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What are the Mental Health Needs of Adolescents in Rural South Australia? The Perceptions of Human Service Providers

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Abstract

BACKGROUND:

Up to 20% of Australian adolescents experience the burden of having a mental health problem. Prior research has suggested that inhabitants of rural areas are at particular risk of mental health morbidity due to their location. The current study sought to investigate how 'rurality' influences the mental health of adolescents in rural South Australia, and to explore the perceptions of the mental health needs of adolescents as described by service providers in rural South Australia.

METHODS:

Four focus group discussions and 14 interviews were conducted with 38 human (allied health) service providers in the Eyre Peninsula, Spencer Gulf, Limestone Coast and Greater Green Triangle regions of South Australia. Semi-structured telephone interviews were also conducted with three Victorian human service providers. Interviews were transcribed verbatim and analysed to identify emergent themes.

RESULTS:

Ninety codes were developed and subsequently categorised into five major themes: Community and Society Factors; Youth Issues, Indigeneity; Service Delivery and Utilisation; and Occupational Factors. Significant gaps in mental health service delivery were identified. Better utilisation of current resources was identified as a greater concern than the absence of resources per se.

CONCLUSIONS:

This study provided a unique opportunity for rural allied and primary health care service providers to discuss adolescent mental health issues in their communities and as part of their work. The data generated by these discussions identified areas where practice could be improved.

Keywords: mental health; adolescent; rural; allied health professionals.

Background

Over the past decade, it has become increasingly clear that mental health problems cause a great burden not only to the individual, but also the community at large. Recent studies have indicated that mental health problems constitute the leading cause of disability burden in Australia, accounting for an estimated 27% of the total years lost due to disability [1]. Indeed, mental health has attracted much political attention and is now recognised as a critical national public health issue.

The National Mental Health Report (2005) distinguished between mental 'illness' and mental health 'problems' [2]. According to the report, mental 'illness' is a term describing a diverse range of behavioural and psychological conditions. In 2005, the most common illnesses included anxiety, depression and alcohol dependence disorders. Mental health 'problems' on the other hand, included issues which interfered with a person's cognitive, emotional and social abilities to a lesser extent than clinically diagnosed mental illnesses' [2]. Such a distinction is particularly important, because most Australian prevalence data are based upon mental disorders and do not take into account mental health 'problems'. As a consequence of this, prevalence data are likely to underestimate the burden and costs of mental health problems to the community.

As many as 14% of children and adolescents in Australia currently experience a mental health problem [3]. However, there is little information available which pertains to the mental health of adolescents residing in rural areas of Australia. Much of the published research reporting the prevalence of mental health morbidity in adolescents living in rural areas is international, mostly from the United States. These studies suggest that approximately 20% of rural adolescents are living with mental health problems which cause some level of impairment in a given year [4].

While some such as Angold et al. (2002), have found that the prevalence of mental health problems among rural adolescents does not differ significantly from metropolitan adolescents, others such as Fergusson and Woodward (2002) in their longitudinal study of rural adolescents, found significantly increased risk of major depression, anxiety disorders, nicotine dependence, alcohol abuse and suicide attempt [5, 6]. They also reported increased risks of educational underachievement, unemployment and early parenthood. Likewise, Puskar et al. (1993) found that rural adolescents have significant problems with stress and coping [7]. Collectively, these findings challenge the myth that rural communities tend to have less stress due to their location.

In 2000, the Australian Commonwealth Department of Health and Aged Care made the promotion, prevention and early intervention of mental health problems a national priority through the development of the Mental Health Strategy, with rural communities specifically identified as a target group [8]. This recognition of the importance of mental health issues to the Australian population generated much interest and support for mental health research. However, the majority of Australian research into mental health issues has focused on problems experienced by adults. Of the existing research into adolescent mental health, there has been little specifically investigating the mental health of adolescents in rural communities. This is a concern because young people living in rural Australia have higher death and hospitalisation rates than those living in metropolitan areas, some of which are undoubtedly related to mental health issues [9, 10]. For example, the

death rates of young males from accidents, injuries and suicide increase markedly with increasing geographical remoteness [1, 9, & 11]. Aboriginal and Torres Strait Islander peoples are more likely than the total population to die from the external causes mentioned above, and are over-represented in rural locations [12]. As a proportion of all indigenous deaths, suicide accounted for 4.3% (2.0% for the total population), transport accidents 4.2% (1.6%), and assault 2.0% (0.2%) in the period 1998-2000, highlighting that indigenous adolescents experience greater risk of death, which is only further exacerbated by their rural location [12].

It has been suggested that the 'culture' of rural settings can influence both the experience of mental health problems and also the willingness to access mental health services [13]. Often in rural settings, especially in isolated, yet highly self-sufficient farming communities, there exists what has been termed a 'stoic culture', where mental health morbidity is not admitted to as it is seen as a weaknesses [14]. Fuller et al. (2000) argue that this has two main effects: first, understandings of mental health morbidity are often inaccurate and stigmatised, with mental health problems being equated with psychiatric disorders; and second, a lack of trust being developed toward 'outsiders' such as psychologists and psychiatrists who offer help. For individuals living in such areas, there are clear negative consequences associated with being labelled as 'mentally unstable', and the burden associated with mental health morbidity is often further compounded by feelings of shame and isolation. Because traditional services such as the local hospital and Royal Flying Doctor Service are often valued more highly than 'professional' mental health services, individuals are discouraged from seeking help from specialist mental health services [15].

While prior research has indicated the presence of risk factors and inadequate support services for adults living in rural areas, there has been a paucity of research into the mental health needs of Australian adolescents and how 'rurality' impacts upon these needs. Much of the research that was available at the commencement of the study was based upon the mental health needs of rural communities in the Eastern States of Australia, with no South Australian, adolescent-specific research being readily available [16]. Also, because South Australia is

virtually a 'City State', with the majority of the population being concentrated around the capital city of Adelaide, there are few specialist mental health services operating beyond the metropolitan area. However, in the Eastern States, the existence of many more and much larger regional centres means that there are likely to be specialist services in existence outside metropolitan areas that are easier for adolescents to access. The different settlement patterns between South Australia and the Eastern States provides an additional basis to investigate the needs and experiences of adolescents residing in rural areas of South Australia.

The current study was initiated to identify the mental health issues that human service providers perceive to be most important for rural-dwelling adolescents in four rural centres in the Spencer Gulf, Eyre Peninsula and Limestone Coast regions of South Australia. It also sought to provide an insight into the challenges and opportunities for providing primary mental health care to adolescents in these rural settings.

Specifically, this study addresses the question: what do human service providers working in rural areas of South Australia, perceive to be the mental health needs of adolescents in their area?

Methods

Study Design

This study utilised qualitative methodology. A series of focus groups and one-on-one interviews were conducted with human service providers offering mental health care to rural South Australian adolescents.

PARTICIPANTS

Participants included 35 human service providers working in four rural townships in South Australia: Port Lincoln, Whyalla, Port Augusta and Mount Gambier (Figure 1). In addition, three service providers from mental health services in Victoria were also recruited, as they provided some cross-border services to individuals living in the Greater-Green Triangle region of South Australia and Victoria. It is important to note that the human service providers targeted for recruitment in this study could be involved in either formal mental health service provision i.e. employed by a mental health service, or informal mental health care i.e. provided support to adolescents but not employed as a mental health service provider. The latter group is often referred to as the 'lay' or 'de facto' mental health care sector [17].

A combination of purposive and snowball sampling was used to identify participants. Initially potential participants were identified from an online health services database provided by the Department of Health and Ageing (Human Services Finder, available at http://www.hsfinder.sa.gov.au). On contacting individuals listed in this resource, the purpose of the study was explained to them by one of the authors (MK) who then sent study information to them if they agreed to participate. These individuals were also asked if they could suggest any colleagues who they believed may be interested in taking part in a focus group or interview.

General Practitioners were identified from three South Australian Division of General Practice membership lists: the Yorke Peninsula Division of General Practice, the Mid North Division of General Practice and the Limestone Coast Division of General Practice. Recruitment of GPs was facilitated by the Head of each Division.

The geographic area serviced by these providers ensured that the clientele consulted resided in rural or remote areas. Each of the rural townships visited had a Rural, Remote and Metropolitan Areas (R.R.M.A.) classification of 4 (small rural centres), except for Whyalla, whose R.R.M.A. was calculated as 3 (large rural centre) [18]. The map shown in Figure 1 illustrates the specific areas included in the study.

DATA COLLECTION

Participants who were not GPs were invited to participate in focus groups with some of their peers. Four focus groups were held, one in each town, and each facilitated by the first author (MK). A semi-structured interview guide was developed in accordance with the methods described by Krueger (1988) and Morgan and Scannell (1998) and included discussion about: the nature of mental health problems among adolescents in their towns; the influence of 'rurality' upon mental health; the specific role of each participant's organisation in providing care to adolescents; perceptions about service access and availability; resource usage; the use of referral networks and finally, extent of collaboration with other human service providers [19, 20].

Eight GPs were interviewed either face-to-face or via telephone. GPs were not invited to attend focus groups, because it was thought that the demands of busy rural practice would leave them with little spare time. In addition to the above topics discussed by focus group attendees, GPs were also asked about the level of mental health training they had received and their feelings of personal competence in being able to diagnose and treat adolescents with mental health problems.

The participants from Victoria were specifically asked about their perceptions of Victorian services accepting clientele from South Australia, and the burden associated with this.

Focus groups and individual interviews occurred from October 2006 to August 2007. Each focus group was approximately 60 minutes in duration, while face-to-face interviews ranged from 45 to 65 minutes. Telephone interviews tended to be shorter, but ranged from 15 to 70 minutes.

Three participants did not consent to their interviews being recorded, but allowed the researcher to take notes. Remaining focus groups and interviews were digitally- recorded and transcribed verbatim.

ANALYSIS

Transcripts were returned to participants to verify the accuracy of dialogue prior to the first author (MK) undertaking analysis. Initial coding was exploratory in nature and a large number of statements and concepts were identified. A hierarchical coding scheme was developed as the coding process continued, and key areas were identified and defined [21]. The 'splicing' technique described by Dey (1993) was used to form the coding hierarchy, with multiple sub-themes being 'fused' together to form broad, overarching themes [22]. The emergent themes were discussed amongst the authors with further coding occurring until a consensus was reached. The program NVivo 7 (QSR International, Sydney, Australia) was used for data management.

Results

PARTICIPANTS

A total of 38 participants were interviewed. Of these, eight were General Practitioners in private practice and the remaining 30 identified themselves across 14 different positions, with three participants working in Victoria but receiving referrals from South Australia (Table 1).

The majority (80%) of the human service providers who participated in the study were female, with the average age being 44 years. In comparison, all of the GPs who were interviewed were male, with an average age of 46 years. Both human service providers and GPs had similar levels of experience in the mental health field: 15 and 19 years respectively.

Four focus groups were attended by 24 human service providers, while 14 individual interviews were conducted with eight GPs and six human service providers who were not able to attend a focus group.

Ninety codes were identified from the transcripts produced. These 90 codes were then organised into five major themes describing impact on an adolescent's mental health, or their capacity to access mental health care as a result of living in a rural setting (Table 2).

① Community and Society Factors: This theme encompassed the characteristics of rural communities which affect the mental health of adolescents (Table 2, Row 1, Column 3). This included statements about rural lifestyle and society, with service providers often commenting on the links between 'resilience' (the culture of self-reliance) and the stigma associated with mental health issues in their communities. Service providers argued that rural adolescents were very aware of the financial burdens experienced within their families, particularly among farming families, and the impact of the drought on the mental health of these adolescents was described as a major concern.

For example:

> *'They hear all the time in the media how terrible it is. They hear, how many times, it's dry, we're in a drought. If we have that rammed down their throats everyday, relentlessly, everyday, in every news, it may impact on the kids you know. And, for some, if that's their future…that's what they've got in their head. Like, my Gosh, Dad gets into trouble too you know?'*
>
> (FG1SP09, Youth Worker, Line 303-312)

② Youth Issues: Various mental health and behavioural problems were identified by service providers, including social and cultural issues which affect the mental health of adolescents (Table 2, Row 1, Column 3). Service providers were not only consulting with adolescents diagnosed with clinical disorders, such as major depression or anxiety disorders, but also those experiencing social problems, often stemming from the family. Participants argued that there were few positive adult role models available to adolescents, and that this was often associated with delinquent behaviour, particularly amongst young males who had been detained.

Self-harm amongst both sexes was identified as a major issue, with service providers commenting that adolescent males tended to use more overt ways of harming themselves, such as hanging, shooting, and burning, whilst females were engaging in other methods, such as cutting and more recently, body piercing. The central concern held by participants was the effect of the excessive drug and alcohol consumption in their communities. Participants commented that whilst in the past, excessive drinking was traditionally associated with young men and 'male culture', drinking amongst the young females in their communities had reached new heights and was seen as 'more of a problem'. Service providers often grappled with the co-morbidity of drug addiction and mental health problems, arguing that drug use was often a form of self-medication for their mental health problems.

For example:

> *'What I'm starting to learn, just lately, is that I get these lads in and the first thing that we do is try to help them with their drugs. As soon as they start doing a bit better with the drugs, they get worse. They have issues coming into their head, and they need counselling; they need anger management. See…with the kids I've been working with, I had the opinion that because they are on these drugs, they have the mental health issues, but I'm starting to see that maybe…they had the mental health issues, and that's why they're getting on the drugs.'*
>
> (FG1SP04, Juvenile Justice Worker, Line 565-579)

③ Indigeneity: Whilst several rural cultural factors were identified as potentially affecting the mental health of adolescents generally, there were specific indigenous cultural factors identified as being important to the mental health of indigenous adolescents, and their ability to access services (Table 2, Row 3, Column 3). Out of respect, it was thought best to keep these issues, which were specifically identified as pertaining to indigenous culture, distinct. In particular, participants commented on the impact the difference between indigenous and Western culture has on the therapeutic relationship between client and service provider. Often, there were communication barriers which needed to be overcome. The most significant difference identified was that 'mental health within the indigenous community doesn't exist' (FG2SP03, Manager (N.G.O.) Line 260-261), and that as a consequence, it was considered a 'shame job' to be seen as having a mental health problem, let alone accessing help for one. Participants also suggested that the majority of mental health problems experienced by the indigenous adolescents they consulted with were the result of grief and loss. In some indigenous cultures of Australia, it is the practice that after someone in the community dies, they are no longer acknowledged and their name is not mentioned again. Consequently, there were cumulative effects of grief and loss which were passed on generationally:

> *'The thing that I see with a lot of those families…is that because they've never dealt with their grief and loss, they've not thought that 'well I'm grieving, but I'm neglecting to look at what my kids are feeling', you know? And it just goes on and on. But we're older people; we've got a bit more life skills than them. They don't know what they're feeling, and this isn't…it's not a Band Aid treatment you know, that you can give to anyone. I say to my kids you know, 'when you lose someone you carry them in here'' (pointing to chest)*
>
> (FG1SP03, Aboriginal Health Worker, Line 853-864).

④ Service Delivery and Utilisation: Factors cited by participants which inhibited the delivery of mental health services to adolescents included: financial barriers to accessing services, communication barriers, long waiting times, distance and travel factors (for consumers) and most importantly, bureaucratic and administrative constraints encountered, which service providers felt prevented them from providing optimal care (Table 2, Row 4, Column 3). Comments supporting this theme were often contentious and provoked heated discussions during focus groups. In particular, participants held very strong opinions about the availability of training and up-skilling for rural staff. The biggest difficulty experienced by participants was the need to travel to the State capital, Adelaide, to participate in training. This was often very difficult to do, due to the cost incurred and impact of extended time away from work. For already understaffed and overstretched mental health services, this time away was unaffordable.

At times, service providers tried to organise for the training to take place with small groups of providers in their town, but this was found not to be cost-effective for the training organisation:

> *'They brought the training down here, and there was nine people attended the training, and then they rang me up the following week and said 'well, we need more than nine people'…And when you think about the sort of professional group that we're in…I thought nine was a pretty good attendance. And then they don't want to come back…because they wanted fifteen, and so that's an issue'*
>
> (FG4SP03, Manager (N.G.O.), Line1592-1604).

As a consequence, a lot of frustration was experienced by participants who believed such organisations were out of touch with their rural staff:

> *'My title is a Student Counsellor. I have no training…and to get a week to go out and do training is…you might as well have asked for a year off! I know I'm under-skilled in this area, and training is not easy to get in a remote area. I think the people in head office are a bit delusional at times. I've just applied to do re-training, and they said, 'yes, we'll pay for it, three hours a night, Wednesday nights, for the next three years…in Adelaide. And that's their acceptable solution for that. They certainly don't make it accessible and they don't make it easy for rural areas…it just shows how much they don't understand.'*
>
> (FG2SP06, Student Counsellor, Line 738-762).

In terms of service utilisation, participants often commented on the need for service providers to become more 'youth-friendly' and to try to establish rapport with adolescents, in order to enable them to feel comfortable enough to access help for their mental health problems. I1GP01 argues:

> *'Because their issues are often complex and because it's so important to build that relationship, if you get off on the wrong foot, or you don't have time, you may never see that young person again. Often you only have a small window of opportunity. If you're running late, or you may not seem as friendly or…or whatever. You often just get that one chance'.*
>
> (I1GP01, General Practitioner, Line 533-547).

The physical set up of existing mental health services was also regarded as problematic, with waiting rooms or entrances of services 'non-friendly' to youth. Participants noted that adolescents were very concerned about their confidentiality, and wary of reception staff or the visibility of waiting rooms to the general community.

Participants stated that slight changes could be made to existing services to encourage youth to utilise them more:

> *'When you go to the mental health unit, there's a great big note on the door and it says stop! Well, it shouldn't say stop. It should say welcome! But the sign on the door says, 'Stop! Report to reception'. So those are the simple, little things that people with mental illness don't want to know about it. A lot of it's got to be, 'change the sign'. It will take you two minutes'*
>
> (I2SP10, Mental Health Academic, Line 687-700).

FG1SP09, a youth worker, suggests that adolescent utilisation of mental health services may be improved if service providers 'start maybe changing the way they work, by going to young people' (Line 515-516).

⑤ Occupational Factors: This final theme described the aspects of human service which impacted on the successful delivery of mental health care and influenced the individual experience of providing care. Some of the codes in this theme included: GP burden, confidentiality, perceptions of competence, time constraints and collaboration (Table 2, Row 5, Column 3). During focus groups, several participants commented on the difficulties associated with keeping up with who was still working in their town and which services were still in operation. This difficulty often hampered their ability to refer to others and form effective relationships and collaborations with other local organisations. Participants also indicated a need for more local events where providers could network and new partnerships could be forged. FG1SP04, a juvenile justice worker, suggests:

> *'I think it would be valuable for me anyway, if some of us from our organisations, even if it was just twice a year, we didn't really have an agenda, but we'd need to have something to get us talking, and we could just talk and get as many people as we can. I'm still finding out services here that I didn't know, and I've been doing this job for eight years now. It's embarrassing. I want to find out more. I know there's probably something more out there that I can use for my clients.'*
>
> (FG1SP04, Juvenile Justice Worker, Line 1387-1393).

Related to this comment, was the issue of resource-usage. Resources were defined as the physical supports which service providers could draw upon when needed, and included extra staff, equipment and facilities, and financial assistance. The issue of financial assistance was particularly contentious during focus groups, with participants adopting one of two views– that there was a clear need for an increase in financial assistance to improve the performance of existing services, or that financial assistance was not necessary, but that current resources needed to be better managed. I1GP01 holds the former view:

> *'From a funding point of view, money's running out. We've got very small grants. The majority of what we do is just people's generosity and time. We've been surviving off…really just crumbs of money which last a few months, and then run out. There's no sustained funding'.*
>
> (I1GP01, General Practitioner, Line 497-502).

I2SP10, a mental health academic, held an opposing view:

> *'You know, for ten years, we've been screaming at the government to supply money. It's not all the case. It just isn't the case. The money we have must be better managed, and we've got to get more staff training, up-skilling current mental health workers, up-skilling nurses. We've got to talk about things that…that don't cost anything. I am not convinced that we just need to throw more money at resources'.*
>
> (I2SP10, Mental Health Academic, Line 325-332).

Discussion

This study sought to address the question of what human service providers working in rural areas of South Australia perceived to be the mental health needs of adolescents in their area. After conducting focus groups and individual interviews with a variety of practicing human service providers, it became apparent that significant mental health and social problems were being encountered in the regions serviced by these providers, and that gaps in existing rural mental health services were evident.

Human service providers in the current study agreed that the main mental health problems experienced by adolescents in their area included major depression, anxiety disorders, self-harming behaviour and suicide, and drug and alcohol abuse/dependency. These observations are not surprising, as they are in line with the existing literature, which has indicated that rural adolescents face an increased risk of the above conditions, especially suicide [5, 6, 7, & 9]. Suicide is documented as the most common cause of traumatic death in Australia in adolescence [11]. Anderson et al. (2004) found in their study of 1,000 Year Ten students, that those from rural areas were significantly more likely to endorse suicidal ideation than their metropolitan counterparts, and that this was consistent across both genders [23]. Prior research has suggested that young males (aged 15-24 years)

living in rural areas are particularly at-risk of suicide, with figures indicating that suicide rates in towns with populations exceeding 4,000 increased by up to four times, while rates in towns with populations under 4,000 increased 12-fold [11]. Considering that the rural towns sampled in the current study consisted of three 'small' regional centres and one 'large' regional centre, this study confirms that suicide is a critical issue for adolescents in regional and rural Australia. The fact that human service providers were observing male adolescents choosing more overt means of suicide than their female peers has also been reported in the literature, with use of firearms and hangings, the top two methods of suicide for males, with poisoning being described as the preferred method for females [11].

Drug and alcohol abuse/dependency was considered to be the most critical social issue identified by human service providers. In particular, the co-morbidity of drug and alcohol dependency with mental health problems. The National Rural Health Strategy has suggested that this particular co-morbidity is more acute in rural locations [8, 24, & 25]. Anderson et al. (2004) found that the rural adolescents in their study tended to consume more alcoholic drinks and more marijuana than their urban peers. They argue this may relate to the limited opportunities for organised entertainment in small rural communities, where a single hotel or pub becomes the 'focal point' for social interaction, as compared to metropolitan areas where there is simply 'more to do' [23]. While this finding is pertinent to the current study, the perception of the human service providers was that alcohol use is now also a serious health issue for many female adolescents. This finding reflects changing social norms in Australia generally and rural and regional Australia, where rural cultures were often perceived as distinctly 'masculine', and where alcohol consumption was regarded as one of the hallmarks of adulthood, particularly amongst men in farming communities [13, 14, 15, & 23].

Participants in this study argued that rural adolescents faced particular barriers preventing them from accessing mental health services. Aside from the obvious barrier of distance and the associated financial burden, other barriers, including social ones, were regarded as being significant, with the biggest non-physical barrier preventing adolescents from accessing mental health services in their town, being stigma. The effects

of stigma have been very well documented in prior research. A recent study investigating mental health literacy amongst 3,000 South Australian residents found that whilst there had been an increase in mental health literacy generally, especially in regards to depression, results also indicated a lack of significant change in psychiatrists and/or psychologists being perceived as therapists of choice in depression management [26]. This finding is particularly noteworthy, as it questions whether increased mental health literacy has actually done anything to curb the social stigma associated with mental health morbidity.

As a consequence of these barriers, participants reported that not enough adolescents were accessing care, and that more could be done to make services 'youth-friendly'. Others have reported that only one quarter of adolescents who are suffering a mental disorder actually seek assistance from a health service [2]. As many as three quarters of adolescents with a mental disorder do not receive any form of treatment [27]. According to the participants in the current study, the organisation and the manner in which existing services were delivered were regarded as factors that are amenable to change in order to encourage adolescents to utilise existing mental health services. Prior research has also suggested this, indicating that the physical characteristics of health services can have a negative impact upon a young person and the sense of safety they require to access help [27]. Studies have found that adolescents may feel intimidated by a formal clinical setting, waiting room and appointment booking procedures, and when coupled with a perceived lack of sensitivity by reception staff, many adolescents forego receiving professional help [27, 28]. Service providers in this study were acutely aware of this, indicating that friendly staff and accessible, discrete services were highly desirable for young people in the rural areas they serviced. This was initially suggested by Griffiths (1996) who argued that due to the sparsely populated nature of rural settings, social isolation and lack of privacy (anonymity - as compared to metropolitan services), rural residents may be discouraged from seeking help [13].

A strength of the current research was the inclusion of the 'informal' mental health service providers as participants. This allowed for a deeper insight into their role within the rural community, and investigated the perceptions they held toward the mental health needs of adolescents in their geographic area. From an

examination of the interviews with these individuals, it was apparent that informal providers are providing a significant level of mental health care to rural adolescents, especially for depression, drug and alcohol abuse/dependency and social issues related to interpersonal relationships. This involvement stems largely from the unmet needs of adolescents as formal sources of care are understaffed and overstretched. In some towns, formal child and adolescent mental health services had waiting periods of up to six months. For adolescents who are grappling with a mental health problem, six months is often far too long to wait to receive support, and may in fact be, too late. Griffiths (1996) argues that whilst the mental health expertise of informal providers may be limited, these individuals often find themselves being the first port of call for emotional support during difficult times [13]. Also, because of the high degree of stigma associated with mental health morbidity in the geographic area covered in this study, it could be that rural residents, especially adolescents, may feel more comfortable visiting an 'informal' mental health provider, rather than a 'formal' service provider. This was a very strong finding in the work Fuller et al. (2000), who argued that adults residing in rural communities in Northern and Western areas of South Australia were far happier to use sources of care that did not have a 'mental health' label attached to them, such as rural financial counsellors or religious ministers [14].

The fact that South Australian mental health services are currently overstretched and understaffed is well-recognised by the State government, with new policies being recently put in place to try to address this deficit and improve the mental health of residents [29]. It was not surprising to the researchers to learn that some South Australian residents were being referred to mental health services in the neighbouring State of Victoria, and more specifically, the Greater Green Triangle region. While it is important to acknowledge that it is easier for residents of parts of South-Eastern South Australia to cross the border and travel a shorter distance to Victoria (than the State capital of Adelaide) to access their mental health care, it should be noted that if existing South Australian mental health resources were increased (i.e. more outreach services) or perhaps organised differently (i.e. better local staff organisation), these people may not be required to travel such distances. Furthermore, discussions with the three Victorian human service providers who were providing mental health care to South Australian residents at the time of this study, revealed a sense of unease and

dissatisfaction. Not only did these additional referrals increase the burden of their workload, but also, presented them with the difficulty of trying to keep track of which human service providers their South Australian clients had seen, as they were obviously more familiar with Victorian staff. The impact that this shuffling around between services between States has on continuity of care for mental health clients needs to be considered.

Despite the fact that the General Practitioner has been cited as the major mental health care provider to rural residents, results of the current study indicated that only three of the eight GPs interviewed were actually providing mental health care to a significant number of adolescents in their area. Such a finding is surprising, considering that participants indicated that significant numbers of adolescents in their towns were experiencing mental health problems. Prior studies have suggested that some adolescents do not visit their GP for fears that their confidentiality may not be maintained; that their GP may disclose their problem to their parents [28]. Other studies have suggested that adolescents may be fearful that their GP may be unsympathetic towards them, or hold an authoritarian attitude. Further research is needed however, to determine if these are the reasons for this lack in GP visits for mental health concerns in the rural settings described here. Also noteworthy is the fact that when GPs in the current study were asked to comment upon the impact a rural lifestyle may have on the mental health of rural adolescents, there was a tendency for them to identify positive, protective factors of rural communities, such as a greater sense of community, closer friendships and an increase in physical activity due to the strong emphasis placed on sport.

STUDY LIMITATIONS

This study involved qualitative interviews with a small, self-selected group of human service providers working in rural centres in South Australia. Whilst this group provided outreach to a wide geographic area, further research is needed to determine if the views expressed can be generalised to more remote locations. In addition, only a small number of GPs were able to be recruited. As the gate-keeper to many mental health

services, particularly for more severe mental health conditions, it would have been advantageous to have collected data from a larger group of GPs. Of those who did participate, there were strong concerns about their confidentiality being maintained, which is understandable considering that GPs in these towns could be easily identified.

Conclusions

This study identified the mental health issues perceived to be most important to formal and informal human service providers in four rural centres in South Australia. The most common mental health problems seen by these human service providers included depression, anxiety disorders, self-harming behaviour and suicide, and drug and alcohol abuse/dependency. The organisation and accessibility of existing services needs to be improved to encourage adolescents with mental health issues to access appropriate, rural services in the future. This may not require more resources per se, but better use of current resources.

In light of the findings generated by this study, the following recommendations to successful adolescent mental health service delivery have been developed:

1. Engaging with young people:

Participants in this study indicated that service providers needed to do more to engage with young people initially, even if this meant trying out novel ideas and utilising non-traditional methods of care.

2. Changing the way in which existing services are being delivered, in order to encourage more young people to access them:

Feedback from service providers indicated that not only does the physical appearance of existing mental health services prevent adolescents from accessing care, but also the way in which services are delivered. Currently, mental health staff are waiting for adolescents to come and see them. Rather, mental health services need to be seeking the adolescents and increasing their public profile to present as being 'youth friendly' i.e. increasing their presence within schools, local community events. This may mean adopting more of a Primary Health Care approach to service delivery, seeking to address the root cause of health problems, such as social problems, within local communities.

3. Increasing collaboration and networking events between existing service providers:

Due to high staff turnover, it is often difficult for service providers to keep up with who is providing what service. Therefore, regular local mental health networking events should be considered as highly important to maintaining good links to facilitate collaboration between existing services and also to prevent any overlap.

Competing Interests

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Authors' Contributions

MK conceived of the study and participated in co-ordinating the drafting of this manuscript. In addition, MK collected all data in this study i.e. conducted all focus groups and individual interviews and also undertook the majority of qualitative analysis.

CB, TW & JE all participated in the conception and design of the study and offered guidance and support during qualitative analysis. JE also assisted in the recruitment of participants for this study.

All authors, MK, CB, TW & JE participated in the final drafting of this manuscript to varying degrees, and all approved the final version submitted for publication.

Authors' Information

Marijeta Kurtin is currently enrolled as a PhD candidate (Medicine) in the Discipline of General Practice at The University of Adelaide. She is due to complete her PhD in late 2009.

Dr Christopher Barton acts as the primary PhD supervisor, with Professor Tony Winefield and Dr Jane Edwards both acting as co-supervisors.

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Tables and Figures

Figure 1 Service delivery areas

----▶	Townships researcher travelled to from Adelaide to conduct focus groups.
——▶	Origins of clientele receiving assistance from mental health services in study.
——▶	Victorian townships in Greater Green Triangle region receiving South Australian clientele from Mount Gambier.

Table 1 Occupations of the study participants

Occupation	Frequency
Aboriginal Health Worker	2
C.E.O./Manager (Non-Govt. Org.)	4
Victorian C.E.O./Manager (Non-Govt. Org.)*	1
Clinical Nurse	1
Drug & Alcohol Counsellor	3
General Practitioner	8
Mental Health Nurse	2
Mental Health Academic	1
Psychiatrist	1
School Principal	1
Social Worker	4
Victorian Social Worker*	2
Student Counsellor	3
Student / Researcher	1
Team Leader (Govt. Org.)	1
Youth Worker	3
TOTAL	**38**

***NB:** These Victorian service providers were receiving South Australian clientele at time of interview.*

Table 2 Description of the five major themes and codes identified

Major theme	Description	Codes
1. Community & Society Factors	Aspects of local communities and society which work to affect the mental health of adolescents.	Rural Lifestyle Boredom Homogeneity Isolation Financial Factors Farming Stigma
2. Youth Issues	Mental health and behavioural problems including social, gender and youth issues which impact upon the mental health of adolescents.	Drugs & Alcohol Risky Behaviour Mental Health Problems Depression Anxiety Suicide School Problems Bullying Relationships
3. Indigeneity	Aspects of (Indigenous) culture impacting on the mental health of adolescents, and their access/use of existing services.	Cultural Differences Indigenous Issues Shame Grief & Loss Barriers to Services Staff & Training

4. Service Delivery & Utilisation	Factors which impede the appropriate delivery of mental health services to adolescents.	Access to System Financial Barriers Bureaucracy Distance & Travel Waiting Times Future Needs Staff/services Training Youth-friendliness Funding Resource Usage
5. Occupational Factors	Factors related to the vocation of human service which impact on the successful delivery of mental health service and influence the individual experience of service providers.	Collaboration Confidentiality Time Constraints GP Burden Competence Psych. Training