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Original Research

Barriers to mental health help-seeking - rewriting the narrative for rural communities

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Abstract

Introduction: Rural communities face significant mental health challenges, including high risk of suicide and poor mental health outcomes. In examining these challenges, research to date has focused on the attitudinal barriers rural people experience when accessing services, yet minimal research has examined these barriers in the context of rural and urban differences. The present study aimed to address this gap by comparing rural and urban populations on various attitudinal barriers and mental health outcomes as well as identifying the unique challenges of rural mental health.

Methods: A total of 527 Australians from rural, regional and urban locations participated in an online convergent mixed-methods questionnaire. Research aims were explored using a series of multivariate analyses of variance and content analysis.

Results: Results found both rural and regional people reported greater levels of wellbeing than urban people, with rural people reporting significantly higher levels of psychological distress than urban people. Rural and regional people also demonstrated higher

levels of mental health literacy, lower levels of personal stigma and, overall, more positive attitudes to mental health than their urban counterparts. Qualitative results indicated that service accessibility was a prominent barrier for rural and regional people accessing support.
Conclusion: The results offer novel insights into the barriers impacting rural people's ability to seek mental health support and provide specific targets to better address mental health service access challenges in rural communities. Recommendations are made for future research and policy to focus on improving service access in rural communities.

Keywords

Australia, barriers, help-seeking, mental health, mental health literacy, rural, stigma.

Introduction

Rural Australians continue to experience significant mental health challenges, including higher suicide rates[1,2], and poorer mental health outcomes[3], compared to their urban counterparts. These challenges remain despite similar mental health diagnosis prevalence rates across geographic locations[4]. The discrepancy between rural and urban people can be understood by the barriers they face in seeking mental health support[5]. These barriers are often described as being either internal (eg attitudes, beliefs, opinions) or external (eg clinician and service availability)[6]. In general, rural people have less access to mental health services, including those of psychologists, compared to urban people[7,8]. However, a qualitative systematic review conducted by Cheesmond et al indicated that various internal barriers – such as high rates of stigma, lower mental health literacy, and stoicism – also impact rural people's ability to seek mental health support[9].

External barriers

Broadly, there are fewer health professionals in rural areas than in urban areas, with health service access a significant issue for rural communities[10]. Levesque et al posit that there are five domains for understanding healthcare access: approachability, accessibility, availability and accommodation, affordability and appropriateness[11]. Specific to Australian rural health care, various strategies have been employed to improve access across these domains. For example, rural generalist programs have been created for general practitioners, nurses and allied health professionals to ensure clinicians are adequately trained for rural practice[12-14]. Rural-based placements and incentivised programs have been used to encourage more practitioners to take on rural-based work and increase service availability[12,15,16]. In order to improve healthcare affordability for all Australians, the government expanded bulk billing incentives for GPs[17]. Also, many health services have adopted digital health initiatives to improve overall accessibility for rural communities[18]. Despite these initiatives, disparities in health outcomes and service access, particularly mental health, continue to exist between rural and urban communities[3,7,8]. Levesque et al further suggest that healthcare accessibility also corresponds with communities' ability to interact with services – specifically in their ability to perceive, seek, reach, pay and engage with services[11]. Through this lens, rural mental health access may also be explored through communities' internal barriers.

Internal barriers

Internal barriers to service access can include a range of attitudes and knowledge relating to mental health and wellbeing, including stigma and mental health literacy. Stigma is conceptualised as encompassing a range of negative beliefs and attitudes to mental health and help-seeking, depending on the type of stigma described[19]. Stigma overall presents as one of the most common internal barriers discussed in the literature, including perceived stigma (beliefs about the negative attitudes of others)[9] and personal stigma (personal beliefs regarding mental health)[20].

While people living in both urban and rural areas are likely to experience stigma[21], globally it is discussed as a significant barrier experienced by rural people in particular[22]. This may, in part, be due to stigma and other negative attitudes to help-seeking often discussed in the context of the rural identity[9]. Traits such as stoicism, self-efficacy and an overall culture of self-reliance have been found to impact rural people's ability to seek help[5,23,24]. Likewise, rural samples have demonstrated lower psychological openness (the propensity to both acknowledge and discuss mental health issues[25]), and a lower intention to seek help[26].

Mental health literacy refers to the application and understanding of mental health knowledge[27]. In Vayro et al's study examining mental health help-seeking among farmers[20], rural participants shared their beliefs that though overall mental health awareness had improved, recognising mental health issues remained a challenge. Similarly, research has indicated that identifying where and how to access mental health support presents as a particular barrier for rural people[9,28]. Despite limited research suggesting mental health literacy may be lower in rural communities[29], overall minimal differences have been found between rural and urban groups when interpreting and identifying possible signs of a mental health disorder[30-32]. Whether rural communities experience differing levels of mental health literacy appears to depend on the way in which this barrier is defined and assessed, with overall inconsistencies in both methods and outcomes observed in the literature.

The research investigating these internal barriers appears to be limited to examining rural people as a single group, with few studies directly comparing urban and rural differences[25,26,31,33]. Current research that has explored rural–urban differences in mental health attitudes suggests that, in Australia, internal barriers to mental health help-seeking are not unique to rural people. In examining attitudinal barriers among older adults, Knight and Winterbotham found no difference in experienced stigma across regional locations, with differences in internal barriers overall lower for rural people than expected[33]. Likewise, rural and urban people have been found to experience comparable levels of both personal and perceived stigma[31]. Batterham et al suggested that urban and rural people experience similar levels of help-seeking and perceived need for help[34]. Furthermore, despite rural people having less access to psychological services, overall rates of professional service use (eg general practitioners and social workers) were the same as for urban people[34]. Kaukiainen and Kõlves found stoicism and negative attitudes to help-seeking impacted help-seeking intentions in both rural and urban groups[26].

The present study

Overall, these findings suggest a lack of understanding of the unique barriers faced by rural people when accessing mental health support. The limited research directly comparing urban and rural differences often examines a specific subpopulation or help-seeking attitude rather than the Australian population or help-

seeking barriers more broadly[25,26,30,31,33]. Accessibility barriers, specifically relating to service availability, have been well documented in rural areas[10]. However, further research is required to better understand the unique internal barriers faced by rural people across Australia, as such barriers have implications for both future health promotion efforts and service allocation. Rural health outcomes are often examined in comparison to urban outcomes, by way of identifying and quantifying geographic health disparities[8]. In order to address these disparities, rural–urban differences require greater exploration.

The present study aimed to extend previous rural mental health research by sampling both rural and urban populations and comparing across internal barriers and mental health outcomes, while also examining rural people's perceived barriers to help-seeking. By measuring barriers across the broader Australian population, the present study aimed to better understand why rural people experience poorer mental health outcomes than urban people[3]. Due to the limited prior research comparing rural and urban populations[25,26,31,33], the present study adopted an exploratory approach rather than one driven by specific hypotheses. The primary aim of this study was to investigate differences in rural and urban populations across various internal barriers, specifically stigma, mental health literacy and attitudes to help-seeking. A secondary aim was to understand differences in mental health outcomes, including wellbeing and psychological distress, within these populations. Third, this study aimed to identify rural people's perceived barriers to mental health help-seeking.

Methods

Demographics

A total of 527 Australian adults completed the study, with 219 (42%) from metropolitan areas, 206 (39%) from regional areas and 102 (19%) from rural/remote areas. See Table 1 for participant demographics.

Participants were asked to provide their postcode, age, gender, employment status, education and cultural background. Rurality was classed using the Australian Statistical Geographical Standard Remoteness Structure[35]. Postcodes that were partially within the Major Cities or Inner Regional categories were classified as urban and regional, respectively. All remaining postcodes were classified as rural.

Table 1: Study participant demographics (*N*=527)

Characteristic	Variables	Urban *n* (%) or mean±SD	Regional *n* (%) or mean±SD	Rural *n* (%) or mean±SD
Location		219 (42)	206 (39)	102 (19)
Age (years)		51.0±16.5	57.3±15.6	54.1±14.3
Gender	Female	102 (46.6)	120 (58.3)	73 (71.6)
	Male	117 (53.4)	83 (40.3)	27 (26.5)
	Non-binary/third gender	0 (0.0)	1 (0.5)	2 (2.0)
	Prefer not to say	0 (0.0)	2 (1.0)	0 (0.0)
Aboriginal/Torres Strait Islander status	Does not identify	218 (99.5)	203 (98.5)	94 (92.2)
	Aboriginal/Torres Strait Islander	1 (0.5)	3 (1.5)	8 (7.8)
Employment status	Working full time	86 (39.3)	33 (16)	27 (26.5)
	Working part time	47 (21.5)	45 (21.8)	17 (16.7)
	Unemployed	7 (3.2)	10 (4.9)	8 (7.8)
	Homemaker/stay-at-home parent	14 (6.4)	15 (7.3)	7 (6.9)
	Student	8 (3.7)	3 (1.5)	3 (2.9)
	Retired	48 (21.9)	77 (37.4)	24 (23.5)
	Other	9 (4.1)	23 (11.2)	16 (15.7)
Education	Primary	1 (0.5)	1 (0.5)	0 (0.0)
	Secondary	47 (21.5)	51 (24.8)	25 (24.5)
	Vocational	40 (18.3)	54 (26.2)	29 (28.4)
	University	100 (45.7)	74 (35.9)	37 (36.3)
	Graduate or professional degree	30 (13.7)	26 (12.6)	11 (10.8)

SD, standard deviation.

Measures

Internal barriers to access

Internal or attitudinal barriers to mental health access were measured using three questionnaires relating to mental health literacy, stigma and attitudes to seeking help.

The Mental Health Literacy Scale[36] is a 35-item univariate scale measuring knowledge of mental health and mental health support. Responses using a four-point Likert scale are scored from 1 ('very unlikely/unhelpful') to 4 ('very likely/helpful'), and responses using a five-point Likert scale are scored from 1 ('strongly disagree/definitely unwilling') to 5 ('strongly agree/definitely willing'). This scale has demonstrated high internal consistency (α=0.87) and test–retest reliability ($r(69)=0.80$, $p<0.001$), and has been found to be a valid measure in differentiating between mental health professionals and a community sample[36]. It demonstrated high internal consistency in the present sample (α=0.91)[37].

The Depression Stigma Scale[19] is an 18-item scale measuring stigma associated with depression across two subscales: personal stigma and perceived stigma. Responses are scored using a five-point Likert scale from 0 (strongly disagree) to 4 (strongly agree). This scale has demonstrated adequate internal consistency (α=0.78) and test–retest reliability of both the personal stigma subscale ($r(435)=0.71$, $p<0.001$) and the perceived stigma subscale ($r(434)=0.67$, $p<0.001$)[19]. In the present sample, internal consistency was high for both the personal stigma subscale (α=0.89) and the perceived stigma subscale (α=0.90)[37].

The Inventory of Attitudes Toward Seeking Mental Health Services[38] is a 24-term scale measuring attitudes to seeking help across three internally consistent subscales: psychological openness, help-seeking propensity and indifference to stigma. Responses are scored using a five-point Likert scale from 0 ('disagree') to 5 ('agree'). This scale has demonstrated adequate test–retest reliability (r=0.85, p<0.01) and internal consistency (α=0.87), with high internal consistency in the present sample (α=0.89)[37]. It has been found to be a valid measure for differentiating between those who have previously used or intend to use professional support in the future and those who have not[38].

Wellbeing

Wellbeing was measured using two questionnaires. The World Health Organization Wellbeing Index (WHO-5)[39] consists of five positively worded items that assess subjective wellbeing using a six-point Likert scale from 0 ('at no time') to 5 ('all of the time'). The WHO-5 has demonstrated high internal consistency (α=0.90)[40], with high internal consistency in the present sample (α=0.93)[37]. The WHO-5 is recognised as an appropriate tool for comparing wellbeing between groups and has demonstrated good validity when screening for depression[39].

The Kessler Psychological Distress Scale (K10)[41] is a 10-item questionnaire, measuring non-specific psychological distress. Responses are scored using a five-point Likert scale from 1 ('none of the time') to 5 ('all of the time'). The K10 has demonstrated high internal consistency (α=0.93)[41], with high internal consistency in the present sample (α=0.95)[37]. The K10 has been found to be a valid measure when differentiating between clinical and non-clinical groups[42]. For interpretation purposes in the present study, scores were categorised into four levels of distress, represented as low (10–15), moderate (16–21), high (22–29) and very high (30 and greater)[43].

Service accessibility

Participants were asked to respond to two open-ended questions relating to service accessibility: 'What are the barriers to you accessing mental health services in your community, if they were needed?' and 'What would make it easier for someone in your area to access mental health services?' Though all participants were invited to complete the questionnaire in its entirety, only regional and rural participants' textual responses were included in analysis. Barriers specific to regional and rural areas were of particular interest for the present study, and open-ended questions directly related to the third aim regarding rural people's perceived barriers to mental health help-seeking.

Procedure

The study consisted of an online convergent mixed-methods questionnaire, accessed at Qualtrics (Qualtrics; https://www.qualtrics.com [https://www.qualtrics.com]). The questionnaire included a series of scaled and open-ended questions to explore the research questions regarding wellbeing and barriers to seeking mental health services. Adults aged 18 years and over were eligible to participate. Participants were recruited using an online data collection agency (Online Research Unit), community networks and social media (eg Facebook). Participation in the survey was voluntary, with those recruited by Online Research Unit receiving a notional credit for their involvement. Participants read the information sheet and provided implied consent prior to completing the questionnaire. Data were collected from February to July 2024.

Statistical analyses

Quantitative analysis

Analyses were performed using the Statistical Package for the Social Sciences v29 (IBM Corp; https://www.ibm.com/products/spss-statistics). Differences in barriers between rural, regional and urban participants were examined using a one-way between-groups multivariate analysis of variance (MANOVA), with participant location as the independent variable and stigma, mental health literacy, and mental health help-seeking attitudes as the dependent variables. A second one-way between-groups MANOVA was conducted to examine the relationship between participant location and wellbeing, with participant location as the independent variable, and wellbeing and psychological distress as the dependent variables. A total sample size of 63 was required to detect a hypothesised effect size of f=0.15 in a one-way between groups MANOVA with three groups and up to three variables (α=0.05, power=0.90; G*Power v3.1 (Heinrich-Heine-Universität Düsseldorf; https://www.psychologie.hhu.de/arbeitsgruppen/allgemeine-psychologie-und-arbeitspsychologie/gpower [https://www.psychologie.hhu.de/arbeitsgruppen/allgemeine-psychologie-und-arbeitspsychologie/gpower]))[44]. Additional participant recruitment was required beyond this sample size due to mostly urban participants responding to initial recruitment efforts. Extended and targeted recruitment of rural participants resulted in the larger sample size (N=527).

Content analysis

Reflexive content analysis was employed to further explore barriers specifically pertaining to regional and rural participants. Reflexive content analysis aims to identify categorical information across the dataset, rather than latent or interpretive meaning[45]. This approach allowed for participant experiences to be clearly communicated, while recognising the need for some interpretive flexibility. As per O'Connor and Joffe's recommendations[46], the first author completed the majority of coding, with a second coder participating in a portion of the initial coding and reviewing codes as necessary. Both coders were researchers and practitioners with training in clinical psychology. Subsequent categories were created by the first author and reviewed by the research team. This approach allowed for ongoing clarification and discussions regarding categories, subcategories and codes, encouraging reflexivity in analysis[45,46].

Ethics approval

Ethics approval was provided by the University of New England's Human Research Ethics Committee (approval number HE23-159).

Results

Quantitative results

The first MANOVA, examining internal barriers across rural, regional and urban locations, indicated a significant effect of participant location on the combined dependent variables (F(6, 1046)=11.48, p=0.001, partial η^2=0.06). Univariate analyses indicated that although overall stigma did not differ between groups, both mental health literacy and attitudes to help-seeking were statistically significant at a Bonferroni adjusted alpha level of α=0.017. Specifically, rural and regional participants both demonstrated significantly higher mental health literacy and attitudes to help-seeking, compared to urban participants. See Table 2 for univariate analyses and descriptive statistics.

Due to both the stigma and attitudes to help-seeking variables containing individual subscales, a further two one-way between-group MANOVAs were conducted to determine if the three groups differed across specific subscales. The MANOVA examining stigma indicated a significant effect of participant location on the combined personal and perceived stigma subscales ($F(4, 1048)=29.19$, $p=0.001$, partial $\eta^2=0.10$), with both subscales also individually significant at a Bonferroni adjusted alpha level of $\alpha=0.025$. Interestingly, though rural and regional participants reported lower levels of perceived stigma than urban participants, they reported higher levels of personal stigma, as evident in Table 2. The one-way between-groups MANOVA examining attitudes to help-seeking indicated a significant effect of participant location on the combined subscales of psychological openness, help-seeking and indifference to stigma ($F(6, 1046)=9.22$, $p=0.001$, partial $\eta^2=0.05$). Univariate analyses of each subscale indicated that though groups did not differ significantly on their attitudes to help-seeking, both the psychological openness and indifference to stigma subscale were significant at a Bonferroni adjusted alpha level of $\alpha=0.017$. Again, rural and regional participants demonstrated greater levels of psychological openness and indifference to stigma, compared to urban participants, as shown in Table 2.

To assess the secondary aim regarding mental health outcomes across location, a further one-way between-groups MANOVA was conducted. It indicated a significant effect of participant location on the combined dependent variables ($F(4, 1048)=9.22$, $p=0.001$, partial $\eta^2=0.87$). Analysis of the dependent variables individually showed significant effects for both wellbeing and psychological distress at a Bonferroni adjusted alpha level of $\alpha=0.025$. Univariate analyses and descriptive statistics are described in Table 2. Both rural and regional participants reported higher levels of wellbeing than urban participants. Interestingly, rural participants also reported higher levels of psychological distress compared to urban participants. Approximately 48% of rural participants indicated a high or very high level of psychological distress[43], compared to 34.7% of urban participants. Regional participants did not differ from either rural or urban participants, with 38.3% also indicating high or very high levels of distress.

Table 2: Descriptive statistics and univariate analyses by location

Characteristic	Variable	Urban† mean±SD	Regional† mean±SD	Rural† mean±SD	*F* (2,524)	*p*-value	η^2
Internal barriers	Stigma	31.2±12.4	29.0±10.3	29.4±9.6	23.03	0.098	0.01
	Mental health literacy	114.3^{b}±17.2	124.9^{a}±14.9	127.3^{a}±15.3	33.61	0.001	0.11
	Attitudes toward help-seeking	57.5^{b}±14.8	640.0^{a}±15.5	65.4^{a}±16.2	13.48	0.001	0.05
Stigma subscales	Personal stigma	13.0^{b}±7.5	8.5^{a}±6.2	7.2^{a}±6.3	34.39	0.001	0.12
	Perceived stigma	18.2^{b}±6.5	20.5^{a}±7.2	22.1^{a}±7.1	12.52	0.001	0.05
Attitudes subscales	Psychological openness	17.2^{b}±6.0	20.8^{a}±6.3	21.8^{a}±6.3	26.62	0.001	0.09
	Help-seeking	20.9±5.8	21.9±6.2	22.5±5.7	2.99	0.051	0.01
	Indifference to stigma	19.4^{b}±6.4	21.3^{a}±6.9	21.1^{a}±7.6	4.64	0.010	0.02
Mental health outcomes	Wellbeing	59.1^{b}±22.0	69.3^{a}±27.2	73.4^{a}±26.8	14.48	<0.001	0.05
	Psychological distress	19.8^{b}±8.8	20.9^{ab}±9.4	23.4^{a}±10.2	5.12	0.006	0.02

† Different superscript lowercase letters in the same row indicate statistically significant difference ($p<0.05$).
SD, standard deviation.

Content analysis results

Of the 308 regional and rural participants included in the overall study, 268 responded to the open-ended question relating to barriers, and 236 responded to the question relating to improvements to access. Responses for each group were initially coded separately, then combined for analysis and interpretation due to similar codes and categories emerging across the two groups. Four main categories emerged across both questions: service availability, administrative barriers, individual factors and rural factors. A proportion of respondents ($n=49$) indicated they experienced no barriers to accessing mental health services. Frequencies and percentages of categories are included in Table 3.

Table 3: Rural and regional participants' perceived barriers to service access

Category	Example codes	Barriers to service access (*n*=268) *n* (%)	Ways to improve service access (*n*=236) *n* (%)
Service availability	Lack of services / More services, wait times, availability, continuity of care	166 (62)	179 (76)
Administrative barriers	Obtaining a referral, finances, technology	97 (36)	86 (36)
Individual factors	Knowledge of services (available), help-seeking barrier/stigma	70 (26)	65 (28)
Rural factors	Confidentiality, travel, distance	66 (25)	31 (13)
No barriers / Improvements to access		49 (18)	4 (2)

Service availability

A dominant category across both questions related to service availability. Over half of rural and regional respondents indicated that an overall lack of services available in their community was a barrier to accessing mental health support. For services that could be accessed, long wait times, staff shortages and limited availability presented as further barriers. In improving access, the majority of respondents suggested a need to increase services and service availability. For example, 'If we had the clinicians here physically … If there was a service for the missing middle that aren't seen as acute enough for admittance or follow up support from community services' (participant 363) and 'having a person face to face locally that people can get appointments for' (participant 352).

Administrative barriers

Respondents indicated that factors such as finances, obtaining a referral and utilising technology also presented as barriers to access. One respondent reported, 'Psychiatry is unaffordable and difficult to access. Psychology services are accessible, however, under a mental health plan there is only very limited access to these services per year' (participant 508). Likewise, in improving access, suggestions were made for a less complex and more affordable mental health system, such as 'easier intake processes' (participant 344) and 'visible services and clear options for referrals to services' (participant 505).

Individual factors

Individual factors encompassed responses relating to attitudes, experiences, perceptions and knowledge of services, and capacity to access services (eg individual availability), such as, 'No idea if they even exist, much less accessing them' (participant 432) and 'just being aware of the tipping point where I think it's necessary' (participant 395). Improvements to access included increasing knowledge of services, such as 'a website or app that gave you information on who would best suit your needs' (participant 281) and reducing help-seeking barriers: 'higher profile people in the community being open and honest about their struggles' (participant 501).

Rural factors

Rural factors related to the geographical (eg travel and distance) and social challenges (eg confidentiality) unique to rural communities. Though it presented as a barrier for respondents (such as 'having to travel a long distance to the nearest town to seek professional help'; participant 486), in relation to suggestions to improve access, this category was less prominent, with only some respondents indicating that having closer and more confidential services would improve accessibility.

Discussion

Greater understanding of mental health help-seeking barriers across Australia is required in order to better address mental health needs, particularly in rural communities. The present study explored differences in barriers for rural, regional and urban participants. A secondary aim was to understand differences in wellbeing and psychological distress among rural, regional and urban populations. A third aim was to identify rural and regional participants' perceived barriers to help-seeking. Both regional and rural people reported higher levels of wellbeing than urban people, while rural people, though not regional, also reported higher levels of psychological distress than urban people. Both regional and rural people indicated overall fewer internal barriers than urban people, demonstrating greater mental health literacy, lower levels of personal stigma and more positive attitudes to help-seeking. It is noteworthy that regional and rural people reported greater levels of perceived stigma, indicating a nuanced understanding of how stigma may impact these groups. Qualitative results suggested that rural and regional people perceived service availability as a prominent barrier to service access.

Wellbeing and psychological distress

The high level of psychological distress found in rural respondents, compared to urban people, was consistent with previous literature[47,48]. It is noted that the proportion of people across groups who reported high to very high levels of distress (38.7%) was well above recent national estimates of 16.7%[49]. This high level of distress may be partially explained by the use of the online questionnaire encouraging more honest responses[50] and is consistent with the high levels of distress reported in similar Australian-based studies[51]. Conversely, rural and regional people demonstrated higher levels of wellbeing compared to urban people, despite overall mental health diagnoses typically observed equally across geographic locations[4]. The overall mental health profile of rural people, such that nearly one in two were highly distressed, and yet had higher levels of wellbeing than urban people, was unexpected. Though further research is needed to explore this finding specific to rural populations, similar mental health profiles have been discussed in prior research[52].

Greenspoon and Saklofske suggest that a person's mental health is made up of two distinct constructs: psychopathology (such as psychological distress) and subjective wellbeing[52]; the two operate differently depending on individual internal and external challenges[53]. People high in both psychopathology and wellbeing, such as the rural group in the present study, are described in the literature as 'symptomatic but content', with their psychopathology typically determined by health professionals rather than themselves[52]. This description is consistent with findings that suggest rural people are more likely to acknowledge their general wellbeing and mental health, rather than mental health issues or specific symptomatology[54]. For example, previous research by Handley et al found that some rural people high in psychological distress were less likely to self-identify experiencing a mental health problem or seek mental health support[32]. Though their finding may be framed as a health literacy or attitudinal barrier, it is possible that their participants fit the 'symptomatic but content' profile observed in the present study, whereby participants acknowledged their distress as separate from their mental health or wellbeing.

People high in wellbeing and distress have been found to engage in similar levels of supportive relationships as those high in wellbeing but low in distress[55]. Having social support and a sense of community and belonging positively impacts a person's wellbeing[22,47], more so than it reduces psychological distress[56]. Rather, adversity appears to be the key impact to psychological distress, regardless of social support or wellbeing[56].

Taken together, the link between adversity and psychological distress may help understanding of the current mental health landscape in rural communities. The rural adversity model, which applies an ecological lens to understanding rural mental health, describes the intersectionality of adverse events on environmental, community and individual mental health and wellbeing[57]. Specifically, these rural communities are exposed to significant adversities, such as greater financial hardship, due to lower incomes and higher unemployment, higher levels of family and domestic violence and greater health risks – yet less access to health care[1]. The impacts of climate change and increased risk of natural disasters have significant impacts on both agricultural and economic activity, particularly in rural areas[58], leading to environmental and financial-related stressors[59]. Despite these adversities, rural communities have been found to have greater social networks and cohesion compared to urban communities[60]. Although not measured in the present study, these rural-specific environmental and social factors may provide a possible explanation for the mental health profile of the rural group.

Attitudes to mental health

Quantitative results of the present study indicated that rural and regional people reported higher levels of mental health literacy compared to urban people. Though these results are consistent

with the perception that rural people's mental health awareness has improved, particularly given increased mental health promotion campaigns and efforts[20], the difference from the urban population is unexpected. Likewise, the finding that rural and regional people have overall more positive attitudes to help-seeking, and lower personal stigma, has not yet been found in the literature. Rather, these results are relatively inconsistent with the literature regarding rural attitudes to mental health, in which stigma and other such attitudes are discussed as significant barriers to help-seeking[9,25]. Considering the dearth of research comparing rural and urban communities in relation to internal barriers, an argument could be made that, by examining rural communities in isolation, these factors have become synonymous with rural mental health, rather than with mental health more broadly. Australia itself is one of the largest contributors to the literature regarding mental health in agriculture[61], and yet minimal research appears to have investigated how the mental health of this population, and indeed the broader rural population, differs from urban samples.

In the present study, personal stigma was found to be lower in the rural/regional groups, while perceived stigma was found to be significantly higher than in the urban group. Griffiths et al suggested that increased exposure to depression psychoeducation (through media and mental health campaigns) may actually increase perceived stigma and create an overestimation of stigmatising beliefs[19]. Level of exposure to such campaigns between urban and rural locations is difficult to quantify, and was not examined in the present study; further research is needed to assist in understanding the differences found in the rural/regional and urban groups. Nevertheless, the results of the present study suggest that although rural people are less likely to experience stigma themselves, they do believe other people are more stigmatising toward mental health, providing a nuanced understanding of how stigma operates in rural communities. Given the social connectedness of many rural towns, such a finding underscores the importance of community-based initiatives aimed at reducing stigma and supporting community members' mental health and wellbeing[62].

Perceived barriers

Qualitative results indicated that rural and regional people perceive service availability as a barrier to help-seeking. This finding is consistent with data demonstrating that rural communities have significantly less access to mental health services than major cities[8]. Likewise, even when services are available, the resources required to navigate a complex mental health system remain a common barrier for rural people[63,64]. Consistent with the quantitative data gathered in this study, though inconsistent with prior research[9,26,64], the textual responses indicated that rural and regional people did not identify common attitudinal barriers to service access. Though a small number of respondents indicated help-seeking barriers, categories primarily centred on external barriers, with most respondents recommending a focus on increasing service availability to improve access.

Clinical implications

Although stigma and other negative attitudes to mental health are likely still significant barriers to mental health help-seeking, the findings of the present study indicate that these are not unique to rural communities. Rather, the high degree of psychological distress reported by rural people in the present study, coupled with the perception of limited service availability, indicates a strong need to adequately address mental health issues in rural communities. Currently, rural people may be more able to access support from a GP, rather than from a psychologist or specialist mental health clinician[34]. Rural people are also less likely to receive a mental health diagnosis or subsequent treatment and are at greater risk of suicide[2].

Considering the results of the present study, the challenges of rural mental health appear to be better understood through a person's access to services, rather than through their attitudes. Continuing to describe barriers in the context of such attitudes may further stigmatise rural communities and detract from other barriers such as service access. Health promotion efforts that encourage rural people to reach out if they need support are unlikely to be effective if there are no support services to reach out to. Indeed, the lack of mental health services in rural areas is well recognised, with significant literature and policy advocacy dedicated to this issue. For example, the Orange Declaration[65] put forward 10 solutions to improve service access and mental health and wellbeing in rural and remote areas. The present study emphasises the importance of ongoing research to further address access barriers and improve the understanding of the mental health service needs of rural communities. For policy and health providers, this may mean that continued focus on increasing access to mental health services is required.

Limitations and directions for future research

There were some limitations in the present study. The rural sample comprised a high proportion of women, which may have impacted some results. Women, on average, report higher levels of psychological distress compared to men[4], and in rural areas men have reported lower help-seeking intentions than women[26]. The overall sample was older and more highly educated than the median population[66], potentially limiting the generalisability of findings to a broader sample. To this end, results and implications should be interpreted with some caution. Further research is needed to investigate the replicability of the present study's findings across demographic and geographic locations.

Furthermore, additional internal barriers linked to the rural identity, such as stoicism and self-efficacy[9], were not directly assessed in the present study. These barriers are often discussed in the context of farming populations[24] and, given the present study focused on broader community comparisons, were not included in data collection. Future research may consider examining these barriers, alongside the barriers investigated in this study, among farming and urban populations to determine if they are indeed unique to rural farmers or a barrier experienced regardless of location and occupation.

Conclusion

The present study provided a novel understanding of mental health in rural, regional and urban locations by broadly examining both barriers and mental health outcomes across a sample of the Australian population. Although rural people reported greater levels of psychological distress, both rural and regional people reported greater levels of wellbeing, higher levels of mental health literacy, lower levels of personal stigma and more positive attitudes to mental health help-seeking compared to urban people. Service availability was identified as a prominent barrier to accessing support, with the majority of rural and regional respondents indicating a need to increase mental health services. This finding suggests that the current understanding regarding attitudinal barriers as a contributor to poorer mental health outcomes may not be unique to rural locations. Rather, future

research should focus on service access as a primary barrier for rural people in order to inform mental health policy and reform directed at these areas.

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Conflicts of interest

The authors have no conflict of interest to disclose.

AI disclosure statement

No generative AI or AI-assisted technologies were used in the creation of this work.

Data availability

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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