

Mental health problems in rural contexts: What are the barriers to seeking help from professional providers?

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Abstract

The aim of this review was to determine which sociodemographic, illness-related and psychological/attitudinal factors impact on a person's decision to seek help and the factors associated with attitudes to help-seeking in rural contexts. A computer search of the literature for 1990–2006 using the terms “help-seeking” and “mental” found 350 studies. Examination of the abstracts by one of the authors (AK) identified 20 relevant studies, which we review under two major headings: those papers dealing with help-seeking studies not specific to (but which may have included) rural settings; and a second group of studies conducted specifically in rural locations or that directly compared rural with urban locations. A number of factors were found consistently to be predictive of both mental health utilisation and attitudes toward formal help-seeking. They included sociodemographic factors such as gender, age, and marital status; illness-related factors such as having a mental disorder, comorbidity, and psychological distress; and, to a much lesser extent, psychological/attitudinal factors, including stigma, stoicism, and self-efficacy. Psychological/attitudinal factors have been poorly investigated compared to sociodemographic and illness-related variables and are worthy of further investigation. Their impact and value may vary according to location. Proposed herein is the development of a comprehensive framework that has emerged from the health and place literature as one way of understanding barriers to accessing mental health care.

We have heard much in the popular press about the problems of attracting general practitioners (GPs) to work in rural and remote settings. The situation is even worse with medical specialists and also true for psychologists. If people in these settings wish to access medical care or access psychological or mental health services they are confronted by a number of barriers. The first is that there may not be a great deal of choice among health providers. Second, the closest practitioner may be located some geographic distance from the person's residence, and third, specialist services are most likely not available and the person is more reliant on the services of the GP. Fourth, given the high workload of GPs in rural settings, they may not be able to allocate sufficient time in assessing and treating an individual patient. Fifth, and arguably of most interest to psychologists, are the barriers presented by psychological variables and knowledge about mental health problems and

their treatment. So if an individual has little capacity to recognise symptoms or has a negative view of mental health problems and mental health services, then are they unlikely to refer themselves to a mental health service if they develop a mental health problem? Likewise, if others in the individual's social network have negative views of either mental illness itself or the practitioners who provide treatment for these illnesses, then are they less likely to recommend treatment from a GP or mental health specialist (Komiti, Judd, & Jackson, 2006)?

This area of work encompassing the influence of knowledge, attitudes and values about mental illness and its treatment in help-seeking behaviour has been led by the work of Jorm and colleagues (Jorm, 2000; Jorm, Korten, Jacomb et al., 1997a,b; Jorm, Korten, Rodgers, Pollitt, Christensen et al., 1997; Jorm, Korten, Rodgers, Pollitt, Jacomb et al., 1997). Much of the literature has focused on demographic and

illness factors as primary moderators of help-seeking. We introduce a range of data that points to the additional importance of psychological and attitudinal barriers to help-seeking. While knowledge and attitudes may influence help-seeking for mental health problems in a range of locations, it has been suggested that there are particular influences which operate in rural areas. Consistent with this, rates of help-seeking and service utilisation for mental health problems are lower in rural than urban residents (Caldwell, Jorm, & Dear, 2004; Parslow & Jorm, 2000). Service utilisation refers to actual presentation to treatment and use of services for mental health problems (e.g., number of sessions with a professional, number of hospital admission days), whereas help-seeking is a broader term that encompasses a range of indicators including attitudes to seeking help, planned behaviour, and consultation with friends, help lines, the internet or professionals. Rural residence is negatively associated with the use of both psychologist and psychiatrist services (Parslow & Jorm, 2000). Caldwell et al. (2004) found that the rate of psychological problems managed by GPs per 1,000 population was far less for residents of large rural areas (population = 25,000–99,000), small rural area (population = 10,000–24,999), and, other rural and remote areas (population <10,000) when compared to capital cities. The specific but related questions we were interested in exploring were: (a) which sociodemographic factors and psychological factors might impact on a person's decision to seek help from a health or mental health professional; (b) are people less likely to seek treatment from formal health or mental health professionals because of attitudes they have towards mental illness and mental health providers; and (c) are any such factors likely to be specific to rural settings.

Searches of the literature published between 1990 and 2006 using words “help-seeking” and “mental” found 350 studies. The literature is relatively sparse as regards studies that identify barriers to help-seeking behaviours in rural contexts. For this reason we identified two kinds of studies: those that looked at actual service utilisation in rural and urban settings; and second, those studies that examined attitudes in broader groups of people who may or may not have received services but in the main had not. This allowed for a bigger pool of studies but importantly, allowed us to appraise whether similar or different factors emerged from the two groups of studies. One of us (AK) then examined the abstracts of those 350 studies and culled them to obtain the most relevant studies ($N=20$) that investigated factors affecting or associated with attitudes to, or actual, help-seeking from formal health service providers for mental health problems; this was

irrespective of whether or not they contained individuals from rural or urban settings. We review the 20 relevant studies below under two major headings: those papers dealing with help-seeking studies that were not specific to (but which may have included) “rural” settings, which we labelled “general help-seeking studies”; and a second group of studies conducted specifically in “rural” locations, which we labelled “help-seeking studies conducted in rural contexts”. Some of the studies in Table 1 include participants from rural settings but only as part of larger studies that include urban populations. Table 2 reports on studies confined to rural settings or which report on direct comparisons of urban and rural participants. The literature that we précis in Table 1 appears to highlight demographic and illness factors as primary moderators of help-seeking or attitudes to help-seeking. The studies reviewed in Table 2 (rural-specific studies) pay more attention to psychological/attitudinal factors.

General help-seeking studies

Of the 11 studies displayed in Table 1 some were focused on factors associated with service utilisation (e.g., Bergeron, Poirier, Fournier, Roberge, & Barrette, 2005; Parslow & Jorm, 2000), while others were focused on examining determinants of help-seeking for emotional or mental problems (Bland, Newman, & Orn, 1997; Mojtabai, Olfson, & Mechanic, 2002). It should be noted that three studies in Table 1 report data derived from the same Canadian survey (Bergeron et al., 2005; Sareen, Cox, Affi, Yu, & Stein, 2005; Wang et al., 2005).

Many studies displayed in Table 1 reported that being female, being alone, widowed, divorced or separated, having a mental disorder (e.g., mood, anxiety or substance), having a physical condition or comorbidity (including physical conditions), were all positive predictors of attitudes to, or actual, help-seeking. That is, such individuals were more likely to display help-seeking behaviour or positive attitudes to it. Age was also a strong predictor in a number of studies, although different studies used different age categories (Bland et al., 1997; Mojtabai et al., 2002; Rabinowitz, Gross, & Feldman, 1999; Sareen et al., 2005; Tijhuis, Peters, & Foets, 1990; Wang et al., 2005). There were mixed findings for education: it was not a significant predictor in some studies (e.g., Bland et al., 1997) whereas higher education was predictive of help-seeking from formal providers in other studies (Parslow & Jorm, 2000; Tijhuis et al., 1990).

Wang et al. (2005) found that for people with major depressive disorder (MDD) in the past 12 months, clinical factors (having chronic comorbid medical/psychiatric conditions, having made a

Table 1. General help-seeking studies

Authors	Study design	Aim/s	Method and sample	Findings
Bayer & Peay (1997) Australia	Cross-sectional	To investigate factors associated with intention to seek professional help for psychological problems.	Sample was waiting list ($N = 142$) for community-based GP. Study was questionnaire based.	Significant factor influencing whether people would seek help was the belief of whether mental health professionals could help or provide support for people's problems.
Bergeron et al. (2005) Canada	Cross-sectional	To identify determinants of service use (using Anderson's behavioural Model of Health Care) by young people with mental health problems.	Data examined from Canadian community health survey and well-being. Study looked at data of subsample of young people (15–24 years; $N = 1092$) who had a mood, anxiety or substance-related disorder in past 12 months as diagnosed by the CIDI.	Being female, living alone, having a mood disorder, and having a chronic diagnosed medical condition were predictors of service use. Social support, size of social network, mental disorders among relatives, and province of residence did not predict help-seeking.
Bland et al. (1997) Canada	Cross-sectional	To examine demographic and clinical determinants of seeking help for emotional or mental problems.	Community adult sample ($N = 1964$) interviewed using DIS and health-care use questionnaire. For those with a diagnosis, sex, age, marital status, education, employment and income were examined as determinants of help-seeking.	Predictors of help-seeking were: gender (female), age (under 45), severity of illness and comorbidity.
Mojtabai, Olfson, & Mechanic (2002) USA	Cross-sectional	To examine correlates of help-seeking in the past 12 months.	Data for this study based on subsample ($N = 1792$) of the National Comorbidity Survey (1990–1992) who met diagnostic criteria (CIDI/DSM-IIR) in the past 12 months for mood, anxiety or substance use disorder. Participants were aged ≥ 15 years. Correlates examined were sociodemographic (gender, age, ethnicity, marital status, education, income), insurance, illness variables (having a DSM-IIR diagnosis, suicidal behaviour, physical health status and disorder), attitudinal (whether the patient would seek help, how comfortable they would be talking about personal problems with a professional, and how embarrassing it would be if friends knew about the professional help).	Correlates of perceived need: psychiatric variables, positive attitude towards mental health help-seeking, physical conditions, marital loss, female gender, younger age (15–24 years), maternal psychopathology, and insurance coverage. Correlates of professional help-seeking among those who perceived need: older age (45–54 years), having a physical condition and positive attitude towards mental health help-seeking.

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Table 1. (Continued)

Authors	Study design	Aim/s	Method and sample	Findings
Parslow & Jorm (2000) Australia	Cross-sectional	To identify sociodemographic and psychological factors associated with mental health service utilisation.	Data examined from the National Mental Health and Wellbeing survey (N = 10,641) of persons aged = 18 years. Participants completed the CIDI for diagnosis of affective, anxiety and substance-use disorder.	Predictors of using any health professional for mental health reasons were: gender (female), higher education, being separated, neuroticism, self-identified depression or anxiety and CIDI-diagnosed substance use disorder.
Rabinowitz, Gross, & Feldman (1999) Israel	Cross-sectional	To examine characteristics of people with perceived need and how persons with need who sought help differed from those who did not.	Participants comprised respondents to a national random phone survey (N = 1,394) which asked questions about perceived need for mental health assistance and help-seeking. Participants were also asked if they went for help.	Of those with a perceived need, the variables that discriminated between those who sought help and those who did not were: age (35–55 years), divorced, Hebrew speaker, not being a recent immigrant, and living in a big city. There was a trend for female subjects to have sought more help but this did not reach statistical significance.
Rickwood & Braithwaite (1994) Australia	Cross-sectional	To assess influence of demographic, network and personality variables to help-seeking, both informal (friend or family) and from professional services (GP, mental health service, educational help service).	Study sample were Australian adolescents (N = 715) aged 16–19 completing their final year in secondary school. This sample was recruited from schools in Canberra.	The only significant predictor of seeking professional help was greater psychological distress.
Sareen et al. (2005) Canada	Cross-sectional	To examine the prevalence and sociodemographic correlates of mental health service use and perceived barriers to service in a nationally representative survey.	Sample comprised subsample (N = 125,493) of respondents aged = 12 years to the Canadian Community Health Survey Cycle 1.1 conducted from 2000 to 2001. Respondents asked about contact with a health professional in past 12 months for mental health problems. DSM-IV major depression and alcohol dependence in past 12 months also assessed with CIDI.	Strongest correlates of mental health service use were: past year depression, female sex, being widowed, separated or divorced, having two or more chronic physical conditions, perceived high stress, long-term disability, and age (30–39 years and 40–49 years). Most common barriers to help-seeking were attitudinal and practical issues: “did not get around to it”, “the waiting time was too long” and “they felt treatment would be inadequate”.
Tijhuis, Peters, & Foets (1990) The Netherlands	Cross-sectional	To examine the relationships between personality characteristics, demographic characteristics and	Data was collected as part of the National Study of Morbidity and Interventions in General Practice. Participants were	People more prone to seek help were younger, had more education and higher income. Also, more likely to

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Table 1. (Continued)

Authors	Study design	Aim/s	Method and sample	Findings
Wang et al. (2005) Canada	Cross-sectional	network characteristics and orientation to help-seeking). Demographic variables studied were: gender, age, marital status, income and education. To identify factors associated with mental health services by people with MDD or mania (diagnosed by CIDI) in past 12 months.	randomly selected as part of 100 participants per participating GP. Data from participants aged ≥ 18 years ($N = 10,171$) were used for this study. Data examined from Canadian community health survey mental health and well-being. Analysis included those with MDD ($n = 1563$) or mania ($n = 393$), and the rates of use of conventional health services.	have acquaintances working in mental health care, and less likely to see chance as the locus of control of health. The researchers did not examine the effects of illness variables. For those with MDD, there was no effect of sex, marital status, income, or education. Conventional health use was associated with being in the 26–45-year age group, having =1 medical disorder, suicide attempts in past 12 months, and any comorbid disorder (except substance use disorder). Among those who met criteria for a disorder, women were more likely to receive help, and less likely to think they didn't need help. Those who were divorced, separated, or co-habiting for more than a year were more likely to have received help than the married and never married. Most common reasons for not seeking help were attitudinal: respondents felt they should be able to handle the problem themselves and believed that the problem would get better by itself. Situational factors (e.g., cost, insurance, time, location) were less important determinants of help-seeking.
Wells et al. (1994) USA and New Zealand	Cross-sectional	To examine perceived barriers to mental health care in two samples: St Louis, US and Christchurch, NZ.	Random selection of adults from each household in the community. Participants 18–64 years ($N = 3908$ for both sites), completed DIS/DSM-III interview and health services utilisation questionnaire.	

Note: DIS = Diagnostic Interview Schedule; MDD = major depressive disorder.

Table 2. Help-seeking studies conducted in rural contexts

Authors	Study design	Aim/s	Method and sample	Findings
Barry et al. (2000) Ireland	Cross-sectional Interview	Examined mental health beliefs and perceptions, level of awareness, current practices, attitudes and stigma concerning depression and suicide.	Community sample ($N = 1014$).	Males showed lower levels of awareness, negative attitudes towards help-seeking, social stigma, and were less confident in dealing with mental health issues.
Fox et al. (1999) USA	Cross-sectional	Examined effect of in-home screening and education intervention on help-seeking on individuals with untreated mental illness. Individuals who screened positive of CIDI assigned to 3 groups: no intervention, educational intervention, education intervention with significant other.	Community sample ($N = 646$).	32.4% screened positive for at least 1 disorder, 566 were followed up but only 5.85 had sought professional help. Only 13% of those who discussed the intervention with a significant other were encouraged to seek help.
Gunnell & Martin (2004) UK	Cross-sectional	Compared GP consultation rates for mental illness between rural and urban young people.	Community sample of young adults (16–39 years) registered with GP practices in rural ($n = 16,043$) and urban ($n = 124,081$) regions.	Consultation rates for rural male subjects were 30% lower and for rural female subjects 16% lower than urban counterparts. Greater perceived stigma of mental illness for rural male subjects.
Hoyt et al. (1997) USA	Longitudinal	Tested a model predicting changes in depressive symptoms using socioeconomic and geographic factors.	Panel study of adults in community ($N = 1,487$).	There was an effect of place for men only. Men living in smaller towns (<2,500 or 2,500–9,999) had more depressive symptoms than men in larger towns. There was greater stigma towards mental health care in the most rural areas and this affected willingness to seek help.
Judd et al. (in press) Australia	Cross-sectional mail-out survey	To examine the role of stoicism, self-efficacy and perceived stigma in seeking professional (i.e., GP and/or mental health professional) for mental health problems.	Community sample ($N = 467$) from rural Victoria and NSW. Participants were sub-sample of larger study (Murray et al., 2005) examining mental health and well-being in rural communities.	Lifetime help-seeking for mental health problems was positively associated with higher distress levels, lower levels of stoicism and lower levels of self-efficacy.
Komiti et al. (2006) Australia	Cross-sectional mail-out survey	Examine the influence of attitudinal factors including perceived stigma on seeking help from GPs for mental health problems.	Community sample ($N = 300$) from rural north-west Victoria. Participants were sub-sample from larger study (Murray et al., 2005) examining mental health and well-being in rural communities.	Significant predictors of having ever sought help from a GP for mental health problems were: having a mood, anxiety or substance use disorder, higher psychological distress, greater

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Table 2. (Continued)

Authors	Study design	Aim/s	Method and sample	Findings
Lin et al. (1996) Canada	Cross-sectional	To describe the predictors of mental health service use for a survey of Ontario household residents.	Data for the study based on responses from portion ($N=8116$) of the sample aged 15–64. The study examined the influence of demographic (age, gender, marital status), socioeconomic (education, receipt of public assistance in past year), diagnosis, and geographic (urban versus rural) variables on help-seeking (defined as anyone who in the past year had been admitted overnight, consulted with a professional or used other services (hot lines, self-help groups, vocational programs) for problems with emotions, nerves or use of alcohol or drugs).	functional disability due to physical problems, having a positive attitude towards seeking professional help, and believing a GP would be helpful. Perceived stigma was not a predictor of help-seeking, neither was female gender. Strongest predictors of mental health service use were: gender (female), marital status (separated, widowed, or divorced), receiving public assistance and having a past year DSM-III-R diagnosis, age (24–44-year age group), and living in urban areas. Education and immigrant status were not significant predictors. There was an interaction effect between urbanicity and public assistance: urban recipients were 3–5 times more likely to use services compared to rural respondents.
Smith et al. (2004) USA	Cross-sectional. Mail survey	Examined influence of age, attitudes towards help-seeking, education and sex towards past and intended mental health utilisation.	Community sample ($N=438$).	Previous and intended mental health utilisation predicted by positive attitudes, female sex, younger age. Intended use also predicted by prior mental health utilisation.
Wrigley et al. (2005) Australia	Cross-sectional. Mail survey	Examined role of perceived stigma and attitudes towards help-seeking from GPs.	Community sample ($N=164$).	Help-seeking influenced by causal attributions and perceived stigma.

suicide attempt in the past 12 months), rather than demographic or socioeconomic factors, were associated with conventional mental health service use. However, severity of mental illness was not assessed in that study. Although not shown in Table 1, there were similar results for those people with mania, except conventional health use in this group was also associated with having ≥ 13 years of education and being at least 46 years of age.

Rickwood and Braithwaite (1994) examined the availability of social support, having greater distress scores, willingness to disclose information, knowing someone else who had sought help, and high private self-consciousness, but found the only significant predictor of seeking professional help was greater psychological distress. Tjihuis et al. (1990) also specifically investigated social network (and personality) characteristics as possible predictors, but instead they found that sociodemographic variables (younger age, higher education, higher income), having acquaintances working in mental health care, and those less likely to see chance as the locus of the control of health, were predictors of help-seeking. People in general were more likely to seek help from a GP than a mental health professional but this was even more the case for those with lower education. Bergeron et al. (2005) also found social support, size of social network, mental disorders among relatives, and province of residence did not predict help-seeking.

An additional series of findings by Sareen et al. (2005) found the three most common barriers to help-seeking reported by respondents were attitudinal and practical issues: "did not get around to it", "the waiting time was too long" and "they felt treatment would be inadequate". Wells, Robins, Bushnell, Jarosz, and Oakley-Browne (1994) found that the two most common reasons for not seeking help were attitudinal: respondents felt they should be able to handle the problem themselves and believed that the problem would get better by itself. Furthermore, Wells et al. (1994) also found that situational factors (e.g., cost, insurance, time, and location) were less important determinants of help-seeking. Bayer and Peay (1997) found the strongest predictor influencing whether people would seek help was whether or not they believed mental health professionals could help or provide support for people's problems.

In summary, three sociodemographic factors consistently predict attitudes to help-seeking or actual help-seeking. They are gender (female), being alone, widowed, or divorced, and age (younger). As regards illness-related variables, there were a number of predictors of actual mental health service utilisation, including having one or more medical conditions, long-term disability, perceived stress, having a

diagnosed or self-identified mental disorder, having comorbidity, or suicide attempts. Greater psychological distress was also predictive of help-seeking. Attitudinal factors predictive of help-seeking were having a positive attitude towards help-seeking, being less likely to see chance as a factor, and being positive about mental health professionals being able to provide effective treatment.

Help-seeking studies conducted in rural contexts

Nine studies of help-seeking were conducted in rural contexts and these are displayed in Table 2. It is important to sound a caveat and recognise that definitions of rurality are complex. Future research may well need to go beyond the somewhat crude geographical label of "rural" and include contextual and social network components (Fraser et al., 2005).

In five of this group of nine studies (Barry, Doherty, Hope, Sixsmith, & Kelleher, 2000; Gunnell & Martin, 2004; Hoyt, Conger, Valde, & Weihs, 1997; Lin, Goering, Offord, Campbell, & Boyle, 1996; Smith, McGovern, & Peck, 2005), gender emerged as a strong predictor and one that also interacted with other variables. For example, Gunnell and Martin (2004) examined differences between rural and urban young people in the United Kingdom and found that overall mental health consultation rates for women were double that of men. They also found evidence for an interaction effect between sex and rurality, indicating that rural male subjects were less likely to seek help from GPs for mental health problems compared to their urban counterparts. The authors suggested that one of the reasons for the finding was greater perceived stigma by male subjects but they did not actually test for it. After controlling for socioeconomic variables, GP consultation rates for rural male subjects were 30% lower and for rural female subjects 16% lower, than their urban counterparts. Barry et al. (2000) in a large study conducted in Ireland, found different issues were identified for male and female subjects. Male subjects had lower levels of awareness of mental illness, held more negative attitudes towards help-seeking, were more concerned with stigma and possessed less confidence in dealing with mental health issues than female subjects. The lack of any measurement of distress or symptom levels of participants was a major limitation of this study.

Aside from gender (female) being predictive of mental health service utilisation, Lin et al. (1996) found that other predictors of mental health service utilisation were: having a *DSM-III-R* diagnosis in the past 12 months, being separated, widowed, or divorced, being a recipient of public assistance, being in the 24–44-year age group, and living in urban areas. Lin et al. (1996) found an interaction

effect between urbanicity and public assistance: urban recipients were 3–5 times more likely to use services compared to rural respondents. The authors suggested that one reason may be that rural residents have different help-seeking patterns by preferring more informal sources of help. Further examination of the data also showed differences in the type of help sought; urban recipients of public assistance were more likely to see psychiatrists than their rural counterparts. This could be interpreted in one of two ways: fewer psychiatrists are available to see poorer rural people, or alternatively, poorer rural people prefer not to see psychiatrists.

Fox, Blank, Berman, and Rovnyak (1999) found that approximately one-third of their sample met diagnostic criteria for a mental disorder but worryingly, only 5.8% had sought significant professional help. Hoyt et al. (1997) found that people living in rural regions expressed significantly greater concern about stigma than those in populated centres, and stigma towards mental health care was associated with significantly less likelihood of willingness to seek formal help in the future. This is an important study because it found that a psychological factor and locality of residence were important predictors of help-seeking. There were no interaction effects for gender – these effects were main effects showing that the results held for both male and female subjects.

As noted earlier, Smith et al. (2004) in a US study found that female subjects were more likely to have obtained mental health services or were more likely to intend to use mental health services. But younger age and more positive attitudes towards help-seeking were also predictive of previous and intended use of mental health services. Importantly, intended use of mental health services was also predicted by prior mental health service utilisation.

Of the only rural-relevant work to be conducted in Australia, three of the studies shown in Table 2 were conducted by our research group and focused on psychological factors predicting help-seeking (Judd et al., 2006; Komiti et al., 2006; Wrigley, Jackson, Judd, & Komiti, 2005). We sought to extend previous work and to examine factors that may be specific to, or particularly important in, rural areas. Our first study took place in Echuca, Victoria (Wrigley et al., 2005). Respondents were asked whether or not they would be willing to discuss mental health issues with a GP. There was only one single predictor: whether or not the respondents believed that the GP was helpful in treating mental problems. All other variables including gender, whether or not the respondents suffered depressive and anxiety symptoms, reported levels of disability, attitudes towards help-seeking and perceived stigma, whether they had previously sought treatment for a

mental health problem or knew someone who had, were not predictive of willingness to discuss mental health issues with a GP.

In contrast, when we examined respondents' general attitudes to help-seeking we found that perceived stigma outperformed all other demographic variables (i.e., gender, age, education, income), their own self-reported depressive and anxiety symptoms, and disability levels. In fact, no other variable predicted attitudes to help-seeking. In order to further explore the issue of stigma, we examined the influence of respondents' beliefs about the causes of two specific clinical conditions, depression and schizophrenia, on attitudes to help-seeking. Possible causes included "upbringing", "stress", "social/environment", "genetics", "drug use", "personality", and "weakness of character". Consistent with the demonstrated effect of perceived stigma, weakness of character was negatively predictive of attitudes towards help-seeking for depression ($B = .35$). Other causes bore no relationship to attitudes to help-seeking for depression. For schizophrenia, again weakness of character was predictive of negative attitudes towards help-seeking ($B = .43$), as was upbringing ($B = .27$). In contrast, the belief in genetic causes of schizophrenia was positively associated with attitudes to help-seeking ($B = -.21$).

The key finding of a difference in general attitudes towards help-seeking and help-seeking from a GP is of note. For various reasons, seeking help from a GP in rural areas may be more acceptable. Arguably, there are three possibilities: first, knowing the GP; second, having a belief in their ability to provide help and support (Bayer & Peay, 1997, Table I); and third, help-seeking from a GP being seen as associated with less stigma. Noteworthy was the fact that female gender was not predictive of either attitudes to help-seeking nor of actual willingness to discuss mental health issues with a GP and this goes against the usual reported findings in Tables 1 and 2 that women are more likely to seek help for mental health issues. There were major limitations of the study, two of which were the very poor response rate (28.4%) and the use of a convenience sample, thereby making generalisations tenuous.

In the second study (Komiti et al., 2006) we investigated a similar set of variables in a sample of 300 people drawn from the Loddon Campaspe Southern Mallee region in rural north-western Victoria. We examined gender, age, annual income, marital status, and education level; lifetime or current diagnosis of mental disorder via the Structured Clinical Interview for DSM-IV (SCID: First, Spitzer, Gibbon, & Williams, 1996); psychological distress as measured by the K-10 (Kessler et al., 2002), mental disability, physical disability, and the respondents' belief in the helpfulness of a GP for

mental health problems, as possible predictors of help-seeking.

We were interested in determining which factors predicted having ever sought help from a GP for psychological or mental health problems. Meeting the full criteria for a past or present diagnosis of any disorder meant the respondent was 3.5 times more likely to seek help for a mental health problem. Other predictors of help-seeking were having a positive attitude towards seeking professional help, believing a GP would be helpful, reporting higher distress levels, and reporting greater functional disability due to physical health problems. Again, it was interesting that gender and perceived stigma were not predictors of help-seeking from a GP.

A third study also examined help-seeking by rural residents for mental health problems (Judd et al., 2006). That study expanded our investigation of the possible influence of attitudinal factors on help-seeking and examined self efficacy and stoicism (a relatively new measure) as well as perceived stigma. The inclusion of these measures was based on a widespread view that rural people are more stoic and more self-reliant in dealing with problems of all kinds including mental health problems (Fuller, Edwards, Proctor, & Moss, 2000) and more stigmatising of those with mental health problems, that is, people who seek help are perhaps viewed as being of weak character (Wrigley et al., 2005). There is also a view that stigma might be worse in small rural communities than in residents of larger town sizes because of the closeness of those small communities – people would be concerned about the lack of privacy and news getting out about their problems (Hoyt et al., 1997).

We found that lifetime help-seeking for a psychological problem or mental health issues was positively associated with higher levels of distress and lower levels of stoicism and to a lesser extent, lower levels of self-efficacy (Judd et al., 2006). In this study, and unlike the two previously reported studies, gender was a predictor of actual help-seeking but not once psychological variables were added, such as stoicism, general self-efficacy, and perceived stigma. Age, marital status, and education were not predictive of help-seeking and this was also true in the two previous studies. So some important insights about help-seeking in the rural context have derived from measuring psychological alongside demographic and illness moderators.

In summary, in line with findings from the general help-seeking studies shown in Table 1, studies of help-seeking in rural populations found a number of sociodemographic factors to predict help-seeking or service utilisation for mental health problems, including being female, being alone, widowed, divorced or separated, and younger age (see Table 2).

Of note however, rural males and females were less likely to seek help or use services than their urban counterparts. Having a mental disorder, experiencing psychological distress, disability and having medical co-morbidity – factors we would define, albeit loosely, as illness-related factors – have all been shown to predict help-seeking in studies from rural settings. Accordingly, past use of services also predicted help-seeking.

Regarding attitudinal-psychological factors, having positive attitudes towards help-seeking and service providers was predictive of help-seeking and is consistent with the findings of the general help-seeking studies. Although not examined by general help-seeking studies, stigma was a factor in some of the rural studies (e.g., Barry et al., 2000; Hoyt et al., 1997) but not in others (Judd et al., 2006; Komiti et al., 2006). Wrigley et al. (2005) provide some specific examples of stigma and its relation to disorders. They found that if respondents believed the cause of a clinical picture of either depression or schizophrenia was due to “weakness of character” (and additionally, “upbringing” in the case of schizophrenia), then this was related to negative attitudes to help-seeking. But if the respondent believed the cause of the schizophrenia picture was “biological” then this was related to positive attitudes to help-seeking. These results are somewhat related to the constructs of stoicism and self-efficacy investigated formally in Judd et al. (2006): lower levels were found to be predictive of lifetime help-seeking for mental health problems.

Discussion

We found evidence to support the capacity of sociodemographic, illness-related and attitudinal factors to predict help-seeking and service utilisation in both urban and rural contexts. However, constructs such as stoicism, self-efficacy and stigma have been underresearched. They have been shown to exert an effect on help-seeking and service utilisation in rural contexts, but at this time we are not able to determine whether they are equally important in urban contexts. Direct comparisons between urban and rural settings are needed.

Limitations of the studies to date

Studies conducted to date in this field have varied dramatically in terms of the types and comparative qualities of the methodologies adopted. Of major importance is the sample selection methods; these have ranged from community health/community mental health surveys to random phone/mail surveys to community GP attendees. Methods of collecting data have included telephone surveys, mail

self-report and face-to-face interviews. Mental disorder has been diagnosed with self-report in some cases and diagnostic interviews in other cases. Although the studies have broadly similar aims, the variable that is the chief focus of interest varies from one study to the next; some are much more focused on sociodemographic variables, whereas others have focused on individual psychological factors. The data analytic techniques varied from study to study, and certainly not all looked at interaction effects, although smaller sample sizes would preclude the examination of these.

Our review also suffers from limitations. The studies reviewed were identified and selected by one of us (AK) and there was no interrater reliability, which would have given greater confidence that the studies reported here were indeed the appropriate set of studies. As it stands the review is open to allegations of potential selection bias. Also, the study is not a meta-analysis but narrative in approach.

Stoicism may not be a uniquely rural characteristic, of course, but may be found in highly urbanised locations as well. Comparison studies are needed. Also, we need to investigate the relationships between gender (maleness), stigma and stoicism and including their multiple interactions (e.g., stigma \times stoicism, stigma \times gender, stoicism \times gender, and stoicism \times stigma \times gender).

Implications for treatment

The results to date suggest that a multi-faceted approach to help-seeking for mental health problems might be beneficial in rural areas, although this approach might equally apply to urban dwellers. First, public mental health literacy might be aimed at the general population (Jorm, 2000). In this approach we would provide information about (a) the clinical pictures of common mental disorders, such as mood, anxiety and substance use disorders; (b) the known causes and courses for these disorders; (c) the evidence-based treatments for these disorders; and (d) how and where to access care. At a second level, there may be a need to target such mental health literacy material directly to high at-risk populations and hard-to-access populations such as men (e.g., farmers), because they may hold more stigmatising attitudes about mental health problems.

Indeed, a consistent finding is the reluctance of rural men to seek help for mental health problems. This combined with higher stoicism and stigma may mean these individuals are less likely to seek help and/or use services, especially when they have subthreshold symptoms. We believe that what is needed to take this field further is to conduct close-in studies such as focus groups with male subjects to

more specifically understand their reluctance to acknowledge and/or seek help for mental health problems. One might attract such men through accessing sports clubs, motor-sports, football and cricket clubs, or community gatherings. In order to overcome access and stigma issues, promising treatment approaches might include personal appearances by admired stars from respective football codes such as Australian rules, rugby league, rugby union and soccer, who have suffered and recovered from mental disorders; they could present their stories at football club events or community meetings. Another possibility would be to have a local person recovering from mental illness talking about their own experiences. This might be especially germane to smaller close-knit communities. DVD testimony from those who have suffered from mental illness might also be useful.

Mental Health First Aid (e.g., Jorm, Kitchener, Kanowski, & Kelly, 2007), and more anonymous approaches such as online counselling or website self-help programs such as MoodGYM (<http://moodgym.anu.edu.au/>) (Christensen, Griffiths, Groves, & Korten, 2006) and relationship help online (<http://www.relationshiphelponline.com.au/>) might also be useful approaches. The effectiveness should be assessed following the implementation of such intervention/educational campaigns.

Where to from here?

Severity of illness was not consistently measured in the studies reviewed but illness variables such as having made suicide attempts in the last 12 months, greater distress, having a diagnosed or self-reported mental disorder alone or in combination with other mental disorders or physical disorders, were all associated with both help-seeking and with mental health service utilisation. On the one hand, it is positive that those who are ill are more likely to seek help but in line with the early intervention paradigm, we want to encourage all ill people to seek help as early as possible, and certainly before they develop comorbidity and their day-to-day functioning is further compromised. We need to ascertain which factors prevent people from seeking earlier assistance.

Of the studies displayed in Table 1 only three examined social network and social support variables in predicting help-seeking from health or mental health services (Bergeron et al., 2005; Rickwood & Braithwaite, 1994; Tjihuis et al., 1990). Those variables had no predictive value in determining mental health or health service use, although Tjihuis et al. (1990) found that having acquaintances who worked in mental health was predictive of help-seeking. Besides the limited number of studies, social

network research related to mental health tends to use rather simple indicators of network structure (e.g., number of ties, density) that may be less than optimal. For example, research within the discipline of social networks suggests that the number and type of regular social interaction settings (Feld, 1981), the number of weak (i.e., acquaintanceship) tie partners (Granovetter, 1973), and the structure of the network (Lin, 2001) are important factors in an individual's immediate social environment, yet these features are seldom examined in mental health studies. The assumption underlying traditional models (Cohen & Sokolovsky, 1978) is that social support has a stress-buffering function and that strong ties are important in providing support and succour, providing there is not conflict within the network. But building on the argument of Granovetter, for instance, that weak rather than strong ties are the means whereby individuals find new information or can access diverse parts of the social world, seeking help from appropriately trained health professionals may be inhibited, not facilitated, by strong tie networks (Kalish et al., 2006). An example of the value of weak ties operating might be the result noted earlier from Tjihuis et al. (1990), that having acquaintances who worked in mental health was predictive of help-seeking. In other words, while strong tie partners may provide levels of emotional and practical support, at the same time they may promote mental ill-health. It is well-established that the collection of strong tie partners will tend to be more close-knit and group-like, with consequent effects on conformity, opinions and behaviours. So depending on the norms and attitudes among strong tie partners, there may be an encouragement of, for example, substance misuse, and discouragement of help being sought from health and mental health professionals. In short, strong-tie networks may function as a barrier to help-seeking. Acquaintances (weak tie partners), on the other hand, are likely to display a more diverse range of attitudes towards mental health issues, and thereby provide access to information about the whereabouts and availability of appropriate care for mental health problems. Rural studies have not looked at this issue but it might be expected to be even more important than in urban areas: in rural areas it is more likely that work, social and sporting activity networks overlap, while in urban settings these networks might be quite separate.

It is clear that sociodemographic and illness factors are important, but individual attitudes and socially influenced (collective) attitudes appear also to be important. We need to develop a comprehensive approach to understanding barriers to help-seeking and further investigate factors such as social networks and social support, stigma, stoicism and self-efficacy in both urban and rural contexts, and their

possible variation by location. The health and place literature provides one such framework for a more comprehensive approach to understanding barriers to help-seeking (Fraser et al., 2005; Macintyre, Ellaway, & Cummins, 2002). Compositional characteristics relate to the characteristics of the individuals who are resident in a place, such as age, sex, relationship status, and personality. Contextual characteristics focus on the special characteristics of rural areas and include availability, type, and accessibility of health-care professionals and services. Collective characteristics concern sociocultural and historical characteristics, for example, the rural ideology of stoicism. Using this kind of framework we can look at barriers to help-seeking in particular contexts. To take two examples, general attitudes to help-seeking and help-seeking from a GP may be different in various locations, and perceived stigma might be more a potent influence in some areas, for example, small towns, than others. To consider a third example, stoicism may be an important variable in some settings where the ideology drives this and/or the lack of services necessitates this. Arguably, and following on from this, if we found differences between locations, then we would need different intervention foci in different areas, for example, if a culture promotes stoicism then the emphasis might be more appropriate on helping people see that it is both important and acceptable to show/feel emotions and seek help for problems of an emotional kind.

Studies of help-seeking for mental health problems in rural populations have focused on seeking help from GPs. This is all the more important given that GPs are the major providers of mental health care in rural areas. Believing a GP would be helpful was predictive of help-seeking by rural residents. However, the question is if a respondent believed that a GP was not useful: was this because of their own experiences at the hands of a particular GP, that of their family or friends, or was it due to stigmatising attitudes they hold generally about doctors or mental health professionals and/or mental disorder? This finding needs to be unpacked and we need to understand more about the factors that contribute to whether or not a person believes a GP will be helpful or not with mental health problems. One possible lead is provided by Bayer and Peay (1997), who found that GPs who are known individuals in a small community may be more acceptable service providers.

There is a further issue: within the Australian context radical change has occurred. From 1 November 2006 Medicare funding became available for clinical psychologists (Prime Minister of Australia, 2006). This change may lead to an increase of clinical psychologists in private practice in rural, remote and urban areas. If there is an increased

availability of specialist providers in rural locations will people choose to attend clinical psychologists or will stigma be a factor, as in the Hoyt et al. (1997) study? Similarly, does it matter who are the health providers? For example, are men more likely to attend a GP, as opposed to a clinical psychologist? These questions should be a very important focus of research into help-seeking for mental health problems.

Ultimately, the existing literature on help-seeking for mental health problems is at an early stage of development and is limited by the absence of an agreed framework. There are many unanswered questions, but it is clear that psychological and attitudinal variables are worthy of much more exploration. Stigma appears to be an important influence on help-seeking in rural areas, as do rural values of stoicism and self-efficacy, but more quantitative and qualitative research (perhaps involving focus groups) needs to be conducted with these variables in both rural and urban areas.

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