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Help-seeking for young rural males disengaged from education

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ABSTRACT

Objective: Young Australian males 15-to-24-years-old have a high prevalence of mental health disorders and suicide but are least likely to seek professional mental health support. Most help-seeking studies fail to consider young males who are disengaged from mainstream education. This research aims to gain an enriched understanding about mental health literacy and help-seeking from the perspective of young rural males disengaged from mainstream education.
Method: Participants included sixteen males aged 15-to-24-years. All participants had disengaged from mainstream education and had experienced disadvantage. Qualitative methodology was employed using reflexive thematic analysis to analyse interview transcripts and develop themes.
Results: There were four major themes and three subthemes: 1) contextual influence, with subtheme of cultural influence; 2) a spectrum of knowledge with subtheme of subjective threshold; 3) battling stigma; and 4) genuine connection, with subtheme of redefining service models.
Conclusions: This research provides the first known insight into the help-seeking perspectives of young rural males disengaged from education. Their narratives, highlight that help-seeking is valued yet action remains ambivalent and hindered by understandings of mental health literacy, stigma, and service models. For these young men, genuine connection that honours their context and experiences is more important than demonstrating clinical expertise. This research offers practical suggestions for tailoring mental health services to meet the needs of young rural men disengaged from education.

KEYPOINTS

What is already known about this topic:

(1) Young Australian, rural males aged 15–24 years old are at heightened risk of ill mental health and suicide.
(2) Young males who disengage from mainstream education face considerable challenges which require support, yet they are amongst the least likely to seek mental health support.
(3) Barriers and facilitators to mental health help-seeking for young people are well documented within the literature and youth participation contributes valuable information towards service design and policies for youth mental health services.

What this topic adds:

(1) This qualitative research provides the first known insight into mental health help-seeking from the perspective of young rural males disengaged from education.
(2) Through participant voice, this research captures in depth understanding regarding mental health literacy and stigma for young rural males disengaged from education.
(3) This research contributes vital knowledge about how services and policies can improve equity of service provision and help-seeking for young rural males disengaged from education.

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Introduction

Young males are at increased risk regarding their mental health evidenced by the consistently high rates of male suicide in Australia (Australian Institute of Health and Welfare [AIHW], 2023b). On a global scale, Australia is among the countries with the highest male suicide rate worldwide, consistently higher than their female counterparts (World Health Organization [WHO], 2021). Suicide and self-harm are the leading cause of burden of disease for males 15- to 24-years-old in Australia (Australian Institute of Healthand Welfare [AIHW], 2023a). In rural areas, the suicide rate for young males is almost double that of their urban counterparts (National Rural Health Alliance, 2021). Despite this vulnerability, an Australian survey showed that only 13% of young males were willing to seek

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professional mental health support (Slade et al., 2009). Further, young rural males are at increased risk of premature disengagement from mental health treatment (Seidler et al., 2020).

Mental health concerns for young males are commonly expressed as externalising behaviour such as aggression, risk-taking or substance abuse and this often leads to misdiagnosis and/or mismanagement (Martin et al., 2013). Within the education setting, externalised behaviours frequently attract negative consequences, such as suspension, which can lead to disengagement (John et al., 2022). Mental health concerns are also a known influence on disengagement from education (Bowman et al., 2017; Klassen et al., 2021). This combination of lower educational outcomes and delayed help-seeking can have immense lifelong impacts on social and occupational functioning (MacDonald et al., 2018; Renner et al., 2024).

Disengagement from education

Disengagement from education is often a gradual process indicated by irregular or non-attendance, lack of commitment to class work, poor academic performance, and/or disconnection with teachers, eventually leading to school dropout (Balfanz et al., 2007; O'Toole & Due, 2014). A review of youth in alternative education settings by Fortems et al. (2023) revealed that a complex, multi-faceted array of risk factors influence disengagement from education. These include Aboriginal and Torres Strait Islander identity (recognising diverse cultural practices of First Nations People of Australia, here on respectfully referred to as Indigenous), culturally and linguistically diverse (CALD), rurality, unstable home environment, low socioeconomic status, lack of parental support, negative school experiences, and multiple-service needs (Bowman et al., 2017; Coles et al., 2022; Holloway et al., 2018). When access to necessary resources like education or services are inhibited by at least one risk factor, this is defined as disadvantage (Australian Bureau of Statistics [ABS], 2016). It is important to emphasise that this disadvantage is not due to inherent qualities for youth who identify with these risk factors, rather, disadvantage is experienced from the systemic inequity of access to resources.

School disengagement can trigger and maintain the experience of disadvantage (Raymond et al., 2018). When multiple forms of disadvantage are experienced, this overlap is termed *intersectionality* (Seng et al., 2012; Smith & Dowse, 2019). Intersectionality is experienced by many Australian youth, especially related to healthcare (Nguyen et al., 2021; Robards et al., 2019). Brown et al. (2016) proposed that when young people experience intersectionality, help-seeking barriers are exacerbated and contribute to inequitable mental health service delivery. Failure to recognise the context of intersectionality misses valuable information to inform service models and facilitate help-seeking (Ellem et al., 2020; Smith & Dowse, 2019). A systematic review by J. C. Clark et al. (In Review) showed that it is imperative to understand help-seeking through the nuanced lens of culture and context for youth who experienced disadvantage. However, they found that the help-seeking needs of youth disengaged from education are absent from the literature. Hence, an enriched understanding of help-seeking is needed from the perspective of youth who experience intersectionality and are disengaged from education.

Help-seeking

Help-seeking is a combination of attitudes, intentions and behaviour towards engaging with professional mental health services (Wei et al., 2015). The Western medical model encompasses a biopsychosocial framework that directs mental health service provision for young people; however, it is questionable how effective this framework is integrated in clinical practice (Farre & Rapley, 2017). The Australian mental health system largely prioritises a biomedical framework for referrals pathways (Malatzky et al., 2022). It has been argued that identification of mental ill health through diagnosis facilitates appropriate help-seeking (Wright et al., 2007). However, this approach focuses on the individual, diminishing the impact of complex social contexts (Malatzky et al., 2022), like intersectionality. Further, many services continue to struggle to integrate cultural perspectives into clinical service delivery (Westerman, 2010). Hence, understanding how the current Western medical model influences young men disengaged from education is imperative to facilitate help-seeking.

Research has identified key structural and attitudinal barriers that inhibit help-seeking for youth, with rurality exacerbating these barriers (Boyd et al., 2007, 2008; Platell et al., 2017). Young males have been found to be significantly affected by help-seeking barriers leaving them vulnerable to more maladaptive coping methods (Ratnayake & Hyde, 2019). Mental health literacy (MHL), stigma, and stoicism are consistently raised as significant help-seeking barriers for young males (Ferris-Day et al., 2021; Francis et al., 2006).

MHL is multifaceted and involves the interaction between knowledge of mental health, positive mental health, attitudes, stigma and help-seeking efficacy

(Dias et al., 2018; Spiker & Hammer, 2019). Low MHL is associated with reduced help-seeking and is a particular concern for males and youth with lower educational acheivement (Nobre et al., 2022; Ratnayake & Hyde, 2019; Reavley et al., 2012). Males demonstrate less knowledge about mental health symptoms, attribute external cause, and endorse sleeping pills or alcohol as treatment options (Cotton et al., 2006).

Perceived public stigma relates to a negative perception that peers and/or society will view an individual with mental illness as socially unacceptable, incompetent or dangerous (L. H. Clark et al., 2018; Vogel et al., 2007). Stigma is particularly relevant for young people, where social perception and acceptance play a dominant developmental role (Leavey et al., 2020). The stereotypes of physical toughness, self-reliance, and emotional control are emphasised in male gender roles (Lynch et al., 2018). From this masculine perspective, help-seeking which demands reliance on others, risks a loss to social status and discrimination (Boyd et al., 2008; Ellis et al., 2013; Lamb et al., 2012). Similarly, self-stigma is socially unacceptable when perceptions become an individual's self-belief, leading to diminished self-worth (Vogel et al., 2006). Masculinity cannot be separated from self-stigma and shame (Rice et al., 2018), with self-stigma shown to be a mediating factor between perceived stigma and help-seeking attitudes (Vogel et al., 2007).

The concept of well-being in rural Australia emphasises productivity, but help-seeking represents an increased risk of productivity loss (Boyd et al., 2006). Moreover, a rural paradox exists with physical distance but social proximation that can silence and exclude mental illness in more overt and acute ways in comparison to urban areas (Parr & Philo, 2003). For example, Bartik et al. (2015) highlighted that for rural youth, stigma is prevalent and the discussion of suicide is often taboo.

There are several facilitators for help-seeking cited within the literature. This includes prior positive treatment experience, higher education, strong connection with school, peers and community (Gulliver et al., 2010; Ratnayake & Hyde, 2019). However, many youths who experience disadvantage have personal and collective traumas (Brown et al., 2016) that cause a relational paradox where a desire for connection and support coexists alongside the fear of experiencing further rejection, judgement or discrimination (Sapiro, 2020). In order to build a solid therapeutic relationship, the foundation for successful help-seeking, this relational paradox must be worked through. The literature lacks an in-depth understanding around the facilitators to form a therapeutic relationship from the perspective of youth not engaged with a mental health professional. Research also takes the perspective of service providers or convenience samples, meaning the voice of young rural men, disengaged from education and mental health services, continues to go unheard.

Objectives

It is not uncommon for youth disengaged from education to experience one or more risk factors which contribute to the experience of disadvantage. The voice of young rural males disengaged from education, and who experience intersectionality needs to be heard. Only through empowering their voice can help-seeking be understood and inequity in mental health service provision be overcome. Hence, the aim of the current study is to gain an enriched understanding about MHL and help-seeking from the perspective of young rural males disengaged from mainstream education.

Method

Participants

Sixteen males, aged between 15-to-24 years from regional NSW Australia participated in the study. All were engaged with a Non-Government Organisation (NGO) supporting young people disconnected from mainstream education. All participants experienced intersectionality through rurality, unmet mental health service needs, and disengagement from education. Further experiences of disadvantage varied across participants and included discrimination and multiple-service needs due to out-of-home care, victims of abuse, homelessness, juvenile justice, incarceration history, drug and alcohol dependence. Participants were proficient in understanding English, had cognitive capacity to provide informed consent, and were not currently engaged with mental health professionals.

Participants were recruited from February 2022 to May 2023 from four locations in rural NSW. The NGOs are referred to as Service 1 through 4, to protect service and participant confidentiality. Participants 15-to-24-years-old were recruited to encompass the perspectives of young males during this developmental period where increased mental health and suicide risk exist (AIHW, 2023b). Participants had an average age of 18.5 years (SD = 2.68), most left school in year 9/10, with an average of 3.31 years since they attended mainstream

Table 1. Participant demographics.

		ARIA+[b]			Cultural Background			
Participant[a]	Service	Inner Regional	Outer Regional	Age[c]	Indigenous Australian	Non-Indigenous Australian	Left School (Grade)	Years since School[d]
Connor	2	✓		15	✓		9	2
Ethan	2	✓		21		✓	11	5
Fredrick	3	✓		18		✓	12	2
Greg	4		✓	17		✓	10	1
James	1	✓		24	✓		11	7
Johnathon	1	✓		18		✓	9	4
Keegan	1	✓		20	✓		9	6
Lachlan	1	✓		22		✓	10	5
Larry	1	✓		21		✓	8	8
Matthew	1	✓		17	✓		10	1
Michael	1	✓		18	✓		10	2
Oliver	2	✓		16	✓		8	2
Robert	1	✓		15	✓		10	0
Steven	3	✓		19	✓		10	3
Thomas[#]	4		✓	15	✓		8	1
Xander	3	✓		20	✓		11	4

[a]Participant names are pseudonyms to protect confidentiality. [b]Rurality was measured through the Accessibility/Remote Index of Australia Plus (ARIA+), which measures rurality based on service access described through five categories ranging from Major Cities to Very Remote. According to ARIA+ Outer Regional areas have considerably less service access in comparison to Inner Regional Areas. [c]Age is in years at the time of interview. [d]Number of years since attended mainstream education. [#]declined permission for quotations.

education (Table 1). It was evident from all participants that whilst there was a definitive year in which they left school that disengagement from education through low attendance or lack of commitment to school work occurred for many months/years leading up to this point.

Procedure

Through written information provided by the research team, each NGO facilitated recruitment of participants. Recruitment continued until understanding had reached conceptual depth. That is, when the richness of information gained from interviews effectively informed the research question (Braun & Clarke, 2019). Following informed consent, individual semi-structured interviews were conducted over zoom, ranging from 30 min to 1.5 h in length. Interview questions included open-ended questions, for example "Tell me about what mental health and well-being means to you?" and "What is helpful for a young person to continue to want to talk to a mental health professional?" Interviews were audio recorded and transcribed verbatim. Participant's wellbeing was supported by providing relevant mental health contact numbers and a debrief with a Service worker as required.

Ethical considerations

Ethical approval for the study was obtained through the University Human Research Ethics Committee. The researcher worked with each Service to allow for flexibility of interviews based on participant's needs empowering their control of the process. For example, choice of location for the interview, zoom camera on or off, what questions to answer and level of information provided, and permission for report quotations.

Overall, 62.5% of participants identified as Indigenous. This unintentional recruitment of a significant proportion of young Indigenous males led to the engagement cultural advisor (PR). This cultural consultation throughout analysis and reporting ensured culturally responsive practice in line with relevant ethical guidelines (Australian Institute of Aboriginal and Torres Strait Islander Studies, 2020, National Health and Medical Research Council & Australian Research Council and Universities Australia, 2023). It also fostered reflexive practice to understand how different cultural perspectives influenced the creation of themes.

Analysis

Reflexive thematic analysis (TA; Braun & Clarke, 2021) was used to analyse interviews that were uploaded to NVivo (Lumivero, 2018) to help manage the data. An experiential qualitative approach was taken with hermeneutics of empathy to retain focus on participants' perspectives. The ontology of critical realism, where multiple realities exist, only knowing partial truth (Braun & Clarke, 2021), was also employed alongside the epistemology of contextualism. This honours the influence of participants context and recognises that themes are constructed from the mutual influence between

participant and researcher. Researcher subjectivity then is seen as a resource, bracketed from analysis through reflexivity (Braun & Clarke, 2021). Through this framework, the nuanced lived experiences of participants were respected, allowing their voice to be heard.

Braun and Clarke (2021) six-stage process was enacted primarily by first author (JC) in a manner that fostered reflexivity. This commenced with transcription and repeated immersion with the data, initial codes then developed based on reoccurring ideas and continual review of broader meaning across codes developed to address the research question. An independent review of transcripts by PS facilitated cultural reflective practice. Themes were shared with each Service for feedback and then collaborative discussion with the research team ensured that the final themes had a coherent narrative that represented participants' perspectives.

Results

The young males' narratives led to four major themes and three subthemes that are illustrated in the thematic map (Figure 1). The first major theme was contextual influence, with a subtheme of cultural influence. The second major theme, a spectrum of knowledge, had a subtheme of subjective threshold. The third major theme was battling stigma. The fourth major theme was genuine connection that encompassed the subtheme of redefining service models. These themes and subthemes are described in more detail next with representative quotes using pseudonyms.

Theme 1 - contextual influence

This theme reflects how participants past and present contexts influenced their help-seeking and included support systems, intersectionality and current NGO involvement.

Some participants acknowledged that their personal support systems encouraged help-seeking; "Mum because … she would probably be able to get me the help I need whereas I wouldn't be able to do so myself" (Oliver). In comparison, other participants spoke how family context inhibited help-seeking such as James who said "You know a lot of people, sadly have not had that [support] growing up and don't know why they feel the way they feel".

Messages about mental health can also be divergent, as Keegan expressed "it just like rubs off onto you I guess. Like 'this is shame, that's shame, everything's shame'", and "…it is good to have people behind you

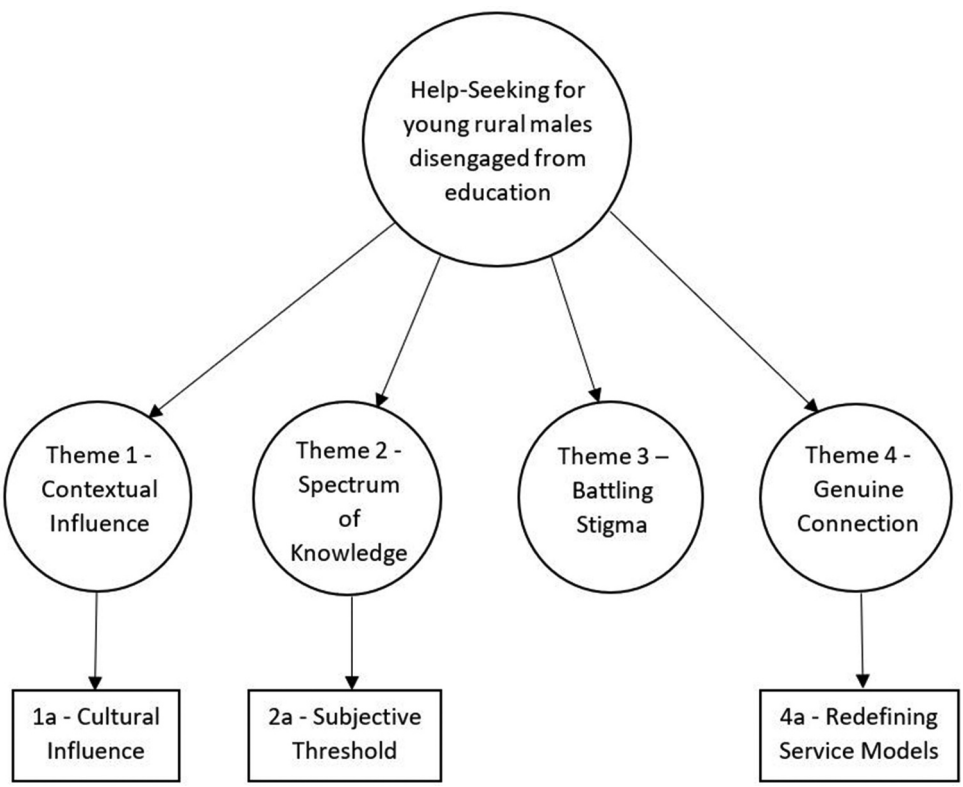

Figure 1. Thematic map.

that you know you can count on to talk to if you're feeling down or need to get something off your chest".

Trusting mental health professionals was difficult for these young men due to their experiences of disadvantage. As Keegan expressed "a lot of people, like a lot of the kids here at [Service 1] have a lot of trust issues and stuff like that, opening up is hard for them". Positive connection and trust with professionals was broken down over extended periods of time. For example, disengagement from school often began prior to officially leaving as Matthew stated "most of year 8 I didn't go, and the same for year 9".

Participants were also part of a unique context within each Service, where mental health is normalised and encouraged daily. As Johnathon explained "see where I work and where I live and the people I am around, it [mental health] is talked about often so it becomes more normal".

Sub theme 1a - cultural influence

This subtheme represents participants' voice about strategies which facilitate connection between client and mental health professionals. These strategies reflect culture as a shared experience of disadvantage, whether Indigenous or not. First, help-seeking was about creating a space where you can have a yarn, "not just talking about their mental health, talking to them about their life" (Greg) or "the more you see more of a person then you sort of can build trust in them" (Ethan). Second, participants spoke about needing to understand more about the client than just clinical symptoms, interpreted as representing the value of deep listening, "you know not so much listening to answers or anything, just listening to understand" (James). Finally, help-seeking with professionals was viewed as reciprocal, "it's gotta come the other way too, that person has maybe gotta open up to that kid to make them feel comfortable" (Michael).

Theme 2 - a spectrum of knowledge

This theme captured participants' understanding about MHL and it was observed that this understanding varied considerably and exhibited uncertainty. "I guess it is just the state of mind I suppose…don't know" (Ethan) to "people want to harm themselves, harm other people" (Connor), or as Michael reported:

> mental health … it's a big one … to me it means when you don't want to live, life's sh*t, nothing is well at home, you can't get a thought off your mind, you're losing sleep, you're not eating, you don't want to be near anyone, you don't want to talk to anyone.

Understanding mental health was challenging "as a young person it is pretty hard to identify emotions and stuff. So, we don't really know what we are feeling and why we are feeling it sometimes" (James). Knowledge and understanding of mental health influenced help-seeking, as Oliver stated "what stops a lot of young people is maybe their knowledge of it, they don't like get help because they don't necessarily know what they need help with". Many participants were able to acknowledge strategies to maintain positive mental health, as Keegan reported "just staying active, keep my mind active not just sitting around all the time".

Most participants knew service options; however, depth of knowledge was lacking. For instance, they were often able to name services such as "Headspace" (Matthew, Robert, Xander). But as James stated "I see the words Beyond Blue with a butterfly but what do they do?". Some participants endorsed GPs as a help-seeking option "I reckon it could probably be a little more comfortable talking to your doctor cos you already have that patient doctor confidentiality" (James). Others demonstrated misunderstanding about these key referral pathways, "he probably might not have a lot of information on it cos he is only a doctor not a mental health thingo" (Robert). Simultaneously, some participants also lacked understanding about counselling efficacy, "it is probably not really no point when I could just see someone close to me and they would give me the same help" (Xander).

MHL was higher for participants who had previous counselling experience or attended the NGO Services longer. As James reported "it was a good way to slow things down and go well this is how I am feeling. I am not frustrated I am angry, or I'm not angry I'm upset".

Subtheme 2a- subjective threshold

This subtheme represented how participants had help-seeking intentions, but their threshold of when help-seeking was warranted was associated with more extreme definitions of mental health such as suicidal ideation. As Fredrick reported "I would ask for it [help] if I really need it"; and as Xander expressed "if you get to that point when you just want to give up then that is the point where you should seek help". Most participants were not able to articulate warning signs of mental ill health, instead they exhibited a dichotomous ideology about when help-seeking was warranted, as Greg expressed:

> Like if they want to hurt themselves then they should definitely get professional help to help themselves but if it is something small that's not really affecting them then, like deal with it

The need for early identification and intervention was recognised by few participants, as James expressed:

> if we are able to get into a point where we are able to identify this [mental health] at a young age it would probably help a lot more kids get through to reach out and say actually yeh I am feeling a bit down, I'm feeling a bit anxious.

Theme 3 - battling stigma

This theme of stigma was inextricably linked with ambivalence about help-seeking. Most participants valued help-seeking. As James stated "you should never feel shame to speak up"; and Larry, "it's harder when you're sitting down with someone you've never met before and telling them some of the hardest things in your life". Consequently, help-seeking in known safe environments was valued by participants. "I rather speak to someone who I definitely know won't judge me" (Lachlan), "it is just a stranger [professional], I don't know what to expect" (Xander).

Perceived stigma remained a prominent concern for participants, "they would get judged for asking for help" (Greg). This included fear of embarrassment or gossip, "embarrassment, you don't want to feel like to odd one out" (Larry). Further, stereotypes about mental health and masculinity were evident. For example, Keegan reported "about being shame and the feeling that you have to be big and strong and tough about how you feel. Show no emotions really, otherwise your weak".

Some participants also spoke of self-stigma as Johnathon explained "people like myself can almost feel guilt for getting to that point and just don't want to talk even more". However, many participants spoke of lived experience of losing a mate to suicide, something they saw as a consequence for not seeking help. As Keegan expressed "I have lost mates because they haven't spoken out"; and Larry reported "I have lost two of my best mates to it [suicide], and all because they didn't want to talk".

Older participants particularly recognised how their perception of stigma and willingness to seek help had changed overtime, for example Steven explained:

> What helped me was … like I used to be sort of shy but after I started speaking to a lot of people and that there it just helped me to speak up and that a bit. So yeh it wasn't shame.

Theme 4 - genuine connection

Clinical expertise was not raised by participants. Instead they spoke of genuine connection and taking the time to get to know the whole person, showing empathy and respect for their perspective. As reported by Matthew "someone to talk to who would actually respect you and have empathy as to what you did go through"; and Keegan "being on their page, understanding where they are coming from". Many participants valued connections that fostered self-determination, as James stated "it's like everyone else is making decisions for you. So, if we are able to switch, and put the shoe on the other foot, give them the responsibility, the power". Some participants reflected how an absence of being genuine inhibited help-seeking, as Larry reported "you know they're just getting paid to try and make you feel better".

There was an array of individual preferences around what would foster genuine connection. Many participants, like Robert reported "I would rather talk to a young person cos I would feel like I could connect to them more". Gender preference was changeable, with Lachlan expressing "I feel like females are more listening and down to earth". In contrast, Johnathon said, "if you're a male its usually, usually more helpful to be with another male". Further, building connection was not all about serious talk but "a bit more of the fun part, cos that could come in very handy, especially when you speak of very sensitive subjects" (Matthew).

Subtheme 4a - redefining service models

This theme spoke to how services need to foster genuine connection by redefining how they approach client contact. Participants emphasised the need to have extended timeframes and consistent presence. As Michael expressed "not just when you step into these doors I'm gonna want to know ya"; and as Fredrick stated "we see [worker] like almost every day so like we just come to her if we are feeln' down or whatever, she just helps us out". Even coming into an office space can have different meaning for these young men, as Michael explained "being in a mental, like being in one of them offices man you don't know, the police could walk in and put cuffs on ya".

Participants voiced that flexibility is required such as Lachlan "I don't know going into an enclosed room with no sound it feels, it's like, I don't know, you're more pressured to speak out about things. But when

you're outside you feel comfortable you know". James also reinforced that "sitting around a campfire really with a group of other people . . . it is a bit more of a laid-back atmosphere with people that you know, rather then, you know someone sitting there behind their clip board sort of thing".

Genuine connection was voiced by many participants as imperative and beyond what online services provide. For example, "I wouldn't like speak'n over the phone to someone, so I'd rather speak in person" (Steven); and, "I would have to meet the person first and just get to know that person on a personal level" (Michael). However, some others felt online services could facilitate help-seeking "I guess for a phone call it would make it easier to talk to someone" (Connor).

Discussion

The aim of the current study is to gain an enriched understanding about MHL and help-seeking from the perspective of young rural males disengaged from mainstream education. From participant narratives, four major themes and three subthemes were identified. First, the theme of contextual influence and subtheme of cultural influence were crucial to be able to understand the lens from which these young men view help-seeking. Following this, the theme a spectrum of knowledge and subtheme subjective threshold; third the theme battling stigma; and finally, the theme genuine connection with subtheme redefining service models. The clinical and practical implications of the themes are considered next.

This research demonstrated that participants held a spectrum of knowledge related to MHL. Mental health referrals are routinely based around the Western medical model (Christina Malatzky et al., 2018; Wilson et al., 2012), so when young men lack the MHL to convey their experience within this framework, help-seeking has additional challenges for them. Further, the Western medical model has even less meaning for Indigenous young men. Instead, for Indigenous peoples, social and emotional wellbeing (SEWB) is a "multidimensional concept of health that includes mental health but also encompasses domains of health and wellbeing such as connection to land or 'country', culture, spirituality, ancestry, family and community" (Gee et al., 2014, p. 55). Participants spoke clearly of the value of yarning, deep listening and getting to know the whole person, not just focusing on presenting clinical concern as defined by the Western medical model.

Dissonance of understanding between professional and client regarding MHL means that referral needs can be misunderstood and misdirected, which has significant concern for Indigenous Australians (Westerman, 2010). There was considerable variation in MHL across participants which impacted help-seeking. Lamb et al. (2012) asserted the importance of recursivity between professional and client to reduce dissonance, especially for youth who experience disadvantage. Kilian and Williamson (2018) found that, especially for Indigenous youth, the Western medical model and limited timeframes inhibited effective referrals from GPs, who are the primary referring agent in regional Australia. Not all participants in the current study understood GPs' role in referral and they asserted the need for reciprocity and time to trust a professional they did not know. The current study highlights that in order to effectively facilitate referrals, flexibility and time to prioritise explicit exploration of clients' MHL is required.

Young men within this study voiced that the threshold for seeking professional support was "black and white", often associated with suicide. This definition, and participants absence of knowledge around warning signs of mental ill health, is in stark contrast with professionals' goals for early intervention. Leaving help-seeking until "at-risk" circumstances present, could be a contributing factor to the elevated suicide rates among young rural men and Indigenous youth (AIHW, 2024; Fitzpatrick et al., 2021). However, a positive finding was that participants with previous counselling experience and/or longer engagement with the NGO expressed a deeper understanding about MHL. The concept of bringing mental health conversations into current structures such as workplaces or sporting clubs has been promoted in recent years (Dowell et al., 2021; Ludowyk et al., 2023). This research extends current literature by suggesting that MHL around warning signs and early intervention may be useful within existing service structures for young rural men, disengaged from education.

Participants' narrative highlighted the positive impact of consistent, genuine, everyday messages about MHL. Previously, Gulliver et al. (2012) concluded from a systematic review that even when help-seeking attitudes improved through intervention, there was no evidence this translated to help-seeking behaviour. In order to promote safety and bring MHL conversations consistently into everyday dialogue, current services and programs need to be adapted. For many study participants, their experience of disadvantage meant that silence replaced mental health conversations with family and peers, and speaking up risked discrimination, stigma, and shame. Instead, participants spoke to the value of their NGO creating a safe space to talk on their terms, indirectly normalising mental health and encouraging help-seeking.

Help-seeking was valued by participants, although ambivalence remained due to the strength of perceived stigma and self-stigma associated with stereotypes. Vogel et al. (2011) showed how dominant masculine norms correlate with self-stigma. For young males, help-seeking represents a threat to masculinity (Ellis et al., 2013), increasing vulnerability to stigma (L. H. Clark et al., 2018), with greater psychosocial consequences for youth who experience disadvantage (Lamb et al., 2012). Additionally, J. A. Smith et al. (2020) showed that young Indigenous males demonstrated greater ambivalence towards Western masculinity norms. Broadened perspectives about stigma were voiced by some study participants, recognising that silence perpetuates stigma and that suicide can be a consequence of not help-seeking. Instead, as Bartik et al. (2015) and Ralph and Ryan (2017) assert, stigma needs to become part of the conversations. The current research demonstrates that stigma is prominent alongside presenting concerns. Hence, it is imperative for stigma to be discussed openly in educational and clinical settings to foster help-seeking.

Participant disengagement with education and experience of intersectionality impacted trust with professionals and highlighted the need for genuine connection. Developing a solid therapeutic relationship is a culturally sensitive and highly valued practice (Ellem et al., 2020). Sapiro and Ward (2020) argued that the value of connection is often unappreciated, yet even more important when mental ill health combines with the experience of disadvantage. They found that because of past experiences youth who experience disadvantage have a unique relational context which requires authentic connections characterised by mutual understanding, empathy, respect, and consistency. Prioritising this genuine connection is consistent with the findings of this research. Further, it is important to acknowledge how the impact of colonisation and injustices for Indigenous Australians has caused intergenerational trauma for Indigenous youth (Dudgeon et al., 2014). The Australian Psychological Society (APS) acknowledged that psychologists as a profession have failed to understand SEWB for Indigenous Australians, disrespecting cultural perspectives and strength and assert commitment to culturally responsive practice in multiple ways including "listening more and talking less" (Carey et al., 2020, p. 265).

The current research embodies this commitment from the APS (Carey et al., 2020). Previous research has predominately recruited convenience samples of service providers, and youth who are engaged in school, or are already engaged with a mental health service (For example; Baak et al., 2020; Burns & Rapee, 2006; Ratnayake & Hyde, 2019). Listening to these perspectives alone restricts how accurately service models are informed to support youth who are outside of these contexts. This current research expands on this knowledge through understanding the voice of young rural males disengaged from education. Both Indigenous and non-Indigenous participants shared difficulties with trust, disengagement from education and intersectionality. Hence, their united voice emphasised genuine connection, self-determination, yarning, deep listening and reciprocity. Getting to know the whole person with a non-judgemental approach, as participants expressed, works to overcome discrimination and stigma whilst building trust. This theme of genuine connection that respects culture and context is consistent with the Model to Understand, Respond and Empower (MURE) proposed by J. C. Clark et al. (In Review). The MURE enables understanding of MHL and help-seeking through the nuanced lens of youth who experience disadvantage, which in turn promotes genuine connection participants need.

Building genuine connection between professional and youth takes time. Ralph and Ryan (2017) assert that current counselling session limits are insufficient to adequately address presenting concerns, especially for Indigenous youth. Outreach models show promise to provide flexibility and self-determination but resources continue to limit implementation (J. A. Smith et al., 2020). Other centre-based and online services aim to provide youth friendly and participatory models of engagement (McGorry et al., 2007); however, they remain informed predominantly by youth already engaged with services. This current study extends current literature through the voice of young males not currently engaged with a mental health service. They highlight that service models need to incorporate greater flexibility and extended timeframes that allows professionals to build genuine connection.

Limitations

Conducting interviews over zoom and differences in cultural background between researcher and participant could have influenced content and depth of knowledge shared. The small sample size provided rich narratives from participants, the views of these young males cannot be overgeneralised as representative of all young males. However, the voice of young rural males disengaged from education has been absent from the literature up to this point.

This research was conducted in the years following COVID-19 lockdowns. COVID-19 increased psychological distress for many young people (Klein et al., 2023;

Upton et al., 2023), restricting social support which is an important protective factor for males in particular (Sharp et al., 2023), and creating additional barriers for access to mental health services (Yonemoto & Kawashima, 2023). Further, Tomaszewski et al. (2022) showed that disengagement from school was significantly greater for Australian youth who experience socio-economic disadvantage compared to youth with higher socio-economic status. Hence, it is important to consider how COVID-19 context could have influenced participants school engagement and perspective about help-seeking.

There are several recommendations for future research. Whilst this study did not intentionally set out to recruit Indigenous young males, it is important for future research to specifically explore MHL from a SEWB perspective with Indigenous youth to further enrich understanding. Second, as female perspectives and CALD youth were not represented in this study, it is imperative that future research prioritises their inclusion. Finally, this study included a wide age range to capture the perspective of males in the high mental health and suicide risk age range (AIHW, 2023b; WHO, 2021). Future research should consider restricting the focus to the perspective of 15-to 17-year old within the context of disengagement from school, to understand the MHL and help-seeking need for this specific developmental stage compared to early adulthood.

Conclusion

For the first time, this research provides valuable perspectives from young rural males disengaged from education, who experience intersectionality, and are not currently engaged in a mental health service. Together, their voice gives an overarching message that help-seeking is valued, and while this is challenging, it holds meaning beyond clinical need alone. To improve help-seeking, the young males spoke of several ways service provision needs to be reconsidered. First, genuine connection is valued over clinical expertise, and this includes listening to understand individual context and experiences. Second, increased time and flexibility for service models to foster genuine connection and value self-determination. Third, mental health professionals need to explicitly explore their client's perspective of MHL and stigma to understand this context alongside presenting clinical concerns. Finally, mental health conversations need to occur, not as singular MHL programs, but embedded into the culture of existing services where disengaged youth already attend. Participants voiced how daily conversations provide opportunity for stigma to be broken down and MHL improved. By listening to and articulating the participants' voice, this research can substantially contribute to addressing the alarming rates of mental health concerns and suicide by improving help-seeking for young rural males disengaged from education.

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- Warren Bartik conceived and designed the qualitative research, supported analysis, reflective practice, and development of themes, authored and reviewed the manuscript including tables and figures, approved the final draft.
- Peter Smith review all interview transcripts, supported analysis, cultural reflective practice, and development of themes, authored and reviewed the manuscript including tables and figures, approved the final draft.
- Kylie Rice conceived and designed the qualitative research, supported analysis, reflective practice, and development of themes, authored and reviewed the manuscript including tables and figures, approved the final draft.

Data availability statement

Due to the sensitive content of this research and to protect participants' confidentiality supporting data is not made publicly available.

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