorm, 2002). Evidence from randomised controlled trials have consistently demonstrated that MHFA increases: (1) recognition of mental health problems (except when course attendees are able to identify problems, such as depression, prior to training); (2) the extent to which course participants' beliefs about treatment align with those of mental health professionals; (3) their intentions to help others; and (4) confidence in their abilities to assist others (Jorm, Kitchener, Fischer, & Cvetkovski, 2010). MHFA training also reduces the stigma associated with mental health conditions. Generally, the changes evident at post-test are maintained at six months (Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010). These outcomes have been demonstrated with a diverse range of audiences, including

people who advise and support farmers (Hossain, Gorman, & Eley, 2009; Hossain, Gorman, Eley, & Coutts, 2009; Hossain, Gorman, Eley, & Coutts, 2010) and rural support workers and community volunteers (Sartore et al., 2008). MHFA is effective when taught by one of its developers (Kitchener & Jorm, 2004) or by trained members of the public (Jorm, Kitchener, O'Kearney & Dear, 2004).

It is evident that MHFA has been useful in increasing mental health awareness among the public, and that there are some benefits that include a stronger bilateral public and professional conversation about mental health. MHFA trainees and some people requiring mental health care have been able to learn some of the language and vocabulary of the mental health professional; however, it is important that health professionals do not rely on this improvement for effective bilateral communication and understanding (Happell et al., 2014). Despite strong efforts to improve mental health awareness, there are still many people who will not easily be able to articulate the emergence of mental health problems, and who will require the particular help of skilled health professionals who are able to interpret their problems in a mental health framework (Aisbett et al., 2007; Happell et al., 2014 ; Lourey et al., 2012). The capacity of nurses to help young rural people with emerging mental health problems is investigated in this study and will be discussed further in later chapters.

It is particularly important that health professionals are able to interpret the mental health implications of a person seeking help, for whom the language of mental health is itself a barrier (R. L. Wilson et al., 2012). For many referrals, the registered nurse in an emergency department, or community/primary health centre, will be the first health professional that a person with a mental health problem or crisis will see, and the importance of this first encounter should not be underestimated. Registered nurses in these clinical settings should have a minimum set of skills that include (but are not limited to) an understanding of the therapeutic relationship, the biopsychosocial model of mental health, social determinants of health, risk assessment and management, physical and psychological treatment modalities, professional, legal and ethical issues, mental health service structures and a recovery approach all of which are reinforced and valued in a national mental health policy (Commonwealth of Australia, 2009; Happell et al., 2014; Mental Health Nurse Education Taskforce (MHNET), 2008).

2.8 Rural people and place

The dynamics of rural communities are changeable and respond to impacts such as environmental changes (for example, drought, flood, salinity, and/or climate change), mining operations and workforce dynamics, downturns in commodity prices, financial pressures with the lowering of land values and loss of productivity, export demands, FIFO workforce, population declines and the related fragmentation of social networks, farm amalgamations and corporatisations, as well as the limited availability of educational and employment opportunities for rural people (Farmer et al., 2012; Haslam McKenzie, 2013; Kilpatrick, Willis, Johns, & Peek, 2012; Speldewinde, Cook, Davies, & Weinstein, 2009).

The way in which people traverse the cultural geography of place is an important consideration as well. People develop habits in daily life as they go about their usual patterns of behaviour, work, and physical movements around the places in which they live and identify (Bissell, 2013). The habits they form connect them to places and they can move about and function with practical competence in their familiar environments (Bissell, 2013). However, as the environment, or components of their place changes, or as people are moved, or people move themselves to unfamiliar territories and places, people tend to lose some of the easiness and smoothness in regard to achieving their practical competencies that are applied to their usual activities, or habits of living, and the human connections that usually require little concentration to fulfil, are also diminished. With unfamiliarity, an awkward and pervasive restlessness develops and habits which are usually ‘second nature’ require more focused attention. Later still, a clumsiness develops related to navigating familiar life habits, when people are located within unfamiliar circumstances or places (Bissell, 2013).

The cultural geography of rural people and places can be considered in a similar way, because when the place is familiar and practical habits are formed that allow people to conduct themselves competently in their cultural place, a sense of mental wellbeing can be fostered. However, as changes occur, either internally or externally, a deterioration of practical competency can develop, and further so if a person is required to travel to unfamiliar places and access unfamiliar services to receive the supports they may need. It is therefore important for mental health service providers to consider how mental health support can be delivered in a way that supports and enhances the usual practical competence of rural people, and to minimise the ways in which services are provided that involve unfamiliar locations, places, or practices, so that vulnerability can be minimised, and mental health can be protected and not

further eroded (Farmer et al., 2012). Locally accessible services may be more likely to enhance the strengths and protective attributes needed for the timely recovery for rural people.

2.8.1 Rural social capital and social ecology

Social ecology has risen to prominence in health research over the past ten years, with a particular focus on social capital (Yang, Jensen, & Haran, 2011). The concept of social capital has been influenced by many commentators, while various strains of the concept have developed over time and have been applied to various situations. Rural sociologists have largely focused on perspectives that define social capital as connections among individuals – social networks and the norms of reciprocity and trustworthiness that arise from them (Putman, 2000; Byun, Meece, Irvin, & Hutchins, 2012; Yang et al., 2011). In combination, social ecology and social capital can be conceptualised as a feature of both social organisations and as a community asset (Boyd et al., 2008; Putman, 2000; Yang et al., 2011). In particular, social trust, help (volunteerism), social connection and cohesion have been identified as social capital attributes that are protective of mental health in rural communities (Allen et al., 2012; Berkman & Glass, 2000; Berkman, Glass, Brissette, & Seeman, 2000; Farmer et al., 2012; Yang et al., 2011).Thus, a form of mental health protective social capital within a framework of rural social ecology can be seen to be a subset of such social capital. From ecological and biophillic perspectives, an exploitation of the characteristics that make up social capital, especially those that form robust and protective mental health within rural communities, will enhance the environment in such a way that human thriving, wellness and productivity is achievable for most people at optimal healthy levels (Kellert, 2012; Krebs, 1985).

2.8.2 Social capital within rural families and schools

The social capital that exists within rural families and schools shapes the future aspirations of young rural people (Byun et al., 2012). Byun et al. (2012) conducted a large cross-sectional survey study utilising a stratified sample of 114 schools, 8,754 students and 667 teachers, in rural communities across 34 states in the United States of America. This was part of a larger nationwide study, and the authors investigated the relationships between social capital and the educational aspirations of young rural people. Higher levels of education are regarded as protective in regard to mental ill-health risks, and so the extent to which young rural people engage in educational opportunities is relevant to this topic and will be investigated in this

study. Byun et al. (2012) used a standardised definition of the term *rural* for the USA, which uses codes based on the location and distance travelled to services as descriptors, in much the same way as Australia does (Department of Health and Ageing, 2011), but they acknowledged the limitations in doing so, especially in regard to the people and place characteristics around occupations, incomes, ethnic composition, population density, isolation and access and diversity of school types across the rural sample communities (Byun et al., 2012). Byun et al. (2012) reported findings about rural families and educational aspirations from their research that are relevant to the present study because lower educational levels are sometimes associated with both rural communities and with increased mental illness prevalence.

Byun et al. (2012) identified that in addition to low expectations about health service provision and access, rural people sometimes also have lower educational expectations for their children (Byun et al., 2012). Rural communities experience difficulties in recruiting and retaining both experienced teachers and health professionals, and this combined with employment opportunities influenced by technical and agricultural sectors may influence the educational and career aspirations of rural young people (Byun et al., 2012; Conomos & Griffin, 2013; Fraser et al., 2002; Judd et al., 2006). Rural people tend to have a higher affinity for social cohesion and connection to people and place and so prospects of leaving the family and home communities to acquire higher education and skills are fraught with tension and conflict in regard to family, community and aspirational occupational goals.

Another finding of the Byun et al. (2012) study was that young rural people may be more inclined to stay within their community of origin and forfeit the opportunities that further education might afford for their futures in urban communities. Byun et al. (2012) found young rural people from stable two-parent families where strong bonds existed and where parents had higher levels of educational attainment, were more inclined towards higher educational goals for themselves (Byun et al., 2012). In addition they found that where mothers in particular, had higher levels of education, this factor further influenced young people, and adolescent girls were more likely to aspire to further education than adolescent boys (Byun et al., 2012). In contrast, the authors found that where family cohesion was weaker, and educational attainment of parents lower, aspiration for education and occupations were also lower for their children (Byun et al., 2012). These influences are likely to be important in

Australian rural communities also, and Byun et al. (2012) recommends further research to better understand the 'push' and 'pull' social influences that exist for young rural people so that future efforts can ensure that disadvantages for rural youth can be mitigated more successfully (Byun et al., 2012). The Byun et al. (2012) study was limited by its cross-sectional design, and a longitudinal study would be able to show whether the aspirations of young people were important in regard to actual attainment of education and future hoped for by them. An additional limitation was that education and family are only two social capital variables that influence the decision-making of young people, and while they are important, other factors such as community groups and friendships are also social influences that could be considered in regard to determination about future aspirations of young people. A wider array of social capital attributes elucidated in this study is reported in chapters four and five.

2.8.3 Mental health: Environmental adversity and land use conflicts

The region in which the study was conducted has been subject to a wide variety of environmental adversities and land use conflicts. Floods, fires, droughts, salinity, water use conflicts, mining rights, and farming land use conflicts especially in regard to fracking of natural coal seam gas under pastoral lands, have all been prominent challenges confronting the study communities. These adversities and conflicts have an impact on the mental health of rural residents because their livelihoods are impacted, and the ecological and human impacts of these factors need to be considered in regard to the appropriate use of health service planning (Factor, Awerbuch, & Levins, 2013; Larson, 2011; Morrice & Colagiuri, 2013).

Dryland salinity is emerging as an agricultural risk within some parts of the study site region for the research reported in the thesis, and some lessons can be learnt from a similar occurrence in rural Western Australia. One study, using a Bayesian spatial method including the triangulation of three data sets, health, population and environmental mapping, examined the psychological impacts of dryland salinity in agricultural zones and has demonstrated linkages between rural environmental degradation and the incidence of depression for people living in rural communities in southern Western Australia (Speldewinde et al., 2009). A rural region was selected for the study and environmental salinity maps were obtained for the region and analysed across their study period (Speldewinde et al., 2009). Population distribution data for the region was added to the map data showing the population during the study averaged 408,111 people over the 1996-2001 investigation period (Speldewinde et al.,

2009). Further statistical analysis revealed that across the same period of time 2669 individuals from postcodes in the study region were discharged from hospital following an admission to hospital for the treatment of depression and these were triangulated with the environmental mapping and population distribution data (Speldewinde et al., 2009). This study is one of very few studies that have explored the psychological effects of environmental decline generally and is the only study to explore the impacts of dryland salinity in agricultural communities in relation to the co-existence of depression (Speldewinde et al., 2009).

The insidious impacts of dryland salinity, that is, the rise of a salty ground water table, is increased as deep-rooted trees are cleared from agricultural areas to make way for productive agricultural landscapes that include shallow-rooted cropping. Farming practices and environmental management are also threatened by a long-term downturn in commodity prices and other environmental impacts such as drought. Thus, the economic impacts are also significant, and when combined with the creeping effects of salinity, are recognised as a vulnerability for mental health decline of residents because psychological distress is frequently associated with people's sense of place, while their relationships and lived experiences influence their psychological quality of life (Speldewinde et al., 2009).

A limitation of the Speldewinde et al. (2009) study was that it was only able to report on episodes of depression that led to hospitalisation, thus a true measure of actual morbidity was not able to be detected because it is likely that while many more people experience depression in the population, only a relative few of those people will require hospital-based mental health treatment. More frequently, depression is treated without the need for hospitalisation. The authors recognised this limitation. However, as their results were able to clearly show a relationship between the environment and hospitalisations for depression, they surmised that the actual incidence of depression would be higher than their findings were able to demonstrate (Speldewinde et al., 2009).

Additionally, the authors indicated that dryland salinity in agricultural regions of Australia is predicted to rise significantly, and their study indicates that a corresponding increase in depression among affected populations of people could be anticipated as well (Speldewinde et al., 2009). This represents an important forecast about the mental health vulnerabilities for rural Australia. A further limitation of this study was that it did not reveal any findings about

young rural people and how they might be impacted by environmental degradation. Further research should be conducted to understand these impacts because it is well known that the majority of mental illness first emerges before 24 years of age (Kessler et al., 2005).

A long-term downturn in the rural economy has been a challenging rural and regional dynamic for Australia over the last 30 years. Population shifts have occurred more recently that have seen coastal rural populations increase, especially with an influx of older wealthier retirees, while inland rural populations and economies have been in decline especially where wheat, sheep or beef have been the dominant farming practices (Fraser et al., 2002; Larson, 2011).

Rural Australia contains a diversity of people and places with location used as a crude universal criterion to describe rural communities in rural health policy (Fraser et al., 2002; Larson, 2011). Rural Australia is made up of much richer human components than just a series of geographical locations. The people and places of rural Australia are characterised by a diversity of socio-economic, cultural, environmental, industrial, agricultural and narrative attributes (Fraser et al., 2002). By contrast, health policy is designed to equitably disperse health service provision using measures that reflect population size, and distance travelled to services as core selection criteria, regardless of the characteristics of places and the people who inhabit them (Department of Health and Ageing, 2011; Fraser et al., 2002; Larson, 2011; R. L. Wilson, 2014c). As a result, it is difficult to mitigate the effects of rural mental health problems relating to rural adversity or conditions because the population sizes that require mental health services are not large enough to sustain local health service financial resources (Larson, 2011).

2.8.4 Vulnerability of young people in regard to mental health

The relationship between drugs and/or alcohol and psychosis has been the subject of health research inquiry for some time, and while it remains to be proven that cannabis misuse causes psychosis, there continues to be a pattern of dual problems that coexist with people who both experience psychosis and use cannabis (Dubertret, Bidard, Ades, & Gorwood, 2006; W. D. Hall, 2006; Henquet et al., 2006; Mental Health Council of Australia, 2006; Raphael, Wooding, Stevens, & Connor, 2005; Van Os, Henquet, & Stefanis, 2005). A Canadian qualitative study across five early psychosis intervention programs aimed to identify the characteristics that led to the initiation of drug or alcohol use for young people who were

enrolled in an early psychosis intervention program (Archie, Boydell, Stasiulis, Volpe, & Gladstone, 2013). Eight small focus groups consisting of 45 participants reported their experiences with drug and alcohol initiation, and these were thematically analysed (Archie et al., 2013).

The study found three dominant characteristics that explained drug or alcohol use among the participant group. First, a need for social connectedness and peer group ties; sometimes fitting into a group of friends required shared drug use experiences. Second, drug use was a coping mechanism to mitigate the distressing or uncomfortable effects of emerging or developed psychosis. Third, drugs alter perceptions and this was desirable because it enhances pleasure or creativity, whether real or perceived (Archie et al., 2013).

A longitudinal qualitative research study was recently conducted in Italy where 159 first-time help-seekers to an adult psychiatric service were interviewed using a validated assessment tool, *Structured Interviews for Psychosis-risk Syndromes (SIPS),* to understand if a history of disorders usually first diagnosed in infancy, childhood or adolescence predisposed individuals to an early adult diagnosis of psychosis (Comparelli et al., 2013). The study assessed retrospectively for disorders usually first diagnosed in infancy, childhood or adolescence, and also administered the *Brief Psychiatric Rating Scale (BPRS)* and the *Global Assessment of Functioning (GAF),* which are both common mental health assessment tools used in clinical settings. The structured interview data was gathered over a two year period and the results of this study indicated that people who had a history of a mental health disorder usually diagnosed in infancy, childhood or adolescence were three and a half times more likely to also experience a first-episode of psychosis, multiple episodes of psychosis or ultra high risk (prodromal) for psychosis (Comparelli et al., 2013).

The study concluded that impaired neurodevelopment may be a characteristic that first occurs in infancy, childhood or adolescence and that leads to consequences of future psychosis risk (Comparelli et al., 2013). In particular, the researchers noted that the element of disorganisation was most significant for participants who had both a history of disorder usually first diagnosed in infancy, childhood or adolescence and who also had developed psychosis (Comparelli et al., 2013). The implication of this finding is that the disorganisation that is usually observed in psychosis may not be exclusively diagnostic of psychosis, but rather has occurred due to an early neurodevelopmental failure, which shows a continuity of

element between early neurodevelopemental problems and later psychosis (Comparelli et al., 2013). Such a finding can be considered from an ecological perspective and thus it may be that where a threat to early development occurs for any internal or external reason, a threat to neurodevelopmental thriving also exists, with consequences delayed until later phases of the life cycle (Krebs, 1985). A limitation of the Comparelli et al (2013) findings is that the retrospective cross-sectional design of the study excluded a number of related dynamics such as the influence of wider social ecological factors that shape early human development. A range of ecological factors that relate to the psychological development of young rural people are discussed in the context of this study in section two of this chapter, and discussed further in Chapter Five.

2.8.5 Resilience in the rural community context

The connections and experiences of social cohesion that some rural people have with other people in their local churches or religions have been shown to offer some resilience and protection in regard to mental health (Hong et al., 2012; Kellert, 2012; R. L. Wilson, 2014d; Yang et al., 2011). The expressions of trust and reciprocity in these environments are thought to enhance social cohesion, and this serves to develop an asset of social capital in those subsets of the wider rural community (Boyd et al., 2008; Yang et al., 2011). Rural place and religious affiliation have been noted as protective of mental health, especially in regard to the health and safety of parents of young people with mental health problems and violent behaviours (Hong et al., 2012). Resilience is recognisable when attributes (such as those described above) contribute to the abilities that a human and/or environmental system has to absorb disturbance or adversity, and to reorganise while experiencing the changed dynamics such that adaption to the new circumstance occurs within the human and/or environmental system (Stokols, Lejano, & Hipp, 2013).

2.9 Rural mental health

Stoicism has been recognised as a rural characteristic and as a barrier to mental health help-seeking for rural people by many authors and researchers (Allan, 2010b; Boyd et al., 2008; Boyd & Parr, 2008; Campbell et al., 2006; Judd et al., 2006; Kilpatrick et al., 2012). Stoicism can be defined as a denial of, or suppression of emotions and an effort to apply self-control to strong emotions with an outcome of achieving coping and self-efficacy (Judd et al., 2006). Despite the recognition of this characteristic it has been largely neglected in research studies

and thus ideas about stoicism largely rely on assumptions that have been made over time (Judd et al., 2006).

Judd et al. (2006) conducted a cross-sectional community survey with a sample of 467 residents of a state border region farming community in northern Victoria and southern NSW, Australia. The purpose of the study was to examine the role that stoicism and self-efficacy contributed in predicting help-seeking by rural residents about mental health problems. The authors found that women were more likely to seek help for mental health problems, while for both genders, lifetime help-seeking for mental health problems were positively associated with higher levels of psychological distress and lower levels of stoicism and lower levels of self-efficacy (Judd et al., 2006). Judd et al. (2006) recommended that greater efforts should be made by clinicians to understand the stoic beliefs of rural people who are less likely to admit to mental health problems themselves, and to ensure that the mental health workforce alleviates barriers that may occur because of low levels of mental health literacy. The authors recognised that improving public mental health literacy had some benefits, but that this was not a universal solution for all people, and other barriers needed to be considered and mitigated as well (Judd et al., 2006). The authors identified some limitations for their study, including that only participants who had roadside mail boxes in the study site were invited to participate (Judd et al., 2006). It is the case that many rural residents use in-town post office boxes and so some potential informants would have been excluded from the study on this basis. The mean age of respondents in the Judd et al. (2006) study was 56 years of age, and so young rural people are underrepresented in their study. A further limitation of the Judd et al. (2006) study is that it was confined to statistical analysis and so the real life experiences and life stories about values and beliefs in regard to experiences of mental health help-seeking by rural people could not be fully explored. This study investigates the real life experiences of rural people in regard to their mental health help-seeking and in doing so adds new description of the rural help-seeking dynamic.

2.9.1 Rural respect, trust, values and credibility

Rural communities value and trust community groups and industry associations in their roles as facilitators of locally accessible mental health programs and other health initiatives (Kilpatrick et al., 2012; Kilpatrick & Wilson, 2012). Public health services frequently fail to demonstrate a coordinated strategy or an adequate understanding of locally conceived and

initiated public health promotion activities within rural communities. This results in a sending-in of misaligned mental health programs into rural communities, without recognising what had preceded it, what was most required in a specific community, and without sufficient partnership with industry and community stakeholders (Kilpatrick, 2009; Kilpatrick et al., 2012; Kilpatrick & Wilson, 2012). When this occurs, a rural positioning of distrust of outsiders is reinforced, and health change agency is compromised because the health promotion messages and health service delivery does not adequately resonate with the experiences of rural people, despite the well-meaning efforts of health service personnel who visit rural communities (Kilpatrick et al., 2012). Repetitive program instruments are administered but without fitting in with community preferences. In doing so, credibility and trust are diminished and so too is the mental health helping capital between health services and local rural people (Kilpatrick et al., 2012).

One way in which mental health helping capital can be enhanced is by utilising the informal and formal interactional infrastructures within each community, and by ensuring that a healthy community with a common purpose is established and maintained by a range of contributions from various stakeholders (Kilpatrick & Wilson, 2012). Boundary crossing champions in rural communities are individuals or organisations who have accumulated respect, trust, value and credibility across two or more sectors and because of this characteristic contribute an important source of social capital within their communities (Kilpatrick & Wilson, 2012). People who are boundary crossers in their rural communities have local credibility across two or more public, private, sporting, service, social, community, agricultural industry, business, education and/or health sectors and are able to broker appropriate mental health support within their communities during difficult times such as drought or other adversities (Kilpatrick et al., 2012). Targeted planning of formal mental health support services in rural communities requires an understanding of the informal interactional infrastructures that are unique within each community, so that social capital is captured to achieve desirable outcomes of community mental health and wellbeing. The interactions that occur within rural communities are best harnessed when champions of mental health are identified within communities and supported in their formal and informal dual roles within that community (Kilpatrick et al., 2012; Kilpatrick & Wilson, 2012). For example, churches; community service organisations such as Country Women's Association; industry organisations, such as New South Wales Farmers Association; school parent groups

and volunteer rural fire services have all been identified as groups that contain strong rural cohesions and social capital, and the individuals who make up these groups frequently have additional community or employed roles (Kilpatrick et al., 2012). Rural champions and leaders in organisations such as these, who are trusted and have attained credibility across a number of domains, are important collaborators for mental health service providers and planners because they provide access to the principal sites of actual health service provision in rural communities (Kilpatrick et al., 2012). These sites are not always the traditional health service provision sites such as hospitals, but instead can be clinics that operate at agricultural field days, rural tennis or football clubs, and other innovative places where people interact in rural communities (Kilpatrick et al., 2012). The concepts of rural trust, credibility and boundary crossing will be investigated further in this study and will be discussed further in Chapter Five.

2.9.2 Recognising a need for rural mental health help

Help-seeking for mental health problems requires that individuals are first able to self-recognise that a mental health problem may exist for themselves, and to believe that seeking some help to resolve the problem may be beneficial. Self-recognition is influenced by health beliefs, attitudes, values and the knowledge that people have about health and health services, along with their attitudes about the perceived helpfulness of any available services (Judd et al., 2006). Rural people in farming communities have been described as being reluctant to adopt a sick role because they believe that they should be able to cope with their own problems and that they should be able to find the inner resources to be self-reliant in regard to their own mental health (Fuller, Edwards, Procter, & Moss, 2000; Judd et al., 2006).

Rural people tend to rely more on family and friends for support rather than health services, because they see it as their responsibility to find ways to cope with their own mental health problems (R. L. Wilson et al., 2012). In particular, rural people are averse to taking time away from their vocational work for mental health problems because they define themselves as healthy if they can achieve strong outcomes such as productivity and work activity (Judd et al., 2006) whereas not working, and not being productive, is counter to their notion of health. Therefore, to be healthy one should try harder to work and be productive, and not less. These beliefs about health are barriers to early help-seeking by rural people for mental health problems. Judd, et al., (2006) found that when rural people recognised that they needed

professional mental health help, they were more likely to seek mental health help at local health service providers, and they considered there was less stigma associated with seeking local health service help for mental health problems than in seeking help with specialist mental health professionals and services.

Judd et al. (2006) also found that rural people were more likely to persist with mental health problems and delay their help-seeking until symptoms had become more disabling because they associated being able to work and being able to be productive as a definition of good health. Therefore, even if health problems exist but the person is still capable of working, then a threshold of ill-health has not been reached and thus no health care is warranted, until such time as a point of disability or inability to work is achieved, because not being capable of work is a definition for illness. This is a plausible explanation; however, a rival explanation is perhaps more practical, and that is, that where mental health care is not easily accessible within the local community, or where significant travel is involved in accessing mental health care, it can be very disruptive to the routine of farming or agricultural work to attend out of town health services (Larson, 2011).

The practical consequences of taking time away from farming duties for a day or longer may require negotiating practical farming help from other people within the family or community. For example, dairy cows need to be milked at regular daily intervals and the duty cannot be missed because of an absence of personnel to carry out the milking. Crop harvesting is another example; it is a time-critical agricultural priority that is vulnerable to weather conditions such as rain. If modules of cotton become damp from exposure to rain, and then later they are warmed during hot weather conditions, the spoilage of the cotton from either combustion or mildew will have devastating economic impacts for the producers because the commodity will have lost its value. Crops such as this are planned, planted and cultivated along annual timeframes, and so the economic risks are also significantly magnified because they represent yearly profits and annual income injections. These types of rural values and priorities need to be understood by mental health clinicians because they underpin decision making about other life priorities such as emerging mental health priorities, which might be seen as less urgent than important agricultural matters.

2.9.3 Time away from rural place, people, work and home

Time away from important and time sensitive farming duties has far-reaching consequences. Rural people are aware of these impacts, so it is reasonable to conclude that rural people develop attributes of self-efficacy and stoicism to mitigate a wider range of risks, of which mental health problems may be considered only one, and perhaps a minor factor, when a more holistic view is taken (Larson, 2011). In addition, the costs of travel, accommodation, and employment of replacement staff, if available, are significant barriers to seeking early health care for a mental health problem (Larson, 2011). Taken together, these barriers to help-seeking are likely to reinforce the health behaviours, values, beliefs and attitudes about mental health help-seeking because the challenges related to lower levels of stoicism and self-efficiency are unrelenting, and especially so if a view exists that early mental health intervention is not likely to be immediately beneficial to the recipient of mental health care (R. L. Wilson et al., 2012).

The findings of the Judd et al. (2006) study suggest that early intervention mental health services are not well aligned to the real life experiences of people in the rural agricultural sector who may experience emerging mental health problems. Some inroads towards improving mental health awareness in these communities have occurred, taking the form of grassroots community development using locally available social capital assets. There has been progress with the delivery of mental health first aid programs to the public in rural communities, and self-help initiatives have developed including support groups for farmers in some progressive communities (Jorm et al., 2004). These types of ventures have been promoted by para-professional groups, and community service sectors (for example, Lifeline, Aussie Helpers, NGO welfare organisations), with infrequent inclusion of the public health service sector. However, short projects to promote mental health awareness occur on a small scale with limited resources and personnel across large geographical areas.

The media has been proactive in recent times to promote mental health awareness to rural communities in the study region reported in this thesis; for example, the *Land* newspaper, and *ABC* local rural radio stations ("Glove box guide to mental health," 2012; R. L. Wilson & Fuller, 2013). Thus mental health awareness and literacy may be improving with the increasing exposure to various programs and activities. However, early access help-seeking opportunities and early intervention services for rural people remain largely unchanged and so

barriers to accessing appropriate and suitable mental health services for early intervention persist for this group (Larson, 2011).

It may be that an influence and social distance phenomenon exists within rural communities and that influential relationships are perceived to create additional barriers in regard to accessing mental health care (Lammers, Galinsky, Gordijn, & Otten, 2012; Larson, 2011). Health professionals, and especially mental health professionals, hold influential positions in the health care sector, whereby they can enforce decisions to invoke mental health treatment and detention of unwilling participants if they deem that use of the Mental Health Act is required to maintain the safety of a vulnerable person because they either have a mental illness or are mentally disordered. This authority is very potent, and mental health professionals should be aware of how it may influence the relationships they have with others in the community, their clients, and other carers. For instance, mental health professionals with some legislative authority may develop a mindset that positions them to feel less close to others, and especially to those who may require their help. Thus, a social distance is accentuated, which has the effect of repelling the people that they are required to help (Lammers et al., 2012). This affect may be further accentuated if a client has to travel to a regional or urban health service away from their local community because rural people report that they have greater confidence in their health and wellbeing if local health services are available to them (Larson, 2011).

Conversely, rural people are known to have a close social cohesion, and therefore experience of a sense of feeling close to others, and this sense of social closeness is associated with a willingness to help others when it is needed (Lammers et al., 2012). Thus, it may be that locally based rural mental health clinicians may have stronger social cohesion and a legitimate insider type of social power that has a stronger affinity for developing trust and a willingness to help others, such as with people seeking help for a mental health problem. Whereas visiting mental health clinicians from outside of the local rural community might be perceived as possessing an illegitimate social power that is more repelling in regard to building trust with people and achieving helpful outcomes (Lammers et al., 2012; Larson, 2011). So, where there are delays when rural people seek mental health help, these can also be explained by rural people fostering their own self-efficacy and stoicism which in turn promotes their propensity for self-sufficiency, and reinforces their perceptions of visiting mental health workers as

holders of illegitimate power, socially distant and uninterested in developing an alliance that might be helpful in mitigating mental health problems (Judd et al., 2006; Lammers et al., 2012). Thus, a perception can exist among rural would-be recipients of mental health care that doubts the usefulness of the professional 'outsider' help that is on offer (Judd et al., 2006; Lammers et al., 2012).

2.10 Rural nurses

Rural nurses are a unique form of social capital in the communities in which they both live and work, because they have dual roles within the community: formal professional roles as nurses employed in rural health settings and informal roles as community members who contribute to service, social and economic capital (Boyd et al., 2008; R. L. Wilson, 2007). Boyd et al. (2008) advocated for an asset-based approach to community mental health development that mobilises the mental health assets that are already contained within the rural community, such as nurses who live and work within the local community.

Nurses are the most numerous mental health professionals in all health settings, and in all geographical locations, and therefore nurses have a disciplinary responsibility to significantly influence the mental health status of the nation (Happell et al., 2014). The public should be able to anticipate a level of knowledge and subsequent mental health care by professional registered nurses that is of a calibre that exceeds that of a mental health first-aider, or of general members of the public (Wynaden, 2010). Nurses are a rich source of social and health capital in the communities in which they live and work, and they represent the bulk of health service delivery per capita across the 24 hour period (Boyd et al., 2008; R. L. Wilson, 2009). Clearly, the educational preparation that nurses receive to carry out this type of work should involve specific training, and this training needs to be beyond the limits of Mental Health First Aid (Mental Health Nurse Education Taskforce (MHNET), 2008; Wynaden, 2010; Happell et al., 2014).

The Mental Health Nurse Incentive Program (MHNIP) was introduced throughout Australia as part of a federal strategy in July 2007 to promote the integration of primary care and mental health specialist care, so that access to care for people with severe or chronic mental health problems could be improved in order to decrease the burden of illness leading to bed-based care of those people (Council of Australian Governments, 2006). The current iteration of the

National Action Plan for Mental Health has recognised the particular challenges of rural and remote settings in regard to the effective delivery of mental health services. It has called for consideration of how the current skills and talents of mental health nurses might be used to a greater extent in primary health settings. because their contributions have been shown to be effective in reducing the burden of mental health care (Commonwealth of Australia, 2009). The uptake of the MHNIP and the mental health care it has provided to people with chronic or severe mental illness exceeded the financial expectations for the program, which led to a budgetary freeze being imposed upon the program in 2012, despite its success in meeting and exceeding service delivery expectations (Australian College of Mental Health Nurses, 2013; Healthcare Management Advisors, 2012).

A qualitative study that interviewed 25 general practitioners and 19 patients about their views of the MHNIP was conducted in Queensland (Meehan & Robertson, 2013). The main objective of the study was to evaluate the reactions of the GPs and patients to the MHNIP. The GPs took part in focus groups and the patients were individually interviewed to ascertain their views about the effectiveness of the program. The data was content analysed and the study concluded that the mental health nurses collaborated with the GPs effectively and that in doing so, the primary care services for the people with severe or chronic mental health problems were enhanced (Meehan & Robertson, 2013).

In particular, Meehan and Robertson (2013) found that benefits existed for mental health clients and health service providers where mental health nurses offered co-located services with GPs. Mental health nurses were valued for performing interventions such as taking sufficient time to listen to the concerns of mental health clients, referring clients to appropriate other service providers when required, providing a communication linkage between service providers, and demonstrating care to clients especially in the context of a sustained therapeutic relationship (Meehan & Robertson, 2013). It was also important that the mental health care delivered by mental health nurses was provided in a general primary care setting because the setting was one that was non-stigmatising and familiar to clients, with the privacy advantage that it might appear to outside observers as though they were attending the health centre for any health reason, not necessarily a mental health matter. These were seen as strengths of the co-located program (Meehan & Robertson, 2013). Mental health nurses were able to develop a rapport in the local settings, which did not offer ‘quick fixes’ to clients but

rather provided time and space for clients to feel as though someone had heard them and connected with them in understanding their daily life challenges (Meehan & Robertson, 2013). Thus the mental health nurses were able to mimic the chance encounters that sometimes serve to bolster self-esteem, and shared understanding that many people without mental illness are able to use to share common human experiences, but which people with chronic or severe mental illness may not have available to them (Meehan & Robertson, 2013). The contribution of mental health nurses to primary care settings such as co-locations with GPs in rural settings is of direct relevance to this study. In particular, the care that mental health nurses deliver by paying attention and listening to the concerns of people seeking mental health help, and providing referral support where it is warranted, is further discussed in Chapter Five.

2.10.1 Clinical supervision for mental health professionals in a rural context

The professional development and clinical supervision available to nurses and other mental health professionals in rural communities is another important consideration. It is recognised that a range of professional support programs are required to enhance the delivery of health care generally (F. Hall & Bell, 2013; Robinson, Hills, & Kelly, 2011). Queensland Health has instigated a professional support framework, which is intended for implementation among all clinical staff employed by Queensland Health, as a component of their clinical governance program (F. Hall & Bell, 2013). Clinical governance in this case is recognised as the responsibility for developing continuous improvements in the quality and safety of excellent health service provision (F. Hall & Bell, 2013). Clinical supervision is a vital element of quality mental health service development, with some disciplines, for example, mental health nursing and psychology, indicating that it is a requirement for practitioners to maintain their clinical credentialing. Clinical supervision is a process by which clinicians undertake professional development to improve their knowledge, skills and attitudes so that they are best positioned to provide safe and excellent clinical practice (Robinson et al., 2011; White & Winstanley, 2011).

Queensland Health has described a model that can be applied to all clinical settings in any location. It is a resource and training strategy that is regarded as flexible, adaptable and transparent and capable of becoming a sustainable clinical supervision model to support clinicians. However, the outcomes of this strategy are still under investigation (F. Hall & Bell,

2013). The work to date indicates possibility for improvements that are likely to be equally applicable to other jurisdictions and that would be suitable for rural mental health clinicians in the study region of northern NSW reported in this thesis.

There are seven elements of the professional support framework described by F. Hall and Bell (2013): mentoring, peer group supervision, peer review, work shadow, in-service, journal clubs, and professional work are specific requirements. Clinicians are supported to self-identify their specific areas of professional support by selecting one or some of the seven elements that are pertinent to them as individuals and their level of practice, in consultation with their professional development planning program with management. The organisation supports professional development by undertaking to provide sufficient policy, training or resources, cultural change, professional support capacity, district planning and implementation and evaluation processes (F. Hall & Bell, 2013). In doing so, a commitment is made by both the clinician and the organisation to work collaboratively towards improvements in service provision, quality and safety (F. Hall & Bell, 2013). Incorporating a variety of professional supervision options enables individuals to maximise their professional developmental needs, and accommodates flexibility and adaptability in regard to the learning and support needs for individuals and their various work unit settings and sizes (F. Hall & Bell, 2013). Flexible professional development models that maximise choice and offerings to rural clinicians are important factors in supporting rural clinicians and in improving rural health service delivery and governance.

2.10.2 Internet-based clinical professional development

Health services and educational institutions consider internet-based modules of professional development education as a convenient and cost effective mechanism to address an identified need to enhance lifelong learning and professional development opportunities for rural mental health clinicians (Robinson et al., 2011). Robinson et al. (2011) evaluated a trial of a 24-week online mental health professional development and orientation program for clinicians in the north coast region of NSW. They conducted pre and post testing of 24 newly appointed multidisciplinary mental health professionals who completed the online program, to evaluate the effectiveness of the education and orientation program (Robinson et al., 2011). A total of 75 people initially registered to take part in the study, although only 24 participants were retained until the completion of the program. The attrition in the program peaked in the first

weeks, and the primary reasons given by program leavers related to a lack of human resources to release staff from their usual duties for the four hours per week required to complete the modules of study (Robinson et al., 2011). The findings of their study revealed that offering online learning programs is not a sufficient model of professional development resource delivery for clinical staff (Robinson et al., 2011). The high attrition levels in the program demonstrated the difficulty in retaining clinicians in internet-based programs, and more research is needed to understand why this might be the case (Robinson et al., 2011).

The authors proposed that rural mental health clinicians are not supported with adequate time away from clinical duties to fulfil the requirements of online learning programs; that clinicians have difficulty in accessing computers where learning programs can be accessed in their rural health employment settings; and that internet-based learning programs may not be a desirable format in which to participate in professional development for this population (Robinson et al., 2011). They concluded that the convenience of online and asynchronous program delivery is favourable in the rural mental health clinical context, and that while using the internet in this way to address the identified needs for professional support of rural mental health clinicians, they were not able to elaborate on any other characteristics that could adequately explain the high attrition rates in these types of programs (Robinson et al., 2011). Thus, despite the popular appeal and cost effectiveness of online learning programs in this context, it appears that they are not sufficiently appealing to the population for which they are intended to provide assistance, and the reasons for this need to be better understood so that professional development education for rural mental health clinicians can be better targeted to suit the needs of that group in the future.

2.10.3 Social media and mental health

R. L. Wilson et al. (2013) conducted a review of social media use in the health professional context in Australia. In particular, they discussed the use of Twitter as a tool for use by nurses, and they demonstrated that nurses are already active on Twitter as mental health advocates for community mental health promotion, and as mental health communicators in both public and nursing conversations in the Twitter environment (R. L. Wilson et al., 2013a). A discussion of social media use by nurses is relevant to this study because many rural nurses work in isolated or sole practice settings and lack meaningful professional conversations and support in their work settings. Social media can reduce the burden of distance and can assist

rural nurses to build professional networks that promote a health dialogue, and so the uptake of social media by nurses has been strong (R. L. Wilson et al., 2013a).

Social media, of which Twitter is an example, refers to a group of internet-based applications used to disseminate user generated content (Kaplan & Haenlein, 2010; Leavy, Rosenburg, Barnes, Bauman, & Bull, 2013). The use of mobile phones with the ability to connect to the internet (smartphones) is expanding rapidly (Kirmayer, Raikhel, & Rahimi, 2013; Leavy et al., 2013) with 75% of the developed world population using a smartphone (ICT Data and Statistics Division Telecommunication Development Bureau, 2013).

The internet is available across an increasing range of mobile devices, including smartphones, tablets, and laptop computers (Kirmayer et al., 2013). In Australia, as at December 2012, there were 12.2 million internet service provider subscriptions and half of those were wireless, while three quarters were household subscriptions (Australian Bureau of Statistics, 2013). In Australia, smartphones are very popular, with 17.4 million smartphone subscriptions and a continuing rapid upward rise in this trend (Australian Bureau of Statistics, 2013). The convenience and usage of social media in rural communities is relevant to this study because supportive professional communication can be enhanced if internet connected devices are readily available to rural mental health professionals and the wider rural population. This will be discussed further in Chapter Five.

In Australia, Facebook is used for social networking and has a high uptake among the population with 11.5 million Australian users as at April, 2013 (Cowling, 2013). Almost half of Facebook users are reported to log on at least daily (Australian Interactive Media Association, 2013). LinkedIn is similar to Facebook and at April 2013, it had 2.7 million Australian users (Cowling, 2013). However, it is more oriented to professional networking than social networking. YouTube, with 11 million Australian users, is mostly used to communicate messages in video format (Cowling, 2013). Skype is used for conference audio and video calls and as a result, it has a slightly different character to the other social media platforms. Skype user statistics are not generally accessible to the public, but commentators report that there are around 280 million global users and that daily use equates to 7 minutes of use per active Skype user (Mercier, 2013). All of these examples of social media present opportunities for rural people to interact with others outside their immediate communities, and this occurrence represents a component of digitally based social capital that can be

harnessed to improve the early mental health help-seeking environments for young rural people, their families, and mental health services, using communication pathways that are increasingly familiar to rural people. The digital aspect of mental health helping social capital is relevant to this study and will be discussed further in Chapter Five.

Social media represents the beginnings of a new era of communication and offers a platform from which health interventions and health communication can develop in the future (Kirmayer et al., 2013; Leavy et al., 2013; McKee, 2013; R. L. Wilson et al., 2013a). Innovative e-health practices have already commenced and will further develop in the future (Griffiths, 2013; Griffiths & Christensen, 2007; Kazemi, Cochran, Kelly, Cornelius, & Belk, 2012; Kirmayer et al., 2013; Leavy et al., 2013; Titov, Dear, & Rapee, 2013). For example, the Suicide Call Back Service (@SuicideCallBack) is a free counselling service for people thinking about suicide or those who are bereaved by suicide. The Twitter presence of this service provides a convenient access to counselling and health promotion commencing in the social media environment. In addition, social media offers an opportunity for nurses to develop a stronger political voice, and in doing so they can influence rural mental health policy (Gainous, Marlowe, & Wagner, 2013; NSW Nurses and Midwives Assocation, 2013; R. L. Wilson et al., 2013a).

There are some limitations to the uptake of social media by rural practitioners, with some people unsure of how to engage, or questioning if social platforms are trustworthy and sufficiently private. However, credibility in social media use by mental health practitioners is developing, with strong rural practitioner leadership in the digital domain (R. L. Wilson et al., 2013a). The capacity for health professionals to develop social media skills will be influenced by their personal willingness to adapt to change, while their uptake of digital literacy, the injection of the confidence required, and their success will be influenced by their engagement with the internet medium for social media (J. Smith et al., 2012; R. L. Wilson et al., 2013a).

Social media is here now and will continue to evolve (Griffiths, 2013; Kirmayer et al., 2013), but there is a pressing need to make good use of this iteration of social media to positively influence the health and wellbeing of rural people and rural communities through the action of nurses as clinical interventionists, policy informants, political agents and developers of new health knowledge and behaviours for the future (Kirmayer et al., 2013; Leavy et al., 2013; R. L. Wilson et al., 2013a).

The nature of social media has expanded to include professional conversations, and while social media has a number of limitations, it also represents extraordinary capacity to do some good, especially in the development of timely clinical conversations and the development of professional networks (Kirmayer et al., 2013; R. L. Wilson et al., 2013a). It is important for nurses to prepare themselves to be early adopters of change generally, because changes to work practices, policies, and evidence-based knowledge will continue to develop, and change will persist throughout professional nursing life (R. L. Wilson et al., 2013a). The early adoption of social media in particular represents many positive opportunities to promote mental health to communities and individuals using a unique and emerging new format (R. L. Wilson et al., 2013a). The willingness of nurses to adapt to change is relevant to this study because nurses contribute to the social capital of their rural communities and they are frequently boundary crossers with credibility and trust across domains other than nursing. Because of this, they are positioned well to identify change and to initiate positive change, including helping in the rural setting. Nurses' contribution to social capital will be discussed further in subsequent chapters.

2.11 Summary of section one

Section one of this chapter has provided an overview of current literature about rural youth mental health and the factors that influence the delivery of mental health help to young rural people when problems emerge. This section has identified the main issues within international and Australian contexts for youth mental health. The expectations and concerns of young people about engaging with mental health professionals have been discussed. The literature about the limitations and conflicts that exist in regard to the timely delivery of mental health care and concurrent legal matters have been explored. Specifically, the rural context and dynamics related to the mental health of rural people have been discussed in relation to rural people and place. Finally, rural nurses and their capacity to contribute to the mental health social capital of rural communities have been discussed. Boydell et al. (2012) recognised that there are gaps in the literature in regard to the interconnections between help-seeking and help-giving for young people, and their mental health and wellbeing. The research reported in this chapter has explored what is known about the help-seeking and help-giving experiences related to the emergent mental health problems of young rural people in Australia. Research studies reported in this section, in the field of young people's mental health, have

recommended that further research should focus on developing more understanding about the experiences of young people and more understanding of how to help them with mitigating early mental health problems sooner. The literature has demonstrated a need for additional research to contribute new knowledge to the rural youth mental health care field, and this study goes some way towards addressing some of the knowledge shortfall. The literature reviewed in this section situates this study in a relevant context and the results of this study are discussed in Chapters Four and Five.

Section two follows, and it will present an overview of the relevant literature in regard to the theoretical framework used as a basis for this study.

CHAPTER TWO - SECTION TWO:

Theoretical frameworks

2.12 Introduction

Section two of this chapter explains and provides justification for the theoretical frameworks selected for the research reported in this thesis. A theoretical framework provides a structure and a lens from which to explore a research topic and in which ideas can be organised logically and informatively, so that the boundaries for the inquiry can be reasonably established (Stokols et al., 2013). All research needs a foundation, and this foundation, whether implicit or explicit, is represented in the theoretical framework adopted by the researcher (Creswell, 2007).

Bronfenbrenner's (1986, 2005) bio-social-ecological systems model of human behaviour was initially considered as a potential theoretical framework for the research reported in this thesis. However, his nested and hierarchical approach to human development was excluded as a theoretical framework as it was not the most useful model for exploring the helping dynamics and social capital available to young rural people in this study. A flat and horizontal theoretical structure was seen as favourable in illuminating and understanding the meaningful relationships between rural people and their capacity to help. Bronfenbrenner's model and the notions of micro, meso, exo and macro systems that underpin his model have been challenged by others as well, and especially where a multi-systemic understanding of the person and their environment is required that accommodates equity across system relationships, as is the case with the research reported in this study (Ungar, Ghazinour, & Richter, 2013). A further limitation of Bronfenbrenner's model is that the notion of person is restricted to ideas that relate to developmental impacts within the environment, and while these are important factors, from a contemporary mental health care perspective, the notion of the centrality of person within the environment is critical, that is, a person-centred approach to mental health care is highly valued. Thus, a more flexible social ecological framework was adopted that was able to explore the environmental and human relationships specifically relating to the research problem, that of understanding how young rural people with emerging mental health problems could be helped so that the extent of their problems was mitigated.

A social ecological framework accommodates a broader range of human and environmental interactions and transactions with exchanges that are bidirectional and mutually influential, and that are able to deal with individuals, small and large groups, communities and organisations (Kilpatrick & Wilson, 2012; Stokols et al., 2013). Additionally, social ecological frameworks draw from a broad range of social and ecological influences and are well suited to accommodating perspectives from functional ecology, biophilia, social capital, and health in an effort to enhance social-environmental systems and improve health outcomes for peoples and environments (Stokols et al., 2013). A social ecological framework that drew from a functional ecological basis with applications to the social ecological context of mental health social capital was important to use as a lens for this research so that all of the relevant factors affecting young people's mental health could be properly considered. Thus, by commencing with a fundamental ecological lens and with filters for social aspects in particular, a logical progression was to funnel towards a social ecological framework to illuminate the social capital and especially the mental health helping capital availability and utilisation within rural communities. The logic of this process also aligns with the case study research design (Yin, 2009) used for this study and which is described in further detail in Chapter Three.

2.13 Ecology applied to rural young people and their mental health

The research reported in this thesis has used a theoretical framework that incorporates a functional ecological model (Krebs, 1985), and a biophillia framework that includes the affiliation people have for the environment (Kellert, 2012), as a means of understanding the influences of relationships and interactions upon the mental health of young rural people and their holistic development (Factor et al., 2013). From both functional ecological and biophilic points of view, it is not possible that young people are solely responsible for the outcomes of their own mental health during adolescent and early adulthood life stages. They have been subject to environments and influences during their lifetimes and in their communities that have either enhanced or detracted from their mental health development, or a combination thereof (Factor et al., 2013; Kellert, 2012; Krebs, 1985). Their resulting mental health function and robustness are influenced helpfully by the abundance of rich developmental opportunities, or adversely by the lack of them, and this background will have an impact on

the quality of mental health for individuals, groups, families and communities (Kellert, 2012; Krebs, 1985).

2.13.1 Person-centred mental health ecology

Poor mental health, and mental health risk or vulnerability, are related to the quality of the whole environment in which a young person with a developing mind and brain progresses towards adult human developmental maturity (Kellert, 2012). If the environment is overcrowded (as an example) it could be anticipated that the consequences for successful and healthy maturation could be compromised, just as it is in other species in natural world settings (Krebs, 1985). Or, another example, if the food supply is of a suboptimal quality to nurture physiological development within the brain during key developmental maturation phases, then it stands to reason that the brain will struggle to attain an optimal developmental potential (Krebs, 1985). A further illustrative example occurs if the brain is exposed to toxic substances in the environment, or if toxic substances are introduced to the body during sensitive brain developmental phases. Such contaminants, for example, drugs, cigarette smoke, or alcohol, can cause developmental harm and compromise optimal developmental maturation (Krebs, 1985). Thus, where the environment is poor, there is a natural propensity for dysfunction, illness and poor physical, mental and social developmental outcomes to occur or proliferate (Factor et al., 2013). The examples used to illustrate in this instance are phenomena that young rural people may experience during their development, and these examples demonstrate a real life vulnerability for rural young people that have mental health consequences associated with them.

While poor mental health may be examined as a stand-alone ecological process, this study has been designed to represent a holistic person-centred real-life experiential approach to understanding how young rural people's mental health circumstances might be improved. Thus, a person-centred mental health approach narrows the investigation so that final theoretical generalisations can be proposed that have specific resonance to young rural people, and enhances early mental health help acquisition during the emergent phases of mental health decline, and in doing so, specifically addresses the research question and aims for this study.

A biophilic perspective illuminates the data through a lens that can explore the affinity people have for interactions with their environments; for example, home, geography, place, social

relationships, connections and cohesions, which underpin both physical and mental wellbeing. Kellert (2012) has described biophilic values as the ways in which people gain meaning and benefit from the environment and how these values either detract from or enhance the physical and mental health and wellbeing of people.

People have a natural attraction to, and appreciation of, nature and the capacity to intellectually comprehend the complex natural environment with logic and reason (Factor et al., 2013; Kellert, 2012). This capacity to reason and understand the environment has safety implications. For example, people are averse to environmental factors that are threatening or that represent danger, such as animals that might consider humans as a source of food. In a similar respect, people are averse to climatic conditions that are too hot or too cold. These types of aversions are representative of mental health conditions also, such as developing a fear of environments and social conditions that may be harmful to mental health and wellbeing (Kellert, 2012). In contrast to the avoidance of harmful environments, people are likely to exploit environments and social relationships that enhance health and wellbeing. For example, harvesting natural resources for practical utilisation and other gains, and social relationships that are enjoyable and satisfying (Kellert, 2012). People also have an affinity to form emotional bonds and attachment with the natural environment and this particularly impacts on a sense of mental health and wellbeing, so much so, that people experience the desire to control the environment (Factor et al., 2013), or as Kellert (2012) describes it, to have dominion over the natural environment. People experience a sense of connection, meaning and purpose related to their experiences of the natural environment that provides a sense of spiritual connection to the world beyond one's self (Kellert, 2012).

Finally, Kellert (2012) suggests that the human affinity for the natural environment is so strong that it is symbolically represented in images, language and designs and that this too enhances a sense of wellbeing for people. With these core biophilic values as the components of a theoretical framework for understanding mental health and wellbeing, it is possible to illuminate the experiences of young rural people with emergent mental health problems from a unique perspective, and to better understand the complex context in which mental health decline occurs for them.

2.13.2 Theoretical lens for the social ecology and social capital theories

Rural social mental health helping capital is a subset of the social capital that is available in rural communities, and it is characterised by the way in which local rural people are able to support and resource each other towards meeting or improving the mental health and wellbeing needs of people who are vulnerable to mental health decline within their community (Allen et al., 2012; Boyd et al., 2008; Farmer et al., 2012; R. L. Wilson et al., 2012). This form of specific social capital builds a robust layer of protection and resilience, and offers a buffer for mental health vulnerability from a unique insider and locally embedded community resident perspective and position (Allen et al., 2012; Boyd et al., 2008; Boyd & Parr, 2008). Social dynamics are intrinsically woven into the experiences of emerging mental health problems in rural communities, and the research reported in this thesis seeks to explore the context in which mental health decline occurs. Thus, it is insufficient to explore causes of mental illness without also understanding the context in which it occurs (McDaniel, 2013). A health system that is limited to a traditional biomedical model of rural health care delivery will inevitably fail with a 'one size fits all' service delivery system because the cultural aspects that underpin the social capital resources, values, and beliefs about rural cultures are crucial in deploying a sufficiently diverse health service in rural communities (Farmer et al., 2012; Fraser et al., 2002).

2.13.3 Social ecology

Social context and social capital are fundamental aspects of social ecology, which can be thought of as the multidimensional structures of human environments that include biological, environmental and socio-political components across time and place (Stokols et al., 2013). Disruptions or threats to the stability of human social ecology create a condition of vulnerability towards adverse events and conditions (Stokols et al., 2013). In a mental health and wellbeing context, this circumstance provides an opportunity for mental health decline to accelerate. The research reported in this thesis has been designed to explore how help can be achieved when vulnerability for mental health problems emerges among young rural people, so it was important to consider how resilience might be nurtured, and helpfulness recognised, within the rural community and among the social capital and ecology available in the study sites. Resilience can be considered as a way in which adverse conditions can be absorbed and reorganised such that individuals, groups or communities can adapt, or be helped, sufficiently to maintain a normative function (Walker, Holling, Carptenter, & Kinzig, 2004).

Exploring the social, human and moral assets, or capital, contained within a rural community that can be directly applied to helping young rural people with emerging mental health problems is of direct importance to understanding the phenomena under investigation in this research study (Allen et al., 2012; Boyd et al., 2008; Farmer et al., 2012). The research problem has been investigated through a social capital theoretical lens that has enabled a full consideration of the relationships between people that enhance helpfulness, the capacities and skills that people have to provide help and the collective desire and resources of rural people to promote mental health help acquisition for young people (Stokols et al., 2013). The theoretical position for this research has its foundations in the broad overarching concepts of functional ecology which was further funnelled through a social ecological lens which enabled a close examination of social capital within the rural community of interest. This positioning facilitated an exploration of the mental health helping capital contained within the broader social capital in the rural community study region.

2.13.4 Pragmatism

Pragmatism, derived from the Greek word for action, is a philosophical movement founded in the late 19th century by American philosopher Charles Sanders Peirce (Shields, 1998). This work was later expanded by philosophers such as William James, John Dewey, George Mead and Arthur Bentley, who rejected traditional assumptions regarding truth, the nature of knowledge and inquiry (Gale, 2005; Shields, 1998). These early pragmatists proposed that ordinary experience was the key to understanding the world (Wolfe, 1999). In essence, pragmatism is viewed as a commonsense approach to research (Shields, 1998).

Pragmatism is driven by the idea of practicality. The researcher who adopts a pragmatist theoretical position looks for what works rather than collects data by ‘what works’ when addressing the research problem (Creswell & Plano Clark, 2007). In pragmatism the multi-stance approach allows the researcher to include both objective and subjective knowledge and recognizes them both as valuable to the research outcome (Creswell & Plano Clark, 2007). In the process of conducting the research, both quantitative and qualitative data are collected and mixed (Creswell & Plano Clark, 2007; Tashakkori & Teddlie, 2003). It is in the phase of integration that both approaches are enriched and differentiated from purely multiple method approaches (Creswell & Plano Clark, 2007; Tashakkori & Teddlie, 2003).

Given that the problem proposed in this research represents a practical problem that requires an answer, the use of a mixed method sequential explanatory design was proposed as the most suitable.

2.14 Theoretical propositions

This study was concerned to collect evidence and to develop theories and explanations derived from that evidence as an outcome of answering the research question and addressing the research aims. Final theoretical generalisations arising from this research are presented in the last chapter of this thesis. However, in the process of conducting this research a chain of logic developed and some earlier theoretical propositions were developed and rival theories were also considered. This circumstance demonstrates the rigour and integrity of the application of the case study research design to the investigation (Yin, 2009). The logical process was used to work inductively to explore the phenomena so that theory was able to develop and be ultimately useful to other people in similar circumstances, and so generalisations could be formed that explained the complexity of human behaviour, actions and beliefs within the study context (Gillham, 2000). It is logical to use a social ecological framework to explore the research question posed for this study. The framework is suited because it helps to describe the challenges that are specific to the experiences of young rural people and their capacity to obtain mental health help when problems emerge within their own communities.

2.14.1 Developing theory

An initial developing theory informed the early phases of this literature review and research investigation, which was expressed as a brief summary of an initial impression of the phenomena under investigation. That is, that mental health helping social capital already exists in rural communities; for example, in the form of registered nurses who live and work in rural communities, and in other forms of mental health help, for example, other health professionals, social and welfare professionals and paraprofessionals, and education professionals. Collectively these professionals should improve their understanding of the mental health help-seekers naive vocabulary and emergent characteristics, and in doing so, helpfulness might be achieved at an earlier point for young rural people.

The developing theory was not designed to be a sophisticated formative declaration, but rather a work-in-progress representation of the beginning of the investigation period. Further discussion in the next chapter provides a transparent account of the development of theory and the route of logic it has followed, and the authenticity within the research design further strengthens the development of trustworthy and reliable findings, in keeping with case study research design principles (Gillham, 2000; Yin, 2009).

2.14.2 Rival theories

As a further component of the early investigation and literature review period, rival explanations were considered in an active attempt to look for contradictory evidence so that the integrity of a full and comprehensive investigation of the phenomena could be achieved (Gillham, 2000; Yin, 2009). Two such rival theories were considered and are listed below:

Rival theory one: Rural young people and their families should improve their mental health literacy so they are more able to identify mental health problems and disorders. In doing so, they are more able to select an appropriate service from which to gain help. An example of this is the campaign to improve lay mental health literacy skills by encouraging members of the public to undertake training in the form of mental health first aid (Jorm et al., 2005; Jorm & Kitchener, 2011).

Rival theory two: It may be that mental health support can be adequately provided to rural communities by using externally-based sources of help, for example, e-health, telehealth, mental health telephone support numbers, FIFO and DIDO specialist clinics, GP clinics or paraprofessional support services from non-government and/or non-health sectors, for example, juvenile justice services (Haslam McKenzie, 2013; Jakowenko, 2012; Statewide telehealth services, 2013; Young & McGrath, 2011).

Both of these rival positions have been supported in the literature and are discussed in section one of this chapter, and have received a great deal of attention in the delivery of mental health strategy and plans for rural communities. This research is not attempting to evaluate the strength or validity of these types of service models but does recognise the current models that encourage the use of these types of health and community service activities. This research does intend to explore the limitations of these approaches by exploring the research problem through alternative theoretical frameworks that will illuminate alternative ways in which the

population of interest can be further helped towards achieving timely mental health care when it is needed. This research seeks to explore the problem from an alternative perspective, so that an increase in knowledge about the phenomena can be achieved and a more diverse array of helpful strategies can be identified, especially when the problem of delays in meeting the needs of young people with mental health problems continue to endure. The outcomes of this research identify additional mechanisms that can be applied to meeting the health demands of young people's mental health problems in rural communities.

2.15 Summary for section two

Section two has provided an overview of the literature that explains the theoretical framework for this study. In particular, it has provided a discussion about the use of social ecology as an appropriate framework to explore the emerging mental health problems of young rural people and it has explored ways in which social capital concepts can assist in understanding how mental health helping capital can be generated and promoted within rural communities.

2.16 Chapter conclusion

This chapter has presented and discussed literature that is relevant to understanding the important issues about rural young people's emerging mental health problems and the measures that have been taken to date to mitigate some of those problems. It has discussed some limitations among the current literature and identified gaps in knowledge that could be addressed to better inform mental health services, clinicians and rural communities about improving rural mental health in the future. The next chapter will outline the research design and methods used for this study, and Chapters Four and Five will go on to present the data analysis, findings and recommendations arising from this study.

CHAPTER THREE

Methodology

3.1 Introduction

This chapter describes the research design and the methodological approaches used to investigate the research problem identified in Chapter One. It commences with the identification of the research problem, a description of the significance of the study and then a justification for the research design, methods and theoretical frameworks adopted for this study. The research setting, recruitment and sampling strategies, data collection, and data analysis procedures are presented in two stages. Stage one describes the procedures for the survey component while stage two describes the procedures for the in-depth interviews component. The ethical considerations are identified and discussed, as are the measures taken to ensure rigour and trustworthiness of the study.

The research aimed to better understand the experiences of young people with emergent mental health problems who live in a rural area and to develop an improved theoretical perspective of rural mental health care that draws from the unique mental health helping capital that already exists within rural communities. As a result, the study seeks to promote and mobilise early identification and intervention (help) for emergent mental health problems that does not create a significant additional financial burden for rural health services.

The phenomenon under investigation is complex, with many variables and located in a particular geographical context. As a result of this, it is well suited to exploration using case study and mixed methods. The research question formulated for this study is:

What helps young rural people with emergent mental health problems?

3.2 Justification for the mixed method case study research design

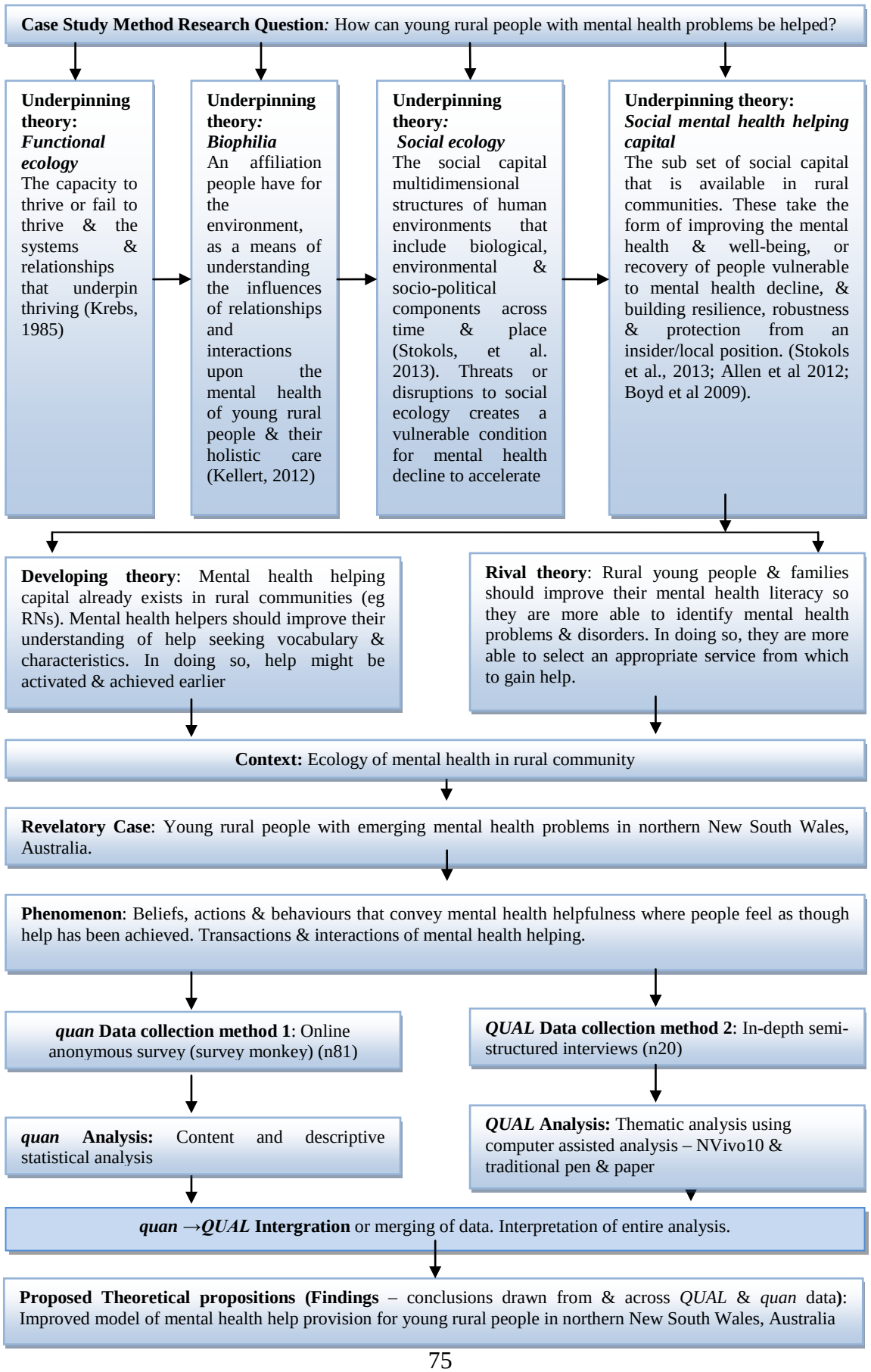
Case study research can be used in a variety of situations and is able to contribute to the holistic understanding of the real life events of individuals, groups and organisations, and their social or political dynamics (Gillham, 2000; Yin, 2009). A case study is a logical research investigation of human activity embedded in the real world and which can best be understood in the context in which it exists (Gillham, 2000). Case study methods allow investigators to explore the full meaning of phenomena in real life contexts; for example, developmental life cycles, group behaviours, family contexts, organisational systems, the processes and changes which occur in those environments over time and the success and failure of helping systems (Gillham, 2000; Yin, 2009). It is considered the most appropriate approach for this study because the real life phenomena of interest in this study are highly contextualised, with a variety of variables that are unsuitable for control or for measurement (Gillham, 2000; Luck, Jackson, & Usher, 2006; J. P. Rosenberg & Yates, 2007; Yin, 2009). Case study design is sufficiently flexible so that it is possible to explore rigorously the particular aspects of phenomena that were under investigation for this study (J. P. Rosenberg & Yates, 2007; Yin, 2009). In addition, the complexity of the phenomena under investigation required the consideration of a range of data and literature sources to adequately inform the investigation (J. P. Rosenberg & Yates, 2007).

It is most appropriate to consider case study as a research method when the research question is formed to ask ‘how’ phenomena occurs, when the focus of the research is on contemporary events, and when there is no intention to manipulate the relevant behaviours that comprise the contemporary events (Gillham, 2000; Yin, 2009). Questions that seek to address ‘what’ issues can be considered exploratory and can also be appropriately researched through case studies, though many other research methods could also address ‘what’ questions adequately. However, ‘how’, ‘why’ and ‘what’ research questions, in combination or independently, that seek to explore the holistic and meaningful characteristics of real life contemporary events within communities can be rigorously addressed using case study as an appropriate and valid research design method (Mantzoukas, 2008; Yin, 2009). The researcher wanted to understand and reveal how it is that rural young people with emerging mental health problems can be helped in the context of their contemporary local rural community. There was no intention to manipulate any variable, but rather to understand the meaningful, holistic and real life dynamics of help acquisition by, and for, young rural people within a specific geographical

region. Thus the research design is appropriately matched to the phenomena under investigation, and this contributes to the trustworthiness of the findings.

This study used a case study mixed method research design because the research question could be directly answered by engaging this method. In particular, three underpinning theoretical frameworks could be engaged within the context of understanding the ecology of mental health in rural communities, and the case of young rural people with emerging mental health problems who reside in the study region of northern New South Wales, Australia. The phenomena of helpful beliefs, behaviours and actions could be explored, and this was achieved by using two data collection methods: firstly, a *quan* survey and secondly, *QUAL* in-depth individual interviews. The data were analysed using *quan* and *QUAL* content, thematic and descriptive techniques. The findings were then integrated (*quan*→*QUAL*) and used to answer the research question and a logical process was demonstrated in so doing (Yin, 2009). Figure 3.1 illustrates the process used in a schematic form and shows how the boundaries were established so that the research question was specifically targeted (Cresswell & Plano Clark, 2003; J. P. Rosenberg & Yates, 2007).

***Figure 3.1*: Schematic representation of case study mixed method research model**



The findings from case study research that are derived from rigorously reported evidence are able to produce theoretical propositions (Yin, 2009) that aim to explain the phenomena that has been investigated. These are presented fully in Chapter Five of this thesis. It is possible to develop generalisations of theoretical propositions using the case study design, although it is less likely that statistical generalisations will be developed. However a mixed methods approach is possible using a case study design, and this has been achieved within this study (Flyvbjerg, 2006; Yin, 2009).

An important strength of the case study method is that it is able to include a wide variety of sources of evidence or data, including direct observations of the contemporary events under investigation, documents, and interviews (Yin, 2009). This was especially important for this study because it enabled the incorporation of a wide range of sources about the problem under investigation, including a review of the literature and other informative sources such as relevant live web sites, published health service telephone book entries, maps of health and other service provider locations and their advertised service menus. Thus, a contemporary description of the experience of searching for, and accessing mental health help within the geographical region of interest, was undertaken and included as data sources. These various information sources have been presented and discussed in the previous literature review chapter. Combined with the interview and survey data collected from individuals within the communities of interest, the sources added an authentic depth to the contemporary experience of gaining mental health help in a rural community. The flexibility of the case study method in this regard assisted in gaining rich data that included the holistic and meaningful characteristics of the phenomena under investigation (Flynn & Brockner, 2003; Flyvbjerg, 2006; J. P. Rosenberg & Yates, 2007; Yin, 2009).

It was appropriate to use a mixed methods case study approach for this investigation because it can be used to develop knowledge about individuals, groups, communities, organisations, and social and political environments (Yin, 2009). In addition, the case study method also allows investigators to explore the ecological and meaningful attributes of real life events using an organised chain of logic to understand the holistic dynamics of phenomena (Flyvbjerg, 2006; Yin, 2009).

3.2.1 Research setting and context

The mental health ecology of rural communities is the context in which this investigation is situated; the case is identified as young rural people with emerging mental health problems within the rural communities of northern New South Wales, Australia. The case for this study is a complex system surrounding and including the young rural people who experience very early mental health problems within the rural communities of northern New South Wales. These dynamics have not been described elsewhere, and so it is appropriate to examine this situation to better understand the complex interactions, characteristics and experiences of the people that make up this case. Informants for the case were drawn from community members of the northern New South Wales study site region (see figure 3.2), and included young people, their families, and the professionals who provided services to young people such as health, police, schools, and other non government organisations. Two groups of respondents make up the units of analysis in this study: survey respondents and in-depth interview respondents. The data from both groups have been merged to illuminate the case and context in such a way that the contemporary phenomena of mental health helping of young people in rural communities can be better understood, and it is these findings that are presented in the following chapter.

3.2.2 Mixed method design

This research has a dominant qualitative core as its theoretical drive. Notation abbreviations have been common to assist in describing the modeling for mixed method research, and it is usual to demonstrate the weighting for the dominant thrust for the research using uppercase letters and for the supplementary to be notated as lowercase abbreviation (Morse & Niehaus, 2009). The direction of the dominant aspect is also abbreviated usually by an arrow to denote a sequential model and for a plus symbol to show a simultaneous or concurrent component (Morse & Niehaus, 2009). For this research, a qualitative theoretical drive was dominant within a mixed method research design with a supplementary quantitative component (QUAL$\underset{\rightarrow}{+}$*qual)* (Morse & Niehaus, 2009). No hypothesis was used as the supplementary *qual* survey was designed to provide descriptive findings and used to inform the development of the interview protocol for the dominant QUAL data collection during individual in-depth interviews with participants. The data was analyzed separately and then merged to form the final study findings. This process is recognized by mixed method practitioners as a valid

process for conducting mixed method research (Creswell & Plano Clark, 2003; Morse & Niehaus, 2009; Nagy Hesse-Biber, 2010).

3.3 Research procedure

An explanatory mixed methods approach was adopted for this investigation that consisted of two stages and included the use of a descriptive cross sectional survey using an online anonymous survey instrument (SurveyMonkey) in stage one and semi-structured, in-depth interviews in stage two. Integration occurred by development of the interview questions from the survey results, especially interrogating any confusing or surprising results, followed by a final integration of both data sets in the final stage of the analysis. Thus, quantitative and qualitative data were collected and analysed using statistical, content, and thematic analytic procedures.

3.4 Setting

The geographical setting for this research was northern New South Wales Australia, in a region that can be described as the northern zone of the public health service district of Hunter New England Health, NSW Ministry of Health. Figure 3.2 shows maps that highlight the study regions. The communities in the study region are all rural and regional towns and villages with two regional larger centres, Tamworth and Armidale, as the larger service centres for the rural community. The dynamics, demographics, and service providers profile for this region were described in more detail in Chapter Two of this thesis.

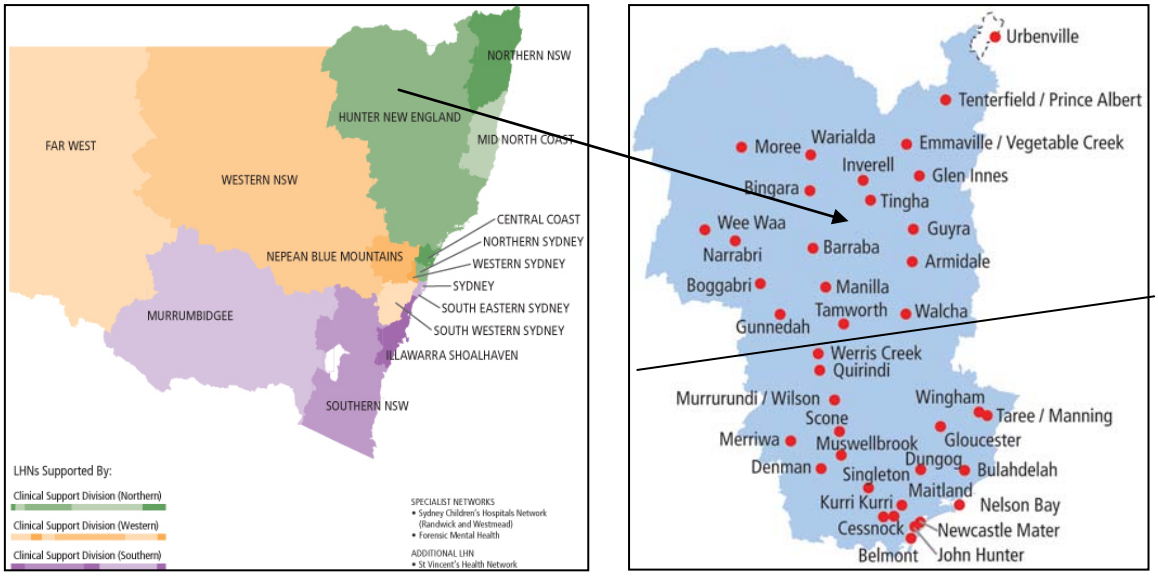


***Figure 3.3*: Study region New England, Northern NSW Australia**

Legend: Study site northern region of NSW Health Hunter New England Region: New England.
Map Source: Hunter New England Health 2013 http://www.health.nsw.gov.au/lhd/Pages/hnelhd.aspx

3.5 Recruitment and sampling strategies

3.5.1 Social media and email lists

Recruitment of participants in this study was achieved using purposive electronic recruitment strategies, and further snowballing occurred from the primary recruitment strategy, where interested participants contacted the researcher directly having heard about the research from an intermediary source who was able to provide the interested prospective participant with the contact details for the researcher. The researcher planned to advertise for recruitment among key informant groups utilising social media, email lists and electronic newsletters as a first phase of a recruitment strategy. A second phase would have included traditional print, vision and radio media release recruitment if required to obtain sufficient participant numbers. However, the first phase of recruitment was extremely successful and yielded sufficient numbers of potential participants, so there was no need to proceed to a second phase using the more traditional media recruitment strategy. If it had been needed, a media release was designed for dissemination across rural voice, print, and vision media agencies to inform the rural community about the research study and to invite participants to share their journey of mental health help-seeking, or giving, in rural communities. This deliberate use of media has

been successfully undertaken before by the researcher when examining the barriers to early identification and intervention of early psychosis among young rural males (R. L. Wilson, 2009).

Digital social media such as Twitter was used to invite interested people to contact the researcher via email, direct message or telephone to volunteer to participate in an interview and/or to complete an anonymous online survey. Hot web links were embedded in these digital mediums, so that when activated, they redirected the potential participant to a specific web-based information page about the research project. An ‘accept’ or ‘decline’ option was used to either allow anonymous non-participation, or informed and consented anonymous participation in the online survey.

Yin (2009) suggested that high-quality analysis requires that all of the possible evidence is collected and then considered. A threat to the inclusion of important evidence is a poorly designed web experience for potential participants (Gillham, 2007). To reduce this risk, participants were provided with a maximum ‘three clicks’ of the mouse experience to activate the online survey, which was aimed at promoting prospective participants with motivation to proceed, limiting drop-out of potential participants, enhancing response rates and therefore strengthening the availability of evidence for inclusion in the study (Gillham, 2007).

3.5.2 Sample size

The online survey instrument yielded 81 responses and 20 individuals participated in the in-depth interviews for this study. The survey sample size was determined by monitoring the postcode distribution and the content of responses. Meetings were held between the researcher and her supervisors to consider the data during collection and a decision was made that the content and geographical distribution of respondents demonstrated equitable voice for all groups identified in the survey content, and these discussions also led to the development of consensus about common themes during the preliminary data analysis phase. The 81 responses received in the survey were considered to have sufficient geographical distribution and the content revealed common themes, so data collection ceased. In-depth interviews continued until no new information was forthcoming and data saturation occurred with 20 individual interviews collected.

Rural NSW has the fewest nurses per 100,000 population in Australia; more specifically, based on an average for registered nurse full time equivalent (FTE) employment in regional NSW, there are likely to be 360 FTE registered nurses employed in mental health roles in the study region (Health Workforce Australia., 2013). Given the small numbers of nurses, combined with a small general population size of 200,000 it was considered reasonable to have a small survey response sample, and that other relevant factors such as the equitable spread of groups and locations also needed to be considered so that despite a small sample, a breadth of relevant responses were represented.

3.5.2 Inclusion and exclusion sampling criteria

A participant selection screening tool was used to selectively include:

- Adults older than 18 years of age. This research was specifically designed to explore the experiences that relate to young adult emergent mental health problems. Therefore children were not included in this study.
- Adults who had no current Mental Health Act orders in any state or territory of Australia.
- Adults who were willing to allow the digital voice recording of interviews (where they agreed to an interview).
- Both males and females were included.
- Only adults who spoke English.
- Adults who currently, or in the past, reside/d in a rural location.
- Adults who had some experience seeking, or giving, mental health help in any capacity because people with these experiences were likely to be able to provide information directly related to answering the research question for this study.
- And/or a willingness to complete an anonymous online 12 question survey regarding one's personal experiences of gaining help or providing it to a young rural person who, at the time of the study, had problems that might include a difficulty in thinking logically, behaving appropriately, or expressing emotion effectively.

The literature suggests that females are more likely to discuss mental health issues than are males (S. P. Rosenberg & Hickie, 2013). Therefore, it was anticipated that more females than males would participate in this study, and this occurred. The data is presented in Chapter Four regarding this demographic. It was also anticipated that the females who participated in the

study would provide help for either males or females equally, thus their experiences of caring for either gender may be reflected more evenly across the study. The gender distribution was considered, and no further efforts were made to gain more male participants, consistent with other investigations about similar topics. Furthermore, the researcher believed that the number of nurse participants in this study would reflect the gender ratio of the nursing workforce, so it was anticipated that more females than males would be likely respondents to this research.

Mental health problems are distributed relatively evenly across both genders, with the only distinction being that males are more likely to experience psychotic spectrum disorders, while mood disorders are more prevalent among females (Kessler et al., 2005). This research was not designed to explore the gender distribution trends of disease, but rather the human experiences of helping people with mental health problems. The research design was chosen to explore human experiences of either gender, and the imbalance of the gender of the participants is not likely to weaken the findings of this study.

3.6 Stage one: Survey

A survey was developed based on a modified version of a survey tool that had previously been successfully used in a rural Australian setting (Boyd et al., 2011). The Boyd et al. (2011) survey instrument was developed to identify barriers experienced by young rural people in relation to accessing mental health services. After consultation with the author of the original paper-based survey, an online survey instrument was adapted for use in this study with the express purpose of identifying factors that might help young people access mental health help in their local community, especially during the emergent phase of the problem, and to understand how local nurses might be perceived as a component of mental health helping capital in these communities.

The modified survey instrument (see Appendix 2) was developed and administered between May 2011 and May 2012, using SurveyMonkey, a web-based online survey collection tool. A web link was generated and this was embedded into social media (Twitter and LinkedIn), and into emails to relevant email lists such as mental health and family health clinicians and health services with membership within the study region. Specifically, Hunter New England Health, NSW Health, former Barwon Division of General Practice, former New England Division of General Practice, former Peel Division of General Practice and the email list for the

Australian College of Mental Health Nurses (nurses@acmhn.org.au). Since that time, the three divisions of general practice have amalgamated and are now known as the New England Medicare Local.

Twitter was an especially responsive component of the recruitment strategy. The survey web link was combined with the hash tags #RuralMH, #Rural, #Nurses and #MHNurses #NewEngland, which ensured a focused distribution within specific feed themes. The tweets for this study were retweeted beyond the researcher's network of followers, and thus the digital footprint for the invitation to participate was extended beyond the researcher's own network.

The researcher had an established professional Twitter account that had been developed 12 months prior to the commencement of the research, and therefore was not exclusively for the conduct of this study. Rather, it was developed as a mental health professional social media site so that the researcher could develop a professional network largely made up of other mental health professionals and rural professionals. The Twitter profile clearly identifies the researcher as a Mental Health Nurse (@RhondaWilsonMHN) and includes a brief biography describing the account holder in generic terms as an active 'mental health nurse academic, clinician and researcher'. During the period of the survey, the profile had 450 followers and these followers were the recipients of short (140 character) microblog messages known as 'tweets', which included an invitation to view the survey link and participate in the research.

Some Twitter message recipients, for example, #CAGNSW (NSW Consumer Advisory Group) and NSW Farmers Association, made an unsolicited decision to include the web link about this research, and an invitation to participate in the research, in their own newsletters (both print and digital). The researcher was aware of this and appreciated the enthusiasm of various community groups to encourage their members to consider participation. This snowballing effect enhanced the recruitment effort.

3.6.1 Stage one: Survey instrumentation

Questions were structured in both closed multiple choice and short answer formats. This was suited to the research design so that both descriptive statistical analysis and content analysis could be conducted with the data (Hsieh & Shannon, 2005). An option was provided to leave their contact details if the respondent was willing to be contacted by the researcher to take

part in a further in-depth individual interview about the topic. The survey was expected to take participants approximately 10-15 minutes to complete and could be navigated quickly; hence, strong engagement with available and willing participants was promoted (Gillham, 2007).

3.6.2 Stage one: Data collection method

Participation in the research involved completion of an anonymous online 12 question survey about one's own experiences of gaining help or providing it to a young rural person who, at the time of the study, had problems that might include a difficulty in thinking logically, behaving appropriately, or expressing emotion effectively.

3.6.3 Stage one: Survey pilot study

The survey instrument was piloted and trialled prior to administration in this study, and the feedback received from those people assisting with the pilot study provided an opportunity to refine the set and type of questions. The nine participants selected in the pilot also met the study inclusion criteria for participants, and thus a simulation of the actual survey experience was achieved (Gillham, 2007). The pilot data was not used in this study because the most important feature changed following the pilot was the selection of web based software, and so the pilot googleweb data and instrument were permanently deleted after full consideration of the pilot study results. The survey proceeded using a purchased premium account with SurveyMonkey web based software (surveymonkey.org). The questions required minor modification only, because the pilot revealed that the questions were sufficiently refined to yield data responses that could be used to answer the research question for this study.

Following collection of the pilot (n =9) and actual (n =81) surveys, Pearson's correlation equations were conducted to assess the similarity between the two sample data sets. Pearson's correlation was selected because it is useful in assessing similarity between two separate data sets which ask the same questions to different sample groups. A strong or moderately strong positive correlation was found between the data sets for all questions ($r > 6$), except for one question about the age range of participants where a weak positive correlation was revealed ($r = 0.3$). The survey was considered valid and reliable based on the predominantly moderate to strong positive correlation findings between pilot and actual data sets and this demonstrated the reliability of the survey instrument.

3.6.4 Stage one: Survey data analysis

Survey data were analysed using both quantitative and qualitative techniques. SurveyMonkey was used to manage the data, and analysis of the data was conducted using Microsoft Excel spreadsheets and software. Quantitative descriptive data analysis was conducted with the quantitative survey data and the results of this analysis describe the case under investigation. The types of descriptive analyses conducted included percentages and distribution of mean averages, and the results are presented as graph figures in Chapter Four. No other tests on variables were attempted because the dominant drive for the research was QUAL→ *quan* and so a clear intention was to gather *quan* data which was supplementary and analysed separately from the core QUAL data but which later had an interface where the data of both the QUAL and *quan* were incorporated into the findings (Morse & Niehaus, 2009). Further content analysis was conducted on the qualitative data contained in the survey data.

3.7 Stage two: In-depth interviews

3.7.1 Stage two data collection method: In-depth interviews

Participation in stage two of the research involved completing an individual digitally voice recorded in-depth interview of approximately one hour's duration, during which the participant provided their own views about gaining help or giving help to a young rural person who had problems that might include difficulty in thinking logically, behaving appropriately, or expressing emotion effectively. In accordance with a mixed method approach, the interview questions for this phase of the research were driven by the answers from the cross sectional survey. For example, an interview question that approached describing preference for accessing mental health help by young rural people was used to clarify responses about seeking mental health help preferences in the survey (Braun & Clark, 2006).

The interviews were held in locations that were negotiated with the participants, and were selected at times and places convenient to the participants. All interviews were preceded by a discussion about the nature of the research. The participants were provided with a hard copy of the Information Sheet for Participants (refer to Appendix 3) prior to the interview and they were given an opportunity to ask any questions they might have in relation to the research. When the participants were satisfied that they understood the nature of the research sufficiently, and the implications of their participation in the research, they were asked to sign

duplicate Consent Forms (refer to Appendix 3) prior to the interview with one Consent Form given to them for their personal files. The researcher gained the participants approval prior to commencing the audio recording of the interview. The researcher informed the participants that they could withdraw their consent at any time without prejudice or penalty. They were also directed to mental health assistance if they felt that they needed to talk to someone following their participation in the research. No participants withdrew their consent over the course of the research and the researcher is not aware of any participants accessing mental health services as a consequence of the interview experience.

At the end of the interview, the researcher thanked the participant and offered to send them either a digital voice file or a transcript of their individual interview. However, they were not required to receive these if they did not wish to have a copy. In some instances, it will add rigour to the research process if participants review their transcript and confirm that the meaning they conveyed is as they had meant it (Buchbinder, 2011). However, according to Buchbinder (2011), it is not always necessary and the real life experiences of people can often be conveyed in a single interview without the need for validating the interview, as some people find the validation process tedious, and as though they had not been heard adequately in the first instance (Buchbinder, 2011). Offers were made to participants for them to view their individual transcripts of their interviews, however, none agreed to review their transcripts.

3.7.2 Stage two: In-depth interviews pilot study

Semi structured in-depth interviews were conducted with participants who volunteered to share their personal experiences of helping young rural people with emergent mental health problems. A pilot interview was conducted, transcribed, analysed and discussed with the researcher's supervisors. A decision was made to continue without any alteration to the research design for interview data collection because the pilot data was able to adequately target the research questions, and it has been included in the complete data set for this research.

3.7.3 Stage two: In-depth interviews data collection procedure

A single question was asked of all participants to commence the interview and then a conversation was allowed to develop naturally from that point so that the participant was free to share their real life experiences about the phenomena under investigation. The question was

designed to initiate a discussion with participants about what steps they take to gain early mental health help when they recognise that mental health problems are beginning to emerge for a young rural person. Thus, the interview was guided by the following initial question to each participant:

You mentioned that you have some experiences of getting help for a young person with a mental health problem. Can you tell me about those experiences?

Participants were interviewed at a place and time of their choosing, and in all cases the interviews were digitally voice recorded and later transcribed verbatim for analysis. Each interview was conducted over approximately one hour's duration. There were no incentives offered to any participants; however, beverages (tea or coffee) were provided for face-to-face participants.

Two participants preferred to visit the researcher's university based office to participate in face-to-face interviews, and these occurred at times of mutual convenience. Two participants asked the researcher to visit them at their home for a face-to-face interview. Six participants preferred the researcher to visit them at their workplace in a private room for a face-to-face interview. Eight participants asked for a telephone interview and one participant requested a skype interview; these where conducted from the researcher's private workplace office with the door closed and signed with 'do not disturb, interview in progress', and using a hands free speaker so it could be digitally voice recorded. The researcher described this in detail to the participant so that they were assured of their privacy during the interview. One participant chose to be interviewed in a cafe setting and a quiet and private place in an outdoor courtyard was selected by the participant as the seating arrangement. There was sufficient privacy in this setting, and the time negotiated was not a peak customer period, so a good quality voice recording was achieved. All participants were able to be provided with an interview experience of their choice.

Twenty interviews were conducted before saturation of the data was achieved with common themes arising throughout the data and no new information forthcoming.

3.7.4 Stage two: Transcription of interviews

Initially it was planned to enlist a research assistant to transcribe the interview data to enhance the effective use of the researcher's time. However, it became apparent from the first

interview that the interview material contained very sensitive topics, which frequently raised issues about violence or fear of violence and domestic violence, sexual abuse, the detail associated with death by suicide, other deaths, and drug use. The research question asked participants about their views of how young rural people could be helped if it was suspected that they might have early mental health problems. In answering this question, participants frequently described experiences of young people who had not reached the threshold of receiving meaningful help. As they described this real life phenomenon, they provided the researcher with a glimpse into the lived experiences of some young rural people and their families, and this included the unfettered dialogue about some of the profound difficulties and problems that they encountered.

On some occasions, incidents that were horrific to the researcher were reported in a matter-of-fact manner about the events that had taken place. During very early analysis of the data, it became evident that the voice recorded material contained information about trauma of various types and that its sensitive nature could result in vicarious trauma for a transcriber.

The researcher is an experienced mental health nurse, who regularly participates in clinical supervision, and based on both this and her advanced mental health nurse practice background, she is professionally prepared and equipped to manage the vicarious impact of human stories of distress and discomfort on herself. The researcher recognised that in conducting this type of research and in hearing the real life narratives of the participants, that emotional labour was inevitable. In this instance, the researcher decided that the data content was especially challenging, and took the view that a research assistant who was solely engaged in transcribing the interview data may be at risk of experiencing vicarious traumatisation as a result of hearing these narratives. Therefore, a decision was made not to engage a transcriber. As a result of this decision, the transcription of all voice recorded interviews was conducted solely by the researcher. An advantage of conducting all of the interviews and transcribing all of the data was that the researcher was better able to undertake reflective analysis of the data on many occasions throughout the analysis phase. This served to strengthen the thematic analytical processes. The researcher was able to be familiar with the data at every point of collection, transcription and analysis and this enriched the analytic process.

The logical chain of evidence required in case study research design (Yin, 2009) was evident because analysis occurred as a continuous and uninterrupted phase. It covered the period during recruitment of each participant, ensuring that they met the inclusion criteria, the setting up of interview appointments, conducting the interview, post interview reflection and writing diary notes, listening to digitally recorded interview, transcription, analysis and initial coding of data, re-reading and re-listening to interviews, uploading data into NVivo10, thematically coding, reading and listening to the data within the computer based software analysis tool, and integrating the key data of each interview into the broader results from both the other cumulative qualitative interview data and the descriptive quantitative survey data.

3.7.5 Stage two: In-depth interviews data analysis procedure

Qualitative data were collected and analysed using thematic analytic procedures. The data for this research was thematically analysed using two rigorous processes to strengthen the trustworthiness of the study. First, a traditional manual pen and paper thematic analysis was conducted for all of the transcribed interviews. Second, the original interviews were uploaded into NVivo10, a qualitative computer assisted analysis software program, where thematic coding took place with hierarchies of trees and nodes being formed to reveal common themes across the transcript data sources (Braun & Clark 2006). The results from both processes were then reviewed in a meeting between the researcher and her supervisors. The results were found to concur, thus strengthening the analytic processes and improving the credibility of findings from this study.

3.8 Reflective journal and research log

The researcher has practised nursing in the areas of mental health and addiction in rural settings for many years, and she was aware that she came to the research topic with a wide range of clinical experiences. The researcher was aware that this experience would inform the research study, but it could also compromise the rigour of the study. The researcher decided to use a reflective journal as a tool to record her clinical impressions if these ideas arose, and to bracket her experiences to further refine the sampling and analytical techniques. Walker (2007) argues that developing authenticity in the data requires that the researcher implement strategies to ensure that the experiences of the participants are recorded faithfully. This is indeed an ethical issue for a qualitative researcher to consider. This bracketing technique was used in this study and is well described in the literature. When applied, it assists the researcher

to deal with preconceived ideas and notions that may bias the collection of authentic data, so that these ideas are firstly acknowledged by the researcher and notionally separated from the data (Glasser, 1978; Husserl, 1970; Liamputtong, 2013; Merleau-Ponty, 1964; J. A. Smith, Harre, & Van Langenhove, 1995; Van Manen, 1990).

The researcher recognised that a core component of her clinical practice experience had required her to develop skills in exploring clinical problems during the interviewing of clients. These are important clinical assessment techniques that are critical in terms of delivering good mental health assessments and proposing suitable interventions. These skills on the one hand lend themselves to proficiency in conducting in-depth interviewing techniques of study participants, and on the other hand, represent a bias towards clinical impression forming rather than researching the nature of human lived experiences (Liamputtong, 2013; Minichiello, Aroni, Timewell, & Alexander, 1995). The goal of this research was not to assess participants in the way a nurse might interview a client, but rather to create an opportunity for participants to share their own experiences of their personal story around the research topic, not for participants to be inadvertently subjected to formal clinical assessment. A reflective journal was used to optimise a rigorous approach to sampling, and as a tool to counter the possibility of exploring clinical style problems during participant interviews.

Yin (2009) suggests that separate reflective journals and research logs are required throughout the research process when case study research design is employed. The researcher commenced a reflective journal and a separate research log at the beginning of the investigation and continued to use this tool throughout the investigation period until the completion of the research project. In this way a continuous record was kept and a research audit trail can be demonstrated (Yin, 2009).

Emergent mental health problems are difficult to decipher from the sometimes less smooth developmental transitions that adolescents negotiate as they transit to the end of adolescence through to young adulthood. The researcher's capacity to think critically through the clinical issues that were evident, while simultaneously conducting a research interview with a research participant, was especially useful. This was particularly useful when issues arose that related to normal emotional ranges and connectedness, delays in perception, or unusual perceptions, disordered thinking and cognitive difficulties. Notably, thought disorder, cognitive compromise and perceptual problems are all characteristic of emergent mental

health problems. Thus, it was important that the researcher was able to pick up on these characteristics as they developed during an in-depth interview. It was useful to be able to enquire further about these issues, once they emerged in the course of the interviews. Thus, an important aspect of this study was that the researcher had explicit clinical mental health competence.

Notes were recorded in the researcher's reflective journal following each participant interview. Clinical impressions developed by the researcher were recorded in the reflective journal, and these ideas were then isolated in the journal to the best of the researcher's ability and not included in the analytical process. Recognition of this potential bias from the outset enabled the researcher to bracket for this potential threat to rigour. Van Manen (1990) makes it clear that it is almost impossible to achieve complete and objective bracketing of clinical impressions and the clinical knowledge by the researcher, when the researcher is both a researcher and an experienced clinician. Additional literature endorses this notion (J. A. Smith et al., 1995; Liamputtong, 2013; Walker, 2007). However, the literature also indicates that rigour is gained and research design is strengthened by the acknowledgement of this potential weakness prior to sampling and analysis of data, and where reasonable measures have been taken to promote authenticity and mitigate interference. The literature also indicates that the researcher should act to minimise any bias in an effort to produce trustworthy and rigorous research findings (Liamputtong, 2013; Smith et al., 1995; Walker, 2007). Thus, bracketing was conducted by the researcher to ensure rigour throughout the research process.

The reflective journal was also a useful tool for recording anecdotes about the research journey. In particular, the researcher was able to use it to record impressions, which became increasingly relevant during the period of investigation. It is noteworthy that the researcher is a resident of a rural community and can be considered mental health helping capital within the community where she lives. This is because, as previously stated, the researcher is a mental health nurse and has dual professional, service and social roles within the community in which she resides. The researcher made notes about the types and frequencies of informal mental health care she provided to others during the course of this study, and was interested to note how often this type of informal event occurred. The researcher reflected on her own sense of personal obligation to serve community members in an informal capacity in the form of mental health helping capital. The reflective journal was a useful place for these

impressions because it provided an opportunity to recognise the phenomena, and to set it aside from the analysis process, so that an effort to bracket the dynamic was maintained.

A separate research log was also maintained for the duration of the study. This differed from the reflective journal because it contained notes that were separate from clinical and reflective ideas formed by the researcher and that were bracketed and separated from the research within the reflective journal. A research log was a useful tool for recording a range of peripheral information that was not central to the research study, but which informed the context in which research was conducted. The research log was used to record and consider non-clinical dynamics that were raised during in-depth interviews, and this became increasingly meaningful following sampling and during the analysis phases of the study.

The research log was also a useful tool to record details about the participants' interviews following the interview. In particular, it was useful for refining the interviewing process for subsequent interviews and to further focus the interview processes. In doing so, a meaningful research log was established and a chain of logic developed within the data collection phase, thus demonstrating a rigorous approach to data collection in keeping with the case study research design (Gillham, 2000; Yin, 2009). The research log formed a logical research audit trail that demonstrates a reasoned and transparent account of the processes and evidence that informed the early phases of the research project. The information contained in the research log adequately summarises the steps taken throughout the research journey demonstrating validity and rigour in the practice of research (Gillham, 2000).

3.9 Ethical considerations

A human research ethics committee granted approval for the study (University of Canberra CEHR11-31 refer to Appendix 4) prior to commencement. The ethics committee approved a plain language Information Sheet for Participants and Consent Form, which are included in appendix 2. Recruitment of participants was conducted using digital social media invitations to participate that were distributed throughout the northern New South Wales region (refer Invitation to Participate in Appendix 5).

The mental health of young rural people remains a sensitive general topic, and is entangled with stigma. Rural communities are often considered stoic communities, and the people are often thought to be mentally robust, so when mental health problems arise in rural

communities there are some barriers and stigmas that complicate social standing and reputation (Judd et al., 2006). These factors have been discussed in detail in Chapter Two; however, it was important to recognise that some barriers to conducting the research may be experienced related to stigma and reputation, and so the researcher ensured that these sensitivities were respected. It was important to ensure that no social harm was done to participants, and that their wishes in regard to interview time and place were accommodated. As previously mentioned, a range of interview venues and styles were selected by participants, and they were free to select an option that best suited them. The researcher was mindful to attend any face-to-face interviews in a quiet and unhurried manner, in plain casual clothes, and with no insignia that might identify her university or her professional status as a mental health nurse. The researcher did not carry any clipboards or note books to interviews, and she recorded interviews digitally on a password protected smart phone. Thus, as an example, a public interview in a cafe would have appeared to onlookers as two people casually talking over a cup of coffee, because there was no other paraphernalia to suggest any other interaction was taking place. This attention to micro detail ensured that participants could talk freely, without the constraints of stigma or threat to their social reputation. Some participants felt that a telephone interview was most comfortable for them, and this was useful because they were able to be in their own familiar and private environment; and they were able to easily control the time they wished to spend in the interview by ending the call at any time. People who asked for telephone interviews were considered to be comfortable in their interview, and all were reluctant to end the interview. None of the 20 participants ended the interview prematurely. This demonstrates that their comfort during the interview process was adequately achieved in all interview formats.

The inclusion and exclusion criteria for this study excluded anyone under the age of 18 years and excluded any person who identified as currently being subject to Mental Health Act orders. Thus, only adults with the ability to fully decide whether they wanted to participate in the study were able to be included. In addition, during the consent to participate process, people were informed that they were free to withdraw from the study at any time if they chose to, without prejudice or penalty. No participants withdrew consent at any time. Finally, in recognition of the sensitive topic, participants were provided with contact information for accessible mental health services and advised that if they found talking about the topic in the research interview distressing in any way, they should seek mental health professional

support. The contact information (provided on the Participant Information Sheet, refer to Appendix 3) contained free mental health support contact details. To the researchers knowledge, no participants experienced any post interview stress, and some participants indicated that it was satisfying to have someone (the researcher) listen to their stories of their personal experiences. Thus, no harm was caused in the conduct of this research, and on the contrary, some participants indicated that they felt encouraged and hopeful that their experiences might in turn help others in the future.

The management and fate of the research data for this study complied with both national ethical standards for human research and the requirements of the Human Research Ethics Committee for the University of Canberra. All data has been de-identified and stored in a password protected computer, and only the researcher and her supervisors have access or permission to view the raw data. The data will be retained in this condition for a period of five years and then will be electronically deleted in keeping with the Human Research Ethics Committee approval conditions for this study.

3.10 Rigour and trustworthiness of the study

The researcher has made every effort to ensure a fair presentation of the data has been delivered (Liamputtong, 2013; Yin, 2009). Rigour and trustworthiness can be recognised in this research throughout all phases, as mentioned earlier in this chapter. The procedures used are clear and supported by a schematic representation of the research design; this promotes rigour in the conduct of the research (J. P. Rosenberg & Yates, 2007). Trustworthy findings are evident when the explicit findings are derived directly from the data and are transformed into themes; the themes then illuminate the real life experiences of the participants (Liamputtong, 2013; Sandelowski & Barroso, 2003). Further, a fully integrative explanation of the phenomenon is achieved whereby the data is able to be transformed into a theoretical proposal or explanation (Sandelowski & Barroso, 2003). Qualitative findings should have an explicit evidence base, which can be demonstrated via the effectiveness, appropriateness and feasibility of the research design to answer the research question, to attract informants with the necessary experiences to address the research question and to organise the findings in such a way that implementation of recommendations can be achieved (Evans, 2003).

The stage one quantitative components of this research have been designed and administered with due care to gaining rigorous and trustworthy results. The survey instrument was adapted from a previously validated survey instrument (Boyd et al., 2011), which had been designed specifically to understand Australian rural youth issues related to mental illness. The researcher consulted with the author of the original survey instrument, and then adapted the survey to meet the specific requirements of this study. The consultation process enabled rigour to be established at the beginning of the process so that a credible chain of logic was evident in the development of an appropriate survey instrument.

A pilot study for stage one of the study was conducted using free googleweb survey software, but during the pilot stage the software was found to be unstable, so more trustworthy software was purchased that offered reliability and a track record of quality assurance. The SurveyMonkey software that was used for the online survey in this research ensured that survey questions were able to be constructed and an easy-to-use participant experience was provided in the online environment. Data was able to be saved and exported in a range of formats so that analysis could take place. Descriptive statistical analysis was conducted and this informed important demographic findings of the study (Gillham, 2007).

Content analysis was also conducted with the survey text data and the study findings were strengthened because the findings were able to be cross-validated across the data sets, thus the mixed method approach to the study enriched the findings of the research and strengthened the trustworthiness of the findings and recommendations (Gillham, 2007). Text data was able to be content analysed using a summative approach by counting and comparing key words and content, and analysing the content to understand the underlying meaning of the words in the content (Hsieh & Shannon, 2005). Summative content analysis is recognised as a trustworthy and rigorous approach to qualitative content analysis and in a mixed method research design it contributes a nonreactive technique, so that an authentic representation of the data emerges that can be used to cross-validate other findings in the data set, as has been undertaken in this study (Hsieh & Shannon, 2005).

The stage two qualitative data analysis for this research has been interrogated fully using both traditional manual analysis and using computer assisted analysis software, NVivo10. The coding process was strengthened in this way; in addition, the researcher transcribed all of the interviews, and then re-listened to the interviews to ensure accuracy in the transcription

process. Transcript integrity and coding meetings were held regularly during the analysis phase with the researcher's two supervisors, who corroborated the accuracy of the coding and thematic findings. There was unanimous agreement that the data collection was of a high standard and that the emerging analysis was trustworthy and relevant in regard to specifically addressing the research question.

3.11 Credibility

Credibility pertains to the extent to which the data and participant views are accurately represented in the research (Liamputtong, 2013). The researcher is an experienced mental health nurse and also a lifelong rural and regional resident. These characteristics positioned the researcher in the rural context and with the research topic. Possession of both these characteristics was valuable in gaining rapport with the research participants and hearing the stories of their life events, because their rural circumstances and mental health experiences resonated with the professional and residential life experiences of the researcher. Rurally based researchers who actively research rural topics and contexts are thought to add a dimension of authenticity that is considered valuable by some commentators (Perkins, 2013). Flyvbjerg (2006) suggests that the proximity the researcher has to the reality of the research topic or case is a prerequisite for understanding the case under investigation. The researcher for this study has a longstanding proximity to the reality of young rural people with early mental health problems, and this strengthens the credibility of the research process for this study. In part, human behaviour and emotions are influenced by the context or environment in which people live, and so to understand the real life experiences of people, it is important to do so within the relevant context such as the rural context for this research (Gillham, 2000). With a background as a mental health nurse, the researcher was able to use this background information and real life experience of rural and regional living as a mechanism to assist the development of the research project appropriately.

As previously mentioned, the researcher kept a reflective journal throughout the research period and this assisted the researcher to process her ideas and to reflect on phenomena. This has been described in the previous section of this chapter and the detail of the description indicates that a transparent process has underpinned this investigation. This consistency demonstrates credibility and believability as core elements within the design and practice of this research project.

The researcher is proficient with social media communication and has recent publications that relate to the professional use of social media in health contexts, including health research (R. L. Wilson, Ranse, Cashin, & McNamara, 2013). These skills enhanced the recruitment process for the project and ensured that there was a wide range of participants with diverse ranges of experiences and this assisted in addressing the research question from a variety of perspectives and so enhanced the credibility of the research process (Graneheim & Lundman, 2004).

An internal consistency was able to be achieved across the data sets with cross-validation of findings between analysis techniques, and across survey and interview comments. This demonstrates evidence of trustworthiness and credibility of the findings that arise from this study (Hsieh & Shannon, 2005).

3.12 Dependability

Dependability is referred to as the criterion used to judge the completeness and accessibility of the research process undertaken (Guba & Lincoln, 1989; Sandelowski & Barroso, 2003). A chain of logic was employed that provides a clear picture of the reasoning used in the design and pursuit of meaningful data collection and its fairly described and internally consistent interpretation. Yin (2009) indicates that this is an especially important component to prove the dependability of the case study method findings.

Data sets have been retained so that they can be re-examined if required to demonstrate a transferability of the process and the accessibility of the data (Liamputtong, 2013). No individuals are identified in the data sets, so that confidentiality of participants is maintained and respected. It is possible to retrace all steps of the research process and to replicate a similar study. Transcriptions were checked for errors against the audio version of the interviews to ensure an accurate and authentic reproduction of the interview.

The researcher’s supervisors have independently reviewed the pilot data and subsequent data, and review meetings between the researcher and supervisors have been held regularly to discuss and compare independent thematic analysis interpretations, and consensus about the findings was achieved. These processes have enhanced the stability of the research across time and research phases and have assisted in maintaining consistency about data

interpretations. This demonstrates dependability of research findings and conclusions (Graneheim & Lundman, 2004).

3.13 Confirmability

Confirmability refers to the degree to which the research findings are directly focused on the phenomena under investigation and are not the biases of the researcher (Guba & Lincoln, 1989). That is, the researcher has presented the data and the subsequent findings honestly, with integrity and without allowing the researcher's own values to intrude unduly into the interpretation of the findings (Liamputtong, 2013).

A reflective journal and research log was used to record any personal ideas and influences so that these could be processed without them interfering with the focus of the research. This process also facilitated setting aside the ideas so that they were not able to influence the data set adversely.

The researcher has declared her clinical experiences and her rural residency and has acted to ensure a separation between clinical and research interpretations, which enhanced the legitimacy of the research.

The researcher supervisors assisted with the thematic analysis process and this has increased the rigour of the research.

3.14 Transferability

Transferability can be considered the extent to which others can see similarities in findings that may relate to other settings (Guba & Lincoln, 1989; Liamputtong, 2013; Sandelowski & Barroso, 2003). There is enough information shared about this study design and analysis to demonstrate a transparency of process so that the study could be replicated and so it could be anticipated that similar findings should arise as a result. The steps taken are adequately outlined and described so that each phase of the study is clearly and fairly represented, and this includes a clear description of culture and contexts, selection criteria for participants, data collection and analysis procedures. The findings are supported by quotations from participants and these steps enhance the transferability of the research (Graneheim & Lundman, 2004).

3.15 Methodological issues and limitations

A single case study design was used for this research. Flyvbjerg (2006), a case study methodologist, suggests that adding further cases to a completed case study is possible, and so additional cases could be added to the outcomes of this study in the future, and these would build additional power and thereby strengthen the theoretical generalisations beyond the case investigated in this study.

The generalisations from this study are limited to theoretical propositions and they make no claims to extend to populations. There was no intention in this study to specify particular outcomes to populations, but rather to understand the un-manipulated real life experiences of the participants in this study (Yin, 2009). The case study design for this research provided a valid framework to explore contemporary events and there was no attempt to explore retrospective or prospective propositions (Yin, 2009).

This study is described as a revelatory case and was designed to observe and analyse phenomena that are common to rural areas (Yin, 2009). It explores *how* questions only. Other angles of the phenomena under investigation might be illuminated by using different questions, and if this were to occur, it would add to a broader knowledge about the phenomena across broader directions (Mantzoukas, 2008; Yin, 2009).

3.16 Conclusion

This chapter has presented the research design and the methods used to carry out the research that has been conducted in this study. The reason this research is important is because rural young people have a high level of mental health morbidity and frequently experience lengthy durations of untreated illness, and so it is significant to understand why this is the case and to discover ways to reduce the incidence of these long periods of untreated mental illness.

Case study research design is well matched to examine the phenomenon of the emergent mental health problems of young rural people, and the aim for the research has been to answer the research question: *What helps young rural people with emergent mental health problems?*

This chapter has covered the steps taken to conduct a rigorous, trustworthy, dependable and credible research study using case study method design. A justification for the research design, methods and theoretical framework used in this study has been provided and a schematic research model (Figure 3.1) has been developed to demonstrate the logical chain of

evidence that has informed the research design. The research setting and context has been described. The recruitment and sampling strategies have described the successful use of social media techniques in detail. The data collection and analysis procedures have been presented in two stages, with stage one describing the survey procedures, and stage two describing the in-depth interview procedures. The ethical considerations have been described and discussed, and limitations of the study have been outlined.

The following chapter will present and discuss the data analysis and findings from the survey and in-depth interview components of the study.

CHAPTER FOUR

Data Analysis and Results

4.1 Introduction

This chapter covers the interpretation of the data collected for the purpose of understanding and describing ways in which young rural people with emergent mental health problems can be identified and helped at a very early point in their episodes of mental health decline. First, an overview of the main results will be introduced with an explanation and justification of the data analysis procedures used in the study. The results are then presented in two sections. Section one will present the data analysis of the online survey, and section two will follow with the presentation of the participants' demographic details and the qualitative themes and sub-themes from in-depth interviews. Both sections will conclude with a summary, and the chapter will conclude with an overall summary. Chapter Five will discuss the findings in detail and propose recommendations relevant to practice, policy and future research.

As previously mentioned, a mixed methods case study approach was used to investigate the experiences of rural people in regard to helping young rural people with emerging mental health problems to gain timely mental health support in their communities. Thus the major aim of this study was to gain insight and understanding into the mental health help seeking experiences of rural people by asking: *What helps young rural people with emergent mental health problems?*

4.1.1 Overview of survey main results

Data was collected in an anonymous 12 item structured online survey using open and closed multiple choice style questions in the online survey collection website of SurveyMonkey (www.surveymonkey.com) (See Appendix 2). The survey yielded 81 responses. From these 81 responses, 19 respondents indicated by leaving their contact details in an optional final question that they would be willing for the researcher to contact them for a potential further in-depth interview in addition to their survey response. Contact was successful with most of these respondents; however, only seven of these progressed to a full in-depth interview. A further 13 individuals contacted the researcher following snowballing of the research

participant invitation information in digital social media and by traditional word-of-mouth. A total of 20 people agreed to participate in an in-depth interview and all of these met the selection criteria and were included in the research. The following three tables (Table 4.1, 4.2 and 4.3) provide an overview of the main findings from the survey data content analysis.

Table 4.1: Demographic overview of participants

81 people living in the northern New South Wales region known as New England.
Most of the respondents were women (80%).
High attainment of education by most people.
Representative breadth of ages with most people in categories of either young person or parent of young person age groups.
Informed backgrounds pertinent to the topic of investigation with understanding of the experiences of young rural people with emergent mental health problems and their help-seeking experiences.

Table 4.2: Main themes of content analysis of survey data

Most frequent views	Moderately frequent views	Least frequent view
People seek mental health care if it is personally required.	Seeking mental health care would be an embarrassing personal experience.	Not able to identify where to ask for mental health help and ambivalent about the usefulness of mental health services.
The best people to provide mental health advice to young rural people are health professionals.	Concerns about stigma and of being acquainted with staff who are involved in accessing and ongoing mental health care services.	
Preference to do nothing and hope that the mental health problem would fix itself prior to seeking professional mental health help.	People are unconvinced that seeking mental health help would be a useful strategy to address the emerging mental health problems of young rural people.	
Young people seek help from their parents and friends if the problems do not resolve spontaneously.	Confidence demonstrated in the mental health advice of other professionals such as teachers, school counsellors, pastors or ministers of religion.	
	A belief that mental health services are not readily accessible in some rural communities	

Table 4.3: Content analysis findings: description of helpful nursing characteristics and nurses' contributions to mental health care in rural communities

Nurses care about people.
Nurses successfully make meaningful connections with people during emotionally complex episodes of emergent mental health problems.
Nurses can be trusted with confidential and private information.
Nurses can navigate complex health systems and select suitable referrals towards appropriate additional mental health care.
Nurses pay attention to people and listen carefully and respectfully to others.
Nurses are valued for their dual roles in the community with their informal participation in their communities adding a further depth of value to their work as nurses in their employed health setting roles.

4.1.2 Overview of in-depth interview findings

The recorded interviews were transcribed verbatim and uploaded into NVivo10 (www.qsrinternational.com), which is a computer software program for qualitative analysis, and this assisted in organising the identification of patterns, contexts and themes within the data set. Hard copy paper interview transcripts were also searched manually using traditional pen and paper approaches, and common themes and patterns were identified. The combination of both computer assisted and traditional data analysis processes strengthened the rigour of the analytic process and corroborated themes and results.

Four major themes and eight sub-themes emerged from the real life accounts of the respondents. Quotations from the respondents are provided throughout section two of this chapter to illustrate each theme and sub-theme. The themes and sub-themes identified during the data analysis process are covered in Table 4.4 below.

Table 4.4: Overview of themes: In-depth interview

Theme 1	**The characteristics of the emergence of mental health problems experienced by young rural people**		
		Sub-theme 1.1	Emerging mental health problems
		Sub-theme 1.2	Family experiences
		Sub-theme 1.3	Barriers
Theme 2	**How others help young rural people with mental health problems: The characteristics of helping**		
		Sub-theme 2.1	Convincing people that mental health help is needed
		Sub-theme 2.2	Basic core need dynamics of young rural people
		Sub-theme 2.3	The social network experiences of young rural people with mental health problems
Theme 3	**Lack of meaningful connection with mental health services**		
		Sub-theme 3.1	Muddling on
		Sub-theme 3.2	Stuck between a rock and a hard place
Theme 4	**Health, welfare and social service provider characteristics**		

4.2 Section one: Survey results

4.2.1 Introduction and age classifications

The 12 item structured online survey included multiple choice and open questions and was designed so it could be completed anonymously. A final question provided an opportunity for individual participants to include their identifying information such as name, address and contact details if they were happy for the researcher to contact them in the future to participate in a subsequent in-depth interview. Nineteen survey responses included identifying personal

information and the remaining 62 responses were anonymous. The online survey was designed to yield specific information regarding the participant profiles and this information is presented in the following Figures 4.1 – 4.4, and is described in more detail in section 4.2.2 of this chapter. The survey participants provided a postcode identifier and all postcodes provided were from the northern region of New South Wales Australia, indicating that the participant profile aligned with the region chosen for investigation. All 81 survey responses were able to be included in the study and none were discarded. An overview of the demographic characteristics is provided in Table 4.1 of this chapter.

The age profile of participants was spread evenly between 18-55 years of age with fewest responses in the 56-65+ year bracket. This was anticipated because the people most likely to have a close association with young people are other young people, or their parents and clinicians, who themselves are likely to be middle-aged. Figure 4.1 illustrates that 23% of respondents were aged between 18-25 years; 21% were aged 26-35 years; 20% were aged 36-45 years; 29% were aged 46-55 years; 5% were aged 56-65 years; and 3% were older than 65 years of age. One person opted not to answer this question. The relatively even spread across the age ranges most in contact with young people strengthens the generalisations that can be extrapolated from the findings of this survey because good representation of the population is clearly identified.

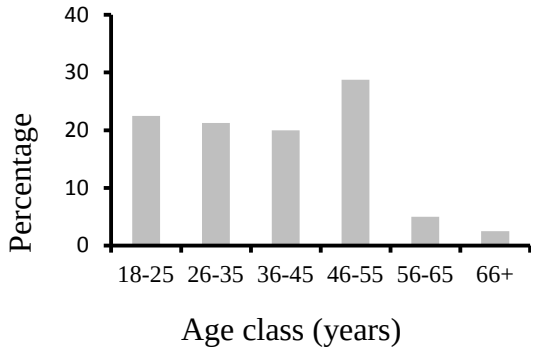


***Figure 4.1*: Age profile of survey respondents.**

Most respondents were female (80%) and the remaining respondents were male (20%), and two survey participants opted not to complete the question.

4.2.2 Background of survey respondents

A variety of people from relevant backgrounds responded to the survey, while six people declined to respond to a specific item (refer Figure 4.2). It may be that a category that suited them was not available to some or all of those six people, and an 'other' option was not available for selection on this item. Statistical analysis using Pearson's correlation revealed a moderately high positive correlation (r =0.6) between the pilot and survey data and this demonstrated that similar types of responses were achieved in both data sets for this question.

Nurses are the most plentiful practitioners as a health human resource in rural communities, and because of this they have been considered in this study separately from the broader other health disciplines. The reason for this decision is that because of their larger proportion within the health service context, nurses represent a rich and dynamic local mental health social capital in their rural communities and the researcher was interested to explore how this might be used in rural communities. The largest group of survey respondents (27%) identified as being either a registered nurse or mental health nurse, so there was a strong representation of nurses with experiences of helping young rural people with mental health.

The range of people types is spread more widely with the second largest group (24%) made up of parents of young rural people with a mental health problem. It is possible that this group was large because they are likely to be the first people to notice that a son or daughter is developing an emerging mental health problem, and this group will have poignant experiences in assisting young people towards achieving mental health help. Thus their large representation in this study is highly appropriate in regard to answering the research questions posed.

The third largest group consists of the friends of young rural people (23%), again an important representation because the nature of emergent mental health problems is frequently an insidious build-up of hard to notice characteristics that, when considered collectively, reveal a developing and emerging mental health problem (Early Psychosis Writing Group, 2010). It is difficult for the affected persons to see this emerging mental health problem for themselves; however, those people who are socially and emotionally close to them, such as their friends and peers, may begin to notice these changes and respond to them accordingly.

Health professionals from all other disciplines other than nursing made up 21% of survey respondents. This group is a valuable representation because other health professionals such as GPs, psychologists, and counsellors are frequently involved in the health care of young rural people with mental health problems. A key point of difference between this group and the nursing group is that sometimes health professionals are not local residents in the rural communities but provide FIFO or DIDO services, whereas rural nurses are more likely to be residents within the local rural community.

Some young rural people (11%) who self-identified as having personal experiences of mental health problems completed the survey. This is particularly relevant because young people are key informants in regard to their own mental health experiences, and can report a unique perspective. The inclusion of a sound proportion of young rural people is helpful in addressing the research question with authenticity and rigour.

People from other professions, for example, police, education, clergy, legal, and social care made up 9% of the responses in this survey. This is a useful professional voice because it has already been established that on occasion, the first avenue to seek assistance for rural people with emergent mental health problems is through professionals from non-health disciplines, for example to consult a solicitor/lawyer to solve a mental health problem (R. L. Wilson et al., 2012).

Other rural citizens concerned about the mental health and wellbeing of rural young people made up 9% of the survey sample. This is relevant because rural communities are often considered to have strong social cohesion, and so people tend to be actively interested in, and concerned for one another (Boyd et al., 2008). Concerned citizens may be motivated towards community service that is aimed at helping young rural people with mental health problems in either prevention or recovery capacities and so their representation in this sample is important.

Finally, the smallest group of respondents in this survey was that of agricultural professionals and workers with just a 4% contribution to the sample. It may be that the online survey format was not appealing to this group, or that the research topic did not strike a chord with them. The researcher is aware that the survey was promoted within the agricultural peak body NSW National Farmers Association (www.nswnationalfarmers.org.au) and among their sub group NSW Young Farmers, with some internal enthusiasm within that organisation. The web

link to the online survey was promoted by them in their regional print and online newsletters and in their social media activity. However, very little uptake from these invitations was sparked. Despite this, it is useful to have some contribution from this important rural group about the research topic, and this informs the study.

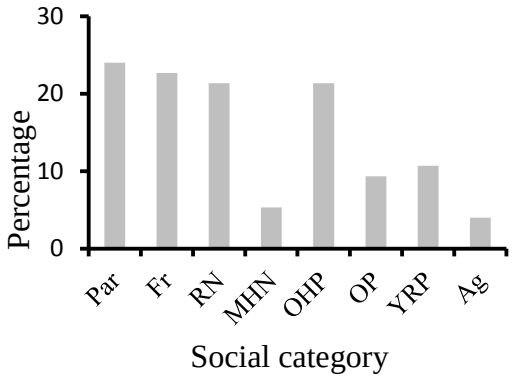


***Figure 4.2*: Types of people who participated in the survey**

Legend: Par (Parent of a young rural person with a mental health problem); Fr (Friend of a young rural person with a mental health problem); RN (Registered Nurse); MHN (Mental Health Nurse); OHP (other health professional); OP (other professional); YRP (Young rural person with a mental health problem); Ag (Agricultural professional or worker).

4.2.3 Educational background of participants

The survey requested information regarding the educational background of respondents and 78 people indicated their highest level of educational attainment (see Figure 4.3 below). Only two respondents indicated that they had completed the lowest level of educational qualification, that being completing year ten in high school only. Over half (56%) of the sample indicated that they had a bachelor level university qualification or above. Technical and further education (TAFE) qualifications were attained by 23% of respondents, and 18% had achieved a year 12 education at high school. The distribution of qualifications among respondents suggests that the people in this sample are relatively well educated and the quality of educational attainment suggests that the majority of people surveyed are highly educated. Pearson's correlation calculations comparing this question for the pilot and actual

survey showed a very strong positive correlation (r =0.9) indicated that the pilot and survey data were matched across both data sets for this question.

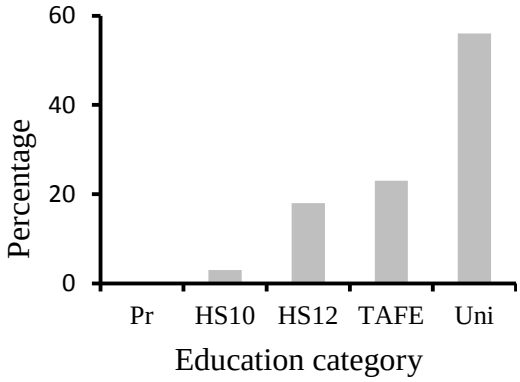


***Figure 4.3*: Educational backgrounds of survey participants**

Legend: Pr (primary school); HS10 (High School year ten); HS12 (High school year 12); TAFE (Technical and further education qualification); Uni (University bachelor degree or above).

4.3 Survey content analysis: Description of respondents' views about mental health helping characteristics in rural communities

The results of the content analysis of the survey are presented in the following sub-sections.

4.3.1 Willingness to seek mental health help

Item one in the online survey asked people: *If you had something worrying you, for example depression or anxiety, would you seek professional help for it?* (Refer Figure 4.4). Responses were invited against any or all criterion options and 65% of respondents indicated that if they found themselves in circumstances where they were concerned about depression or anxiety, they would be likely to actively seek professional help to assist them in coping with the issues. Despite this confidence of most respondents, 21% of people indicated that they would either be embarrassed or concerned about the stigma related to asking for mental health help. Comments provided by respondents for this question revealed that people would be concerned about the small town dynamics in relation to either recognising, or being acquainted with, the professional health providers or administrative staff who would be consulted in the process of seeking mental health help.

A total of 14% of respondents indicated that they were unconvinced that seeking mental health help would be useful to them, and 5% of the sample said that they would not seek mental health help. Perhaps the most concerning response is the 6% of people who were ambivalent about accessing mental health help and who were unable to identify where they would go to find mental health help if they needed it. Utilising Pearson's correlation, a strong positive correlation ($r = 0.9$) was achieved between the pilot and survey data demonstrating that similar types of responses were achieved in both data sets for this question which indicates that the survey instrument is reliable across two data sets.

Figure 4.2 above demonstrates a significant proportion of respondents who identified as being a health professional, and who are therefore likely to be able to locate mental health services generally, because of their familiarity with health services. The proportions of non-health professionals are potentially less familiar with mental health service opportunities. Some of these people are ambivalent about accessing health services or reluctant to do so because of stigma, embarrassment or some other reason. Not knowing where to go for help if it is needed is of significant concern in regard to identifying and addressing the emergent mental health problems of rural people. This finding is further pronounced when taking into account that most of the participants are health professionals. This finding aligns with findings in the interview data in section two of this chapter, which further confirms that rural people find it difficult to locate appropriate local mental health help when it is required, and that accessibility and availability of mental health professional help is not well communicated to the general rural population, and this hinders early engagement in mental health care.

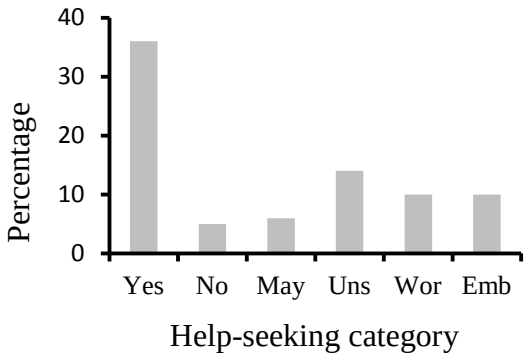


***Figure 4.4*: Mental health help-seeking**

Legend: Yes (Yes-professional help); No (No-professional help); May (May, but unfamiliar with any mental health helpers); Uns (Unsure and unconvinced of need); Wor (Worried about stigma); Emb (Embarrassed to ask).

4.3.2 Difficulties accessing mental health help

The survey asked an open question and 77 people responded by writing a brief statement about their view on the difficulties related to obtaining mental health help: *What would be difficult about getting help for a personal or emotional problem in a rural community or country town if a young person wanted it?*

The responses were explored for similarity with almost 20% of respondents reporting a perception that mental health services and professionals were not readily available in many rural towns. Also about 12% of people were concerned that long waiting lists for obtaining mental health care existed in rural communities. Approximately 10% of responses were concerned about not knowing where to find, or obtain, confidential help for young people, while 7% of people were especially concerned about their privacy and the stigma attached to mental health problems. Around 4% of people felt that the costs associated with obtaining timely mental health care for young rural people would be prohibitive. Thus, people responding to this survey think that accessing mental services for young people in rural communities is limited because of a lack of mental health service providers who are able to see new clients in a timely manner. They are also concerned about how others in their communities may perceive the receipt of their mental health care, the distribution of private information in a small population, and the financial implications of accessing mental health

care. These survey findings concur with similar themes that arise in the experiences of the interview respondents in section two of this chapter.

4.3.3 Nurses contribute to rural mental health care

Survey participants were asked about their level of agreement with pre-loaded statements that relate to nursing dynamics in rural communities: specifically, about nursing capacity to contribute towards helping a young person with a mental health problem: *A nurse could be a helpful person in a rural community or a country town to help a young person with a mental health problem. Thinking about your circumstances, which options below do you agree with?*

Seven people skipped the question, however 74 people responded to this question (see Figure 4.5 below). The strongest attribute with a weighting of 57% indicated that nurses care about others and this was noted as a helping characteristic. Care is an attribute that is difficult to describe accurately, but the idea that nurses are able to connect on the emotional level of caring for the adverse mental health problems of another person was clearly seen by this group as a very important and positive factor in the mental health care of young people. This finding concurs with the experiences of interviewees that are reported in section two of this chapter, who also reported that emotional connection was an important aspect for the effective mental health and wellbeing of young rural people.

One third of responses indicated that nurses would be of no assistance to a young person with a mental health problem. A further one third of people identified that they themselves were nurses and so their positive view about nurses could be assumed. The remaining one third of people who responded to this survey item indicated their confidence in the capacity of nurses to contribute positively to the mental health care of young people. Thus two thirds of respondents considered nursing favourably in regard to helping young people. Comparative statistical analysis using Pearson's correlation showed a moderately high positive correlation ($r = 0.6$) was achieved between the pilot and survey data and this demonstrated that similar types of responses were achieved in both data sets for this question.

Nurses are seen as people who can hold confidences, can navigate pathways towards appropriate additional help, are trusted and have a part to play in providing mental health care, are helpful and they listen carefully and respectfully to mental health help-seekers. Half of the non-nurse participants considered nursing favourably. These nursing characteristics are

valued as important aspects in the delivery of mental health helping within local rural communities. However, the confidence of this sample seems to firmly align with a positive/favourable value of these nursing attributes.

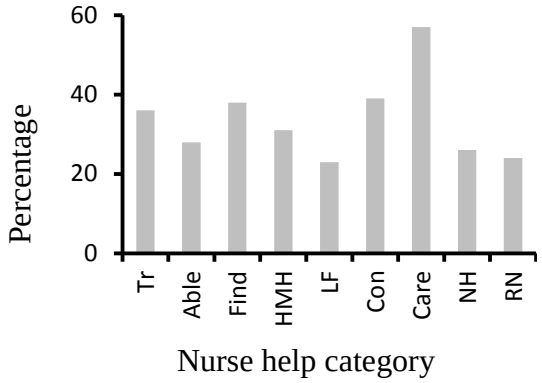


***Figure 4.5*: Nurses' contribution to mental health care**

Legend: Tr (Local nurses trusted); Able (Nurses able to help); Find (Know how to find nurses); HMH (Nurses help people with mental health problems); LF (Nurses listen fairly); Con (Nurse confidentiality); Care (Nurses care); NH (Nurses are no help); RN (I am a nurse).

4.3.4 Personal connections with nurses in rural communities

Nurses are well known in rural communities and the survey results indicated that 78% of the respondents were personally acquainted with a nurse.

4.3.5 Types of nurses who can help with a personal, emotional or mental health problem

All 81 participants completed the survey item that asked people to identify the type of nurse who could help with personal, emotional or mental health problems (refer Figure 4.6): *Do you know a nurse that you think would be ready to help you with a personal, emotional, or mental health problem? If so, what type of nurse do you know?* This question provided a range of drop-down options and participants could select as many or as few options that reflected their view on the matter. A similar number of people as in the previous survey item reported above in section 4.3.4 could not identify a type of nurse. This may be because they did not know a nurse. This consistency in reporting between survey questions demonstrates integrity in the authentic answering of questions by respondents, because the view is reinforced between items and the inter-item reliability is consistent.

Registered nurses and mental health nurses were most commonly selected in this question, however the respondents were able to identify a number of other types of nurses who might be helpful for a young person with a mental health problem; in particular, community nurses and nurses based at general practice clinics were noted. Pearson's correlation revealed a strong positive correlation (r =0.7) between the pilot and survey data signifying that similar types of responses were achieved in both data sets for this question, and this contributes to the reliability and validity of the findings.

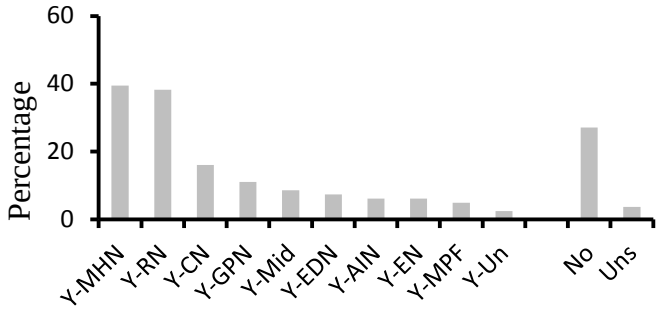


***Figure 4.6*: Type of helpful nurses in relation to mental health problems**

Legend: Y-MHN (Yes. Mental Health Nurse); Y-RN (Yes. Registered nurse); Y-CN (Yes. Community nurse); Y-GPN (Yes. General practice nurse); Y-Mid (Yes. Midwife); Y-EDN (Yes. Emergency department nurse); Y-AIN (Yes. Assistant in nursing); Y-EN (Yes. Enrolled nurse); Y-MPF (Yes. Multi-purpose facility nurse); Y-Un (Yes. Unsure of type of nurse); No (No nurse known); Uns (Unsure).

4.3.6 How should a nurse be able to help young people with mental health problems?

Participants were asked two questions, as separate survey items, seeking their suggestions about ways in which nurses should be able to assist young rural people with their mental health problems. The first open-ended question was: *Do you have any ideas about how you think a nurse should be able to help a young person with a personal, emotional, or mental health problem?* Suggestions were provided by 60 people and the comments were searched for common topics to reveal the strength of common ideas. The most striking theme among the responses was the identification of the importance of nurses helping by *listening* (27%) to young people in regard to their *problems* (17%). The importance of listening is a key finding from the interview data presented in section two of this chapter. The finding that the

characteristic of listening is identified as helpful in both data sets demonstrates internal consistency within the study and reinforces and strengthens the findings of this study.

A further 54 comments were harvested in a second open-ended question that asked: *What else do you think a nurse should be able to do to help when a young person needs mental health help?* Exploring nursing capacity to help in two survey items was useful because it yielded a broad range of responses and reinforced the importance of some key concepts raised previously. The content was searched for common concepts (each italicised below) and the percentages recorded below indicate the strengths of frequency of each of the concepts within the content of the data. The synthesis of the responses to this question revealed a concise finding that showed that respondents believed that nurses should be *able* (17%) to *assist* (17%) people who present to *health services* (15%) *seeking* mental health help for *young people*, and that this help should be *supportive* (10%), *professional* (10%), *appropriate* (10%) and should connect help-seekers to *meaningful referral* (10%) for additional *ongoing* mental health care and *treatment* (8%).

In these two items in the survey, respondents clearly identified important nursing interventions related to listening in a supportive and caring manner, then using the information gained at that time to advocate for, and to deliver a seamless transition of care towards practical and meaningful health care, such that the real life experiences and complexity of mental health problems are alleviated. The respondents have described nursing interventions that can be applied in health care contexts in all settings. The responses reported here concur with the themes and findings drawn from the experiences of interview participants in section two of this chapter.

4.3.7 Selecting type of help

Survey participants were asked to select from a range of drop-down options regarding which types of help they thought would be most useful to young people with an emergent mental health problem overall; which help they considered rural young people would select for themselves, and the type of help parents might select for young people with emerging mental health problems. Figure 4.7 below shows the responses of 80 people for this item.

First, respondents were asked to rate what they considered to be best sources of help for a young person in a rural community. Overwhelmingly, most respondents' (83%) considered

that the most appropriate action was to talk to a health professional about the mental health problem, as a mechanism to commence mental health care. No respondent believed that it would be appropriate to leave the problem unattended.

Second, people were asked how they believed young people would choose to manage help-seeking for an emergent mental health problem. Over half of the respondents (51%) believed that young people would be most likely to attempt to allow the problem to fix itself without any external help provided, while 38% of respondents considered that young people would be most likely to seek help from their parents in the first instance. This finding concurs with findings from previous research about a similar topic by the author that also found young rural people prefer to seek help within the family in the first instance (R. L. Wilson et al., 2012). Only 8% of people felt that young people would talk to a health professional about their early mental health problems.

Finally, this survey item asked about parents of young people, and where they might seek mental health help for a young person. Half of the respondents (50%) believed that the most appropriate help would be found with a health professional, and there was some confidence shown (34%) that parents themselves would be a good initial source of help. This view also confirms the previous research by the author where it was noted that parents were a first choice for young rural men seeking mental health help (R. L. Wilson et al., 2012). A small number of people (8%) considered that some parents may choose to allow the mental health problem to fix itself with no external support. Pearson's correlation was used to test for similarity of responses between the pilot and actual survey and a strong positive correlation ($r = 0.9$) was achieved between the data sets for this questions which confirmed that similar types of answers were provided in both data sets for this question.

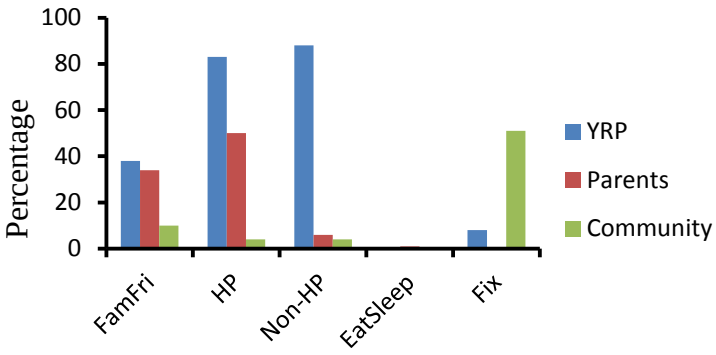


***Figure 4.7*: Perceptions about how mental health help is best initiated and by whom**

Legend: YRP (Young rural person); Community (community members not identified in any other category) FamFri (seeking help with family and friends); HP (talking to a health professional); NonHP (talking to a trusted non health professional in the community); EatSleep (by improving healthy eating and sleeping behaviours); Fix (by allowing the problem to spontaneously resolve or fix itself).

4.3.8 Ways in which others can help

The survey participants were asked about the types of actions readily accessible in rural communities that might be considered helpful by various types of people. The actions available to choose from in the survey item included listening, giving advice, suggesting treatment, careful assessment of the current situation, and no help. Nurses consistently were seen to be able to provide help to young rural people with mental health problems across all domains except the 'no help' option (refer Figure 4.8). Therefore, it can be seen that there was a firm belief held by the respondents that nurses had a helpful role to play in the rural community in regard to the initial mental health care of young people.

Family, friends and pastors or ministers of religion were all seen to be helpful and could listen and give advice that was seen as advantageous. However, the respondents believed that they were less able to assess the situation and suggest useful ways forward about treatment possibilities than the nurses. Teachers and school counsellors were identified as people who could listen, give advice, and also assess the situation with moderate confidence. They also were seen as being able to commence referral processes towards treatment with more confidence than parents, friends, and pastors. Solicitors were seen as the least helpful group for helping young rural people with mental health problems; however, some people

considered they did have a role to play. Comparative analysis with Pearson's correlation a very high positive correlation (r =0.9) was achieved between the pilot and survey data indicative of very similar types of responses across in both data sets for this question and this signified that the survey tool was reliable.

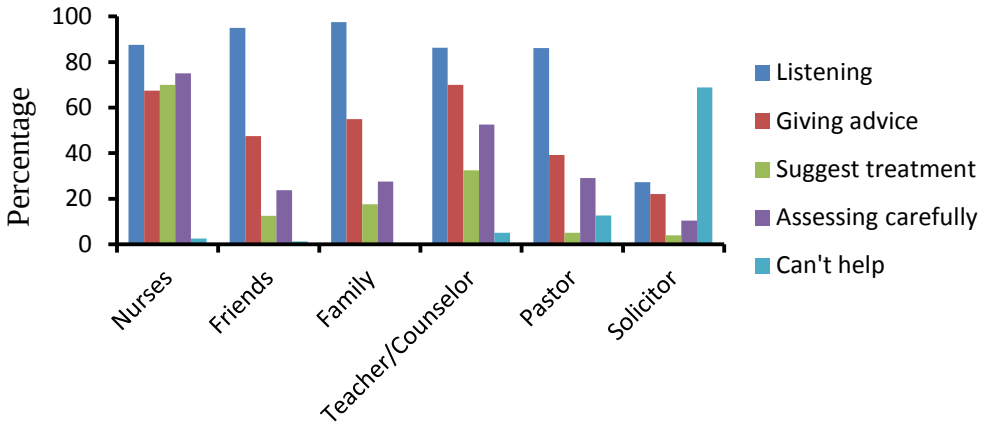


***Figure 4.8*: Ways of helping**

4.3.9 Rural nurses are mental health helping social capital for young people

Respondents were asked their views about how nurses might contribute towards improving accessibility of mental health care for young rural people. Figure 4.9 below outlines the responses provided by 77 people. The percentage refers to the strength of the common view about the associated helping attributes. The participants in this survey believed that nurses have a significant role to play in regard to young people accessing mental health help, and in particular, nurses' *listening* (49%) and *referral* (71%) skills were again endorsed as key characteristics of early mental health helping. The importance of nurses being employed to work across a 24 hour period in a hospital, or hospital-like setting such as a multi-purpose health care setting, was also noted. It was recognised by the respondents that nurses are *available* and *accessible* (58%) in the rural communities and that this promotes the possibility of timely access to mental health care for young people when it is required.

In addition, nurses were further recognised for their *informal* (27%) and *unpaid roles* (18%) in the community, which respondents believed to enhance mental health care and community support for young rural people. The fact that these nurses were both *local* and *approachable*

(46%) was also believed to be important. These three elements taken together indicate that the ways in which locally-based nurses participate in rural community life inherently adds an element of mental health support and is regarded as a significant rural, social and wellbeing value. As previously discussed in Chapter Two, Kilpatrick (2013) and her colleagues call this type of dual credibility a 'boundary crossing' dynamic and the contribution this makes to collective social capital is a protective quality for health and wellbeing.

Although, 18% of people were unsure about how nurses actually contribute, they still believed that it was possible that nurses do make a contribution that may help young people. Only 5% of people indicated that nurses could not contribute to the rural community in a way that improved access to mental health help for young rural people. Pearson's correlation was used to test similarity of response between data sets and a strong positive correlation (r =0.8) between the pilot and survey data was found which demonstrated that similar types of responses were achieved in both data sets for this question.

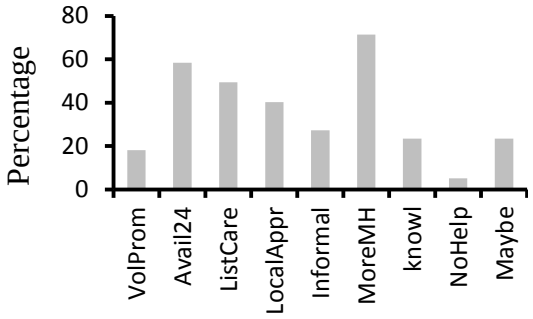


***Figure 4.9*: Helping characteristics of nurses**

Legend: VolProm (Volunteer and promote health in wider community outside of nursing employment); Avail24 (Available 24 hours per day in hospitals); ListCare (listening and caring); LocalAppr (Local and approachable); Informal (Informal support and advice); MoreMH (Nurses can locate and provide referral for additional mental health help if it is needed); Knowl (Nurses know how to help people with mental health needs); NoHelp (Nurses are no help); Maybe (Nurses may be able to help with a mental health problem but unsure how).

4.4 Summary of survey findings

The results of the online survey of 81 northern New South Wales people have been presented in section one of this chapter. The survey has provided some descriptions and insights into the experiences of the respondents about their circumstances and experiences related to helping young rural people with mental health problems. The results have specifically addressed the research question and the findings have contributed to describing the context in which young rural people with mental health problems can be helped and supported with early or initial mental health care within the rural community setting. Most of the respondents were women, and all of the respondents were residents of the identified study site region. Generally, the cohort of respondents were well educated people, and their demographics confirmed a breadth of ages and backgrounds that were pertinent to the topic of investigation; that is, understanding the experiences of young rural people with emergent mental health problems and their help-seeking experiences.

In summary, the survey found that most people would be interested in seeking personal mental health care if they required it. For some respondents seeking mental health care would be an embarrassing personal experience and they were particularly concerned with stigma and also of recognising, or being acquainted with staff who would be involved in the access, and any of their ongoing mental health care requirements. While some people were unconvinced that seeking mental health help would be a useful strategy to address the emerging mental health problems of young rural people, a small number of respondents were not able to identify where to seek mental health help if they decided it was required. It can be reasonably assumed that the high number of health professionals who participated in this survey will be more likely to know where to find, and how to access mental health services. This amplifies the responses from those people who did not know where to find mental health help, or were ambivalent about seeking help because it confirms the view that rural people find it difficult to locate and access mental health care for young rural people.

People who responded to this survey expressed concerns that mental health services were not readily accessible in some of their local communities. There was a perception by some people that waiting lists and costs associated with accessing mental health care would prohibit timely access to mental health care.

A strong view existed among respondents that nurses are important contributors to mental health care in their local rural communities. Respondents believed that nurses care about

people and were able to interact with others in ways that made a meaningful connection with the strong emotions that arise during the early stages of young people's mental health decline. This characteristic in part can be recognised as a caring attribute. Nurses were recognised for their ability to be trusted with confidential and private information and their advice was trusted in regard to navigating and selecting suitable pathways, or referrals, towards comprehensive and appropriate additional mental health care. Additionally, nurses were considered to have strong attributes in regard to paying sufficient attention to listening to people, so that people with challenging personal experiences felt that their situations and their emotional discomfort had indeed been heard and their experiences valued. Third, nurses were recognised and valued as having dual roles in the community with their local residency and informal participation in their communities adding a further depth of value to their work as employed nurses. Concordance in regard to these nursing attributes between section one and section two in this chapter is noted and the similar findings confirm the importance of nursing contributions in the mental health care of young rural people.

Finally, the findings from the survey indicate that people in rural communities believe that the best people to provide mental health advice to young rural people are health professionals. However, there was a strong view that, prior to speaking with a health professional, a first step would be to do nothing and hope that the mental health problem would fix itself. A second step would be that young people would seek help from their parents and friends if the problem did not resolve spontaneously. Moderate confidence was demonstrated in the mental health advice of other professionals such as teachers, school counsellors, pastors or ministers of religion.

Section two of this chapter will present the findings of the in-depth interview data component of the study.

4.5 Section two: Results of qualitative in-depth interviews

4.5.1 Introduction

Twenty participants who met the selection criteria for this study were selected to participate (refer to Table 4.4 in section one of this chapter). They agreed to participate in in-depth interviews that were digitally voice-recorded for transcription and thematic analysis. To commence the interview each participant was asked the same opening question: *You mentioned that you have some experiences of getting help for a young person with a mental health problem. Can you tell me about those experiences?* The researcher was interested to explore the experiences of rural people who either had an experience themselves as a young person with a mental health problem, or of helping a young rural person with a mental health problem to gain some mental health help. The researcher was aware, following her previous research about the emergent mental health problems of young rural men, that barriers existed in regard to the early identification of mental health problems and early intervention in rural mental health problems (R. L. Wilson et al., 2012; R. L. Wilson, 2009). Thus, understanding the emergent mental health help-seeking experiences was seen as relevant to better determine how timely mental health help can be provided to young rural people in the future.

The profile of the interview participants (5 males and 15 females) is presented in Table 4.5. Participants included three young people who were able to share their personal stories of developing a mental health problem and their experiences of factors that helped or hindered mental health help-seeking for them. A further three young adults were employed in professional or paraprofessional roles to provide help or services to other young people who sometimes had mental health problems, and one of these was a registered nurse.

Twelve middle-aged people agreed to participate in the study and of those, five had dual experiences that were related to their employed roles of helping young rural people, but they also had personal experiences of mental health problems for either themselves or their young adult children or relatives. Eight middle-aged participants were parents of young people with mental health problems and four of those eight had their own personal experiences of a mental health problem in their own lives. Three middle-aged people shared their experiences solely from their professional experience of providing help to young people. Only two participants were older adults, with one being a parent and the other a young people's mental health professional.

Consistent with case study research design (Yin, 2009), the findings from this study have been presented in themes. The diverse range of people who were willing to share their experiences for this study was sufficiently broad to inform the core themes and to describe the contexts related to the research topic. A logical chain of evidence formed and as a result, it was possible to develop some theoretical generalisations that arose from the findings of this study because enough people with enough relevant experiences from a wide socially significant capital pool within the rural region, as discussed in Chapter three (3.5.2), participated in the study. The results of the in-depth interviews for this study are set out as themes and sub-themes in section two of this chapter and they describe the common patterns of experiences that participants reported in this study.

4.5.2 In-depth interview participants' profile

The profile descriptions of the interview participants are presented in Table 4.5 with pseudonym of respondents listed in alphabetical order while the demographic locations of interview participants are listed in alphabetical order in a separate Table 4.6. This was done in an effort to protect the identity of respondents while demonstrating the geographical and demographical characteristics of the interview participant cohort for this study.

Table 4.5: In-depth interview participant profile

Pseudonym	Age	Gender	Personal experience	Professional experience
Barney	<30	male	Personal experiences of mental health problems self	
Bernie	> 60	male		Mental health youth health professional GO (health)
Christine	30-59	female	Parent (sons) & friend of young people with experiences of mental health problems	Community paraprofessional NGO (housing)
Clare	30-59	female	Volunteer parent helper at a high school with experiences of working with young people with mental health problems	
Connie	30-59	female	Parent (daughter) young person with experiences of mental health problems	Community youth paraprofessional GO (Justice)
Debbie	>60	female	Parent* (son) young person with experiences of mental health problems	Community carer advocate
Erin	<30	female		Mental health youth health professional NGO (health)
Esther	30-59	female		Community youth worker paraprofessional GO (local government)
Fiona	30-59	female	Parent* (son) young person with experiences of mental health problems.	
Joanne	30-59	female	Parent* (daughter) young person with experiences of mental health problems.	Youth worker NGO
Joyce	30-59	female	Aunt (nephew) young person with experiences of mental health problems.	Community para professional NGO (welfare)
Kevin	30-59	male		Community para professional NGO (welfare)
Lisa	<30	female		Health professional GO (Registered Nurse)
Martha	30-59	female	Aunt (nephew) young person with experiences of mental health problems	Community paraprofessional NGO (housing)
Mitchell	<30	male	Personal experiences of mental health problems self.	
Patrick	30-59	male		Community youth paraprofessional GO (Justice)
Sally	<30	female	Personal experiences of mental health problems self.	
Susan	30-59	female	Parent* (daughter) young person with experiences of mental health problems.	
Veronica	30-59	female	Parent* & aunt (son/ niece) young person with experiences of mental health problems.	
Yvette	<30	female		Community professional NGO (welfare)

Legend: Age: YA (<30 years young adult); MA (30-59 years middle age adult); OA (>60 years older adult)**;** **Personal experience:** a personal experience of mental health problems during young adulthood either self, or close family member. * denotes additional personal mental health problems experienced by the participant. **Professional experience:** Professional experiences of assisting young people with mental health problems; **NGO:** Non Government Organisation; **GO:** Government Organisation

Table 4.6: Geographical locations of in-depth interview participants

Locations within the New England region of Northern New South Wales, Australia	**Number of participants**
Armidale	8
Glen Innes	1
Invergowrie	1
Inverell	1
Moree	4
Narrabri	1
Tamworth	2
Tenterfield	1
Uralla	1
Total number of interviewed participants	20

4.5.3 In-depth interview results

The following Table 4.7 outlines the main themes and sub-themes derived from the thematic analysis of the data. Each theme and sub-theme is subsequently discussed in more detail later in this chapter.

Table 4.7: In-depth interview results: themes and sub-themes

Theme 1	**The characteristics of the emergence of mental health problems experienced by young rural people**		
		Sub-theme 1.1	Emerging mental health problems
		Sub-theme 1.2	Family experiences
		Sub-theme 1.3	Barriers
Theme 2	**How others help young rural people with mental health problems: the characteristics of helping**		
		Sub-theme 2.1	Convincing people that mental health help is needed
		Sub-theme 2.2	Basic core need dynamics of young rural people
		Sub-theme 2.3	The social network experiences of young rural people with mental health problems
Theme 3	**Lack of meaningful connection with mental health services**		
		Sub-theme 3.1	Muddling on
		Sub-theme 3.2	Stuck between a rock and a hard place
Theme 4	**Health, welfare and social service provider characteristics**		

4.6 Theme 1: The characteristics of the emergence of mental health problems experienced by young rural people

The emergent mental health problems of young people can be difficult to detect, and it can take some time for a diagnosis to develop (Early Psychosis Writing Group, 2010; R. L.

Wilson, 2014b). This difficulty in early identification was also reported by participants, for example, *it is very hard to put your finger exactly on it* (Christine). Theme one identified the characteristics expressed by respondents that describe the emergent aspects of mental health problems for a young rural person.

Early identification and early treatment can be further complicated by factors related to rural circumstances such as the availability of mental health services, close social proximity of rural people, and rural agricultural, mining and environmental dynamics such as drought, flood or fire and related agri-economic factors that accompany these circumstances (Allan, 2010a; Australian Bureau of Statistics, 2011; Boyd et al., 2008; Boyd & Parr, 2008; Department of Health and Ageing, 2011; Haslam McKenzie, 2013; *The Roadmap for National Mental Health Reform 2012–2022*, 2012; R. L. Wilson, 2007, 2014c).

It is difficult to extract the elements that predispose young people towards mental health problems, because some circumstances are fluid and not sufficiently stable to enable the causal factor or factors to be isolated or pinpointed. However, the ecological environment in which a young person develops, is nurtured, and matures influences the opportunity that the young person has to thrive or deteriorate. Where environments are poor, vulnerable individuals are not likely to thrive (Kellert, 2012; Krebs, 1985). Poor environmental impacts are amplified in the presence of emerging mental health decline, and in combination, for some young people they are overwhelming. The findings for theme one and its sub-themes illustrate the importance of the complex environmental influences that are brought to bear on the experience of emerging mental health problems. This theme presents the characteristics of emerging mental health problems, and the adverse social and environmental factors that interface with them for young rural people. It is not surprising that some young people who experience difficult circumstances will develop mental health problems, and this is related to their opportunities and environment. This concept was well described by the following participants.

> Quite often, (they are) quite young and they have got huge, huge, issues to deal with in their families… I don't see how a young person can grow up (thrive) in a family with massive domestic violence, and drug and alcohol issues (and with), a huge homeless population floating in and out of their house, and all the risks that can bring with it (Christine).

> What I have noticed with a lot of young Aboriginal people… they have been in gaol, are drug users, a lot with fairly bad family backgrounds, growing up in domestic violence (Martha).

> After swallowing 40 Panadol, my 12 month journey through psychiatric hospitals began. … One of the hardest things about that year was the shame of surviving… But inside I was me, scared, hopeless, but still me (Sally).

Anger

Anger was a characteristic that was frequently raised by participants and denotes a particularly challenging relational time for young people, their families, friends and others in contact with them. Anger was usually raised in the context of other extenuating environmental circumstances such as family problems, physical ill-health, school social degradation, drugs and alcohol misuse, homelessness, poverty, abuse and geographical isolation. The impact that these factors have on the mental health development of young people was seen to be detrimental among the experiences of people in this study.

Parents reported how they could see in retrospect the emergence of anger issues developing in their child. For example, one participant could look back and see a background of anger from the age of seven for her daughter. This, she felt was out of step with the experiences she had had with her other children, and that her anger was partially explained by her daughter having a congenital heart problem that required lifelong treatment:

> And from the time she was seven, this behaviour started to emerge…. quite violent behaviour when she didn't get her way … (Connie).

Barney, a young man who had experienced some challenging emotional times throughout his adolescence and young adulthood said that his more extreme episodes of anger coincided with his feelings of wanting to die, and his comments below are stated in this context.

> I just got angry, and so much and so easily … and I wanted to take it out on others more (Barney).

For this young man, a trigger for anger developed as a result of frequent disagreements with his father. He describes some of the manifestations of this anger in the following comments.

> …shouting and screaming. …conversation(s) with my father …ended in shouting and screaming, or in tears… I threatened him a couple of times with a knife. I thought about go(ing) nuts, and getting emotional, and killing as many cops as I could before they took me down (shot me). I remember sitting in the shed and looking at a geologist's hammer and wondering how many people I could kill with that, and how long it would take before the cops would just shoot me on sight. …my way of calming down was I would … break a car. …with a piece of reinforcement bar, and a rock, and a seat belt and I just hit the car… (Barney).

Despite these outbursts of anger, Barney could reflect back on his past experiences and considered that *nothing helped much*, to relieve the feeling of anger and this left him confused, depressed and despondent about what the future might hold for him. Similarly, other participants described how, although anger outbursts might have provided an initial outlet, that in hindsight, it was not helpful.

For several other participants, anger was triggered by the experience of having been subjected to periods of bullying or abuse. One participant described how bullying at school had fostered anger for one young person she had attempted to help and that the experience of anger was coupled with ideas of suicide, just as it had been for Barney.

> ...the teasing was worse… he had initiated the fight… he was just so angry and he really wanted to hurt that other boy…he got in trouble for the fight and on the weekend he tried to kill himself (Clare).

For some young people, their uncontrolled anger led to legal problems and sometimes to criminal and detention outcomes as the following participants indicated.

> …mental health problems… impact on their offending behaviour and so they end up in a juvenile detention centre and they have to wait to get (mental health) assessed there (Connie).

> I just bottled it up, and I became quite aggressive and angry. And basically I turned into a street fighter. I was 14… I was rebellious… If anyone gave me any form of stress, or confronted me, they would be sorry because I would violently erupt (Joanne).

> …the kids I worked with really seemed to take offence easily, and to put up this front. … if someone says something to you, just let it go, it is only words, we all get that in life, but they just couldn't get that concept … and they just had to retaliate. They couldn't let it go; it just didn't seem that that was part of their nature. I just didn't seem to be able to break through this mentality (Patrick).

> …there are a lot of kids, a lot of break-ins, and a lot of theft from cars… Because of the drugs and alcohol, and there is no home to go to. And, there are no parents to talk to so they stay in the main street and they steal ...(Esther).

> …we have got one young person, he's got mental health issues and it took us about four days to get him in just to see a counsellor over here at the hospital. … he gets really agitated, aggressive and he says I am going home to cut Dad's throat. So, you just don't know if he is serious because, he could. He picked his sister up one day and threw her into a tree. And then another day he was driving on the round-about with his dad and he said 'stop the car'. His dad said 'I can't', so he opened the door and jumped out on the roundabout. So you know – he has got a lot of mental health issues … we have got a couple of boys ...and they always have that look about them that they could just explode. Snap – yep (Kevin).

Drug and alcohol misuse

Drug and alcohol misuse was identified by some respondents as a factor that co-occurred or exacerbated the emerging mental health problems of young rural people in this study.

> …they are coming out of families that have a high level of drug abuse or domestic violence in their family of origin (Christine).

> ... a lot of young girls here… who are prostitutes, and, just for drugs… (Yvette).

In particular, some participants noted young people behaving oddly as though a psychosis might be developing and described their views about drug-induced psychosis.

> Alcohol has a high impact on the way kids turn out …(Connie).

> …in the very beginning… I had a feeling that something wasn't ticking. Because as most of them do, about that age, you know when they are 18, they go through a bit of this, and a bit of that, and with alcohol with his mates, and with marijuana… (Debbie).

> …he has been a bit like this since he was 16 or 17. He was smoking marijuana… we had a big conversation about it, and I realised that I couldn't stop him, and he has just got gradually worse and worse (Martha).

One mother participant who had an extensive family background of both mental health problems and drug and alcohol misuse, which included her own mental health recovery, considered that if young people were to use drugs, they should moderate their use and attempt to conduct their drug use safely. She held this view because she conceded that drug use by many young people was probably inevitable, and so lower risk drug use was the preferable form of this behaviour. It was interesting to note that she held this view even though her daughter had recently been discharged from an involuntary mental health unit following her daughter's first episode of psychosis, which was triggered by drug use.

> It is OK to use drugs in moderation. I have also seen youth who come from a fairly functional upbringing who have smoked (cannabis) too much, or participated in too much hydroponic marijuana that has these mental side effects as well (Joanne).

Some participants in this study identified a wide variety of drug and alcohol misuse that they related to the mental health problems and challenging behaviours they observed that were arising in conjunction with drug and alcohol misuse. To some participants the linkages between the mental health problems and drug and/or alcohol misuse explained the behaviours explicitly. The following excerpts illustrate the dual-natured problems:

> marijuana …alcohol just seems to be a rite of passage for these guys. … … you are a bit of a hero if you do it. There are no barriers to stop kids having smoko (cannabis). It is not something they see as wrong …it is just what you do. Same with alcohol. It is just what you do. Alcohol is more readily available to them and that is a big issue, or doing a break and enter, and stealing it. It is not so easy to do a break and enter and find some marijuana. But the alcohol is more available. They get intoxicated... And same with marijuana. There was one guy … Every time he had smoko (cannabis) he

was just this terrible person… anyone would look at him sideways he would belt them… He couldn't control himself (Patrick).

The psychiatrist explained that I was being scheduled and that I had elevated levels of alcohol and caffeine in my system. He explained that I had a psychosis and that I needed to get help (Mitchell).

…when we first started here we were just working with the homeless and hungry kids and now it is like it has just exploded into the heroin addicts and all that sort of stuff …whether they have gone home and had a big hitto (IV drug use) that night or gas (inhalants) and the next day they are coming down and that is when you see a lot of the mood swings.... A lot of them start on Ritalin… and their parents sell it (Joyce).

I think ice (methamphetamine) is the biggest thing. Yeah maybe ten years ago, it was more marijuana … now it is more the ice... (Yvette).

One respondent suggested that a possible way to reduce the purchase of drugs, alcohol and cigarettes was to use a social welfare voucher system so that cash was not readily available for the easy purchase of these items. It was interesting that this participant was a young woman herself, and held the view that limiting cash flow and removing a cash economy might be a solution to the drug and alcohol misuse problems that existed for the young people in her community.

Give them vouchers. Where you can't buy alcohol and cigarettes (Yvette).

4.6.1 Sub-theme 1.1: Emerging mental health problems

The characteristics of emerging mental health problems are defined and described by respondents in this sub-theme. They are derived from the real life experiences of mental health problem emergence.

Everything is disordered with her. I would query a level of depression… but they just drop out the edges of the system. They are not picked up when they might be a bit troubled. Sometimes the mental health issues are overt. You know that there is probably an issue when there is a third person in the room and joining in the conversation and they are actually not there! (Christine).

> …it just festers, and festers (Connie).

> Do they recognise something is wrong? And then know what to do? I don't know. I have got one child (young adult) that I think is probably melancholy and I have asked him on occasions, and I think a lot of it is environmental where he is at [working and living on a isolated farm]. …I asked him whether he thought he was depressed and he said 'no', but I think there have certainly been times in his life where emotionally he doesn't cope with things, and he was bullied at school… he tends to see things that aren't there (Veronica).

A steady state of flat mood and an absence of experiences of happiness, satisfaction or enjoyment were identified by one participant. The external and internal influences seemed to reinforce a continued steady state of depression and nothing seemed to help or to alleviate this poor and eroded state of mental health for some young people. In addition, this participant, Patrick, recognised that the diminished condition was not isolated to one individual but rather to whole families and so the ramifications of low mood as a steady state existed as a way of life for some people.

> I'd say with a lot of these guys that depression was so evident that it was part of who they were. It was very hard to see the depression. Because it was just who they were. …Because it was an underlying part of their life … I would say that it was something that they lived with. I think with some people depression it is up and down and then they go into this lull of depression. For me, I just see these guys that I was working with at a lower level all the time. So it wasn't this up and down into depression, out of depression. It was just this lower level of not smiling, not being happy, finding it very hard to enjoy anything in life (Patrick).

'Genuinely suicidal'

'Genuinely suicidal' was a term coined by one participant to identify the issue of suicidality and emergent mental health problems. Families are in uncertain and unfamiliar territory when their adult children are experiencing mental health difficulties for the first time, and it is difficult for them to assess when they need to seek urgent mental health help. They often make family-based judgments, in a similar way that clinicians make clinical judgments, about the risk of suicide, or the risk of harm. This following comment illustrates this complexity,

where a mother would only seek bed-based or involuntary mental health care for her daughter if she deemed the daughter to be 'genuinely suicidal'. This mother went on the explain that her daughter frequently had episodes of 'suicidal thinking' and self-harming behaviours, and that she talked about a preference for dying; however, these attributes did not equate to genuine suicidal risk in the mother's view. In this case, the mother was essentially sensitive to mental health decline and improvements, both for herself and her husband, as well as with her daughter. She was somewhat attuned to the fluctuations of mental states. Yet, determining the point at which external mental health help was required was difficult to discern for her. Thus, she waited until she felt convinced of genuineness as an indicator for action.

> I really don't want her to have to be admitted because I have my own personal hesitation to be admitted to a psychiatric unit. But if she was really genuinely suicidal then that might be the place she needs to be. If she was genuinely suicidal, then I would obviously just have to get the police or an ambulance. That would be the only option (Susan).

Other participants described their experiences of suicidal thinking during the emergent phases of mental health problems:

> On a morning in April, 2010, I gave up. I could see no way out of the darkness I was in and no hope for a future…I attempted to end it all (Sally).

> I quite seriously considered suicide for a while. And I knew it would hurt Mum, so that was one of the main reasons that I didn't (Barney).

> I thought about just being dead. I knew somehow I couldn't kill myself – I was in a hospital, but if I willed to die, that would make this all end. I felt a need to admit defeat as I could no longer keep up (Mitchell).

On a background of lengthy and insidiously slow mental health decline, participants indicated that it was difficult to instigate change that might improve mental health, yet one young female participant, Sally, was able to develop both some personal insight and her own internal motivation to embark on some help-seeking changes.

> For eight years I had struggled with Anorexia Nervosa and Bulimia, never letting anyone know a secret that was killing me. From… 13 to 20 I was consumed by

> undiagnosed mental illnesses… self-harm, eating disorders, PTSD and depression were my life, but nobody knew. In December of 2010 I came to the realization that I needed help. I told someone close about my illness and set about searching for treatment (Sally).

4.6.2 Sub-theme 1.2: Family experiences

This sub-theme identifies and describes the experiences of mental health decline in the context of the family environment of young rural people. Family and emotional connections were frequently described as deplete of quality bonding or strong emotional connection. People seemed to express a lack of satisfaction and enjoyment of family life, and many participants described home environments where arguments, threats, violence and abuse occurred, and this proved to be an ecology in which adverse mental health conditions and behaviours flourished. The narratives that follow highlight some of these experiences within families of participants and/or their clients.

> She was living in the home with her kids and the schizophrenic (sic) brother and (he) was violent towards the family members, all of them, including her children. It's not unusual, young, very young women with …five, six children. And the mothers are under 25 (Christine).

> There was one kid I worked with, and his family was a really nice family. Trying to do well. Trying to look after him and help him. And he was the sort of kid that was pretty level. Like he would talk to you, and smile, there was an expression on his face. Whereas the other kids I dealt with, came from families that were just really struggling, and (with a) really poor attitude of life, and there was no expression of happiness or anything. … so I think their family, and the house that they come from, as in the people in the house that they come from, really impacts on their everyday outlook and how they react to things and interact (Patrick).

> I got into a dysfunctional relationship when I was 16. He was awfully violent, it wasn't very good, and then at 18 I fell pregnant and my first daughter was born… I was hoping it would fix the relationship with my partner, and of course it didn't. He got worse and I had to protect her. So I was forced to leave him, and we went off on our own for about a year and a half (Joanne).

Families are units where love, care and emotional connection ideally foster humans to develop and thrive in every sense. According to the respondents, when these characteristics were absent or scant, mental health and other problems gained prominence.

> ...he was just this kid that was sad just all of the time. No one loved him. He felt that no one loved him, and poor esteem from his mum. His mum kicked him out of home. His grandmother took him in, but then they had issues and she took out an AVO on him, and so he couldn't live there, and he went to live with his grandfather... But that didn't work out, his grandfather tried to give him everything that he wanted, and he just got abused in the end… I don't think I have ever seen that poor kid smile. So he is just a sad kid, and then he would have those lulls within that about 'life is hell' and 'everybody hates me' (Patrick).

In some circumstances the drug activity of the parents and family members contributed to the low quality environment for young people, as in the case that participant Patrick describes below.

> …marijuana…if they can get their hands on it, unfortunately there were some guys that I dealt with and their parents were dealing so it was quite accessible for them. And they could get their hands on it. And so they had a lot of smoko (Patrick).

Some participants under-rated their family experiences of helping other family members with mental health problems. Veronica, a participant, seemed to have many experiences of helping people with mental health problems and later in her interview, discussed the support she provided to her son, and his friends, who experienced emotional problems and in one case psychosis; however, she minimized this exposure to mental health problems and suggested that she had not gained much experience. This seemed incongruent on one level, because Veronica did not seem to recognise that her close connection with significant people in her life was influenced by a context of a range of mental health vulnerabilities. The mental health ecology of her family life seemed saturated with mental health adversity in various forms. Her comment below illustrates some of her experiences.

> I have a niece who gets quite depressed and has mental health issues. I don't know that she has got a diagnosis, but certainly there have been occasions of concern with her and whether she would do something to harm herself or not. Also my mother

> experienced panic and anxiety after my father died. So I saw a bit of that … nothing that was like a critical mental illness that I physically helped anyone with, probably more just a chat. Had a couple of instances of a bit of anorexia in the family. …and in-laws with acute anxiety and relational difficulties I suppose. Not a lot of experience really (Veronica).

One young participant, Barney, was able to provide some insight that describes the emotional landscape of a young person in a rural setting who does not have the ecological conditions, heredity, biology and systems to support emotional thriving based on his experiences. A result of these conditions for him was that he noted some dissonance between his capacity to know of, and to actually experience, the internalised feelings of being loved within his family setting.

> I could see that I was always loved, but I couldn't feel it. In hindsight I can see that it would have looked to others like it was my problem. But in hindsight I can see that it was not just my dad's problem but it was his father as well, the generation before him, because I don't think my dad was shown how to be a loving father by his father, or by anyone, ever. So that would have put some barriers there. My brother had a few issues with my dad as well (Barney).

Some respondents also believed that parents also experienced emotional labour when the mental health difficulties of their children escalated and one non-drinker mother participant, Debbie, describes her emotional challenges and her strategy for coping on one occasion.

> I know when my son was going to (involuntary mental health unit) for the first time, I was a bit apprehensive, you know I couldn't sleep, and anyway I said that to my husband... and he said 'Well look that wine that is in the fridge, is it any good?' and I said 'oh I think it has been sitting there for 12 months' it was half a bottle of white. He said, 'well it tastes all right, taste that' and he gave me a glass, and down the hatch, and I said, give me another one! Down the hatch! I had no problems sleeping that night! (Debbie).

This study showed that for some young people, the reality of their lives is that they are constantly in a compromised family or home environment that poses major threats to their thriving capacity in physical and emotional senses. Some young people do not recognise that

they are in an environment that is sub-optimal, because they are in the midst of growing and changing. However, they are not subject to any rich environmental experiences so they remain unaware of the contrast between the ranges of positive and negative environmental experiences. Their emotional attachment to their parents, or care-givers, further reinforces this inflexible state of emotional existence.

Joanne, a participant, was able to reflect on her experiences and her narrative revealed many aspects that may have predisposed her towards her own experiences of mental health problems during her adolescence and her early adulthood. A common aspect which unites Joanne's experiences with those of some other study participants is that these types of stories are recounted in a 'matter-of-fact' voice and tone, and with an acceptance that these types of occurrences are commonplace and therefore of little importance. Yet mental health clinicians would recognise the context as a significant matter, and one that is congruent with mental health vulnerability and decline. The extent of Joanne's experience and her reflection on it indicates that poor environments have enduring consequences that are not easily dealt with in terms of mental health and wellbeing.

> There feels like there is no safety zone for us kids, especially when you know that the authorities- DoCS (Department of Community Services) might come at any time. Especially when… you are scared of them too. It is like hell. Where is there to go?... if you don't feel your parents can protect you? Basically my upbringing… the trauma was extensive. We witnessed child molestation, violence. I had witnessed every form of death by the time I was 12; including murders, suicides. This is just roughly touching the surface for you. We witnessed things like bestiality. Just walking in on somebody doing the wrong thing with an animal. There were a lot of occult practices. Just absolutely horrific devastation type things that no child should ever have to experience. And in my opinion, when you see things, there are some things you just can't unsee (Joanne).

In some circumstances the shared care of children and adolescents created an adverse condition and a participant (Patrick) describes his frustration about this in the comment below:

> It was frustrating with the Aboriginal community. That if a kid got in trouble at home, then he'd just go to an auntie or an uncle's house and be warmly accepted into that home, which is nice in one way. But the problem was if he had done something, and got in trouble and his parents had maybe grounded him or something. He'd just climb out the window and go and turn up at aunty and uncle's, and they'd say 'hi, why are you here?' and he would say 'oh I got in trouble at Mum and Dad's house', and they would say 'oh well, come on in!' And so instead of there being any discipline, he'd live there for a week or two with the auntie and the uncle, until everything settled down at home and his parents would say come back and that was the end of it. And so there is no discipline. … if there are no consequences for your actions that is what happens. And so the kids I was dealing with all the time. …there were no consequences for these guys, for their actions because they just move around (Patrick).

Sometimes it was evident that family support was strong and that this was an important characteristic related to effectively helping a young person with a mental health problem.

> Well, (the) mum is really open about it, so it is just trying to support her, and let her have a cry, and not be critical or judgmental of what was going on. Because, if you're not in that situation, you don't know how you would react and this lady is a really good mum, but the little girl, when you looked in her eyes, she just wasn't there. You could really see that she had really left you, just by looking at her eyes. It was just no kind of interaction or recognition or anything (Veronica).

4.6.3 Sub-theme 1.3: Barriers preventing engagement between young rural people and mental health services

There are a number of barriers that prevent the successful engagement of young rural people with mental health services; such as, difficulties with transport, geographical isolation and distance, as well as the changing dynamics of communities such as transient DIDO and FIFO workforce populations. Relocation is sometimes a factor that helps some young people to access the help they need for their mental health problems, and certainly a participant, Barney, felt that a move away from an isolated agricultural property and into a town environment assisted his emotional wellbeing significantly. Other participants in this study also commented that relocation had either been helpful or had adversely impacted the mental health of rural young people. Some participants reported temporarily relocating to live with

family members in metropolitan centres in an effort to access adequate mental health help that was not available to them at their rural community residence. Other participants indicated that some people wanted to do this, however, the financial and vocational strain of doing so was prohibitive.

> …it took a long time for things to change after we moved into town, a long time being at least two years (Barney).

Transport

Transport was identified as a significant aspect in relation to the geographical distances that need to be travelled in rural communities to achieve social and cultural connection as well as access to health, vocational, and training opportunities. In rural communities, there is very little public transport available for young people to access and there are low socioeconomic circumstances for some families. This means that there are some family and social groups without cars, that is, car-less families, car-less extended families, and car crowding, that is, where cars do exist, more passengers than seat belts to accommodate them. The quality of cars owned by these groups are often older vehicles, used for employment purposes, expensive to operate and offering less reliability. The cost of fuel, maintenance and other vehicle ongoing costs are prohibitive for extended travel for many people, which, for example, may make travel to regional or metropolitan centres to access mental health care or other health services, an impossible and unrealistic goal.

> …if you are working out here at a mine, doing your apprenticeship, you can't necessarily afford to go into Tamworth, two hours away…they are not putting the resources further out where they are actually needed (Erin).

> I know of some people, of whole communities where they really have to plan to just have enough petrol in the car. I know that is true for a lot of young rural people and their families (Bernie).

Alcohol and driving is a significant matter in rural areas, and particularly in regard to the scale of distances that need to be travelled. Young people were identified as being a population available to provide transport to others, such as employers, who had lost their driving licence for various periods of time, only to be taken advantage of in regard to employment and training prospects. This factor is relevant to the discussion because it is an environmental

factor that provides context for inevitable disappointment that must eventuate for young rural people and because factors such as this influence emotional mental health and wellbeing. The example below illustrates this point aptly.

> We also have a huge drink driving issue. A lot of DUIs around this neck of the woods. So you can lose your apprenticeship because you can't drive, but you might have got that apprenticeship as either a sparky or a plumber apprentice, because your boss couldn't drive (DUI) so he took on an apprentice just so they can drive him from point A to point B. And then they lose their apprenticeship when he gets his licence back… And that is another huge issue. There is a lot of non-completion because as you go further on you have to pay your apprentices more money (Erin).

Isolation in rural communities

In this study, isolation related to non-driving in rural communities was noted as a factor that contributed to the wellbeing of young people. One participant, Susan, said both she and her daughter had difficulty maintaining social and practical contacts with others. Susan did not have a driving licence, and her daughter was reluctant to seek a learner's driving permit, although she was at an age where this was available for her. The family of three live in a small rural town where there are no mental health services available in that community. There is a daily bus that is available to transport passengers to the next town approximately half an hour away; however, the timetable is limited, and a return trip accommodates a full day. This is sometimes inconvenient and not practical for people such as her daughter who take medication that has side effects that include sleep disturbances. The ecological factors related to the successful use of public transport in this instance, are complex and impact on the feasibility of usage for some people.

> I don't have a licence…buses are the only option and there are only a couple a day, and even then, only on some days. Transport options are fairly limited. If there were an emergency, I can't wait for my husband to come from the next town, obviously I can't wait for the bus to take her in…I would have to get the police or the ambulance (Susan).

Distance

Distance could also be considered from a digital environment perspective. It is common for many families to have internet-connected home computers, tablets or smartphones (R. L. Wilson et al., 2013a), and e-mental health strategies and interventions will become more common and relevant to rural people in the future (R. L. Wilson, 2014c). However, it should be noted that many vulnerable young rural people do not have access to digital or cyber-based mental health care or other services. So, despite relative digital landscape proximity in terms of availability for purchase, a significant digital distance remains. Tele-psychiatry and e-mental health are floated as a panacea for the inequity of rural mental health service provision, but the reality of such an approach reaching a significant vulnerable group is still in its infancy and it is not yet a suitable substitute for face-to-face mental health service provision (Early Psychosis Writing Group, 2010; Rickwood, 2012).

Another factor that was identified was that despite the good quality and evidence-based online web-based services that are readily available, including to the rural people in the locations for this study, the navigation of these services can be difficult for some people. Navigating the digital landscape and a requisite level of digital literacy is not homogenously applicable to all of the individuals or clients of participants in the study. Thus, when complication of mental health problems such as cognitive decline has commenced, digital help-seeking is more difficult.

> …everyone says that it is good to use teletherapy… we don't have good enough, fast enough or capable enough internet connections in this region to be able to offer that… we don't even have decent digital TV that doesn't drop out every two minutes. How do we expect to offer telemedicine? It basically doesn't work…. And remember we are talking about many people who don't have the finances to own an iPad. So, it is the poorest of the poor who get screwed with telemedicine. If you are rich enough to have an iPad, you are probably rich enough to have private health insurance… or the wherewithal to get services… (Erin).

> When they were ready to discharge my son from hospital they should have arranged a videolink (telehealth) up at the hospital so my husband and I could have judged for ourselves to see that he was prepared to come out of hospital. I would know just by looking at him, the way he walks and moves, after all these years you sort of know

> these things…I have got skype on my computer and …we could have used that, but they didn't, just the phone…When he got home (after four hours travelling by car) I said 'My God, what have they done to you? Good God what is wrong with him?' He was walking like a 90-year-old man, he looked drugged-out, he couldn't hold a sentence… (Debbie).

Fly-in-fly-out/ Drive-in-drive-out.

FIFO workforces have been very disruptive to many rural communities, which often find it difficult to plan services and infrastructure to accommodate the influxes of larger transient populations. To date, there has not been sufficient Australian census data collection to understand the extent of the FIFO populations or their service needs (Haslam McKenzie, 2013). In addition, it is recognised that local authorities are not able to capture rates from this population, so the ability of small communities to service a FIFO population lacks a financially sustainable basis. The burden then falls to the resident-wide smaller community rate-payer population to develop services that can accommodate the FIFO population (Haslam McKenzie, 2013). According to respondents, some communities in the research study region experience the challenges of a mining FIFO workforce, which has seen relatively recent large transient populations of mining workers set up temporary housing 'camps' known as 'MAC' on the outskirts of one small town (Narrabri), and these challenges have impacted and stretched the health service delivery capacity of the local region significantly. The impacts for local young people are raised here.

> We have gas mines and also coal mines in this region. A lot of young people earn serious money working there. A lot of them leave school in year ten, and there are a lot of anxiety, depression and stress problems with them. But a big issue is that both state and federal governments are under the assumption that everything from education to mental health like 'headspace' is nice and close. Well guess what? It isn't. The nearest mental health centre is 2 ½ hours away from where I live… and there is nothing specifically for children. We don't have a 'headspace'… (Erin).

4.7 Theme 2: How others help young rural people with mental health problems: the characteristics of helping

As previously discussed in Chapter Two, mental health help for young rural people can be provided by a diverse range of people in a rural community. Some of the dynamics about how this is achieved and how it is threatened are presented in this theme.

Some parents described the criteria they used to select mental health helpers for their children and revealed some of the shortcomings as well.

> I went to see her first, because I didn't want some raging feminist…I thought he probably needed someone who was gentle with him, because… to me he seemed quite damaged. And I think she was that, but after a couple of weeks he just decided that it wasn't doing any good. I only went along and met her beforehand… I thought she was the right person, but then when I went to see her after he stopped going and she seemed really airy-fairy to me…I knew I couldn't stop the train wreck and I knew I had to be there at the end of it, but I knew I had to get off it. Because it was just doing my head in, and everyone else's in the family (Veronica).

A person-centred approach was used by a policing participant (Patrick) who used a simple framework of treating others as he would like to be treated as an effective way to help young people, but it took time to build rapport and to achieve results.

> …treating them how I would want to be treated, just as people, treating them well. Speaking to them how I would want to be spoken to… they would see that I was trying to help their kids… I would sit down and … and say 'look this is what little Joe Blogs is doing. I am not here to arrest him, or put him into gaol. I am here because I want to help him to not get into trouble… to find out if he is hungry. Instead of stealing a pie, let's find another way to get him food so that he is not committing a crime'. So I tried to work with them, and to explain why I was doing it, and that I was actually trying to help him. …I had to make it clear that if he does the wrong thing, I won't arrest him, but there are other coppers who will. I have got no problem with that, but I am here to help, and I don't want him to get locked up, and I don't want him to commit crime either. …Doing that sometimes had me at odds with my colleagues,

but got you some usable ground in preventing these young people from reoffending (Patrick).

Moving and changing

Moving and changing jobs was a helpful action that was initiated by the son of one participant. The family encouraged and supported this move and recognised the importance of this step. The following excerpt describes his mother's recollection of a recognition of positive change in the young rural man's life (her son):

> …yeah he came through that period, and in order to do that, he said that he wanted to come home, so we went and got him. Because he had to move his job. He was doing an apprenticeship at the time, and so he finished his second year and he resigned and went and worked with his brother-in-law on a rural property… And I think that was really the saving grace (Veronica).

Hope

Hope is a well-known concept in the mental health intervention context, and the instilling of hope is a recognised mental health intervention (Barker, 2009; Kylma, Juvakka, Nikkonen, Korhonen, & Isohanni, 2006; C. J. Wilson, Deane, & Ciarrochi, 2005) that is believed to improve mental health and wellbeing and reduce suicide risk and vulnerability. Knowing how to assist a young person to regain a hopeful outlook for the future is a concept that was apparent in the interview data. The following quote illustrates the importance of orientating a young man towards hopefulness, in this case his grandmother was able to achieve this.

> …that REALLY helped, because she knew how to steer the conversation, and she knew how to point me towards hope again (Barney).

One participant suggested that a wider public conversation about suicide was necessary because in having this, the community would be more likely to be able to recognise suicide risk and vulnerabilities and recognition might lead to preventative action that would be a good thing for rural communities.

> If we don't discuss suicide, does that make it easier for people to miss the signs? (Erin)

4.7.1 Sub-theme 2.1: Convincing people that mental health help is needed

This sub-theme identifies the challenges that arise around convincing people that mental health care is, or could be, beneficial. Sometimes service providers attempted to convince people that they should seek mental health help. On other occasions, parents and young help-seekers tried to convince health staff of legitimate mental health needs. It was apparent that both health professionals and help-seekers found it difficult to be heard when the need for help was identified by at least one party. The following quotes from participants demonstrate the lack of hearing or listening that occurred, and the efforts to be heard and convince others when mental health care is required.

> Our clients, across the board, are hugely reluctant to go to the community health centre. Nine times out of ten times we will talk to them about counselling and referring them to a counsellor, and they won't go (Christine).

> I think they should be starting to assess them (for mental health problems) in primary school, year 5 and 6, and BINGO! …some people here say they shouldn't be taught safe sex at that age, but if they live in (X community) they better! (Joyce).

> I don't think there are words to describe feelings (Barney).

> I had a young person through work about three weeks ago that was doing very bizarre things, threatening, sleeping in a cupboard… trashed police cars out the front of a police station. …even the people he was living with said they were really worried about this kid. So the magistrate sent him up to (involuntary bed-based unit named) for an assessment, and within two hours they had transported him back to the police station saying there was nothing wrong with him (Connie).

> When I arrived at the hospital, I made my way to the triage nurse. She looked at me and said I looked fine. I tried to explain I didn't feel right, but I didn't know what was wrong with me and I couldn't really explain why I felt something was wrong with me. (Mitchell).

> …we went to the hospital and requested help, they sent the police after him…I tried to explain that he doesn't need to go to gaol…he has never harmed anyone…I just worry

> when he starts talking nonsense…that was upsetting… my son is not a criminal… nobody would listen. They said it is just standard procedure (Martha).

Do workers blame parents?

It is possible that mental health workers hold parents responsible for the mental health wellbeing of young rural people. A psychologist participant who visited a number of rural towns to provide mental health services indicated that there was, generally speaking, a deficit in parenting talent. This predisposed young people towards poorer wellbeing and lack of success generally, and these vulnerabilities were a risk in regard to the development of future mental health problems. Her comment below suggests that parents need additional education to successfully provide a healthy environment for a young person to thrive, and that these resources were missing in rural locations. She has identified a problem, and a target group who may benefit from an intervention; however, it is not clear if parents would share the same view. It is not known whether those parents would utilise such a resource if training resources were available to them. It is a conundrum that on the one hand a need has been identified by the mental health worker, but it is unknown if her proposed solution is useful, or if this is merely a convenient node on which to locate a problem: that is, that parents require parenting education and in a sense are to blame for their inadequate functioning as a parent. In this case, the mental health worker aims to convince the parents that change is needed and a particular course of action is warranted.

> …a lot of the young people that live in the country areas, and I am not saying all, I am just saying a lot of them, don't seem to have good boundaries to place their bearings. Because there are not a lot of good training facilities for the parents… when the training occurs, it occurs way too late. It is when the trouble is so advanced that there is nothing you can do about it (Erin).

Another mother respondent indicated that mental health professionals frequently made decisions about the origins of problems but that these conclusions did not always have synergy with the experience-based views of the family. For this mother, past 'traumas' did not resonate as a reasonable explanation for the basis of the problem, and that even if common adverse life events had contributed to the problem, it was not useful in terms of dealing with the present pressing circumstances to attribute an origin to the problem without a sound basis of evidence on which to underpin such a view. Mental health workers who focused on the

point of origin of problems did so at the cost of damaging a therapeutic rapport with the client and carer, and in doing so they extinguished the hope of recovery. The experience of this parent was that mental health service was not a trustworthy or reliable source of practical and proper help.

> I am sick of counsellors just saying it is because of all these traumas in her (daughter's) life. There are not that many really. There was a marriage break-up and then there were a couple of significant deaths, but nothing more than any other person experiences, but it was a lot more pronounced with her. And in saying that too, I have got a 20-year-old son who I have never had a day's problem with. So it was definitely, you know they were both brought up in the same household the same environment, the lot… it was just so hard to convince anyone, even police (Connie).

Mental health literacy

As discussed in Chapter Two, mental health literacy programs are often considered a solution for community mental health; however, the evidence to support these notions lacks rigour (Wei et al., 2013). It is not yet established that mental health literacy programs have a positive effect in regard to enhancing mental health knowledge, reducing stigma, or improving help-seeking behaviours for the young person cohort between 12-25 years (Wei et al., 2013). Additionally, there is no evidence to suggest that mental health literacy programs are harmful or counterproductive to improving knowledge and help-seeking (Wei et al., 2013). It is recognised that mental health literacy program implementation research is still in its infancy and that further research is needed to test the effectiveness and demonstrate the usefulness of mental health literacy programs (Wei et al., 2013). Despite this lack of evidence, there are calls for continued implementation of mental health literacy programs for young people, including from participants in this research as demonstrated by the comments below.

> I would like to see mental health studies introduced into high schools, especially for depression and schizophrenia. Because I think knowledge is power; power to recognise what you or what someone else is going through, knowing how to address their pain. To take the necessary steps to have something done… they just need to be equipped (Susan).

> Suicide… self-harming…if we don't discuss it, we are pretending it doesn't exist…Do we need to put in a mental health first aid for teens? Hell yes. (Erin).

It is apparent that mental health literacy is not entirely one directional. Mental health awareness programs such as Mental Health First Aid™ (MHFA) (Jorm, 2012; Jorm, Kitchener et al., 2007) have taken the view that if mental health literacy is enhanced and awareness of mental health is improved in communities, then this will improve mental health and wellbeing, and reduce stigma related to mental health problems generally. MHFA have been able to attract 1% of the Australian population to take part in their 12-hour training programs, and this can be noted as a significant success (Jorm & Kitchener, 2011). However, 99% of the Australian population has not undertaken MHFA training, and this leaves a considerable population that may, or may not, have the knowledge and vocabulary to articulate early mental health decline. It is therefore important for health professionals to be literate or knowledgeable about how people express their mental health problems, the vocabulary that lay people use, and the types of expressions related to behaviours and thoughts that do not readily lend themselves to health language paradigms (Happell et al., 2014). It is especially important for mental health professionals and emergency department clinicians to develop literacy about young people's mental health problems as expressed by the young people, their families or their peers. The following quote from the data emphasises this issue.

> …when you are dealing with young people, it is a different ball game… you have got to be approachable, you have got to have a different language, a different kind of speaking…perhaps a little more laid back, because they will not open up, they will not feel safe, if you are not a genuine person… distrust goes up immediately (Joanne).

Access to services.

During the course of this study there have been some significant changes in the access to mental health service practices within the area health service located in the study region. At the beginning of the study period, a mental health intake telephone number (1300-type) was available to the public, and registering with this telephone number was the formal prerequisite process for gaining access to a first appointment, commonly referred to as 'intake' by health professionals. The telephone number was not widely advertised beyond local health professional networks, or the local telephone directory (hard copy and web-based). The call

centre for this service was operated by Hunter New England Health Service in a Newcastle office, and outside of business hours, the calls were automatically diverted to the bed-based mental health service in Tamworth for the New England region. A limitation of this 1300-type of telephone service was that it was not possible to call the telephone number from outside of the geographic region of Hunter New England Health Service.

The limitations were recognised by the health service and a change was implemented in April 2012, with a new triage *NSW Mental Health Line* and an 1800-type telephone number established for the state. The new telephone number has not been widely advertised to the public to date. Registering a call with this number is the process used to establish a first appointment with a public mental health service in NSW. Alternatively, presenting to an accident and emergency department of a public hospital is also an entry point for the public to access public mental health services. However, the telephone registration is the preferred entry pathway for new mental health requests for service. Upon calling this number, the caller is greeted by an automated message informing that if an emergency has occurred, then the caller should hang up and call 000 for the police, ambulance or fire service. If it is not an emergency then the caller should choose from one of three options, and select an option by pressing the corresponding number for that option. A diversion to the appropriate department then takes place and if the caller has selected an option to speak to a mental health clinician, they again hear an automated message that advises them to hang up if they are experiencing an emergency and dial 000 or to hold the line until a clinician is able to respond to the call. During the call waiting period a variety of pre-recorded general health promotion advice information can be heard; for example, advice about low risk consumption of alcohol, using sunscreen in the outdoors and other general information. The call is placed in a queue until the next available mental health clinician answers the call. The process is repetitive and is dominated by automated functions that use at least three different audio voice personas across the range of automated instructions prior to speaking with a real person, in real-time. In addition, it is a requirement to listen to a number of options, remember the options, and then select appropriate options in order to achieve communication with a mental health clinician.

It is common for a person with a mental health problem to also experience thought, cognition and logical processing problems, and this combined with poor persuasive speech may pose some challenges for a person seeking help. To telephone a mental health intake line and

convince the intake officer that one meets the criteria sufficiently to be provided with an appointment to see a mental health intake clinician for initial assessment is a complex set of interactions and procedures. This can be difficult for people with deteriorating mental health. In this study, some respondents pointed out the difficulties that are experienced in accessing mental health services using the mental health telephone triage process. One participant indicated that it was a common practice in some systems for people to circumnavigate the telephone intake system, whereby some services and clinicians share direct line telephone numbers. Thus, there was a parallel system that operated as a local work-around to avoid the cumbersome state-wide system; however, it is based on personal, local, trusted relationships between service providers and clinicians of various types and services.

> If it is something serious…they try and get in through CAMHS, the Child and Adolescent Mental Health Service intake number, which gets vetted via the phone in Tamworth to see if they are suitable as a CAMHS client…and there are huge waiting lists… if you have to see a psychologist, you have to go through the intake number and the intake officer…it is a phone call…and you have got to say the right things, and hit the right buttons…suicide… an attempted suicide will always work, attempting to kill someone else doesn't classify. CAMHS is really hard core, and we don't have enough. The reason they are so hard core is there aren't enough clinicians to see the clientele (Erin).

> …you have to phone up and do intake. Lost them already. Not happening….it is the biggest barrier…they may learn to trust it…but that first intake thing doesn't feel good. For one thing, you have to tell your personal stuff to someone on the phone, you can't even see them (Christine).

> I am not sure if a young person can make an intake call for themselves…I promote the intake number with a card and posters and by emails as I travel around the district. The number has recently changed, it use to be Newcastle, but now it is state-wide, so it has become bigger. Wherever you are, at anytime you can speak to someone… It is not like lifeline, it operates in a slightly different way. It is a system and there are processes to follow. …intake numbers are distributed within systems (eg education systems, anglicare, GPs school counsellor). Quite often it is direct between school counsellors and CAMHS clinicians. It seems to work well. The direct lines seem to

> work well. It is up to promotion and prevention (another department) to tell the rest of the community about intake numbers so that they can use them when things go a bit pear-shaped. I think the structures are there. (Bernie).

One participant recognised a need for access to mental health services for young rural people. She indicated that while her expectation was that a GP would be able to contribute some assistance, that something else was needed. She reflected on her experiences with her babies and how she had used baby health clinics, and that this had provided her with the support she needed during the early years of caring for her babies and young children; however, a gap of a similar service existed for the needs of adolescents and young adults. The quote below describes her experiences further.

> I guess the GP is the one you look to first for guidance on this type of thing because we don't have that much experience in it, even though there is a bit more education around nowadays. You know when you had babies you use to go and see the clinic sister? So it is not as if there is someone accessible like that. It would be good if there was (Veronica).

4.7.2 Sub-theme 2.2: Basic core need dynamics of young rural people

Many respondents considered that young people were more likely to enter into a downward life spiral if their basic needs of safety, food and shelter were not adequately met. There were many examples in the interview data of inadequate housing, lack of food, exposure to domestic violence and sexual abuse that impacted on young people who also experienced dual difficulties with crime and mental health problems. Some examples of these deficits in basic needs for young people are demonstrated in the following participant interviews.

> Housing… growing up homeless is no way to improve anyone's mental health. Overcrowding isn't either. But having a house isn't the whole solution. It is a damn good start. You can do parenting training till your teeth drop out, you can put in good public health things, you can send them to the best school, but if they go home to a house with 20 people and no privacy, and Uncle Bert is a bit funny, and the big brother's shooting up, what have you gained? (Christine).

> Alcohol… maybe it is not a basic need, but they want to drink alcohol and they will do a break and enter for alcohol. But I would say food is the biggest one. And it is

because they are just not getting it at home. They are not getting food at home (Patrick).

Oh it is – a bed, food, really. And an environment where your mother isn't getting bashed or... there are not 20 people in your front yard drinking all day and gambling, playing 'cuttleman' as the Indigenous call it (Joyce).

Because that is what they do, they go to Woolworths in the morning. I see kids walking out with chocolate and a bottle of coke to go to school with and then the rest goes on grog (Yvette).

We run a regular cooking group, to teach people how to cook if they don't know … and they take home the leftovers so they have something for dinner that night. And talk about nutrition and hygiene and you know fairly low scale, easy to understand way... it's just that a lot of people have never even been shown how to do even the most basic things (Martha).

4.7.3 Sub-theme 2.3: The social network experiences of young rural people with mental health problems

Social successfulness

Social successfulness is a developmental milestone that young adults need to master. Social milestones have a significant impact on the robustness of mental health and successful thriving in all areas of adult life. This sub-theme outlines how the social networks and experiences of young rural people impact on their mental health.

That is where I got really frustrated in my job, of just hitting my head against a brick wall. I can help these guys for half an hour a day or an hour, but they are going to go home to their families and it is going to be exactly the same. And that is what really frustrated me... (Patrick).

And because of her sleeping problems, because she is not sleeping till 4 or 5 in the morning, and then having to sleep through until lunch time, she is probably getting half a day. She is doing lots of craft, she has motivated herself, she has a stall at the town markets …she has only done it every now and then. But she wants to do every one. That is a really positive step for her. She doesn't socialise. That is one reason I

really want her to finally get her car licence. And I say to her 'It will be really good when you are independent, you will be able to drive Dad to work and then have the car for the day.' And Kim's attitude is 'Well what would I do? Where would I go?' I think that is probably part of the depression… kind of apathetic, well what's-the-point attitude. But maybe when she does have her licence, and she can drive herself around, and even if I actually just do a few things with her – go indoor bowling, or go to a movie or something, and then just encourage her to do things on her own. Perhaps that will get her kick started. But the sleep problem has to get resolved. She is not getting quality sleep, even though she is sleeping to lunchtime. She is exhausted all the time and it is not helping her want to have a full life (Susan).

But I think peer pressure is a lot to do with it. Like if you want to fit in with me, and then come, and we'll have a joint. You know, and there is a lot of peer pressure and you know there is low self-esteem. They don't believe in themselves (Yvette).

… he doesn't have the ability to maintain a relationship… (Martha).

I asked him if his mum and dad knew about the bullying at school... He said they didn't know how bad it was, and just told him to ignore them. I told him he really needed to tell his teacher and his parents, and that I'd go with him to tell the teacher if he wanted that support. He didn't want to upset his mum more at that time (Clare).

Church-based experiences

Church-based experiences, faith, and relationships were important to some participants in this study, and for some people they offered useful supports. One participant had noted that a young woman in her local church had experienced a mental health problem, and while she was unable to fathom the problems herself, she stated in her interview that she was grateful to be part of a church community where there were others who were more able to understand and support the young woman. The community of shared caring within the context of the church setting, demonstrated a micro social network within the wider rural community that was able to contribute helpfully to the broader mental health ecology of the community.

> I have seen a young woman at church. I've known her since she was eight and just such a lovely, lovely girl. And just seemed to have everything going for her, and very talented in lots of things. We went on a picnic, and I saw her arms... and my heart really goes out to her. But, I really don't understand how she has got to that point, and how to help her. I am not really a warm friendly cuddly sort of person, whereas other people are. And I haven't really approached her as somebody to talk to, even though I have known her for a fair while. I don't feel I have got the skills to do it. And it is just a big murky area. It is just too big and murky to get my head around… mental health just seems a very long hard road. (Fiona).

Loneliness

Loneliness and the absence of a social network adversely impacted the mental health of the daughter of one parent participant and she describes this impact in the quote below. Other participants described a sense of loneliness for themselves or that they observed this characteristic in other young people with emerging mental health problems.

> I would say to Kim do you want to go and do this? And she'd say 'I don't want to'…She was like that because the incredible discomfort she experienced every time. And I am sure if I'd known at the time, if there had been a diagnosis then. Then it would have made it so much easier for me to understand her needs. But instead it was just a total struggle. To get her to participate in anything. I really wonder how she would have gone if she had been at school. If she had been forced to be in a social situation five days a week. She did that at school for her first four years of schooling. And ended up a very introverted person after being bullied. So that is why I started homeschooling her in the first place. Just don't know – because she was so suicidal for so long. So she might have overcome the social anxiety? But I am personally very glad that I pulled her out of school. Once the anxiety was treated, it lessened but it was still very much there. And because of the (adverse) experiences with the GP and the child psychologist it took a very long time to get some therapy from a psychologist for the anxiety. Not that it helped a great deal, but until she is ready and feels able to deal with the problems, it is not going to happen. So the problem is ongoing. She is still isolated (Susan).

> She is quite depressed at times. She gets very lonely (Christine).

4.8 Theme 3: Lack of meaningful connection with mental health services

Many participants indicated that they had experienced difficulties in making connections with mental health services and clinicians that were meaningful to their specific situation. Some respondents did not consider that they had been heard, and distrust developed because help-seekers did not find sufficient common ground on which to work towards mental health recovery. This concurs with previous research findings by the author where young men and their families did not feel that their situation had been adequately understood by first appointment and triage clinicians (R. L. Wilson et al., 2012). The experiences reported by participants in the current research are described in this theme section, and they demonstrate a lack of meaningful connection that occurred for many in this study when they attempted to gain mental health help.

> And you know the GP didn't seem to think there was a sense of urgency…she even got to the stage where she had just amazing tremors. They had just started. And she looked as though she had full-on Parkinson's (Veronica).

Missing out

It was apparent to the respondents that sometimes services existed where it could be expected that young rural people might access mental health help, but frequently opportunities were lost because of the poor quality, poor resourcing, or absence of mental health services. What was seen to be important was that a meaningful connection between clinicians and help-seekers could be established from the outset. Throughout the interviews, there was an underlying thread of belief that rural communities are in a constant condition of 'missing out' on adequate and sufficient mental health service.

> I got tired of having to go back and tell my story, I just got constantly tired, and then I'd get a new mental health worker. So I would go back and start again. And then there would be another one and so having to familiarise with another one just about every second time. Because it is government funded, it is like oh my God! Can't anyone just stay with me throughout?… So now I have to tell you the story. Back to the start, and this is what happened. I went through it a few times and I thought this is just useless (Joanne).

> Well I will give you an example. Adam (clinician) had a case and case workers cannot go to these cases... on their own. They have to have two case workers. Right? This in under the mental health ruling. Anyway, apparently he had to go this one – this person was really bad, and he rang for police back-up. And he said, 'Well, I will let it go one day. I've still got no call from the police, so I let it go a second day'. And then he said, 'I can't leave it any longer – I will have to go.' And he said 'I brazed it and went out on my own, and everything went well. He got the call on the fourth day, from the police. Now you see there has got to be some better interaction between services… I think rural areas miss out on a lot (Debbie).

> Well, just that there are no counsellors in a lot of areas for young people to go to. There are your Anglicare counsellors, but they are just not equipped, they are nowhere near equipped, to deal with kids with real issues … Even mental health counselling, you might get an hour once a fortnight which is just not enough. They would be shocked if these kids could even tell them the truth, they would be absolutely shocked at what some of these kids have had to put up with in their life, and you know, it's all they could do really is be a shoulder to cry on. They couldn't actually do any proper counselling intervention with them I don't think. They are counsellors, but they are not professional specialist adolescent counsellors. And that is what we lack; you know a big lack (Erin).

> He didn't have any hope that anything would change, but said the pill would hopefully make him care less about it (Clare).

> We just don't get any service really at all… I have spoken to lots of mothers of clients that just don't know where to turn. There is nowhere to turn…and consequently their kids end up in custody and with long offending history. Because if these things were nipped in the bud, there wouldn't be any offending history. It is affecting their offending behaviour (Connie).

Too little too late

The majority of the respondents believed that mental health and other services for young people are *too little, too late* (Erin). The following two participant quotes describe situations where young people with mental health problems encounter additional difficulties and in

some cases are in state-sanctioned circumstances that breach the human rights of children. They are dealt with by non-health services, and barriers to accessing appropriate mental health services persist for rural young people. It is particularly concerning that some participants reported significant barriers where young rural people are precluded from accessing sufficient resources to meet their basic educational needs; and further, to encounter reports that numbers of juveniles are regularly being detained in juvenile justice custody as a measure to access a first comprehensive mental health assessment. The problem of very high rates of mental illness among the prison population of NSW was covered in Chapter Two of this thesis. The data confirms that the problem exists, but also illustrates a further concern about the human rights of children who are incarcerated for mental health purposes within the rural region where this study has taken place. In addition, it must be noted that one participant observed that while young people should not be in custody for a mental health problem, she saw that the magistrate was 'good' because he or she facilitated the practice, so that at least the young people were able to get a mental health assessment this way.

> For the more severe mental health issues… The education department has to have a diagnosis by a clinical psychologist. Not by any psychologist, they have to be a clinical psychologist, otherwise you do not get funding. There are very few clinical psychologists west of the ranges. And of those, very few of them do children. So, who gets them done? Very few of them (children)! And the lucky ones get dragged off to Sydney to get assessed. We don't have… educational psychologists, and child psychologists ought to be able to do that. People that specialise in children, should be able to make these assessments, or even just any psychologist who has done the appropriate tests that have been evaluated, should be able to do this for (child educational support) funding purposes (Erin).

> …there are just not the services on the outside. We often would write to the court and say… we have concerns about the young person's mental health and could you remand the young person in custody while we arrange for a psychological or a psychiatric assessment to be carried out. And the magistrate is pretty good. You know, they sort of take our word for that, or they know themselves that especially in this area that those kids aren't going to get a mental health assessment in the community. So it is better to try and get a good assessment done in custody…A lot of our kids, it is not a

> justice issue, it's a welfare issue, or a mental health issue, but they still end up in the same place, which is custody in the juvenile justice system. And that is really wrong. A lot of these kids shouldn't be in juvenile detention…But, where else do you put them? …we usually ask for 6-8 weeks…for a proper one to be done…I could name four or five (young people) that we have got waiting for a psychiatric assessment or psychological assessment in custody just in my area at the moment (Connie).

Clinician personalities

Clinical rapport, trust, gender and personality are important factors and ones that can be seen as either enablers or barriers for young people when they are selecting a mental health professional or general health professional they are happy to work with. Susan, a participant, is a good example because her situation is illustrative of some of the barriers that can be established when young people do not like, or choose not to engage, with the clinicians they meet early in their help-seeking journey. The importance of young people liking clinicians was covered in Chapter Two of this thesis, and its relevance is reinforced in this study. Susan visited her psychiatrist, and her daughter was asked to join the consultation session. Her daughter was not happy to see a psychiatrist whom she considered seemed to lack a conversational style of rapport building. Her daughter needed time to build rapport and trust with the clinician, and she was repelled by the structure of the clinical interview that she witnessed in Susan's appointment. This was especially unfortunate because Susan's daughter was also experiencing profound mental health distress, with symptoms of depression, which included thoughts of suicide. Susan's daughter had the vicarious opportunity to meet a psychiatrist, and this gave her the opportunity to assess for herself whether suitable help might be found with this clinician. She was repelled during this encounter, and this served as an enduring barrier to accessing mental health help. Susan had hoped that a helping possibility might be enabled, but this was not to be. Susan's hope about her daughter's mental health deteriorated, yet again.

> But my (Susan/mother) first appointment with this psychiatrist, I was sitting in the waiting room with Kim (daughter), and so he knew she was there. And he said, 'Do you mind if she comes in?' And, he was asking her questions about her perceptions of me so it could help him with his assessment of me – it was a first appointment. She decided that he was very abrupt, and I don't think she would see him. Very

> straightforward. Very to the point. There is no sort of building up to asking questions in a certain way …so ... my hopes aren't high that Kim would go along to see him (Susan).

A particularly concerning aspect for Susan's daughter was her access to only one inappropriate counsellor. Despite her young age and her limited social interactions more generally, she only had public health access to a sole male psychiatrist, who had a regular FIFO clinic in her neighbouring town and community. There was not the possibility of any alternative, and this also presented a barrier of access to appropriate mental health service for her. The accumulation of seemingly minor barriers to access, in combination, presents a stronger reinforcement of a barrier to accessing help. For the family, hope for future mental health help access was dwindling. The family managed this circumstance by trying to alleviate the daughter's mental distress as best they could by using their own experiences as a basis for their decision making about how they might help. Yet, a concern remained that for periods of time when the daughter experienced distressing suicidal ideation, they had no clear plan about how to achieve help for an acute situation.

Care plans

Health services operate using systems that produce care plans. Care plans are incongruent to many clients with mental health or drug and alcohol problems because many people do not plan anything in their lives, so the clinical development of a care plan is not a valued intervention. Respondents indicated that care plans are more suited to middle class, middle income, literate and affluent people and therefore do not have synergy with some client groups who are especially vulnerable to mental health problems; for example, low socioeconomic people with low literacy levels, poor educational attainment, unemployed, with food and housing insecurities. Some participants in this study were able to describe the clash of cultures that exists between service provider systems and vulnerable individuals and communities. There were reports in the data that suggested access and intake processes, assessment consultations and development of care plans under case management structures were obscure concepts to many respondents and that they bore little relevance to the real lives of some people because they were unrealistic constructs and unfamiliar processes.

> Case management… care plans, is the way we are suppose to operate, but it is not the way our clients think…people sit down with a clipboard or a folder, and they write

> things,… that is the way the system works… and our clients don't trust it. Planning is not something some people have any experience of – they sometimes don't have the resources to plan their lunch, so it is not surprising that they find the planning and case management stuff weird in mental health (Christine).

Meaningful first appointment

For some respondents, it was difficult to get beyond either accessing an initial appointment or attending the first appointment or two. The events that led up to seeking a professional mental health appointment were often extremely stressful. When difficulties had escalated to such a point that professional help was sought, there was a great deal of anticipation that the health professional would be able to contribute positively towards a solution to improve the circumstances. If improvements could not be recognised or anticipated within the first appointment or two, then people reverted back to their usual coping strategies with a sense of relief that they had tried to address the problem appropriately despite the personal belief, or suspicion, that it would not help anyway.

Sometimes the first appointment was with a generalist counsellor, rather than a health professional, as the following mother respondent reported in a situation where she had taken her 16-year-old son to a counsellor. However, successful engagement and meaningful help was not achieved:

> Emotionally he (son) doesn't cope with things, and he was bullied at school … I got him to a counsellor once, was pretty useless (Veronica).

One mother participant recounted her daughter's first mental health clinical experience that she considered was inappropriate. However, a clinical opinion may not identify the interventions in the same critical light. For this family, the treatment the daughter received as an involuntary client in a bed-based unit was regarded as inappropriate, and has served to reinforce a barrier about seeking formal and traditional mental health help in the future. The implications of this are potentially serious and should not be taken lightly or dismissed by health service providers, because these are the authentic and real life experiences of consumers and carers of a first episode of mental health care, where the mental health care seemed to them to be seriously lacking.

> I really don't like what I have observed at all. And one was very, very close to me in the last few months. …my daughter had been given some (illicit) drugs and she was in an episode of psychosis. She had been missing for 12 hours. I contacted the police... No one had seen her. Nothing. Meanwhile she (daughter) is in a mental health unit, screaming because she just wants to speak to her mother. She has been told 'No' she is not in a state to talk to anybody. And then they kept giving her a drug that turns her into a vegetable. To stop her from screaming, to the point where she is totally numb and drooling. …(later) she asked a nurse: 'Can I please talk to my mother?' And a nurse that had just come on shift was prepared to do that. And then the phone call was made. You know that is not cool. It pisses me off. Excuse the language. But it made me feel, for 12 hours I was thinking that she could have been raped or something horrible had happened somewhere, and something horrible did happen, but she wasn't allowed to call me, and the stress that happened over a 12 hour period, should never have happened. …When she did start to come down from her experience, she wakes up, she is in a crazy place, with permanently crazy people, not someone who is having a temporary experience. So there is something that is not right about that either. It wasn't a long-term experience, it was temporary thing, and she should have at least been made comfortable in a nicer environment. Not in the stark whiteness of a typical mental health unit (Joanne).

4.8.1 Sub-theme 3.1: Muddling on

The mental health ecological impact of family life goes on to influence the relationships with the family and is the backdrop from which mental health helping capital either flourishes or struggles. Use of a biophillic framework assists in understanding how the dynamics of the different aspects of participant Fiona's life helps to clarify the complexity of the family context, and how this in turn has either helpful or detrimental impacts on vulnerable members, for example, her son. In one sense, it seems as though *'muddling on'* is the only coping option available to some families.

> …A part of me thought I should be able to do all of this, and with God. And you know, a bit of guilt I suppose that I was feeling depressed. Yeah, that being a Christian should be enough. And when Peter (brother) died (by suicide) a part of me thought - he was the only other Christian in my family…. And I thought how could he....? And

> that was a point of disillusionment for me. ...I didn't go to seek help. At any of those times. Also – I am not actually that much of a talker. I tend to be more introverted and just deal with things myself. Which isn't necessarily a good thing (Fiona).

Several years later, when things had not improved in the mental health environment for Fiona or her family, and especially her son, she decided to have one attempt at seeking help, and selected a family therapy private counselling service. According to Fiona, the experience was uncomfortable and short-lived and it was abandoned with no alternative professional assistance sought. In the next excerpt Fiona describes her feelings about seeking and trying counselling.

> Oh it was stressful – but it was 6 years ago. And when it didn't work, in a way it was almost a relief. Oh we have done that, we've tried that it didn't work. We will just have to muddle on somehow. I am not a good one at confronting problems. I'd rather let everything work out in the end. Which isn't healthy, but, I hated the confrontational aspect of counselling. I saw that it could be a good thing - but when it didn't work after two or three times, I thought 'phew we don't have to go there again' (Fiona).

Other participants considered that muddling on occurred as a result of no one being able to provide tangible and practical help.

> …well, teachers, school counsellors, GP many times, through to acupuncture, massage, community health dieticians, more GPs, until…a visit to Sydney….there wasn't a label attached to it. Basically it wasn't referred to as a breakdown, but it was an emotional breakdown. They think what triggered it off was that they moved out of town from their house on the edge of town, to a property in between Town A and Town C. And she had to go on the bus, and there were a lot of Town B kids on the bus…. the population of Town B is probably difficult… I think she was afraid… she must have just been vulnerable, and her mum ended up driving her in and out every day to get her to school. Because you know she was so tired, she could barely get out of bed. It would have been for about 6 months, you know it wasn't just a 6 week kind of drama. And they got really concerned when she wasn't eating. It wasn't insignificant… (Veronica).

> They get in to see a mental health worker once and then all hell breaks loose and they can't get into see the workers again, so there is a lack of mental health workers on a day they really need one, and the clients say, well I have seen that worker once, I can't get in again, what is the point of having a mental health worker. I have rung the mental health unit many times, but I can never get a client in…(Martha).

4.8.2 Sub-theme 3.2: Stuck between a rock and a hard place

People do not plan to have a mental health problem, but most people do not plan to avoid a mental health problem either, and subsequently some people tend to get stuck between the structures of help provision.

> Because a lot of our kids aren't justice issues at all, they are welfare and mental health. Unfortunately they just end up in our system because they offend (Connie).

One participant mother described some very difficult times in her family when her younger mid-adolescence aged son was struggling to keep himself alive. The family lived on a rural agricultural property about 40 minutes by car from the nearest commercial town. The family consisted of a traditionally married mother and father and four children consisting of two older sons and two younger daughters. The family struggled financially, and times of drought prevailed, adding more pressure to the day-to-day life for this family. Not only were there financial pressures, but also additional distressing farm work involving emotional labour such as feeding animal stock, destroying animals that had succumbed irreversibly to poor availability of food, bushfire hazard reduction, to name a few. In such a context, there is little emotional time within the family to attend to the mental health needs of a young person. For Fiona, the situation was one that built at an insidiously slow pace, and on the background of a general lowering of mood across the family unit, reduced emotional connection and satisfaction within the family, and with the suicide of her brother a couple of years earlier. The accumulation of these ecological impacts did not propel the family towards seeking mental health support for any family members; not even when on one occasion the participant and her older son would not have been surprised to discover that the younger son might have been 'hanging from a branch'. The inertia of the burden of emotional labour for the family seemed to paralyse the helping capacity within the family and they coped as best they could on a moment-by-moment basis, stuck, and with no internal mechanism to seek help beyond

that moment. Similar struggles were identified within other participant interviews. This excerpt below describes the experiences of mental health burden.

> …he had a really rough trot during his teenage years, and he was certainly depressed and he ran away from home about four times. And there was one time though that, (named older brother) and I went for a drive up the back paddock when we were out along X Road and I was looking for a boy hanging from a tree branch. And yeah, he was in a bad place. And yeah, we probably didn't deal with that one as well as we could have. So yeah, that is my experience...(Fiona).

It is not only the parents and young people who struggle to find meaningful and timely appropriate mental health services. Rural staff do too, as Lisa, a rural registered nurse in a small hospital, highlights in her comment below. The 25-year-old young man she refers to had to re-present to hospital on a number of occasions having overdosed on prescription drugs, and with a range of mental health problems. However, there was no capacity to offer him any local mental health interventions and he had to be placed on a waiting list to see the next available DIDO mental health worker. During his waiting period, his mental state continued to deteriorate and Lisa tells what happened next in her narrative below.

> As predicted, he did re-present. This time, instead, he took a chainsaw to his leg…his injuries weren't too severe. His injuries were treated and he was sent home… again. After that, I heard he got involved with the police. He had anger management issues and then, only then, was he sent to the nearest mental health facility. To me, this was a classic example of negligence and something needs to be done about mental health in rural areas. It took three times for this man to get the attention that he needed. That's three times this man was crying out for help. If this man had an infection in his body which had the potential to kill him, he would undoubtedly be in hospital until it was cleared up - not flippantly sent home and just hope for the best that he would be OK (Lisa).

Parent emotions: 'I cried'

As found in previous research (R. L. Wilson et al., 2012) the emotional burden for parents of young rural men can mean that parent mental health is tenuous. This following mother respondent indicates that the mental and behavioural problems she experienced with her 16-

year-old son took a significant toll on her own mental health. In an effort to cope, she was able to find a private health professional who was able to assist her. However, she was not able to find someone who could help her son.

> …I can't remember her name right now but she is a clinical psychologist. Anyway, when he (son) was going through that and I was just absolutely distraught all of the time, and I went to see her. I actually feared my own mental health with it, through it, because, I just cried every day for six months (Veronica).

Furthermore, sometimes people remain stuck because a number of circumstances occur and coincide to such an extent that the 'stuckness' is reinforced. The next participant account illustrates this further.

> …she has spoken to the GP about it, and he has printed out some information for her and has given her a web address for a series of DVDs that were recommended by the college of GPs somewhere. It's alternative kind of approach without medication, without sleeping tablets, to fix sleep problems. So, I am hoping that Kim will be motivated to investigate that. But there is actually another problem contributing. Whenever she is bitten by mosquitoes, she really reacts, swells up – probably 5 or 10 times the size it would for anyone else. And we have mosquitoes all around our house, during the day and if she wants to go outside at all, and she needs to get the sunlight to fix up her body clock, she has to cover up so she won't get bitten by mosquitoes and I suggested: 'you need to get some exercise. Do you want go for a walk?' But she is not into walking. She doesn't want to get on the trainer. She was doing wii fit for a while. And that was very good for her. And I think really helped her with her sleep, even if it (the sleep) was only an hour or two. But there are so many factors that to Kim it seems like too much to conquer… it is a bit of a cycle. You know - you are exhausted then you have less energy to do everything you need to do to get out of the cycle. (Susan).

4.9 Theme 4: Health, welfare and social service provider characteristics

Throughout the interview data it was evident that there were both helpful and unhelpful characteristics that impacted on the rural young people and their willingness to engage with service providers. The characteristics of the health, welfare and service provider professionals were of importance to the respondents in this study and their descriptions of these

characteristics are outlined in this section. Sometimes the flexibility required by professional people to carry out their work in ways that promote access to help for young people puts them at odds with the systems, organisational and cultural norms of their workplace. This can make it difficult to either prevent adverse happenings or to react to the adversity of young people in the most engaging and helpful ways. This is the case with policing, as the following participant identifies.

> That worked against me with the cops because they saw me as not doing my job. Because they saw, I am a police officer; I need to be arresting people. This is some of the cops at the (community identified) police station. I wasn't there to protect kids, but I was actually there to prevent them from committing crime to start with. Trying to get through to a lot of coppers is really hard. And there are still some who go 'Oh you have got a bulgy job and you don't do anything, 'cos you don't arrest anyone'. But, no, if I find him (a young person wanted for arrest), I will bring him in. That is not a problem. But I will do it in a way that I will actually get him to come in, and I won't be dragging him by the ear. And that is what we used to do, if a kid got into trouble, I used to go around to the house and have a chat to the parents and go 'Look I know he did this, this is why, he needs to sort this out, he needs to come down to the station'. And the parents would go 'Yeah no worries, we will bring him down,' and it was just an easier way of doing it. And some of the coppers there realised that, and went 'Oh this is great having Patrick here to do this' and others still saw it as a big, big issue… Get the parents on board, they all wanted to help their kids, and that is how I broke down a lot of the barriers by doing that. And as I said to people, I have always said to people, other coppers, trainee coppers, treat other people how you would want to be treated. And it is amazing how far you get with people (Patrick).

It is evident within the data for this research that the rigid structures within public service systems such as health, police, and education sectors leave little room for place-based flexibility, and that the rigidity stifles and admonishes the innovation of some people as they attempt to make meaningful professional contributions to young rural people with mental health problems. There are currently renewed calls by public health leaders in Australia to reconsider the models of health service delivery for Australia so that better use of resources, skills and health outcomes can be achieved (Brooks, 2013). The current models limit the

capacity of health and other professionals in rural communities to adapt their practice to the specific needs of young rural people. This was a dynamic that was demonstrated in the participant quote above.

Relevance

Public mental health support and services should be relevant to the target populations; in this case, relevant to young rural people. There are a range of non-government supports and services in place that supplement government public mental health care; however, they are often staffed by a low skilled workforce. Strength is noted because an element of mental health helping social capital can be seen, whereby community organisations are able to utilise the skills within a community and draw together these skills in an organised fashion. A limitation of this type of activity is the scope of skilled helping proficiency within an organisation or group. Additionally, the skills mix is not always relevant to the needs of some important groups within the community, despite a well-meaning spirit and a strong desire to help.

Young rural people are a subgroup within the rural communities with specific needs. When young rural people require mental health care, there is a particular need to ensure that the helping experiences they are first exposed to are positive and trustworthy experiences for them. Where their first experiences with mental health care is suboptimal, and where they have not liked the interaction, they are unlikely to engage with further mental health care, despite the availability of help on offer. This then becomes a barrier to future help-seeking for young people, as was covered in Chapter Two in some detail. It is clear that where mental health help is not appealing to young people, limitations exist in engaging with mental health care. The following comment of one participant, Connie, demonstrates that these limitations occurred for her situation.

> You know my daughter would never go to an Anglicare counsellor or a church counsellor or anything like that and talk about her issue, because a lot of these people are older, they don't understand young people. You need a younger person, oh well, not a young person, but a counsellor that is able to deal with the issues that kids these days have. You know some of these counsellors are decrepit things in their 50's and 60's and they have just got no idea (Connie).

Vocabulary challenges

Vocabulary challenges are a significant hurdle because the jargon that mental health practitioners use to describe mental health problems and the words that non-health practitioners use are often very different. As the following participant described it, sometimes health workers 'talk gobbledegook'. This finding concurs and builds upon previous research by the researcher where it was found that the vocabulary used by both those requiring mental health help and those clinicians who deliver it can be a barrier to early intervention (R. L. Wilson et al., 2012).

> This guy is from XX hospital CAMHs telepsychiatry outreach service… he is a senior consultant psychiatrist – and he is funny as! He is a crack up! But more importantly he explains things in a way that people get. You get a lot of (other) specialists that come out and talk gobbledegook, and then you get others who come out and talk in normal language that others can understand. It is a barrier for the local clinicians and it is definitely a barrier for the clientele. They hate it. They hate it when they have seen a psychiatrist or someone else and they get 'Hmm and how do you feel about that?' they feel like they haven't been listened. Yuck! (Erin).

Boundary crossing

Boundary crossing, as previously mentioned in Chapter Two, is a characteristic that is evident when a person is an expert in one field and is a champion in another different field and is able to orchestrate dialogue and trust over both domains. The charisma of the visiting mental health professional identified in the participant quote above is a demonstration of the boundary crossing dynamic. It is apparent that the rapport and the meaningful connection between the local rural health professional population and the metropolitan non-local FIFO and telehealth professional were enabled and that the outcomes of this interaction were beneficial. This factor is noted because it has assisted with the smooth passage of knowledge exchange in this case, and attention to place-centredness will have flow-on impacts in regard to the way that local health professionals are able to transfer knowledge to their client populations and communities.

Confidence about assessing mental health

Nurses and GPs have similar educational preparation in regard to mental health examination of people. GPs are perceived by many of the respondents in this study as capable of treating

mental health problems. However, GPs report that they are not equipped or educated to do much to help a young person with mental health problems other than to prescribe medications (Alexander & Fraser, 2008). Whereas nurses are not as positively perceived by the public as equipped to treat mental health problems, many are highly educated and experienced in focused mental health assessment and interventions for people, including young people, with mental health problems (Lakeman, Cashin, & Hurley, 2013). Some nurses lack confidence to provide early help to young people despite their adequate training in basic mental health care at an undergraduate level. An illusion of specialty exists about basic mental health assessment by both the public, and some nurses, which causes some nurses to suspect that they might be missing out on some key knowledge about the subject, when in fact they are not. This occurrence is significant because it means that skills that exist throughout the entire nursing workforce population are under-utilised and undervalued by health systems, the public and nurses themselves. The human resource implications of employing a skilled workforce, and then not fully exploiting the skill set, have implications for health economics, and the impact of this in rural settings is of specific concern. Where nurses consider that they are not sufficiently equipped to conduct basic mental health care in any setting it falls to their own professional responsibility to address this knowledge deficit, because competency in basic mental health care is expected of all registered nurses in Australia (Happell et al., 2014).

The following respondent's quotes indicate that other service providers have doubts about the suitability of nurses when it comes to assessing and delivering mental health care to young rural people.

> … I don't think the nurses there are actually trained to deal with mental health people there. I am not too sure, but it doesn't feel that they understand mental health at all because the first thing they do is ring the police straight away… I think every nurse needs to have some mental health training… to be able to calm a patient down (Martha).

> We get the odd mental health nurse through area health… they usually get chewed up and spat out by the system. They are emotionally not supported… they are losing them like flies because they throw them (complex)…stuff at them without some training… (Erin).

Ways forward

Development of ways forward will need to take into consideration the importance of the whole environmental context to improve the mental health prospects for rural young people. A biophillic understanding of the context will be necessary and that will involve developing the emotional connections that young people require to enhance their mental health and wellbeing. The following participant, Connie, strives to help young rural people in her work, some of whom have very complex social, legal and mental health problems. Connie recognises the complexities and yet her underlying framework and personal ethic for helping these young people, is that despite the difficulties love and emotional connection are necessities.

> Due to the mental health problems, or due to the substance abuse, all that sort of thing. It is very hard. You have to have a love for kids, and remember that they are still children too, but that is what I like about working in the juvenile system (Connie).

There is a particular 'knowing' that service providers have about the young people they work with who have multiple complex problems, as the participant Patrick alludes to below. This 'knowing' is a shared knowledge among those professionals yet it is difficult for them to articulate the characteristics that they recognise in the attitudes and behaviours of young people. However, this intangible 'knowing' positions service providers where they can see from a young person-centred perspective, such as participants Patrick and Connie describe below. This unique vantage point from embedded rural service providers in rural communities provides a valuable insight, which should be used to forge effective new ways forward to improve the appropriate and timely service delivery to rural young people. For example, if young people *'blame society'* for their circumstances, and cannot recognise *'good things about themselves'*, then they may anticipate that help and support should come closer to them, rather than the traditional approach of health services anticipating that clients would move closer to them by attending clinics and participating in care plans as mentioned earlier. It is likely that young people anticipate the obligation is with health services to come to them, and it seems on-the-ground service providers 'know' that this is likely. However, the current models of service delivery are restrictive because they operate counter to young people's expectations. Health services which aim to improve the health and wellbeing of young rural

people may need to consider shifting their established models in ways that are adaptive to meeting young people where their expectations are more closely aligned.

> I think if the other service providers have been working with the person or this social group long enough, they would understand, I think they would sort of go 'Yeah I know what you are talking about,' 'I know what you are saying.' I think the young guys would blame society…. It is all about society has done this to me, and so this is how I am retaliating and not about how they can better it for themselves (Patrick).

> It is amazing how many… people have never heard anything good about themselves. And that simple depression test. Write down 6 positive things about yourself. No. None. We are trying to show them the other side of their story a little bit. But that is just what we do (Christine).

Flexibility was important in response to complex helping situations as participant Patrick identifies. It was clear to him that this was a very difficult circumstance and despite the needs of the young person not neatly fitting into any care workers portfolio, he saw a need and attended to it. This is important because in rural communities service providers of all descriptions have limited personnel with limited functionality and role diversity. There was no specialist worker or program available, and so in this instance and many others in this study, the local workforce developed a champion worker who practiced in a specialist generalist capacity in the effort to afford some level of appropriate help, and this became the 'glue' to assist in healing the complex human mental health and ecological problems. It takes a willingness to break the rules, look outside the square, and adapt to the generalist role to address specialist considerations within rural practice. This should be seen as an asset among rural workers, and one that should be encouraged.

> This guy hadn't attended school for 6 years or something and he was only 12. So we were trying to look at how we were going to educate him. Couldn't put him in a school, no school would accept him, because of risk assessment because he would belt someone or something. Or, he would go off at a teacher, so we had to look at schooling in different ways, so DoCs brought the money into it, and education brought the education into it, and I brought, I was the glue that tried to bring these things together, and make it happen, so sort of my job. Well it wasn't my job, but it was what

> I did. I saw a need, and to help this kid, this is what needs to happen, and so, I just did it (Patrick).

Expectations about who helps: where, and when

The respondent Veronica noted that young rural people need to have convenient access to approachable mental health care support, other than going to a GP, and she acknowledged young people may have little insight into their own mental health decline. Hence, a safe haven needed to be available to them so that, when they felt bad, they had somewhere to turn where some appropriate advice might be available to them, and which would point them towards mental health treatment if this was required. Her view, and the view of other participants in this study, is that a GP is not always the most useful starting point to assist young people with mental health problems, yet they are portrayed as an appropriate starting point among health professionals and service providers. This incongruence between service provider expectation and rural community expectations creates a tension to some extent that fails to achieve a sense of meaningful accessibility to appropriate mental health care when it is needed.

> …if there was somewhere they could go that was approachable rather than having to go to a GP. I don't know if there is a safe haven for them to go to, but also I think they don't know when something is wrong; they just feel bad. You know, and they may not know it is an actual mental health issue. That could be treated perhaps, or not, I don't know! Um but I don't know that they would recognise feeling bad as opposed to perhaps something a little bit more serious …It depends how long their feeling bad lasts for. You know, sometimes if you are feeling a bit down in the dumps then that is just feeling down in the dumps, as opposed to this is going on a lot longer than the normal level of feeling bad would be. And then becoming something that is more serious. Longer term perhaps. But I don't know if young people recognise that? (Veronica).

Participant Erin suggested that sometimes local information about the mental health of young rural people was not adequately respected, and as a result, early intervention was not achieved. Moreover, when adverse outcomes occurred, such as suicide, they were concealed under a shadow of hush and secrecy. The public conversation about the emotional health and wellbeing of rural young people was dampened down by some sectors, and an undercurrent of mental health distress remained among the young people in one community. It would not

have surprised the participant, a clinician in the region, for a combined legal case to develop and that if it did, she considered this might be helpful in instigating some better support for the young people in her community. In her view, the topic of mental health for young rural people in her community was not sufficiently discussed, and measures had been taken to keep messages about mental health problems out of the public conversation.

> The school system is not taking bullying… seriously. The local high schools are unable to figure out how to deal with this issue. We have got bullying on the buses to and from school as well as bullying at the actual schools. I'm waiting for one of the lawyers to do a class action to (town named) High to tell you the truth. It is that bad, and it is not being addressed appropriately. I have also heard that (another town named) High, (latter town renamed) High had a huge suicide rate a couple of years ago. It is of kids suicide (sic), yet that was all kept reasonably quiet, My question is why? (Erin).

The expectations of some rural people about access to mental health services in their communities were low according to some participants. Some respondents, such as Joanne, considered that despite many years of seeking appropriate mental health help, it probably could not be found in the public health system.

> …my husband said, look we will pay , we are not well off, we can't afford too much, but just try paying for some (mental health) help, maybe you get a better quality of service. So I found a woman in (town named). Abbie is her name. She is fabulous, and I still can call her now. And she can guide me through most things. But she was a little bit alternative. So she did numerology, and lots of other things and reiki and as well as her individual counselling technique. And she was the one. She was the one that helped me a lot. She had the time, there was no one sitting there tapping their watch 'Oh you know we have only got 10 minutes left'. …I think when you are recovering from severe, or even minor mental illness, there is that security that goes with having the same continual support… (Joanne).

A participant from the non-government housing sector suggested that access to mental health services might need to be reconfigured so that they were responsive to the need where and when it is actually placed. In addition, ongoing services should be considered, because in her

view, mental health problems cannot be resolved in short periods of time. Nor could they be solved in isolation from other complex problems such as housing or food insecurity and both need to be provided over longer periods of time, such as a year, to achieve meaningful outcomes.

> We have been considering whether we should get somebody on a retainer, or trained up as a counsellor, so it is all in house, so it is the people they know. We have got them, and to put it bluntly, we have got the biggest stick there is, we have got a house. And we encourage them to do something in that period of time while we have got them and we have them for a year… if you are going to go to the counsellor, you have got to have someone to look after the kids. And if you are going to see someone, you have got to be able to take the child along, and obviously you can't take them into the counselling room with you, so you need a service that looks after the kid while you do it, or you can't do it (Christine).

Burnout

Collaborative care arrangements are sometimes challenging to negotiate between service providers, however participant Patrick found that finding innovative ways to work together across service streams enhanced the way in which young people could be more effectively helped. He acknowledged that it took time and commitment from service providers; however, it also required that individual staff were willing to work in this way, because from time to time these work arrangements would need to have a flexible approach to roles, job descriptions and boundaries.

> …well they were involved anyway with this one kid, but from a different angle. So we went well, we are both working with this kid so let's get together and look at this as a team and how we can do this better and who can we access the money through. And DoCs were able to get funding through, and then we were able to do something. And then we brought the Education Department in to it as well (Patrick).

A consequence of dynamic collaborative service provision and of staff who are willing to step out of their safe and traditional roles is that staff feel unsupported and they are not provided with sufficient resources to thrive in their roles. For a time, they add a significant additional value to the mental health capacity of organisations across sectors, and within rural

communities, but it is with a great deal of personal commitment and sacrifice, and unsurprisingly it is not a sustainable or viable long-term strategy. Burnout arises and is difficult to satisfactorily address. This was the case for an innovative participant who left the police service, but remained in the community and moved on to a self-employed business with little involvement in further mental health social capital initiatives; a loss to the community, despite his local residency.

> …so when I left, police, I am not doing it anymore. But when I left… I took the top ten offenders, in (named community) for the juveniles under 18's. ...I would say in my experience it needed to be under 15. If you wanted to work with these kids and get anywhere, then ideally you would want 12-14 years of age. Anything over that, you are hitting your head against a brick wall. They had got to an age where they just didn't want any help, they just didn't want anything to do with you. So they were hopeless. So I got to the stage where I was looking after 12-14 year olds, and trying to grab those guys before they got into too much crime and help them. So low risk offenders. I was honing in on these guys, go around and meet their parents… Have a chat with them, tell them who I was, and what I was about. I'd be in police uniform and carrying a gun and all that, so the barriers went up straight away, but the people would get to know me after a while, 'Oh it is Patrick' they knew me as 'Patrick' not as a police officer - the cops, 'Oh Patrick is here, come on in'. And so I was able to break down a lot of barriers with a lot of families. I even had one lady who used to hate me, I arrested her son a number of times when I was in Detectives, and then in the end she ended up calling me 'Detective' 'Detective Smith' so there was a little bit of respect. Just that I can't repeat the names she used to call me, but it wasn't good, but there was a bit of respect shown in the end. So I broke down a lot of barriers with families in my time (Patrick).

There was another incident that may have been a situation of burnout, which was reported by a participant from a small town in the study region. Debbie, a participant, was especially grateful for the long-term care that her son, and others in her community, had received from the only mental health nurse in her community. She described the mental health nurse as one who was renowned for her generosity in caring for young people with mental health problems. This nurse might be described as one who represented mental health helping capital

within her community; however, she was the only public mental health professional residing in her community and the burden of mental health need was greater than she was able to provide assistance for. Extra staff and further supports were put in place after her death; the participant indicating that it took more than one person to replace what their previous nurse had been able to contribute. It is not possible to draw conclusions about cause and effect in this situation; however, it may be that one mental health nurse, without adequate professional support in a country town, may experience an overwhelming burden of care for people in a community, and this vulnerability should be considered when rural mental health services are planned in the future. This mental health nurse's death represents a significant personal and mental health helping capital loss to a small rural town.

> She went over and above all the time, and especially for the young ones, She went over and above her duties, but she just loved her work, she loved it. And the kids loved her. And when she died, she committed suicide, there was a big funeral, and the kids, all of us felt it, hit the lot of us. The kids (young mental health clients), they really felt it…now we have another mental health nurse, and we can understand why he doesn't work out of hours… they have asked for two more case workers to be put on… (Debbie).

4.10 Summary of section two

Section two has covered in detail the analysis and results of the in-depth interviews of twenty participants in this research. The results drawn from the data have been able to directly answer the research question for this study. Thematic analysis has revealed three main themes and eight sub-themes, and each of these themes and sub-themes have been discussed in detail and are supported with verbatim quotes from the data to substantiate each one.

Theme one describes the characteristics of the emergence of mental health problems for young rural people, and highlights that anger and drug and alcohol problems are key features that accompany the emerging mental health decline of young rural people. Sub-theme 1.1 demonstrates that the insidious onset of mental health problems is difficult to detect and indicates the ways in which rural people decide if a young person is genuine in regard to their suicidal thinking, and what steps should be taken, if any. Sub-theme 1.2 describes the family experiences associated with the emerging mental health problems of young rural people and

highlights the importance of emotional bonds within families, and the risks to mental health where these bonds are poor.

Sub-theme 1.3 indicates some barriers that participants experienced in regard to accessing timely and appropriate mental health services. Distance and transport were significant factors for young people, who may be expected to travel by private transport distances that sometimes required an overnight stay to enable them to access mental health care. In addition, isolation was a factor that is seen to contribute to the mental health of young rural people, and particularly where people were isolated because of a lack of access to transport. FIFO or DIDO workers, such as those people who are employed in the mining sector, were recognised as experiencing difficulty in accessing mental health care, and some young people are dependent on this type of employment. It was evident that the population growth in this sector has exceeded the capacity for supporting services such as mental health service to cater to the needs of this specific group of rural young people, and that health service models have not yet adapted to meet the needs of this group.

Theme two discusses how others in the community help young people with emerging mental health problems, and describes the characteristics of helping behaviours. For some respondents, it was apparent that the most helpful strategy was to help the young person to either relocate their residence or their employment to a place or setting that reduced mental health vulnerabilities for them and increased their sense of hope for the future and their access to mental health services.

Sub-theme 2.1 described the ways in which people convince others that mental health care is warranted. According to the respondents, in some cases, non-government service providers were trying to convince their clients to seek help, and at the same time attempting to convince mental health service providers to accept their referrals for people with mental health problems. Mental health service providers attempted to convince parents to improve their parenting skills to reduce the risk of mental health problems for their children and mental health literacy programs were suggested as a solution for rural communities. The respondents believed that people with mental health problems encounter difficulties in registering for mental health care using a telephone triage system in rural communities, and some service providers indicated that there were informal access pathways that they used to convince mental health services that acceptance of a client was warranted.

Sub-theme 2.2 described some basic needs for rural young people that emerged from the data with an emphasis on needs for safe and secure housing and food, and an absence of violence. However, it was also revealed by the respondents that young people may consider alcohol a basic need and in its absence they place themselves at criminal risk by undertaking dangerous behaviours such as break, enter and stealing offences.

Sub-theme 2.3 describes the social network experiences of young rural people with mental health problems and indicated that a lack of social successfulness occurred for some respondents. For some participants, church-based experiences were identified as very helpful. However, for most people social loneliness was a significant factor that increased as mental health problems escalated.

Theme three presents the data that describes the ways in which people are unable to make meaningful connections with mental health services. Many participants indicated that they considered that rural communities perpetually missed out on sufficient mental health services for young rural people, and this concerned them. According to the respondents, people had grown accustomed to 'missing out' and so their expectations of service provision were sometimes low and they were resigned to a 'too little, too late' approach to mental health service provision. The personalities of mental health clinicians were a factor that either enhanced or diminished the experience of young people seeking mental health care, and they made decisions about whether to proceed with treatment based on whether they felt comfortable and at ease with the clinicians they encountered. Care plans and case management were seen as incongruent to young people's cultural norms, with a clash of service provider and youth cultures that imposed unfamiliar constructs that were counter to the values and beliefs of the young adult population.

Sub-theme 3.1 demonstrates how respondents make decisions about enduring the emerging mental health problems of young rural people in a way that was described as 'muddling on', suggesting that they would select a default position of managing to cope the best way they could without pursuing outside professional assistance. Sub-theme 3.2 follows the 'muddling on' sub-theme and goes on to describe the characteristics of a paralysing inertia experienced by the respondents when their efforts to seek help exceeded their internalised motivation or personal resources to proceed with professional help. The emotional labour of this situation is

a significant burden with some parent participants indicating that the emotional labour invested in young rural people was considerable.

Finally, theme four presents the characteristics that describe a range of service providers. In particular, and according to the respondents, the vocabulary that is used by professionals can hinder engagement with the mental health help-seeking public, especially in the case of rural young people. However, some professionals are able to cross the boundary between the jargon-laden and metropolitan-focused mental health service mainstream, and transfer appropriate knowledge and engagement so that mental health promotions are enhanced. Ways forward were evident in regard to improving the rapport between service providers and the client population, particularly in adaptively improving the flexibility within rigid traditional models of service provision. Burnout of rural service providers was also evident among the respondents, which led to a significant loss of mental health helping capital and experience in some rural communities. This factor may have contributed to the mental distress of one mental health nurse who died by suicide and is greatly missed by her clients in her small rural town.

4.11 Conclusion

This chapter has discussed the descriptive and content analysis and findings of an online survey with 81 respondents in section one, and the thematic analysis and findings of 20 in-depth interviews in section two. These findings will be further discussed in the next chapter of this thesis. Chapter Five will then discuss the implications for practice and policy that arise as a result of this research, and will propose recommendations based on the research findings of this study that are suitable for implementation across clinical and governance mental health domains. The limitations of the study will be reviewed, and finally recommendations for future research will be indicated.

CHAPTER FIVE

Discussion and Conclusions

5.1 Introduction

The previous chapters have described the context for the research that has taken place, discussed the relevant literature, outlined the methodological underpinnings of the research, and described the data analysis, and findings of the research. This final chapter will discuss the findings in relation to the current literature and identify the implications and recommendations for policy and practice in both clinical and interdisciplinary domains. It will conclude with the identification of further research suggestions and propose three possible future research studies that would add to knowledge about rural mental health needs in this field.

5.2 Discussion

The study was conducted to contribute new knowledge about the mental health of young rural people because it is well recognised in the literature (presented in Chapter Two) that gaps exist in understanding and addressing the problems of young people with emerging mental health problems in rural communities. The study succeeded in contributing new knowledge about the research topic and a discussion of this new information follows.

The survey used was adapted from the work of Boyd et al. (2011) who used a similar cross sectional survey designed to understand the mental health help-seeking preferences for young rural people in Victoria, Australia. Discussions with the chief investigator for the Boyd et al. (2011) study were held during the development of the cross sectional survey used in this study. This was useful for refining the adapted survey instrument and using it to investigate a wider age group and include a broader range of relevant rural informants to add a further breadth of help-seeking preferences and influences that impact the decision-making processes of young rural people.

Boyd et al (2011) found that 55.7% of their sample of 201 participants across eight rural locations was prepared to seek mental health help when it was needed. However, Boyd et al.

(2011) limited their study to include 11-18 year old rural high school students, which differs from the sample in the study reported in this thesis that excluded participants under 18 years of age. Despite this, participants in this study were reporting on their experiences of young rural people with emerging mental health problems at any age. The Boyd et al. (2011) study sample indicated a strongest preference for seeking help with school counsellors which might be anticipated because all of their participants were interviewed in a high school setting during a face to face interview with the researchers, and the context may have influenced their thinking because of their familiarity with the concept of school counsellor services generally within that environment.

The findings in this study indicate that young rural people are willing to seek mental health help when it is needed, with 65% of respondents indicating that they would seek help. This is slightly greater than that of the Boyd et al. (2011) study who found that 55.7% of their sample would seek help. The finding confirms the previous work that a willingness to seek help exists generally, where previously it has been considered that a reluctance to seek help exists (*cf* Allan, 2010b; Campbell et al., 2006; Judd et al., 2006; Kilpatrick et al., 2012), especially in rural areas. While the results of this study do indicate that young rural people are willing to seek help, the results also demonstrate that barriers and inconveniences do exist that prevent young people from gaining mental health care in some instances despite their general willingness to participate in the available services.

As discussed in Chapter Two, it is known that in Australia only 35% of people with mental health disorders receive appropriate mental health care (S.P. Rosenberg & Hickie, 2013). Rickwood (2012) reports that approximately 875,000 12-25 year old people are likely to benefit from mental health intervention, yet the national mental health strategy, *headspace*, only registers fewer than 30,000 clients per year. The mental health of young people in Australia is thought to be grossly underserviced (Coughlan et al., 2011, 2013; Mendoza et al., 2013; Rickwood, 2012; S.P. Rosenberg & Hickie, 2013). This research demonstrates that young rural people are willing to access mental health services if these opportunities are reasonably available to them; however, it is clear that the availability of mental health services to young rural people is not conveniently available which may explain a significant public health limitation to early mental health care for this group.

Boyd et al. (2011) also found that young peoples' fear of local gossip was a barrier to them accessing mental health care. In contrast, the study reported in this thesis has been able to determine that while embarrassment and the consequences of rural stigma and gossip are factors for 21% of survey respondents, 65% of the survey respondents indicated that even though small town gossip and any associated embarrassment was uncomfortable, they would still seek professional mental health help if they need to do so. This is an important finding because it demonstrates an underlying rural ecological resilience whereby despite the discomforts, young rural people and their families express a willingness to participate in mental health care. This is important new information for health and other service providers because it is clear that if mental health care is conveniently located and accessible, then it is more likely that young rural people will access these services.

5.2.1 Providing positive first mental health encounters for young rural people in their rural communities enables ongoing mental health helping.

First encounters and first conversations with young rural people who are mental health help-seekers are critical, and they underpin successful early engagement with mental health care for young people. Chance encounters and brief interventions are important early components of rural young people's mental health early intervention strategy. Clinicians should be located conveniently so that these help-seekers can take advantage of easy and uncomplicated local access to initial mental health care. Rural people prefer to wait and see if what appears to be a mental health problem will resolve without intervention, and they are prepared to give some time to waiting and hoping that the problem will spontaneously resolve. If the problems continue, young people are most likely to initially seek help and advice from their parents and their friends, prior to seeking any formal mental health help from a health professional.

In contrast to other studies discussed in Chapter Two (cf. Allan, 2010b; Boyd, et al., 2008; Boyd & Parr, 2008; Campbell, Manoff, & Caffery, 2006; Judd, et al., 2006; Kilpatrick, et al., 2012), where it has been identified that rural people are less inclined to seek mental health care because they are stoic, the findings of this study demonstrate that rural people are generally willing to seek mental health help despite the discomforts associated with embarrassment, stigma and social acquaintance. Rather, it is difficult for rural people to identify where it is appropriate to ask for mental health help in rural communities, and who can be approached. This *not knowing* who, or where, to ask for initial mental health help

further fuels an ambivalence about whether it would be useful, or not, to seek mental health help for a young rural person. Respondents in this study believed that the best people to provide mental health care to young rural people are health professionals. They also believed that other people in the community, such as teachers, counsellors and ministers of religion, had an important role to play in providing advice and support to young rural people and their families in the context of emergent mental health problems. According to the respondents, there is a moderately strong belief in rural communities in the study region that mental health services are not readily available in local settings.

The findings from this study indicate that a significant quantity of under-tapped social mental health helping capital exists within rural communities in the form of rural nurses and others; however, it is frequently not used to the full extent of that capacity because current health service systems do not have structures and polices in place that enable the natural exploitation of the relatively abundant human resources. The social mental health helping capital in each rural community is made up of people within that community, some of whom have unique boundary crossing roles that do not lend themselves to state or national health strategic plans or medical systems. Thus, the mental health helping capital within rural communities is under-utilised and is not harnessed formally to support young rural people. However, the latent capacity to support young rural people seeking mental health help is present in rural communities. Enabling the successful early mental health care of young rural people requires the strategic use of local human resources; that is, mental health helping social capital specific for each rural community, because formal youth mental health service options are lacking in the communities in this study site region. This research has been able to expand knowledge, and build on what has previously been known about mental health and rural capital in the study region, providing evidence to support the more effective use of rural mental health helping capital in addressing the mental health needs of young rural people.

Parents in this study described how they make decisions about whether their children were '*genuinely suicidal'*. Parents indicated that they recognised the fluctuations in the mental state of their children, and they used their knowledge of this to determine if they were convinced that the observed behaviours were sufficiently genuine and if a risk of suicide existed for their child. However, once a decision was made, the selection of local help available to them was very limited, and often required considerable travel, making it very difficult for parents to

access timely and appropriate mental health help when it was needed. They were reluctant to undertake travel or access emergency help unless they were certain that an emergency situation existed. However, the threshold for what would constitute an emergency was vague, and a 'wait and see' approach was usually selected as a first option. Parents expressed concern about the suicidal ideas that their children may experience, and they were willing to act to provide necessary mental health care. Parents were also attuned to their children's mental health condition, and this knowledge lends itself to facilitating timely and appropriate mental health interventions. However, the practical difficulties associated with rural places, together with the limitation of few youth mental health services in these places, acts as a deterrent for rural people to access early mental health care despite early access being positively associated with better outcomes for young people. This study supports the findings of other studies reported in Chapter Two, which identified that mental health services are difficult to access for rural people (Aisbett et al., 2007; C. Black et al., 2012; Boyd et al., 2006; Hoolahan, 2002; R. L. Wilson, 2009). Furthermore, the findings of this study demonstrate that the difficulties associated with access to mental health services for rural young people and their families continue to persist. The findings of this research concur with previous findings (R. L. Wilson et al., 2012) which show that parents understand and are attuned to the mental health of their children and that they are a valuable source of information for clinicians to confer with in assessing the mental health status of a young person.

For some people, the actions that helped them recover from an early mental health problem, including relocating to a new place, gaining new employment, or attending a new health service provider, were seen as useful. Relocating from an uncomfortable physical or emotional living environment helped some young people to cope and to reorganise their circumstances so that they were less vulnerable to an accumulation of emotional difficulties. For others, moving away from unhelpful relationships with others, both clinical and personal, was useful for them. This was the case when the mental health clinician or counsellor did not appeal to, or was not liked by, the young person. Young people in this study were more likely to persist with a clinician who appealed to them, especially when that clinician demonstrated an ability to connect on an emotional level. The genuine and authentic conveyance of care and interest in the young person by the clinician were very important. In addition, some respondents indicated that the clothing clinicians wore, together with their level of interest

and knowledge of youth culture, their age and gender were all important factors for young people. The findings of this study concur with the results of other studies with similar findings conducted in metropolitan regions (Watsford et al., 2013); that is, young rural people are more likely to be engaged with a clinician who exhibits characteristics that they like, and with whom they feel at ease and comfortable. Most of these characteristics are modifiable, and clinicians who work with young people can adopt or develop skills and attributes that can promote engagement with young rural people. However, gender is not a changeable characteristic, and this needs to be considered carefully in ensuring that young rural people have opportunities to work with clinicians of a gender that they feel comfortable with. Age is not a modifiable characteristic; however, it was less of a problem than was gender for the respondents in this study. Thus, older ages of clinicians can be mitigated to some extent by ensuring that other likeable characteristics such as clothing, interest, and caring characteristics are sufficiently available.

Respondents in this study recognised that e-mental health strategies were likely to be of significant assistance to them if they could be used in a coordinated way that involved clients and families, and if the access and availability of these resources were improved in rural communities. This finding concurs with other research and scholarship that has determined e-mental health is a valuable resource for the young rural people and their families (Christenson & Petrie, 2013a; Rickwood, 2012; R. L. Wilson, 2014b; R. L. Wilson et al., 2013). The current e-mental health initiatives that are available such as telehealth and health service-based video conferencing resources are currently limited to health service staff usage and are centred on the needs of staff, rather than the needs of clients and families or rural communities. Respondents in this study considered that telehealth would be helpful if it assisted them to see their son or daughter prior to discharge from a bed-based unit so that they could be more involved in discharge planning and transfer of the young person back to their home town. This opportunity was not provided to parents in this study despite their requests. Parents reported arriving at a bed-based unit and discovering that their child had experienced adverse side effects of medications or that he or she continued to be so unwell that a long drive home to a town without adequate support service to assist the recovery of the young person was an overwhelming challenge. This type of situation was reported frequently with readmissions to a bed-based unit occurring within a very short period, and well short of the NSW Mental Health Commission target of 28 days (New South Wales Health, 2012).

Discharge planning was limited to telephone calls between nurses and parents, and young people were included in a landline telephone call if they were able. Occasionally respondents reported that they spoke with a psychiatrist or doctor prior to a discharge; however, these parents reported that they preferred the better indication of how their son or daughter was responding to treatment from telephone discussions they had with the mental health nurses in the bed-based units. Respondents in this study were keen to utilise e-mental health technologies but they did not see that the possibilities would be an adequate substitute for face-to-face local mental health care available in their communities. They reasoned that both local and digital mental health resources should be available to them in their rural communities and that e-mental health constituted an additional source of help, not a replacement source of distant mental health help. The findings of this study are consistent with other research conducted in Australia in rural settings, which concluded that e-mental health services are not an adequate substitute for face-to-face mental health care (Early Psychosis Writing Group, 2010).

The rural respondents in this study reported that their experiences with mental health telephone triage were unsatisfactory for two reasons. Firstly, telephone triage lacks face-to-face and local connectedness components; thus, people seeking mental health support were not in a position to connect emotionally with the health professional on the telephone. They did not consider that their emotional pain had been sufficiently recognised, considered and attended to during the telephone call process. They reported experiences where they felt they had not been adequately listened to and that their situations had not had meaningful attention paid to them, so they felt that the care ascribed to their situation was incomplete. While they recognised that they were getting some help, they felt they were not getting enough help for meaningful mental health care to be initiated. Help-seekers reported a fatigue in attempting to convince health professionals that mental health assistance was required, a finding that concurs with a previous research in this field (R. L. Wilson et al., 2012).

Secondly, health professional and other professional respondents who work in rural communities reported that they were dissatisfied with their experiences of mental health telephone triage. These professionals recognised that the protocol to access public mental health care required them to log an intake telephone call through the mental health telephone triage system, but many respondents outlined the actions they took to find an alternative way

to avoid using or solely relying on the mental health telephone triage system. Some of these alternatives included speaking directly to local mental health professionals in their own locality or region, and developing a personal professional network that included direct contact with mental health professionals. Some professionals and paraprofessionals who regularly worked with clients whom they attempted to refer to mental health services indicated that the telephone triage process was cumbersome and incongruent with the needs and experiences of people in need of mental health care. In particular, they reported that young rural people were repelled by making a telephone call to someone they could not see in person, and whom they perceived to have very different geographical and social circumstances to them, because the telephone-based staff were based in metropolitan call centres. In addition, people who were in the midst of emotional distress and mental health and/or cognitive decline were expected to make a convincing case to the telephone-based mental health professional and to indicate the extent of their need for mental health care, as a first step towards initiating a referral to a local or regional mental health team. Health and other professionals reported that when young rural people, or those who cared for them (for example, their parents), had an unhelpful experience with the mental health telephone triage service, these people were disinclined to seek future access to mental health care using the mental health triage services. This was seen as a barrier to accessing early mental health care for young rural people and it also instilled a sense of distrust and reduced confidence in the likelihood of mental health professionals or services being able to help to reduce the problems that young people and their families experience during the emerging and early phases of mental health problem development. This finding contributes further knowledge about the difficulties that are associated with telephone-based mental health triage services and complements other research discussed in Chapter Two (Elsom et al., 2013).

It is concerning that some respondents in this study considered that one method of enabling young rural people to undertake mental health assessments and treatment was by providing that service as part of their criminal custody arrangements. Processes were outlined by respondents that supported and promoted the detention of young rural people in custody for the sole purpose of achieving a mental health assessment, and not for criminal behaviour matters, despite the clear violation of human rights in detaining young people in custody without any other reason to do so. Thus, a disturbing belief exists among some respondents

that some young rural people are best helped with their mental health problems by incarcerating them for the purpose of initiating mental health assessment and treatment.

5.2.2 Rural nurses are mental health helping capital in rural communities.

According to the respondents in this study, rural nurses are a significant mental health helping capital asset in their rural communities. Rural nurses are boundary crossers in the sense that Kilpatrick (2009) has described the boundary crossing concept; that is, as experts in health care in their work roles and in their dual local community roles. They can utilise this position to champion health promotion in other sectors of their local communities, such as community groups, schools and families. They are important local resident mental health helping social capital community assets in their rural localities. Respondents in this study recognised nurses' contribution to emergent mental health care of young rural people and they emphasised the nursing characteristics of listening carefully, conveying care, paying attention and connecting with others in regard to the emotions of distress and concern that accompany emergent mental health problems for young people, and those that care for them. These attributes were seen by respondents as important mental health interventions that were critical during the emergent phases of mental health problems, and respondents valued these interventions and sought them out to commence their mental health help-seeking experiences. The receipt of these nursing interventions enhanced engagement with, and referral to, appropriate further ongoing mental health care. Nurses were seen as health care professionals who could be trusted with private and confidential information. This is important because one of the moderately frequent views of respondents was that rural people are concerned for their local reputations and about stigma related to seeking professional mental health help. Thus, rural nurses are able to reduce the burdens and barriers of embarrassment and stigma because nurses are perceived to be trustworthy with private information. This aligns them ideally to be the first point of contact with a young person seeking mental health help because their trustworthy status mitigates a barrier to engagement with mental health services.

In this study, respondents indicated that nurses are able to navigate the complex public health systems, because they know how and where to access appropriate additional mental health help for young rural people. Some respondents indicated that it was necessary to find someone such as a nurse, who could navigate around the systemic obstacles that hinder young rural people and their families' capacity to access appropriate care. For example, some

respondents considered that registering with a telephone triage system to commence the process of accessing public mental health care was a barrier, so finding ways to navigate around this barrier was important for them to achieve personalised and convenient access to mental health care. Respondents in this study conveyed a sense of not always having their circumstances fully understood by telephone-based mental health triage services, and the attributes that were especially valued, such as being cared for, listened to with full and present attention, were not experienced in the telephone triage context by study respondents, and this concurs with research findings reported by other researchers (Elsom et al., 2013). Thus, the presence of rural local nurses in a face-to-face context was desired by the respondents in this study.

Rural nurses are valued in their local communities because they are approachable and they are the most frequently present and available health professionals who are also resident in local rural communities. The findings of this study suggest that their presence should be extended to places where first encounters with young rural people with emerging mental health problems are more likely to occur; for example, police stations, schools, GP medical centres, and family and community welfare settings. In this way, rural nurses can act to reduce the duration of untreated mental illness for young rural people, as they can detect emergent mental health problems and engage young people in early intervention without complicated delays.

5.2.3 Barriers to mental health help-seeking for young rural people persist.

Participants in this study were asked '*How can young rural people with emergent mental health problems be helped?*' and their responses to this question were frequently negative, describing the ways in which mental health help had not been achieved for young rural people. A major finding of this study is that there were many barriers and challenges that made it difficult for young rural people to access mental health care, and the social ecology related to people and places complicated help-seeking for them. Some respondents recognised that episodes of anger and violence deteriorated the family and social environments significantly and that once these behaviours had become entrenched they were very difficult to manage. Parent respondents reported that health professionals did not appear to recognise the magnitude of these difficulties within their families until they had reached extreme conditions, usually when police and the law had to be involved in controlling these

behaviours. Young respondents recalled their extremely uncomfortable emotions associated with anger, and a sense of finding no other coping mechanism to control the extreme emotions related to their personal distress. Some respondents, with the benefit of hindsight, could articulate a sequence of personal events that had commenced with exposure to bullying at school or home, and/or the unstable and emotionally deplete family environments, which had been triggers for anger and/or violent behaviours. The more complex circumstances resulted in legal problems and sometimes in criminal or custody outcomes for young rural people. In all cases, respondents were able to identify ecological conditions such as home life or school life that were not conducive to a thriving and adaptive psychological development for young people. So it can be seen that the respondents believed that the environments in which young people lived were sub-optimal in promoting mental health strength, coping and resilience. The evidence supporting this finding from the research supports the findings of other researchers and scholars who have previously demonstrated that poor environments for human developmental growth result can result in poor health, educational and social outcomes for children and young people (Krebs, 1985; Kellert, 2012; Factor et al., 2013; Byun et al., 2012; Conomos & Griffin, 2013; Fraser et al., 2002; Judd et al., 2006).

Respondents reported that drug and alcohol use and misuse were widespread in the study region. Drug and alcohol misuse was recognised as a feature that was simultaneous with the onset of mental health problems, and occasionally also with violent or criminal behaviours, for young rural people. Some respondents held a perception that the extent and diversity of drug use among rural young people had increased in recent times. The use of drugs and alcohol has the capacity to mask the onset of emerging mental health problems and complicate the early identification of mental health problems and mental health assessment and treatments. This research concurs with the findings of other researchers who have reported that drug and alcohol misuse complicates the assessment, management and resolution of mental health problems for young people, as previously discussed in Chapter Two (Boydell et al., 2013; Early Psychosis Writing Group, 2010; S. P. Rosenberg & Hickie, 2013; R. L. Wilson, 2014a).

An additional concern is the drug and alcohol use of parents, and the condoning of drug and alcohol use by some parents in this study. It is clear from the findings of this study that some young rural people are exposed to the drug and alcohol misuse of their parents and that the

condoning of this behaviour creates a socioecological condition whereby young rural people develop drug and alcohol misuse behaviours of their own. This was not seen as unusual by respondents in this study; on the contrary, there was an expectation among some respondents that it was inevitable that young rural people would use drugs. Thus, when adverse events occurred that diminished mental health, it was often attributed to generalisations of young rural people *'having nothing else to do'*, that it was the fault of the cannabis because '*it is stronger these days'*, and that it was easily accessible because some parents and by proximity, their children, already had access to drugs in their homes.

Additionally, this research has discovered that the consequences of adult drink driving offences has created job opportunities for some rural people because they were able to gain employment when employers had lost their driving licences and so employed young people as apprentices or rural workers, with key roles as drivers, in an effort to maintain the transport mobility of their employer. The dynamics of rural drug and alcohol misuse identified in this study suggest such misuse is condoned in some rural communities, and this condition may pose a risk to vulnerable individuals and increase risk for young rural people in their development of emergent mental health problems.

Health, police and law and public health services are not aligned to promote the mental health care of young people with emerging or early mental health problems. This is evident in the literature because, as discussed in Chapter Two, young people with mental health problems make up a significant proportion of people detained in NSW detention centres (New South Wales Law Reform Commission, 2012). Respondents in this study reported that young rural people in the study site region experience both emerging mental health problems and criminal or police matters concurrently, and that managing these dual problems is entangled with mental health law and interagency collaboration challenges. Frequently, young rural people are without appropriate access opportunities to early or preventative mental health care until they enter the justice system and become mandated to participate in mental health assessment and treatment either during their incarceration, or by community court order. Delays in engaging young rural people with emergent mental health problems have significant detrimental impacts on the reputation of young people and on all domains of their development. Clearly, the practicalities of helping young rural people with emerging mental health problems are left to a far too late point in the sequence of addressing mental health

needs. It may be possible to mitigate and prevent some of the criminal and policing matters for young people if mental health promotion and mental health service engagement can build earlier trusted therapeutic rapport with young rural people in their local communities. The literature discussed in Chapter two identifies that a longstanding difficulty exists in regard to collaborations and transfer of care between justice, police, health and ambulances service in NSW (New South Wales Law Reform Commission, 2012).

An underlying chronic low, flat mood, where happiness, satisfaction and enjoyment in life are intermittent or non-existent, was identified as deterring young rural people and their families from seeking mental health care. This study found that it was not uncommon for a depressed state to pervade across whole families, and where this occurred, the people in the family experienced a paralysing inertia where it was not possible for them to muster sufficient self-awareness, motivation, energy or the personal resources such as time, transport and/or finances, to either identify or access appropriate mental health care. This led to people delaying any engagement with mental health care, or if it was trialled, developing an internalised lethargy about proceeding with the challenges of accessing, and the telling and retelling of painful life stories to multiple clinicians. In addition, the perceived threats to social reputation; the challenge of attempting to convince health professionals that mental health help was required; or feeling as though they were blamed for their circumstances, for example, because of inadequate parenting, use of drugs or alcohol, or not travelling to arranged appointments or services outside of the local community, further hindered ongoing engagement with mental health care.

This study identified transport pressures as a significant barrier to accessing youth mental health care. Specifically, the costs associated with fuel and vehicle maintenance to travel long distances to health services are prohibitive for many people, so it is not possible for them to engage with mental health services. Negotiating with others to be available to drive to appointments is difficult for many young people and their families. The complexity of travelling to appointments in other regional centres, or major metropolitan centres, required people to take time away from employment, and this might include time away from work or school for the young person and for one or two parents. The loss of income can be significant, especially if several days' absence from work might be required, because distances travelled may require a day of travel to and from the appointment and perhaps a day spent attending

appointments, culminating in several nights' accommodation as well. In addition, the cost of food away from home, and other incidental costs were also burdensome to young people and their families.

Respondents for this study reported that frequently people do not have cars, or licences to travel, and in some communities in the study region, whole families and extended families do not have access to a car for distance transport. There is little or no public transport available in some of these communities, and where cars are available, they are sometimes crowded with more people than there are safety belts and seats. For many respondents, travelling to other towns or regions to access mental health care is an unrealistic goal, and if it is achieved on one occasion, it may not be possible to plan subsequent appointments. As discussed in Chapter Two, rural transport difficulties, and the geographical and social isolation that result, persist as a major barrier for young rural people in accessing any services not available in their local community, in this case, mental health care (Larson, 2011; Judd et al, 2006; Lammers et al., 2012; Boyd et al., 2006; C. Black et al., 2012; R. L. Wilson, 2009).

Changes in the population dynamics of communities are significant factors that create an additional local rural community burden of care, and these have not been adequately planned for in the distribution of health and other public service resources. In particular, FIFO and DIDO populations related to a surge in the mining industry in the study region has led to entire new small housing developments being established on the outskirts of one town in the study region. A significant increase in mining workforce individuals as temporary residents of the community has increased the pressures on local public infrastructure and services. However, the local council has not had the benefit of official population data or revenue accumulation from this new population to provide the additional local services required by the influx of people. This dynamic has been noted in other research, in other communities both in Australia and beyond, and new problem-solving around these transient populations is currently being developed. However, adapting to these changes still lags behind, and the tensions of public service demands and gaps escalate (D. Black & Black, 2009; Haslam McKenzie, 2013; Zandvleit et al., 2008). The barrier for young people who may be new to the rural community is unknown; however, the respondents in this survey indicated that mental health service provision to young people in this population was strained. Transport was a significant barrier for this population because while in the rural setting for work, they often

did not have access to their own transport and could not easily find transport to attend health appointments in town.

It is a finding of this study that a perception exists that clinicians blame parents for shortcomings in their parenting skills and consider that these shortcomings are responsible and/or causal of factors related to the mental health decline of some young rural people. This study did not seek to explore causal factors; however, it is clear from the findings of this study that when parents encountered clinical situations in which they felt judged and criticised by clinicians for their parenting skill, and this detracted from engagement with families, this was a barrier for commencing or continuing mental health care. In addition, the parents in this study did not always agree with the conclusions that clinicians formed about family contributions to the origin of a mental health problem for their children, and this made parents sceptical about the usefulness of suggested mental health care strategies because they did not believe that a realistic and fair assessment had preceded the treatment or helping suggestions. This is further supported by other findings in a previous study by the researcher where it was found that parents doubted the quality of assessment by clinicians of their children's mental health and where the parents had not felt as though their views were considered and that they were not adequately listened to (R. L. Wilson et al., 2012).

5.3 Implications for policy

- The findings of this research support the need to resolve the longstanding difficulty in developing a meaningful memorandum of understanding across ambulance, police and health services sectors identified in Chapter Two. Interagency collaboration is a vital component of improving the early mental health care of young rural people in Australia.
- Young rural people are regularly detained in custody for the purposes of obtaining a comprehensive mental health assessment because a perception exists that a mental health assessment will not be available or achieved by young rural people in their local rural community setting. This represents a violation of human rights for young people, because it is a violation of freedom of liberty where they are held in detention on grounds where the lawfulness of such detention is ambiguous. Mental health and detention policies and legislation should be urgently reviewed by Justice, Health and

New South Wales Health departments and steps taken to ensure that no serious human rights violations occur for young people in the future.

- E-mental health is increasingly available in Australia, and extensive resources are being deployed by government and public health services to develop a range of digital resources to improve access to health care generally. E-mental health has a number of limitations; for example, in rural communities digital literacy is thought to be generally lower than for urban communities, and it is not an adequate substitute for face-to-face services in many instances (Christenson & Petrie, 2013a). However, it does offer an opportunity to mitigate the problems associated with travel and distance for some rural people, and it creates an opportunity for a broader distribution of specialist clinicians to work across a larger geographical range. While some forms of e-mental health have been at least notionally operational for some time, it is clear from this study that the activities of telepsychiatry, telehealth, videoconferencing and web-based mental health interventions have not been used to their full capacity, and that rural people and digital material infrastructure stakeholders and owners need to collaborate more closely to improve the distribution and effectiveness of e-mental health generally. NSW Health should ensure effective carriage and transfer of knowledge about e-mental health because it will not just happen simply because related material has been uploaded onto a website. It will need a more organised public health platform with an appropriate skills mix of health and communication specialists to ensure the infrastructure and associated knowledge brokerage results in helpful outcomes for rural young people in particular (Christenson & Petrie, 2013a; Rickwood, 2012; R. L. Wilson, 2014c; R. L. Wilson et al., 2013a; R. L. Wilson, Ranse, Cashin, & McNamara, 2013b). Rural nurses will need to actively participate in the development of a coordinated approach to health educational and health access and referral for the rural communities, because they are experts in those fields and have pre-existing place-based trust and respect within rural communities, which are important components in the successful development and operation of a rural e-mental health strategy.
- The national mental health strategy *headspace*, does not currently possess the capacity to be extended to every rural community in Australia. E-*headspace* does have some scope to contribute a useful component to a rural youth mental health strategy if rural

e-mental health knowledge brokers are available in community rural nursing settings or Medicare Local centres to facilitate this strategy in the rural environment.

- The headspace initiative should be reviewed by the Department of Health and Ageing with an aim to facilitate the redistribution of federal funds to include a contribution to the operational costs of rural nurses to act as e-mental health knowledge brokers for young rural people on a per capita basis, so that at least population-based equity of distribution of youth mental health financial resources is available in all communities, rather than, as is currently the case, restricted to one service centre in one regional community in the study site region.
- Further reform of youth mental health services is required to ensure that rural young people have reasonable access to mental health services in keeping with international progress and development about youth mental health services that challenge the traditional paradigms of youth mental health service delivery (Coughlan et al., 2011, 2013). There is wide agreement in the literature that young Australian people are underserviced in early mental health care, and that for rural young people this circumstance is further amplified (Coughlan et al., 2011; Mendoza et al., 2013; Rickwood, 2012; S. P. Rosenberg & Hickie, 2013).
- Rural nurses should be adequately funded to support e-mental health kiosks in appropriate community settings such as hospitals, multi-purpose health facilities, community agencies, schools and police stations. Rural nurses are able to collaborate with professionals from all of these sectors in such a way that collaboration of mental health helping and capacity building in rural communities is achieved and coordinated. The architects of health, social and law policy will need to accommodate the inclusion of new and innovative roles in the future. In particular, the function, role description of rural nurses, and specifically the role of rural community nurses will need to be expanded so that meaningful mental health help can be provided to early mental health help-seekers.

5.4 Implications for clinical practice

The findings of this study specifically identify the important clinician characteristics that underpin the successful engagement of young rural people in mental health care. Clinicians who are able to listen carefully, pay mindful attention, demonstrate authentic caring, engage

emotionally, present with likeable traits (clothing, interests, authenticity, gender) and who are located in convenient places for rural young people to access, are best positioned to assist young people who are seeking mental health help. It is therefore important that rural nurses and other clinicians attend to their own professional development needs so that they can develop and adapt to changes over time in the modifiable characteristics identified, so they can contribute to early engagement and ongoing intervention of young rural people in need of mental health care. Clinicians' behaviour, appearance, and ability to develop a therapeutic rapport with young people are important components of establishing a meaningful and trusted connection with young people. Clinicians who work with young people should include the development of youth-friendly attributes as a proportion of their professional development, because the maintenance of these skills and attributes enhance their capacity to connect with young people in a way that enhances their early engagement with mental health care.

The findings of this study support the further development of e-mental health strategies for young rural people as an adjunct to a substantive local face-to-face rural youth mental health service provision strategy. There is a growing expectation among rural people that e-mental health services should be a component of a more extensive suite of local youth mental health services. A prerequisite for the successful use of e-mental health is that both clients and clinicians are proficient in digital literacy. Therefore, rural clinicians should undertake sufficient professional development so that they are able to adapt to the ongoing changes of e-mental health capacity using a variety of digital formats (for example, Web1.0, Web2.0, telehealth, video conferencing), beyond the limits and accessibility of health intranet services. Additionally, rural clinicians, including nurses, will increasingly require additional digital resources, access permissions and computer hardware (for example, internet compatible tablet and or notebook style computers and smartphones), and access to social media (such as Twitter, Facebook, Google+) so that they are able to continue to adapt and improve the quality of mental health service provision and knowledge brokerage to rural youth populations. Health services should forecast future budgets to include rural internet usage for mobile computers and smart devices used in the further development of e-mental health to rural populations. In addition, rural clinicians should consider that personal ownership of basic internet connected computers become the minimum requirements of a professional tool kit that they maintain as a personal professional development resource for themselves, and

they should expect to develop and maintain professional proficiency in the use of these personal resources.

Nurses should be co-located in rural police stations and schools where they are most likely to engage in critical first conversations about introducing mental health help for young rural people. This would increase the opportunities to enhance chance encounters with vulnerable young rural people and would create an opportunity for them to be present and to commence care at an early point. Such a strategy could improve transition arrangements for accessing early mental health care for young rural people who exhibit emergent mental health problems and who come to the attention of the police prior to seeking mental health care. Public health services should consider instigating the memorandums of understanding, line management arrangements, and other policies that would enable the deployment of rural nurses to rural police commands.

5.4.1 Recommendation: Co-location ofnursing assets in rural communities

Nurses are the most abundant population of health workers in rural areas of Australia (Rajkumar & Hoolahan, 2004), so it is important to consider how this resource might be used most effectively to address the needs of young rural people with emergent mental health problems. These authors also indicate in their literature review that nurses, especially generalist-specialist nurses, are well placed to assess and to intervene early in rural and remote communities (Rajkumar & Hoolahan, 2004). Generalist-specialist nurses are nurses who have developed expert knowledge and practice in generalist nursing. Operationally, this level of skill by nurses is recognised as specialisation in general nursing (Edwards & McGorry, 2002; R. L. Wilson, 2007). Rajkumar and Hoolahan (2004) suggest that further research should be conducted to explain why the clinical work of such nurses, given its proven efficacy, is not implemented on a widespread basis. Currently, state health systems and national Medicare provider rebate models of health service delivery in rural Australia do not adequately support nurses taking a more assertive role in managing this health problem phenomenon more actively and decisively.

All rural registered nurses have a sufficient level of educational preparation and ongoing competency standards to maintain that positions and prepares them to identify and commence intervention and referral for young rural people with emergent and early mental health problems (Happell et al., 2014). They represent the largest health discipline in rural areas, and

occupy dual roles as local community residents and local health service practitioners. The delivery of nursing care is provided within a context of fostering health promotion, health, wellbeing and recovery. Rural nurses are likely to have real life work experiences that place them in a position for helping individuals, families and communities with emergent mental health problems. It is likely that they will have a great deal of important information about how they can help young rural people with emergent mental health problems. Thus, helping young people and communities with emergent mental health problems is a fundamental nursing function, and such roles require health system structures, systems and policies to activate nursing care to a full delivery potential in rural communities.

The rural nursing population has both specific direct knowledge and clinical experience of youth mental health. This, combined with their workforce distribution in rural communities, would assist in developing a model of care that could make more effective use of health care assets. This could include nursing services being co-located in a range of settings such as in police stations, schools, and other interagency-type services that are convenient for rural young people to access and where young people can be engaged early in mental health care.

5.5 Implications for interdisciplinary collaborations

Rural families need adequate community and health system supports, especially during challenging environmental or financial downturn times such as drought or other rural adversities, as the rural family unit is an important component of rural social ecology. Where family units are able to provide strong emotional bonds and sufficient practical care for their children and young adults, resilience, coping and the development of mental health helping capital within that family are fostered. In this way, opportunities for mental health to thrive are enhanced, and this will reduce the vulnerability for mental ill-health.

Support services should have meaningful and straightforward labels and titles for service providers so that there is no ambiguity regarding the types of supports that might be available. For example, family support specialists could be made available in rural communities where they could promote healthy, emotionally stable family relationships, sufficient shelter, access to nutritious food and food preparation, and parenting education. These ecological prerequisites are important foundational aspects of thriving rural communities and could be enhanced by specialist generalist family professional workers. Based on the findings of this

study, specialist generalist family support professionals could be usefully co-located in health settings such as multipurpose and community health centres, schools, commonwealth service centres such as Medicare Local centres, non-governmental community services, and/or churches. The infrastructure, supervision and support structures for family services are likely to already exist in rural communities and collaborations between organisations in rural communities are also likely to already exist. Developing a specialist generalist family professional workforce with these established structures is plausible, if the will to adapt and collaborate across services and sectors can be initiated and supported by the NSW ministries of health, education, family and community services, and justice and police departments, combined with the federal Department of Health and Ageing.

A new rural professional role such as a specialist generalist family support professional could be derived from a number of disciplines; for example, nursing, social work, psychology, occupational therapy, education, social science. The specialist generalist family support practitioners' responsibilities should include the promotion of family health and wellbeing, assisting families to adapt to changes in social, family, developmental, and local conditions, and acting as knowledge brokers to inform local communities and individuals about basic nutrition, food security, housing security, drug and alcohol risk, sexual risks and vulnerability, parenting skills, and to generally develop local capacity for families to thrive in rural communities. A skill set such as described here would not seek to provide case management to individuals or families, because that may replicate the services provided by other services such as professionals who work in the NSW Department of Family and Community Services, and who generally work with high risk situations where more intensive care is required. However, a knowledge brokerage role is currently a missing element in rural communities, and such a role would add a strengthening component to community development and would reduce the burden of serious child protection services. A family support professional should also work with families and young people up to an age of 24 years, which exceeds the brief of state-based family and community services, because the risk for mental health problems and the burden of care for young rural people with mental health problems is experienced by families at least up to the age of 24 years. A generalist specialist should be available in all rural towns and communities and so a collaborative interagency model of care that is sufficiently flexible to align with a range of service providers, for example, health, police, or education, is ideal to address the emotional labour experienced by families associated with the

mental health problems of young rural people. Ideally, a position such as this could use a similar governance structure as that proposed previously for nurses employed by state health services and co-located in a diverse range of settings with particular emphasis on what is most useful for individual rural communities.

Digital literacy is increasingly a skill that is required for navigating and interacting in many aspects of a contemporary digital lifestyle. Many mental health resources are now available on the internet, via email, or on social media. It is clear that there are many e-resources available and that these types of innovations are gaining some popular momentum; for example, rural people with access to the internet and health service providers who are interested in distributing health interventions and health information to more people, at less expense. Smartphones and internet usage at home is now very common in Australia, and the trend is set for this to continue (R. L. Wilson et al., 2013a). It will be important for health services to work collaboratively with communication and public relations specialists in the future to ensure that e-health communications achieve successful marketing to the specific target audience for rural mental health intervention campaigns so that e-health options are relevant and available to rural young people with mental health problems. Some rural communities will require the additional support of e-mental health knowledge brokers who are able to assist people with comprehending the digital environment and the content of e-materials. Rural nurses are ideal to also work in e-mental health knowledge broking capacities because they already live and work in rural communities, they are health promotion specialists, and they are trusted boundary crossers. These skills extended to the digital domain have capacity to assist others to engage usefully with e-mental health resources.

Extending the functions of a rural nurse in this way makes logical use of current and available human resources in the rural communities, and aligns with the socioecological functioning of both the rural community and the health services community. E-mental health knowledge broking could fit within a community nurse role in rural communities, and this would assist in mitigating the lack of face-to-face mental health services available in rural communities. Rural community nurses would need internet access and sufficient access to computer resources that could be used with their clients, in order to achieve meaningful outcomes. Other researchers have identified that rural literacy rates are generally poorer than urban literacy rates and they have suggested the need for knowledge brokers in rural communities

(Christenson & Petrie, 2013a; Rickwood, 2012). The findings of this study support the notion and extend the concept so that a practical alignment with present rural health service provision is achievable in proposing that rural community nursing roles are extended to include this knowledge broking function, and that this builds on the traditional roles of nurses in providing relevant health education for their clients.

5.6 Limitations

The dominant theoretical drive for this research was qualitative and so the generalisations from this study are limited to theoretical propositions and they make no claims to extend for populations. There was no intention in this study to specify particular outcomes to populations, but rather to understand the unmanipulated real life experiences of the people de-identified as participants (Yin, 2009). The case study design for this research provided a valid framework to explore contemporary events and there was no attempt to explore retrospective or prospective propositions (Yin, 2009). This study is described as a revelatory case and was designed to observe and analyse phenomena that are common to rural areas (Yin, 2009). It explores *how* questions only. Other angles of the phenomena under investigation might be illuminated by using different questions and if this were to occur, it would add to a broader knowledge about the phenomena across broader directions (Mantzoukas, 2008; Yin, 2009).

The sample size for the survey in this research was small, with fewer males than females taking part, and this is acknowledged as a limitation for the study. The total population of the study region is 200,000 and this combined with a large geographical region of 98,000km² and with only approximately 360 FTE registered nurses in mental health roles in the study region, a small sample size of 81 survey respondents is reasonable (Health Workforce Australia, 2013).

The design of this questionnaire is a further limitation. The survey contained questions that were designed to elicit descriptive and open-ended responses and so limited statistical analysis was conducted, and this is a limitation of the study. No test retest was conducted on the pilot survey, however Pearson's correlation was conducted to assess the similarity of responses between the pilot and actual data sets and these correlations were shown to be strongly similar which demonstrated a valid process was used to produce trustworthy and reliable statistical findings.

The recruitment process was convenience and purposeful in the two phases of the mixed method study. Randomised sampling will always give a more reliable outcome (Liamputtong, 2013), however, this is not always possible in research with humans. In this case, as in all convenience sampling, it is possible that those who volunteer to be interviewed may have reasons for doing so and this may not be representative of all rural nurses or rural community members.

5.7 Theoretical propositions

In Chapter One of this thesis a developing theory and a rival theory were identified in keeping with the case study research design process for this study. A final theoretical proposition is now proposed, which upholds and confirms the original concepts identified in the initial developing theory.

*New Theoretical Proposition:*The case study research has demonstrated that mental health helping capital is contained within the unique social capital of small rural communities and is represented by registered nurses and other residents of those communities. It is important that mental health helpers develop literacy skills and community awareness that include the interpretation of life problems and emergent mental health problems of young rural people. Health professionals (and other professionals) should have a better understanding of the help-seeking vocabulary and characteristics of young rural people and their families so that the gaps between emergent mental health problem onset and appropriate professional mental health service provision might be reduced, resulting in briefer durations of untreated mental health illness and resulting in more promising recovery prognoses for this group.

5.8 Further research

- Further research should seek to identify the specific criteria that parents of young rural people use to determine whether young rural people have reached a threshold of experiencing suicidal thoughts or behaviours, and to determine at what point parents of these young people consider that professional mental health help is warranted. This study has identified a risk that delays the seeking of mental health treatment for young rural people to occur, and that this, in part, depends on the ways in which parents prioritise the urgency and worth of seeking help. More needs to be known in the future so that young rural people can be helped earlier, and so that deterioration of mental health and risk to life can be mitigated or reduced. Further research with parents of young rural people using a Delphi study design may be able to isolate the criteria that are most frequently used by rural parents.
- Barriers to accessing mental health care are experienced by young people who are new to the rural setting; for example, FIFO or DIDO workers in mines, or those who have relocated to the rural community from an urban centre to access work, or have

relocated later during adolescence as part of a family during a ‘tree change’. The needs of these micro/sub populations are not yet known, and their experiences and needs may differ from those of long-term rural young people. Further qualitative research using in-depth interviews or focus groups is required to understand the real life needs of new-to-rural-community populations of young people in the first instance.

- It is known that caring for adolescent and adult children with mental illness involves a host of challenges and requires a great deal of personal and family investment in the adult child’s recovery. This caring is burdensome, constant, and the emotional toll for carers and family members is significant (R. L. Wilson et al., 2012). The extent to which rural carers acquire mental illness or distress, whether chronic or episodic, is not fully known. In this study, some rural parent carers indicated that their own mental health had suffered as a direct result of their caring roles and that they themselves became consumers of mental health services and psychiatric medication usage. These rural carers experienced stigma and self-stigma because they believed that others would view them as weak and unable to cope with the burden of caring for their family, and that this sometimes acted as a barrier to them accessing any support services to assist them in their caring roles. Valuable insights could be gained by conducting an audit of the Prescribed Benefits Scheme and Medicare data to determine how many members of a family are prescribed antidepressant medications using a Medicare family unique identifier and the number for each individual in a family for rural postcodes or regions. Analysis of data such as this would reveal co-morbid mental illness within families and would also be able to discriminate between geographical regions or postcodes where higher and lower density of co-morbidity may exist, and this level of information could inform mental health promotion interventions and service planning for meeting the needs of the population. Future studies should explore the nature and extent of the rural carers’ level of emotional burden and how this might be alleviated to promote the mental health and wellbeing of rural carers, rural families and rural adult aged children with mental illness.

5.9 Conclusion

This chapter has discussed the results that arise from this research. First, a description of the ways in which young rural people are enabled to engage with mental health help and the

importance of favourable first encounters with mental health clinicians. The second main finding describes the characteristics that rural nurses contribute to the mental health helping capital in rural communities. Lastly, a description of the barriers that currently exist that detract from young rural people's convenient access to early mental health care was provided.

Implications for clinical practice and interdisciplinary collaboration have been presented, which include innovative deployment of current health resources to places of greater convenience for young rural people. In particular, rural nurses should be co-located across other sectors (for example, rural police stations and schools), and more broadly in health settings (such as multi-purpose health setting and medical centres). Co-location of nurses in diverse service settings enables enhancement of very early engagement with rural young people where first conversations about mental health care can conveniently take place. For this to be achieved, a broader understanding of interdisciplinary collaboration that is inclusive of multiple non-traditional collaborators is required. The make-up of this collaboration would mirror the capacity within the local community (for example, police, schools/teachers, non-government community organisations and churches). New professional skill set needs have been identified and new rural professional roles that align with rural community needs about mental health care have been proposed. Ideally, specialist generalist family support professionals would fill a gap where families lack general support to promote mental health and wellbeing for young rural people, and communication and public relation specialists and e-mental health knowledge brokers would make e-mental health strategies transferable to target communities and to young rural people generally.

The implications for policy coming from the findings have been presented in this chapter. In particular, there are longstanding issues that have prevented interagency collaboration, and these need to be resolved so that interdisciplinary collaboration, such as proposed in this research, can improve in the future. It will be important for national youth mental health strategies and e-mental health funding to be reviewed so that an equitable distribution of youth mental health services are more readily available to all rural young people wherever they live. The proposed e-mental health knowledge brokerage functions described in this chapter provide an opportunity to utilise the local mental health helping capital in rural communities. Ideally, local rural nurses can be deployed in such a capacity, so that mental health promotion and early intervention can be achieved in all rural communities, with only

thrifty and moderate financial changes to health service budgets, and with an emphasis on reducing rural inequities in accessing mental health care and maximising current rural human resources. The most pressing implication for policy identified in this research is the urgent need to address the detention of young rural people in juvenile justice settings for the main purpose of achieving a comprehensive mental health assessment. The human rights implications of detaining young people in custody for reasons other than legal matters are important because they place Australia in a precarious position in regard to the treatment of children.

The primary recommendation arising from the implications was described as a co-location model for nursing assets in rural communities to promote the early engagement of young rural people into appropriate mental health care when it is required. Current models, while they provide some levels of mental health care, are not sufficiently aligned with the rural social ecology of young rural people and their communities so that many young rural people are unable to access enough of the mental health care that would be of greatest benefit to them. Rural nurses are ideal mental health human resource assets to deploy in co-located rural settings because nurses are able to contribute expertise in the form of paying adequate attention, carefully listening, providing authentic care that is mindfully present and understanding the local context for young rural people.

Finally, this chapter has identified areas where further research is required, including further exploration of the decision-making processes used by parents to initiate professional mental health help-seeking for their children, together with the extent to which the mental health of parents declines in parallel to their children's mental health decline. Finally, a new area for research consideration is the mental health needs of young people in FIFO rural workforces.

5.10 Summary of thesis

Chapter One covered the context for the research, identified the research problem and discussed the significance of the topic. In particular, it identified a significant problem for young rural people in accessing appropriate and timely mental health help when it is first required. Young rural people often experience long durations of untreated mental illness. Delays in early intervention for emergent mental health problems lead to extended recovery periods because the longer a mental health problem is left untreated, the more resistant it can

be to treatment. The difficulty that young people and their families encounter when they seek mental health help in rural communities, in particular the difficulty related to limitations in mental health service provision in many rural communities, was introduced. In combination, these conditions contribute to significant delays in young rural people achieving mental health service provision when it is required.

Finally, Chapter One concluded with an introduction to the selected research design, the research question and the proposal of a developing theory. The researcher provided a background account explaining the personal professional context for the initiation of the research.

Chapter Two covered a discussion of the relevant literature about the topic under investigation, and in particular demonstrated that both the international and national definitions for the context of youth mental health have changed in response to the identified widening of adolescence and young adulthood developmental phases, from 18 years of age towards 24 years of age. It was identified that mental health services should provide services that better align with the context of human developmental phases. The current context of youth mental health morbidity for Australia was discussed and the deficit of youth mental health services in rural communities was identified. Further, the barriers to accessing mental health services for young people were addressed, and the specific health service context in the study region was discussed. The dynamics of mobile and e-health service were presented and discussed and rural and regional factors considered. The challenges associated with telephone-based mental health triage were discussed and the expectations of young people about their mental health service encounters were outlined.

Chapter Two also explored the limitations and conflicts associated with mental health and legal matters, and identified the high prevalence of diagnosed mental health disorders among the young people in custody in NSW, Australia. The preference for diverting young people with mental health problems away from courts and into mental health care was discussed as were the challenges and barriers in achieving these outcomes. The inadequacies of assessing risk for violence in relation to mental health adversity within families were covered. Mental health literacy and awareness in rural communities was outlined. The context of rural people and place was described and relevant rural social capital and social ecology dynamics were discussed, including an exploration of the environmental and land use interactions with

human health and wellbeing. The vulnerabilities for young rural people's mental health were identified, and so were the barriers related to them accessing appropriate mental health help. Rural nurses and web-based mental health supports were identified as important forms of social capital for addressing the mental health needs of young rural people. Finally, Chapter Two covered the theoretical frameworks used in this research, and provided a rationale for their use and relevance to this study.

Chapter Three covered the research design and methodological approaches used in the study, and described the mixed method approach that was used to answer the research question: *How can young rural people with emergent mental health problems be helped?* Case study research design (Yin, 2009) was selected because it was capable of accommodating a range of data sources and allowed the investigator to explore the full meaning of the phenomena in a real life context. Chapter Three provided a schematic representation of the case study research model (Figure 3.1) for this study and outlined the chain of logic that underpinned the integrity of the study. The research design for the survey and in-depth interview components of the study were covered, ethical considerations were discussed, and the measures outlined to ensure that the findings of this study would be rigorous, trustworthy, credible and dependable. The limitations of the study were described.

Chapter Four presented the data analysis and findings for the study. The descriptive statistical analysis and the content analysis of the survey findings were discussed, and the thematic analysis of the in-depth interview findings was also discussed. The survey findings provided insights from 81 respondents and these described the experiences of rural people in helping young rural people with emergent mental health problems. The main findings of the survey included identifying a general willingness among respondents to seek mental health help if it is needed. However, some people considered that embarrassment, stigma and local personal acquaintances were factors that may be uncomfortable for them in their seeking mental health help experiences. Some respondents were ambivalent about seeking mental health help for young rural people, and were not convinced that it would be useful, and/or they had difficulty in locating a suitable youth mental health service in their location. Some respondents believed that waiting lists and associated treatment costs would prohibit them from achieving any desired access to mental health care.

Survey respondents held a strong view that nurses are important contributors to mental health care in their rural settings. In particular, respondents recognised nursing characteristics such as listening, paying attention, caring and connecting with the emotions of mental health distress, and these attributes were seen as helpful, especially in the mental health care of young rural people. Twenty in-depth interview respondents held some similar views to the survey respondents about the attributes of nurses in the rural mental health context. Four main themes and eight sub-themes were identified in the in-depth interview data. Theme one identified the characteristics of the emergence of mental health problems experienced by young rural people while the sub-themes identified specific characteristics of the emerging mental health problems, and the experiences and barriers that families encountered when attempting to access mental health help when it was initially required. Theme two described the helpful characteristics demonstrated when other people helped young rural people with mental health problems and further sub-themes identified the difficulties people experienced in convincing others that help was needed; the basic core needs of young rural people; and the social network experiences of young rural people with emerging mental health problems. The third main theme described the lack of meaningful connections with mental health services experienced by respondents. The sub-themes described the challenges as 'muddling on' and being 'stuck between a rock and a hard place'. The final main theme identified the characteristics of health, welfare, and social service provider characteristics in young rural people's mental health care needs.

Chapter Five presented and discussed the results from this investigation, including the practice and policy implications. Recommendations for further research were identified and proposed, and a final conclusion was provided.

This thesis has identified a research question with particular relevance to the mental health care of young rural people in northern NSW, Australia. An appropriate and logical research design was selected to answer the research question: *What helps young rural people with emergent mental health problems?* Data analysis has revealed trustworthy findings that have led to conclusions and recommendations that specifically answer the research question. It is apparent that person-centred rural mental health social ecology is a useful framework for the exploration of rural youth mental health. The findings of this study indicate that it is too simplistic to suggest that young people are solely responsible for the outcomes of their own

mental health during adolescence and early adulthood. Rather, poor mental health and mental health risk and vulnerabilities are the product of, and are related to, the quality of the total environment in which a young person, with a young mind and a young brain, progresses towards developmental physiological and psychological maturity. If the environment is less then optimal, then it can be anticipated that the prospects for successful and healthy maturation will be compromised, just as it is in other natural world settings (Krebs, 1985). There is, therefore, a natural propensity for dysfunction, illness and poor physical, mental and social development to proliferate where conditions are poor. Respondents in this study considered that treating others as you would want to be treated is a helpful position for health professionals to adopt, so that they can provide help to young rural people with early mental health problems; that is, a respectful, authentic and person-centred approach contributes to developing a socioecological environment that enhances mental health helping capital within a rural health service provision context. The health ecology of each rural community should be promoted and prioritised so that the systems, structures, and relationships that operate within the rural communities are able to promote youth mental health and wellbeing and so that young rural people can easily and seamlessly access appropriate mental health care when it is required.

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APPENDIX 1

Relevant publications and presentations by Wilson, R.L. during PhD candidature

Publications and presentations arising from and informed by this research

Journals:

- **Wilson, R. L.**, Cruickshank, M., & Lea, J. (2012). Experiences of families who help young rural men with emergent mental health problems in a rural community in New South Wales, Australia. *Contemporary Nurse, 42*(2), 167-177.
- **Wilson, R. L.**, Ranse, J., Cashin, A., & McNamara, P. (2013). Nurses and Twitter: The good, the bad, and the reluctant. *Collegian*(0). doi: http://dx.doi.org/10.1016/j.colegn.2013.09.003
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- Happell, B., **Wilson, R. L.**, & McNamara, P. (2014). Undergraduate mental health nursing education in Australia: More than Mental Health First Aid. *Collegian, x*(x), x-x.
- Ranse, J., Hutton, A., Jeeawody, B., & **Wilson, R. L**. (2014 under review). What are the research priorities for the field of disaster nursing? An international Delphi study. *International Journal of Nursing Studies, x*(x), x-x.

Book Chapters:

- **Wilson, R. L.** (2014). Rural and Regional Mental Health. In N. Proctor, H. Hamer, D. McGarry, **Wilson R. L**. & T. Froggatt (Eds.), *Mental Health: A person centred approach.* Melbourne: Cambridge University Press.

- **Wilson, R. L**. & Riley, S. (2014). Mental Health of Children and Young People. In N. Proctor, H. Hamer, D. McGarry, **Wilson R. L**. & T. Froggatt (Eds.), *Mental Health: A person-centred approach.* Melbourne: Cambridge University Press.
- **Wilson, R. L**. (2014). Mental health and substance use. In N. Proctor, H. Hamer, D. McGarry, **Wilson R. L**. & T. Froggatt (Eds.), *Mental Health: A person centred approach.* Melbourne: Cambridge University Press.

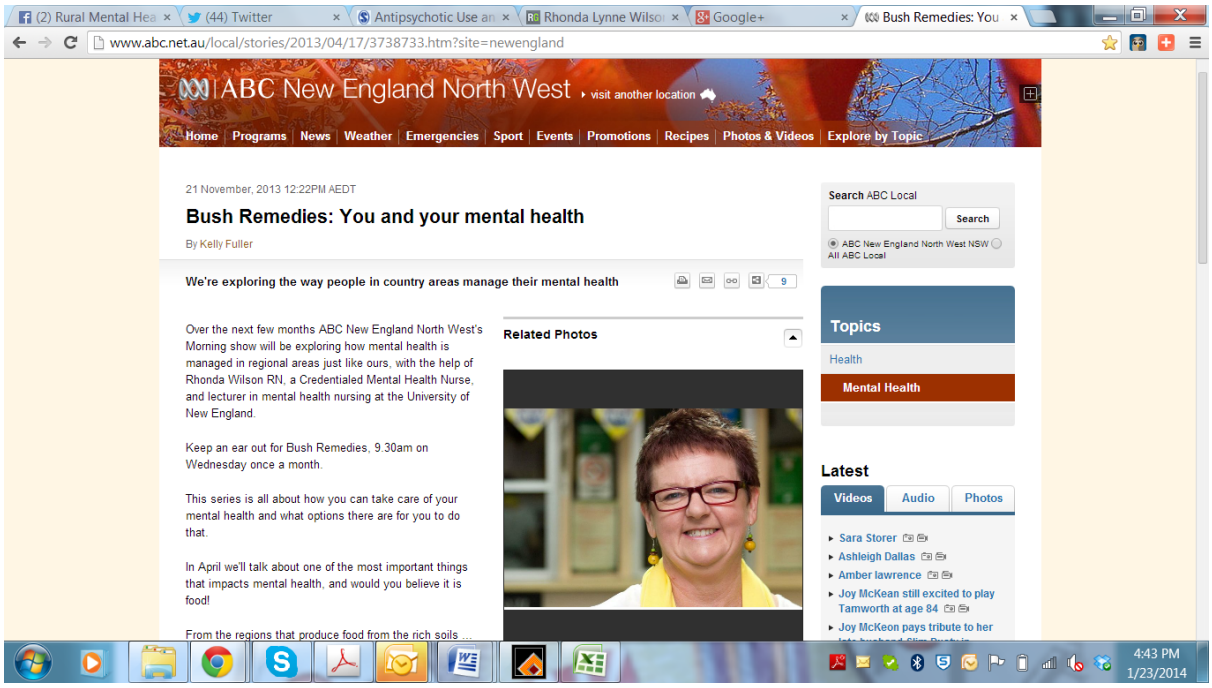
Conferences:

- **Wilson, R. L**., Cruickshank, M., & Lea, J. (2011). Experiences of families who help young rural men with emergent mental health problems in a rural community in New South Wales, Australia. Paper presented at the World Federation of Mental Health, Cape Town, South Africa.
- **Wilson, R. L**., Cruickshank, M., & Hercelinskyj, G. (2013). *The mental health needs of young rural people.* Paper presented at the Australian College of Mental Health Nurses International Online Research Symposium, Canberra, ACT.
- **Wilson, R. L**., Cruickshank, M., & Hercelinskyj, G. (2013). *May 2013. Are the needs of young rural people with early mental health problems in rural Australia being met or ignored?* Paper presented at the International Conference of Nurses 2013 Melbourne Victoria Australia
- **Wilson, R. L.,** Cruickshank, M., & Hercelinskyj, G. (2013). *Are the needs of young rural people with early mental health problems in rural Australia being met or ignored?* Paper presented at the 21st World Congress Social Psychiatry, Lisbon, Portugal.
- Happell, B., **Wilson, R. L.** & McNamara, P. (2013). *Beyond bandaids: Defending the depth and detail of mental health in nursing education.* Paper presented at the Australian College of Mental Health Nurses 39th International Mental Health Nursing Conference Perth, Western Australia, Australia.
- **Wilson, R. L.** (2013). *'I was about to explode': The experience of young rural people with emergent mental health problems*. Paper presented at the Australian College of Mental Health Nurses 39th International Mental Health Nursing Conference Perth, Western Australia, Australia.

- **Wilson, R. L.** (2013). *A conversation to build mental health rural recovery capital in a church setting: A story about a patchwork quilt, a young person and a mental health nurse*. Paper presented at the Australian College of Mental Health Nurses 39th International Mental Health Nursing Conference Perth, Western Australia, Australia.
- **Wilson, R. L.**, Ranse, J., Cashin, A., & McNamara, P. (2013). *Twitter: a contemporary nursing conversation tool*. Paper presented at the Australian College of Mental Health Nurses 39th International Mental Health Nursing Conference 2013, Perth, Western Australia, Australia.

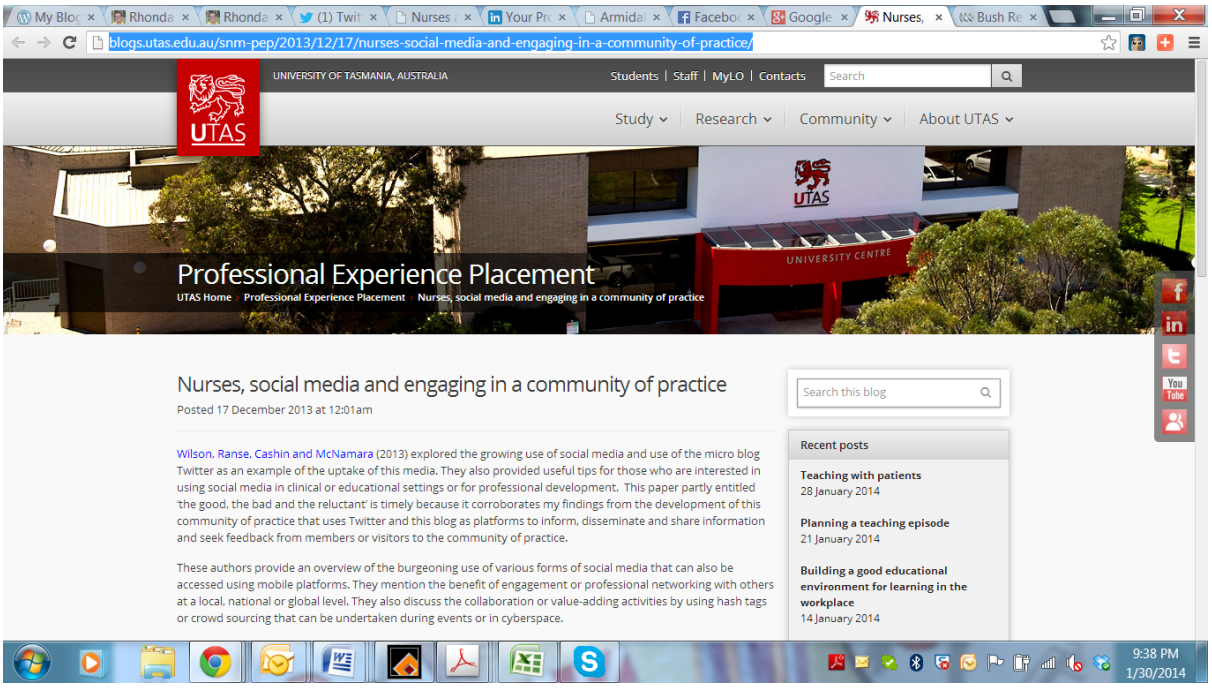
Other:

- **Wilson, R. L.**, & Fuller, K. (Producer). (2013, 30 September 2013). Six part podcast series about mental health awareness for rural people. *Bush Remedies. You and your mental health*. [radio podcast] Retrieved from http://www.abc.net.au/local/stories/2013/04/17/3738733.htm?site=newengland



Blogs:

- **Wilson, R.L.,** Commentary - University of Tasmania Blog post published 17 December 2013 by Carey Mather http://blogs.utas.edu.au/snm-pep/2013/12/17/nurses-social-media-and-engaging-in-a-community-of-practice/



Community feedback research report:

- Wilson, R.L., & Carey, J. (2014). *Connecting mental health helping capital in rural communities to young people with emergent mental health problems.* : (1-4pp) University of New England, Armidale. ISBN 978-1-921597-62-6

Connecting Mental Health Helping Capital in Rural Communities

To Young People with Emergent Mental Health Problems

The researcher

Rhonda Wilson is a registered nurse with a broad range of rural nursing experience. She teaches and researches at the University of New England's School of Health. Rhonda's interests include the development of e-health strategies and the use of social media amongst health professionals. She is an advocate for rural mental health and contributes to contemporary rural health conversations in social media such as Twitter @RhondaWilsonMHN #RuralMH. Rhonda has a regular ABC radio series 'Bush Remedies: You and your mental health'.

This research sought to understand how young people in rural communities can be helped in the early stages of experiencing a mental health problem.

Who and where?

Young rural people (14-25 year olds) in the New England area of northern NSW.

Why?

The study was designed to understand the experiences of young rural people and their families, and to look for new ways that mental health services might improve how they help people with mental health problems.

How?

Survey and individual interviews were conducted, and information was analysed using descriptive, content and thematic techniques to find common patterns.

What was discovered?

The research describes the characteristics of mental health problems experienced by young rural people; the ways in which others try to help; the lack of meaningful connection with mental health services; and health, welfare and social service provider characteristics.

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The study area was the northern part of the Hunter New England Health region, down as far south as Tamworth.

What we already knew

Young rural people have high levels of mental illness.

Most mental health problems first emerge during teenage years.

Early mental health care promotes recovery and stops the long-term detrimental effects to health.

What the survey revealed

The survey responses showed that people in rural communities think nurses are important members of the rural community and they are able to help young people.

The survey data was able to describe the helpful characteristics that rural nurses contribute to helping young rural people. The survey was also able to show that rural people are generally willing to seek mental health help in their communities, even when it was uncomfortable for them to do so.

They were still willing to get the help that was needed, but they considered that their options for mental health help in their local communities were very limited and less then what the community needed.

"A big issue is that both state and federal governments are under the assumption that everything from education to mental health like 'headspace' is nice and close. Well guess what? It isn't. The nearest mental health centre is 2 ½ hours away from where I live… and there is nothing specifically for children. We don't have a 'headspace'."

How nurses help

Nurses care about people.

Nurses successfully make meaningful connections with people during emotionally complex episodes of emergent mental health problems.

Nurses can be trusted with confidential and private information.

Nurses pay attention to people and listen carefully and respectfully to others.

Nurses are valued for their dual roles in the community, with their informal participation in their communities adding a further depth of value to their work as nurses in their employed health setting roles.

2

The primary recommendation arising from this research is a co-location model for nurses in rural communities to promote the early engagement of young rural people into appropriate mental health care when it is required.

Nurses are the most abundant population of health workers in rural areas of Australia. All rural registered nurses have a sufficient level of education and competency to identify and commence intervention and referral for young rural people with emergent and early mental health problems. They occupy dual roles as local community residents and local health service practitioners, and their nursing care is provided within a context of fostering health promotion, health, wellbeing and recovery.

Rural nurses are likely to have important information and real life work experiences that place them in a good position to help individuals, families and communities with emergent mental health problems. Helping young people and communities with emergent mental health problems is a fundamental nursing function, and such roles require health system structures, systems and policies to activate nursing care to a full delivery potential in rural communities.

The rural nursing population has both specific direct knowledge and clinical experience of youth mental health. This, combined with their workforce distribution in rural communities, would assist in developing a model of care that could make more effective use of health care assets. This could include nursing services being co-located in a range of settings such as in police stations, schools, and other interagency-type services that are convenient for rural young people to access and where young people can be engaged early in mental health care.

"…he had a really rough trot during his teenage years, and he was certainly depressed and he ran away from home about four times. And there was one time… I went for a drive up the back paddock... and I was looking for a boy hanging from a tree branch. And yeah, he was in a bad place..."

3

Three main findings

- **Providing positive first mental health encounters for young rural people in their rural communities enables successful initial and ongoing mental health helping.**

However, rural people may not know who, or where, to ask for help. Experiences with mental health telephone triage services were unsatisfactory.

- **Rural nurses are mental health capital in rural communities.**

This study suggests their presence should be extended to places where encounters with young rural people with emerging mental health problems are likely to occur.

- **Barriers to mental health help- seeking for young rural people persist.**

These include widespread misuse of drugs and alcohol, transport issues, dynamics around Fly-In-Fly-Out and Drive-In-Drive-Out workforces and familial depression patterns.

"When you are dealing with young people, it is a different ball game… you have got to be approachable, you have got to have a different language, a different kind of speaking…perhaps a little more laid back, because they will not open up, they will not feel safe, if you are not a genuine person… distrust goes up immediately."

Acknowledgements

I acknowledge and show my respect to the Aboriginal Gamilaroi and Anaiwan people and their land where this research has taken place. My most sincere thanks go to the people who shared with me their most personal stories about mental health and allowed me to use their experiences in my research. Without the generosity of these kind people, it would not have been possible to complete this project, and so I am very grateful for each person's contribution.

Rhonda Wilson, School of Health, UNE

This research summary report was written by Rhonda Wilson and Janene Carey.

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une University of New England

APPENDIX 2

Hardcopy of online survey instrument for data collection

Rural Young People Mental Health Helping Survey

Rural Young People Mental Health Helping Survey

Participant Information

This survey is part of a research study to find out how young rural people in the New England region of NSW can best be helped when they develop a mental health problem. This research is being conducted by Rhonda Wilson RN MHN, who is a Doctor of Philosophy candidate at the University of Canberra.

If you live in the New England region and have some experience of either having a mental health problem, or helping someone who has, please take a few moments to contribute your ideas and experiences to this survey.

This survey will take about 10-15 minutes of your time. Please answer all questions. You may have had experiences in either helping, or being helped, when something is not quite right with a young person. Your experiences and ideas are very valuable in this study and will help us to understand how young rural people can be best helped as soon as possible when a mental health problem emerges.

The information collected in this survey, and in interview discussions with some willing participants, will be carefully analyzed. The findings from this study will help to improve the ways in which health services can plan to better help young rural people with early mental health problems in the future.

Your contribution to this survey can be anonymous if you choose. If you would like to contribute more information about your experiences in relation to this topic, please fill in your chosen contact details at the bottom of the survey. If you don't want to discuss your experiences beyond the anonymous survey, you do not need to include your name or contact details.

This research has been approved by the Human Ethics Committee, University of Canberra. (CEHR11-31).

If you would like more information about this research you can contact the researcher, Rhonda Wilson on 02 67733952 or 042703774 and/or email rhonda.wilson@une.edu.au

Alternatively you can discuss this research with Rhonda's Supervisor, Professor Mary Cruickshank on 02 62015949

By choosing to proceed with this survey and submitting your online response at the end of this survey, you are indicating your agreement to consent to participate in this survey.

Thank you for taking the time to respond to this survey. Your time and ideas are valued, appreciated and will contribute to finding new ways to help young rural people with mental health problems in the future.

If you had something worrying you (eg depression or anxiety) would you seek professional help for it?

- [ ] Yes professional help.
- [ ] No professional help.
- [ ] May. Unfamilar with MH helpers
- [ ] Unsure. Unconvinced.
- [ ] Worried about stigma
- [ ] Embarrassed to ask

Other (please specify)

Page 1

Rural Young People Mental Health Helping Survey

What would be difficult about getting help for a personal or emotional problem in a rural community or country town if a young person wanted it?

A nurse could be a helpful person in a rural community or a country town to help a young person with a mental health problem. Thinking about your circumstances, which options below do you agree with?

- [ ] Local nurses trusted
- [ ] Nurses able to help me.
- [ ] Know how to find nurses
- [ ] Nurses help peoples MH
- [ ] Nurses listen fairly
- [ ] Nurse confidentiality
- [ ] Nurses care
- [ ] Nurse no help
- [ ] I am a nurse.

Other (please specify)

Do you personally know a nurse in your community?

- ◯ Yes
- ◯ No
- ◯ Unsure

Rural Young People Mental Health Helping Survey

Do you know a nurse that you think would be ready to help you with a personal, emotional or mental health problem? If so, what type of nurse do you know?

- [ ] Yes - RN
- [ ] Yes - MHN
- [ ] Yes - AIN
- [ ] Yes - EN
- [ ] Yes - Midwife.
- [ ] Yes - type unknown
- [ ] No - no nurse known
- [ ] Yes - a community nurse.
- [ ] Yes - ED nurse.
- [ ] Yes - MPF nurse
- [ ] Yes - GP nurse
- [ ] unsure

Do you have any ideas about how you think a nurse should be able to help a young person with a personal, emotional, or mental health problem?

Please select a statement below (in drop down menu) that best answers the questions asked in your view.

	Types of help
Best help community	
YRP help choice	
Parents help choice	

Please tick as many options below that explains who will be most helpful when help is needed for a personal, emotional or mental health problem.

	Listening	Giving advice	Suggest treatment	Assessing carefully	Can't help
nurses help	☐	☐	☐	☐	☐
Friends help	☐	☐	☐	☐	☐
Family member help	☐	☐	☐	☐	☐
Teacher/counselor help	☐	☐	☐	☐	☐
Pastor help	☐	☐	☐	☐	☐
Solicitor help	☐	☐	☐	☐	☐

Other (please specify)

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Rural Young People Mental Health Helping Survey

What else do you think a nurse should be able to do to help when a young person needs mental health help?

Why do you think a nurse could be a helpful person to have in the community, to improve access to mental health care for young people?

- [ ] volunteer & promote health
- [ ] Available 24hr hospital
- [ ] Good listeners & caring
- [ ] local & approachable
- [ ] Informal support &advice
- [ ] Can find more help
- [ ] Know how to help MH
- [ ] No help
- [ ] May help/ not sure how

What is your age group?

- ◯ 18-25
- ◯ 26-35
- ◯ 36-45
- ◯ 46-55
- ◯ 56-65
- ◯ 65+

What is your gender?

- ◯ Male
- ◯ Female

Please write your residential postcode in the space below.

Rural Young People Mental Health Helping Survey

Please indicate what categories below apply to you.

- [ ] Parent of YRP MH.
- [ ] Friend of YRP MH
- [ ] Registered Nurse.
- [ ] Mental Health Nurse.
- [ ] Other health professional
- [ ] Other profession
- [ ] YRP MH 18-25
- [ ] Agricultural worker/professional
- [ ] Concerned citizen

Other (please specify)

My highest educational qualification is:

- ◯ Primary school.
- ◯ year 10, High school.
- ◯ year 12, High school.
- ◯ TAFE qualification.
- ◯ University Bachelor degree or above.

Other (please specify)

Are you willing for the researcher to contact you in the future to take part in a further interview following this survey? If yes, please leave the contact details of your choice below, and the researcher will contact you to discuss arranging an interview at a time and place convenient to you (either in person or on over the phone).

Name:	
Company:	
Address 1:	
Address 2:	
City/Town:	
State/Province:	
ZIP/Postal Code:	
Country:	
Email Address:	
Phone Number:	

Thank you for taking the time to fill out this survey. Your contribution is greatly appreciated and your comments are valued.

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Rural Young People Mental Health Helping Survey

APPENDIX 3

Information sheet for participants and informed consent form

UNIVERSITY OF CANBERRA
AUSTRALIA'S CAPITAL UNIVERSITY

COMMITTEE FOR ETHICS IN HUMAN RESEARCH

PROJECT INFORMATION

The following study has been reviewed and approved by the University of Canberra's *Committee for Ethics in Human Research.*

Project title:
Connecting Mental Health Capital in Rural Communities to Young People with Emergent Mental Health Problems

Project number:	**Principal researcher:**
CEHR 11-31	*Ms Rhonda Wilson*

INDEPENDENT COMPLAINTS PROCEDURE

1. As a participant or potential participant in research, you will have received written information about the research project. If you have questions or problems which are not answered in the information you have been given, you should consult the researcher or (if the researcher is a student) the research supervisor. For this project, the appropriate person is:

   Name: Professor Mary Cruickshank
   Contact details: Faculty of Health
   University of Canberra
   Email: mary.cruickshank@canberra.edu.au
   Phone: 02 6201 5949

2. If you wish to discuss with an independent person a complaint relating to:
   - conduct of the project, *or*
   - your rights as a participant, *or*
   - University policy on research involving human participants,

   Please Contact: **Ethics and Compliance Officer**
   Telephone (02) 6201 5870
   Room 1 D116
   UNIVERSITY OF CANBERRA ACT 2601

Providing research participants with this information is a requirement of the National Health and Medical Research Council *National Statement on Ethical Conduct in Research Involving Humans*, which applies to all research with human participants conducted in Australia.

Further information on University of Canberra research policy is available in *University of Canberra Guidelines for Responsible Practice in Research and Dealing with Problems of Research Misconduct* and the Committee for Ethics in Human Research *Human Ethics Manual.*

These documents are available from the Research Services Office at the above address or on the University's web site at https://guard.canberra.edu.au/policy/policy.php?pol_id=3136 (Research Guidelines)
http://www.canberra.edu.au/research/ethics/human-ethics-manual (Human Ethics Manual)

UNIVERSITY OF CANBERRA
AUSTRALIA'S CAPITAL UNIVERSITY

Informed Consent Form

Project Title: ***Connecting Mental Health Helping Capital in Rural Communities to Young People with Emergent Mental Health Problems***

Consent Statement

I have read and understood the information about the research. I am not aware of any condition that would prevent my participation, and I agree to participate in this project. I have had the opportunity to ask questions about my participation in the research. All questions I have asked have been answered to my satisfaction.

Name…… Signature……
Date …….

A summary of the research report can be forwarded to you when published. If you would like to receive a copy of the report, please include your mailing address below.

Name…….
Address……
……

Should recall of experiences cause any discomfort for participants, it may be useful for them to visit their regular counsellor (if they have one), or a local community health centre or General Practitioner to seek further help. Alternatively, the Hunter New England Health service can be contacted on 1300699757 to arrange mental health support if required. Other useful mental health supports might include:

Lifeline	13 1114
Beyond Blue	www.beyondblue.org.au
Headspace online counselling service	www.eheadspace.org.au

www.canberra.edu.au
Postal Address:
University of Canberra ACT 2601 Australia
Location:
University Drive Bruce ACT

APPENDIX 4

Human research ethics approval

UNIVERSITY OF CANBERRA
AUSTRALIA'S CAPITAL UNIVERSITY

24 May 2011

COMMITTEE FOR ETHICS IN HUMAN RESEARCH

Approved

Project number CEHR 11-31

Ms Rhonda Wilson
School of Health
University of New England
Armidale NSW 2351

Dear Ms Wilson

The Committee for Ethics in Human Research has considered your application to conduct research with human subjects for the project entitled *"Connecting Mental Health Capital in Rural Communities to Young People with Emergent Mental Health Problems"*.

The Committee made the following evaluation:

Approval is granted until the anticipated completion date of 1 May 2012.

The following general conditions apply to your approval. These requirements are determined by University policy and the *National Statement on Ethical Conduct in Research Involving Humans* (National Health and Medical Research Council, 2007).

1) **You must immediately report to the Committee anything which might warrant review of ethical approval of your project, including:**
   (a) serious or unexpected adverse effects on participants;
   (b) proposed changes in the protocol; and
   (c) unforeseen events that might affect continued ethical acceptability of the project.
2) **Monitoring:** You, in conjunction with your supervisor, must assist the Committee to monitor the conduct of approved research by completing and promptly returning project review forms, which will be sent to you at the end of your project and, in the case of extended research, at least annually during the approval period.
3) **Discontinuation of research:** You, in conjunction with your supervisor, must inform the Committee, giving reasons, if the research is not conducted or is discontinued before the expected date of completion.
4) **Extension of approval:** If your project will not be complete by the expiry date stated in the application, you must apply in writing for extension of approval. Application should be made

before current approval expires; should specify a new completion date; should include reasons for your request.

5) **Retention and storage of data:** University policy states that all research data must be stored securely, on University premises, for a minimum of five years. You and your supervisor must ensure that all records are transferred to the University when the project is complete.

6) **Changes in contact details:** You should advise the Committee of any change of address during or soon after the approval period including, if appropriate, email address(es).

Please add the Contact Complaints form (attached) for distribution with your project.

Yours sincerely

[redacted]

Hendryk Flaegel
Acting Secretary

Cc: Professor Gordon Waddington, ADR, Faculty of Health
Professor Mary Cruickshank, Supervisor, Faculty of Health

www.canberra.edu.au

Postal Address:
University of Canberra ACT 2601 Australia
Location:
University Drive Bruce ACT

Appendix 5

APPENDIX 5

Invitation to participate in research

UNIVERSITY OF CANBERRA
AUSTRALIA'S CAPITAL UNIVERSITY

Rural Young People Mental Health Helping Survey

Participant Information

This survey is part of a research study to find out how young rural people in the New England region of NSW can best be helped when they develop a mental health problem. This research is being conducted by Rhonda Wilson RN MHN, who is a Doctor of Philosophy candidate at the University of Canberra.

If you live in the New England region and have some experience of either having a mental health problem, or helping someone who has, please take a few moments to contribute your ideas and experiences to this survey.

This survey will take about 10-15 minutes of your time. Please answer all questions. You may have had experiences in either helping, or being helped, when something is not quite right with a young person. Your experiences and ideas are very valuable in this study and will help us to understand how young rural people can be best helped as soon as possible when a mental health problem emerges.

The information collected in this survey, and in later interview discussions with some willing participants, will be carefully analyzed. The findings from this study will help to improve the ways in which health services can plan to better help young rural people with early mental health problems in the future.

Your contribution to this survey can be anonymous if you choose. If you would like to contribute more information about your experiences in relation to this topic, please fill in your chosen contact details at the bottom of the survey. If you don't want to discuss your experiences beyond the anonymous survey, you do not need to include your name or contact details.

This research has been approved by the Human Ethics Committee, University of Canberra. (CEHR11-31).

If you would like more information about this research you can contact the researcher, Rhonda Wilson on 02 67733952 or 042703774 and/or email rhonda.wilson@une.edu.au

Alternatively you can discuss this research with Rhonda's Supervisor, Professor Mary Cruickshank on 02 62015949

By choosing to proceed with this survey and submitting your online response at the end of this survey, you are indicating your agreement to consent to participate in this survey.

Thank you for taking the time to respond to this survey. Your time and ideas are valued, appreciated and will contribute to finding new ways to help young rural people with mental health problems in the future.

www.canberra.edu.au

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