Mental Health & Prevention 36 (2024) 200378

Contents lists available at ScienceDirect

Mental Health & Prevention

journal homepage: www.elsevier.com/locate/mhp

Experiences of people referring to a rural school-based mental health support service for young people: A qualitative study

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ARTICLE INFO

Keywords:
Rural mental health care
Schools
Young people
Model of care
Referral

ABSTRACT

Background: Healthcare provision across rural and remote areas is challenging, requiring adaptability and careful management of scarce resources. In Western New South Wales (NSW), Australia, youth mental health services have been identified as a priority. Rural schools are well-placed to address some of these barriers and facilitate access to mental health services. This study explores the experiences of people referring to an innovative school-based mental health support service in western NSW for young people aged 12-25, and their perceptions of the benefits and challenges of the service.

Methods: A qualitative descriptive approach was used to explore the experiences of people who had made referrals to the service. Eight semi-structured interviews were conducted, with data analysed deductively.

Results: The participants described the rural mental health service's model of care as the overarching feature which facilitated access to mental health care for young people. The model of care was described as easy to access, flexible, and offering quality service delivery. Suggestions for improvement included making the service more inclusive for young people after they leave school and finding ways to address staffing challenges to ensure consistency of service delivery.

Conclusions: Locating services in schools makes mental health support accessible and convenient for users. Participants reported high satisfaction with referring to the service, and positive school-related outcomes for young people. This small study supports the expansion of school-based mental health services which could be rigorously evaluated.

1. Background

Healthcare availability and access in rural areas is a global challenge. Rural and remote locations require adaptability and ingenuity in an environment of scarce resources (Allan, 2018). The World Health Organisation recommends a range of policy and practice initiatives for supporting rural health care provision in high income countries including financial incentives, rurally-based education experience and personal and professional supports (Russell et al., 2013). The OECD has long suggested that health care distribution problems need to be addressed using place-based solutions, service delivery innovation, and resource pooling to find acceptable solutions (OECD, 2006). Governments and their public health services must find ways to operationalise policy recommendations for rural healthcare that are practical and cost-effective.

In Australian rural and remote areas that have long distances, low referral rates and few specialist staff, service delivery is typically organised around fly-in-fly-out or drive-in-drive-out staff who visit on a fortnightly to quarterly basis (Allan, 2018; Gallego et al., 2015). To monitor and fund a more place-based approach the Australian government established thirty-one Primary Health Networks (PHNs) across the country to identify location specific health needs and coordinate services to meet them. In the Western New South Wales PHN 2019-2022 Health Needs Assessment, the most important need for action identified was for mental health services including suicide prevention. Young people are a priority within this area of need (Western NSW Primary Health Network, 2020).

Mental health concerns are a significant problem in Australia. A national Australian youth mental health survey conducted in 2020 found that over one in four (26.6%) respondents reported psychological distress (Brennan et al., 2021). Groups more likely to be distressed included females, non-binary young people, First Nations Australians

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https://doi.org/10.1016/j.mhp.2024.200378
Received 21 June 2024; Received in revised form 9 November 2024; Accepted 12 November 2024
Available online 14 November 2024

and those with a disability (Brennan et al., 2021). Importantly, the national survey did not analyse results by rurality omitting the context specific circumstances of young people in rural areas. However, an earlier survey found that Australian young people living outside capital cities are more at risk of mental illness than those living in capital cities, and risk of suicide increases with remoteness (Lawrence, 2015). There is also evidence that the lower the mental health treatment capacity in an area, the greater the risk of suicide in young people (Goldstein et al., 2022). In rural Australia, the mental health challenges of young people are exacerbated by mental health workforce shortages and the difficulty of accessing appropriate services (Policy Writing Group., 2020).

The national youth mental health survey identified that young people found the key barriers to seeking support were: not knowing where to go, embarrassment, competing responsibilities, lack of transport, lack of services and lack of available appointments (Brennan et al., 2021). Schools are ideally placed to address some of these barriers for school-aged young people because they have sustained and significant contact with young people over several years (Simon, 2015). However, teachers who have the most contact with students have limited knowledge or training in responding to mental health concerns, and limited time in their educator role (Henderson Smith et al., 2023). Professional mental health expertise is required. In rural areas where mental health services are limited, support for teachers and for the young people they are concerned about is difficult to access. Schools as an accessible site of mental health services has been suggested for decades e.g. (Salmon & Kirby, 2008). However, funding and supply of rural mental health services for young people is piecemeal and subject to funding and policy changes (Smith, 2018). In Australia where health and education are funded through different government departments, coordination of mental health and school services is challenging.

Many child and adolescent mental health services focus on those with serious conditions requiring specialist treatment (Weist et al., 2023). In practice this means that opportunities for early intervention and mental health promotion are missed (Rickwood et al., 2019). School mental health and psychology programs have been growing worldwide and are associated with improved academic and social outcomes (Splett et al., 2013). In-school resources are limited (Connolly et al., 2024). In Australia, the way school counselling services are provided varies from state to state and according to whether the school is public or private (Campbell, 2017). However, traditionally in-school psychological services have focused on academic assessments, responding to crisis and referrals to outside agencies (Campbell, 2017). More recently schools have employed psychologists and social workers to focus more on mental health care for school students. However, limited research has been conducted on school mental health programs and the practices of school counsellors (Berger et al., 2023). Research on rural school mental health supports is even more limited (Smith, 2018). The high satisfaction of young people and parents with an external agency providing mental health services within Australian rural schools is reported in only one study (Allan & Thompson, 2023).

Rural areas in Australia have significant mental health service delivery challenges. Western NSW is approximately the size of the United Kingdom but has a much smaller and widely dispersed population of 318,000 people living in regional centres, towns, villages and on farms (Western NSW Primary Health Network, 2018). In comparison the United Kingdom has an approximate population of 66 million people. Public community-based health and hospital services are centralised in the larger regional towns with most mental health and other allied health services provided to smaller towns via visiting clinicians on weekly, monthly, or quarterly basis (Gallego et al., 2015). While Covid-19 has accelerated online healthcare provision it remains largely unevaluated in this region (Allan et al., 2021).

In 2018, in response to the need for mental health services for young people and limited availability of existing services in rural NSW, the WNSW PHN commissioned a mental health support service for young people aged 12-25 with targeted funding from the Commonwealth Government. The funded organisation created the Rural Youth Mental Health Service, an outreach model covering a large part of western NSW, providing early intervention mental health services in schools, and linking with other agencies and community networks in twelve small towns in the region. The experiences of young people and carers with this service has been reported elsewhere (Allan & Thompson, 2023). However, given that access to mental health services is typically facilitated by referral from concerned adults, primary healthcare or community agencies, the experience of referrers in enabling mental health support for young people is important to understand how and why a service is used.

The aim of this study was to explore the experiences of people referring young people to this service to identify their experiences of access to rural mental health care and perceptions of the benefits and challenges they perceived for young people and families in having local school-based support.

2. Methods

2.1. Study design

A qualitative descriptive approach was used to explore the experiences of people making referrals to the rural school-based mental health service (Sandelowski, 2010). Qualitative description develops a comprehensive summary of events or experiences using the terms of the interview participant rather than the interpretation of the researcher as would be the case in grounded theory or interpretive phenomenology (Neergaard et al., 2009; Seixas et al., 2018). The role of the researcher in this approach is to compile research participants' accounts of a phenomenon to reconstruct a picture of what has been experienced in multiple sites or on various occasions to identify commonalities and differences (Seixas et al., 2018). In this study the accounts of participants described their experience with referring to the rural service and their perceptions of how it worked in their area.

2.2. Program description

The Rural Youth Mental Health Service was operated by a large national non-government organisation who had won the tender to provide youth mental health services in the western region of NSW. The objective of the service was to provide easily accessible free mental health support for young people aged twelve to twenty-five years with or at risk of mental illness, for as long as they wanted to attend. No diagnosis was required to access this service and referrals could be made by anyone. However, parental consent to attend was required for young people under the age of 16. Staff employed were required to have a relevant under-graduate degree and skills in developmentally appropriate counselling methods. Support and counselling was delivered via one-to one individual sessions and included case management. However, no specific therapeutic methods were mandated. The counselling strategies used by the staff are described from the young people and carer perspective; and included a focus on engagement and rapport building, mindfulness and cognitive behavioural techniques and support to access other specialist mental health and primary health services. These experiences of young people and carers are reported elsewhere (Allan & Thompson, 2023).

The service delivery area was divided into regions with three or four towns in each region where services were provided. Clinicians employed by the service attended each of the towns in their designated region once or twice a week or fortnight, depending on demand. Once established, most services were provided in schools to young people aged between 12 and 18 years. Approximately 200 young people accessed the service annually between 2018 and 2021.

In accordance with the Australian Code for Responsible Conduct of Research (Council, 2018), ethical approval for the study was obtained from the Aboriginal Health and Medical Research Council of

NSW–Human Ethics Research Committee (1830/21).

2.3. Participants and materials

Participant recruitment was facilitated by the service Team Leader who provided email contacts of people from twelve agencies who had made referrals in the preceding 12 months. Referrers were contacted by email to invite them to participate in an interview about their experience with the service. Interviews were conducted between 6 and 24 September 2021. Eight people participated in a phone or Zoom interview and one person provided feedback via email. While the sample was small it was considered appropriate because the phenomenon of interest was experiences with a specific service in a defined area by a specific group of people (Malterud et al., 2016). All participants except one were employed in schools in the region and all had personally made referrals to this service. The other participant was a senior manager in a regional child and adolescent mental health service who had also referred to the service.

The semi-structured interview guide was developed by both authors based on the study aim to explore people's interactions with the service as a referrer. It included open-ended questions such as, "Tell me your role and how you come into contact with young people with mental health concerns?" and, "Tell me about how you work with the service". In addition, prompts were utilised to encourage participants to reflect and expand on their experiences including asking for specific examples of young people they had referred (see supplementary material). Due to COVID-19 restrictions on contact and travel, interviews were conducted by phone or online using Zoom, lasting between 25 and 50 minutes. Interviews were conducted by J.A., a social work researcher with more than twenty years of experience in qualitative rural health research with vulnerable groups, particularly examining the impact of government and service-delivery policies and practices on service users. With the consent of participants, interviews were audio-recorded, professionally transcribed, and de-identified.

2.4. Data analysis

The data analysis was conducted by J.A. and A.T. A.T. is a clinical psychologist with extensive experience working in rural mental health and conducting mixed-methods research. The authors held debrief meetings after every two or three interviews to discuss and make notes on key themes or events described. J.A. manually coded the transcribed data into preliminary themes using a deductive approach based on the interview questions and the field notes. The questions asked of the data included: How was accessing the service described? How were the needs of the young people described? What benefits for young people were attributed to The Service and what challenges were identified? Text from each interview that answered the question was combined and each new document was reviewed for similar details and exceptions. Specific examples of a young person's referral were sought to confirm a theme. The final themes were supported and confirmed through a review of the interview debriefing notes and discussions between J.A. and A.T. to ensure the lived experiences of the participants were reflected in the analysis, consistent with the qualitative description method and to ensure interpretive validity (Houghton et al., 2013; Sandelowski, 2010). In practice this means providing the reader with the participant interpretations of events and experiences rather than a researcher interpreted account that reconstructs narratives according to a theoretical perspective or interpretive meaning (Neergaard et al., 2009; Sandelowski, 2010; Seixas et al., 2018).

3. Results

The rural youth mental health service's model of care was described by participants as the overarching feature that facilitated access to mental health care for young people they had referred. The model of care encompassed several factors. The key themes indicated a model of care that was easy to access, flexible, and provided quality service delivery. Some participants suggested changes that could improve the service, and these are described separately. The letter R and the number after each quote identify the referrer interviewed Fig. 1.

3.1. Theme 1: ease of access

Access to the service was facilitated by *staff*. First, the way staff purposefully connected with young people to build relationships was important. For example, "*She's [staff member] out in the playground chatting with the kids, they know which office she works out of. They trust her" (R1)*. Second, the way people could move into receiving a service was streamlined with few requirements – "*There's a very low-key system, they're not bureaucratic. You don't have to jump through 78 hoops to get an appointment" (R4)*. Third, flexibility was a key element of day-to-day implementation at each site so that people did not have to wait for long periods and last-minute changes could be managed. For example, "*[staff member] will come to me and say, 'I've got a space in period 5, have you got someone for me to see?'" (R7)*. Overall, referrers perceived there was a lack of formality in the model, flexibility in processes and an emphasis on building relationships between staff and young people that facilitated ease of access.

Another factor related to ease of access of the model of care was the *location* of the service within schools. The location of mental health support within a school, during school time was seen to be important for young people knowing it was available, being able to access it without requiring parents or other adults to take them.

> *It was a no-brainer for us.* This service *has been the perfect thing for our school. In a regional area there is limited access to services and parents are unable to always travel to* [other towns] *for access. Having a service that comes to our school and works with our students during school time has been wonderful. (R6)*

Schools facilitated the service's operations on their grounds wherever possible. While space was sometimes noted as a problem it was prioritised by schools because they valued the service: "*We have given her a room, it's next to my office and it's a walk in, walk out, informal sort of thing. Other kids wouldn't even know what they are doing" (*R5).

The location of the service in the school was noted as appropriate for a modern approach to schools as community resources and a benefit to the town as well as young people using the service. "*Schools used to be like private kingdoms but not anymore, they are a community resource." (R2)*. However, the service staff did not just turn up at a location ad hoc. There was a formal process to engage with each school. For example, "*We did the formal MOU and got the legalities out of the way and it's just easy" (R4)*.

The location on school grounds was also noted as a resource to teachers who were unsure what to do for some young people who had complex and chronic problems including attempted suicides and self-harm. One teacher, referring to a referral they had made, noted, *"I feel better knowing she has someone who knows what to do if things escalate again"* (R8).

In summary, ease of access to the service was facilitated by the practices of staff and the location within school grounds at each site.

3.2. Theme 2: flexible processes

The second theme underpinning the model of care was Flexible Processes. This included how referrals were made and the methods of communication used by staff with young people and families and with schools.

Referrals to the service could be made by anyone, including the young people themselves. There was no requirement for a diagnosis or a previous assessment to evidence the need for support. One participant noted "*They have picked up every kid we have referred to them" (R3)*. The

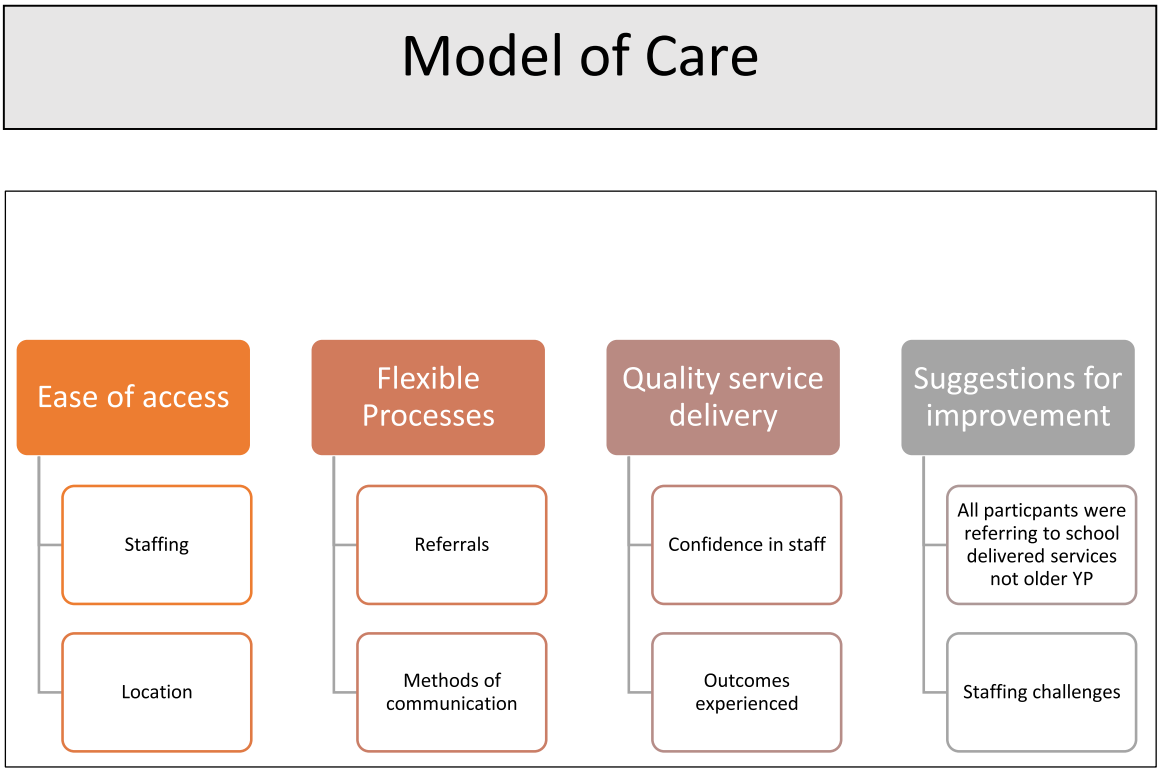

Fig. 1. Study themes describing the rural youth mental health service's Model of Care.

service staff had different ways of signalling their availability, but a common method was attending the school assembly. For example, "*We have daily assemblies and when [*staff member*] is here she just stands up and says, 'I'm in today' and that's all it takes" (R8).*

Participants had confidence that while referrals were easy to make, they were supported by robust processes that provided oversight of what was happening in each location. For example:

> [Service Team Leader] *triages all the referrals and allocates them. That does two things, one is makes sure the kid is getting the right level of service but the other is ensuring the staff are adequately supported and able to do their job safely.* (R4)

The model of care was structured and planned to facilitate referrals. However, one person identified a challenge with the referral form that contradicted other views on both ease of access and flexible processes. This referrer stated, "*the referral form is several pages, its comprehensive but some kids and their families struggle to fill it out" (R3).* Another participant noted that the requirement for young people under the age of 16 years to gain parental consent to attend was a barrier for some young people because "*the parent says that's not necessary or doesn't want their child talking about the family to someone else" (R5).* However, there were no specific examples provided of a service being denied because of these processes.

Several participants noted that *methods of communication* used by staff of the service were appropriate to their audience. For example, using texts to keep in touch with young people was frequently noted; "*I like that they use texts. They keep in touch with children, keep them up to date, and follow-up" (R7).* Communication was maintained with referrers without compromising confidentiality "*They are brilliant at follow-up. They walk that line…I get just enough information to know what's going on but not to break confidentiality" (R1).* Another participant noted that regular communication included service delivery information as well as updates about young people when required – "[Team Leader] *always keeps in touch about staffing, days and follow-up that's required with kids we might have to keep an eye on. It's a godsend" (R2).*

Both referral methods and communication techniques ensured flexible processes shaped the model of care for young people, staff and referrers.

3.3. Theme 3: quality service delivery

This study did not examine the outcomes of interventions provided by the service. However, referrers perceived this service to be of good quality because they had confidence in the staff, and they could describe positive outcomes. Participants had confidence in service staff to be able to deliver the support young people required:

> *The service has filled a gap in our school. I cannot fault the counsellors we have had. As far as I know we haven't had anyone have a session and then go, 'actually I don't want to continue this' and that's because of the great staff.* (R7)

One participant when discussing some traumatic events that had affected the school and the wider community stated: *"We have had some pretty raw and challenging times in our school and [staff member] was outstanding" (R8).* Another participant noted that the service staff became part of the school community – "*For us it's about the person who sits here, who fits in and we can trust she understands the place and the kids" (R5).*

Participants were asked to describe specific examples of ways the service had provided positive outcomes for young people. Each participant gave examples of referrals they had made and changes they saw in the young person involved. For example,

> *I can think of one boy in Year 9 who was suspended a few times last year and he's been working with [the service] last year and this year. He would normally have got really defensive and really angry, really quickly and then would tell you what he thought of you. Whereas now he will stay and he will listen and we don't get those really big angry outbursts. And no suspensions. (R4)*

One participant had linked mental health concerns with poor school

attendance and noted *"The thing I notice most is the improvement in attendance with those kids"* (R1). As teachers, the outcomes most referrers pointed to were changes linked to school performance. However, one participant noted that for a young person who was suicidal the service was able to get her connected with a more intensive child and adolescent mental health service *"that saved her life really"* (R8).

The outcomes referrers had experienced caused them to perceive the service as providing good quality care and gave them confidence that the counselling staff were skilled at addressing the mental health concerns of young people.

3.4. Theme 4: suggestions for improvement

Study participants were mostly positive about the service, its staff and the model of care, whilst also identifying improvements that could be made, such as catering for a wider group of young people outside of school students. Others highlighted that while they perceived the service was effective it did experience staffing challenges typical of rural healthcare services.

All referrers clearly stated that they were lucky to have access to the service, in the context of limited mental health services in the region and patchy and inconsistent service delivery. The need for mental health support in the broader community, for example young people who have left school, was noted by several participants. While the service had an eligible age range of 12 to 25 years most young people accessing the service were school students. *"It's great for us but once a kid leaves school that's it. They are on their own"* (R1). It is not clear from the data how much demand for the service there was from older young people, but participants perceived young people aged 18 to 25 were an underserved group and given the lack of services in rural areas it can be assumed there was an unmet need. For example, *"There's a significant need, a significant need. Mental health services aren't there"* (R4).

Staffing was identified as a key challenge for delivery of the service, impacting service availability and quality:

> *We have had some staff changes with [the service] and some gaps of time with no one. They are all good but of course some are better than others, more independent, better with the kids.* (R4)

One participant noted that the way funding was distributed impacted availability for rural populations:

> *"Organisations like [Not For Profit organisation delivering the service] probably spend a lot of time chasing funding and I wish the government would just go 'we're going to back you in, just go for it' and keep services like this coming. I don't want to sound like Pollyanna but if it ain't broke….." (R8)*

The key suggestion for improvement to the service was expanding the model of care to include young people who had left school. While the target age group included up to twenty-five years of age, the delivery of services within schools effectively precluded non-school attenders from being referred by most of the study participants because they were teachers in schools referring their students. Study participants noted that staffing was mostly appropriate and consistent but highlighted that the service was not immune to rural healthcare workforce shortages. Referrers perceived that staffing would continue to be a challenge for maintaining the model of care.

4. Discussion

Study participants who all referred young people to the rural youth mental health service, perceived it to deliver quality mental health support primarily to school age young people in Western NSW. Participants reported high satisfaction with the service. The service was considered an important resource in the Western NSW region where mental health services are limited and dispersed populations, qualified clinician shortages and distance are major service delivery challenges (Goldstein et al., 2022; Policy Writing Group., 2020; Lawrence, 2015).

The model of providing services in schools made mental health support accessible and convenient for service users attending the schools where rural mental health service staff worked. Study participants noted positive school related outcomes for young people such as improved attendance and fewer suspensions. This is consistent with research on providing social work and psychology services within schools which has identified improved academic and social outcomes (Splett et al., 2013). However, there is limited research on the delivery of mental health services within Australian schools and related benefits and challenges (Berger et al., 2023). While this study had a small sample and focused on a specific model in a regional area it does provide some encouragement for the expansion of similar services that could be rigorously evaluated. More comprehensive evaluation should include outcomes of the program for young people in terms of improving their mental health and wellbeing as the results described here are the perceptions of referrers not the changes experienced by young people. The details of the theoretical and therapeutic elements of the individual sessions are not available. This limits replication of the program and its methods in other locations. While young people and carer's high satisfaction with the service has been reported elsewhere (Allan & Thompson, 2023) the effectiveness of the program and its interventions is unknown.

A secondary but significant benefit of having the mental health service located in schools was that it supported teachers in feeling confident students would be assisted with their mental health concerns. Study participants described young people in serious distress and said they felt helpless to do anything about it. Teachers are frequently in a position of vulnerability, knowing young people in their class are distressed but lacking both the skills and the capacity to intervene (Campbell, 2017; Henderson Smith et al., 2023). Government policy and funding for schools could incorporate specific mental health supports as the school environment appears conducive to delivering support services in that it provides both regular and frequent contact with young people (Campbell, 2017; Henderson Smith et al., 2023; Simon, 2015) and it addresses the typical service access barriers of transport, embarrassment and not knowing where to go (Brennan et al., 2021).

5. Conclusion

Planning for future services should incorporate key features of the model of care described by referrers as key to its effectiveness: flexibility in referrals and delivery processes, staff who can engage well with young people and respond to daily changing demands in service delivery; and provision of a quality service that was able to address the mental health needs of the young people referred.

List of abbreviations

New South Wales: NSW
Primary Health Networks: PHNs
Western New South Wales Primary Health Network: WNSW PHN.

Declarations

Ethics approval and consent to participate

In accordance with the Australian Code for Responsible Conduct of Research, ethical approval for the study was obtained from the Aboriginal Health and Medical Research Council of NSW–Human Ethics Research Committee (1830/21). Informed consent was obtained from all subjects participating in the study. No participants in the study reported here were under the age of sixteen years, therefore parental or carer consent was not required.

Consent for publication

Not applicable.

Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available due to compliance with ethical approval on confidentiality and privacy of participants but are available from the corresponding author on reasonable request.

Funding

WNSW PHN provided funding for the direct research costs of this study including participant reimbursements and interview transcribing costs.

Authors' contributions

XX designed and planned the study, collected the referrers data and wrote the first draft of the manuscript. XX obtained ethics approval to conduct the study, recruited participants, assisted with data collection and analysis, and reviewed and edited the manuscript. All authors read and approved the final manuscript.

CRediT authorship contribution statement

Julaine Allan: Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization. **Anna Thompson:** Writing – review & editing, Writing – original draft, Investigation, Formal analysis.

Declaration of competing interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

Julaine Allan reports financial support was provided by Western New South Wales Primary Health Network. If there are other authors, they declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgments

Not applicable.

References

Allan, J. (2018). Doing more with less: Suggestions for transdisciplinary healthcare for rural populations. *The International Journal of Interdisciplinary Social and Community Studies, 13*(2), 25–36. https://doi.org/10.18848/2324-7576/CGP/v13i02/25-36

Allan, J., & Thompson, A. (2023). Experiences of young people and their carers with a rural mobile mental health support service: A qualitative study. *International Journal of Environmental Research and Public Health, 20*(3), 1774. https://www.mdpi.com/1660-4601/20/3/1774.

Allan, J., Webster, E., Chambers, B., & Nott, S. (2021). This is streets ahead of what we used to do": staff perceptions of virtual clinical pharmacy services in rural and remote Australian hospitals. *BMC Health Services Research, 21*(1), 1306. https://doi.org/10.1186/s12913-021-07328-w

Berger, E., Mackie, G., Reupert, A., Greenfeld, D., Allen, K. A., May, F., Wurf, G., Summers, D., & Morris, Z. (2023). The experiences of Australian school mental health professionals during COVID-19 lockdowns. *Children (Basel, Switzerland)*, (7), 10. https://doi.org/10.3390/children10071157

Brennan, N., Beames, J., Kos, A., & et al. (2021). Psychological distress in young people in Australia [Report]. Mission Australia. https://apo.org.au/node/313947.

Campbell, M. (2017). Public policy and policy research on school-based counseling in Australia. *International handbook for policy research on school-based counseling* (pp. 427–436). Springer International Publishing/Springer Nature. https://doi.org/10.1007/978-3-319-58179-8_28

Connolly, A., Giles-Kaye, A., Smith, A., Dawson, G., Smith, R., Darling, S., Oberklaid, F., & Quach, J. (2024). Barriers to supporting children's mental health in Australian primary schools: Perspectives of school staff. *Mental Health & Prevention, 33*, Article 200323. https://doi.org/10.1016/j.mhp.2024.200323

Council, N. H. a. M. R. (2018). Australian code for responsible conduct of research. (R41). Canberra: National Health and Medical Research Council Retrieved from https://www.nhmrc.gov.au/sites/default/files/documents/attachments/grant%20documents/The-australian-code-for-the-responsible-conduct-of-research-2018.pdf.

Gallego, G., Dew, A., Lincoln, M., Bundy, A., Chedid, R. J., Bulkeley, K., Brentnall, J., & Veitch, C. (2015). Should I stay or should I go? Exploring the job preferences of allied health professionals working with people with disability in rural Australia. *Human Resources Health, 13*, 53. https://doi.org/10.1186/s12960-015-0047-x

Goldstein, E. V., Prater, L. C., & Wickizer, T. M. (2022). Preventing adolescent and young adult suicide: do states with greater mental health treatment capacity have lower suicide rates? *The Journal of Adolescent Health : Official Publication of the Society for Adolescent Medicine, 70*(1), 83–90. https://doi.org/10.1016/j.jadohealth.2021.06.020

Smith, Henderson, Franco, L., P, M., & Bottiani, J. H. (2023). "We're teachers right, we're not social workers?" Teacher perspectives on student mental health in a tribal school. *School Mental Health, 15*(4), 1113–1127. https://doi.org/10.1007/s12310-023-09607-9

Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigour in qualitative case-study research. *Nurse Researcher, 20*(4), 12–17. https://doi.org/10.7748/nr2013.03.20.4.12.e326

Lawrence, D., Johnson, S., Hafekost, J., Boterhoven de Haan, K., Sawyer, M., Ainley, J., et al. (2015). The mental health of children and adolescents: Report on the second Australian child and adolescent survey of mental health and wellbeing (Young minds matter). C. o. Australia. https://research.acer.edu.au/well_being/1/.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research, 26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description – the poor cousin of health research? *BMC Medical Research Methodology, 9*(1), 52. https://doi.org/10.1186/1471-2288-9-52

OECD. (2006). Rural policy. https://doi.org/10.1787/9789264023918-4-en.

Policy Writing Group. (2020). *Fit for purpose: Improving mental health services for young people living in rural and remote Australia*. Orygen. https://www.orygen.org.au/Orygen-Institute/Policy-Areas/Government-policy-service-delivery-and-workforce/Service-delivery/Fit-for-purpose-Improving-mental-health-services-f.

Rickwood, D., Paraskakis, M., Quin, D., Hobbs, N., Ryall, V., Trethowan, J., & McGorry, P. (2019). Australia's innovation in youth mental health care: The headspace centre model. *Early Intervention in Psychiatry, 13*(1), 159–166. https://doi.org/10.1111/eip.12740

Russell, D. J., Humphreys, J. S., Ward, B., Chisholm, M., Buykx, P., McGrail, M., & Wakerman, J. (2013). Helping policy-makers address rural health access problems. *The Australian Journal of Rural Health, 21*(2), 61–71. https://doi.org/10.1111/ajr.12023

Salmon, G., & Kirby, A. (2008). Schools: Central to providing comprehensive CAMH services in the future? *Child and Adolescent Mental Health, 13*(3), 107–114. https://doi.org/10.1111/j.1475-3588.2007.00468.x

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health, 33*(1), 77–84. https://doi.org/10.1002/nur.20362

Seixas, B. V., Smith, N., & Mitton, C. (2018). The qualitative descriptive approach in international comparative studies: using online qualitative surveys. *International Journal of Health Policy and Management, 7*(9), 778–781. https://doi.org/10.15171/ijhpm.2017.142

Simon, D. J. (2015). *School-centered interventions: Evidence-based strategies for social, emotional, and academic success*. American Psychological Association. https://psycnet.apa.org/doiLanding?doi=10.1037%2F14779-001.

Smith, J. (2018). Locational disadvantage and the role of school counsellors and social workers: "Doing whatever it takes" to support children, families and communities [Journal Article]. Communities, Children and Families Australia, 12(1), 43-63. https://search.informit.org/doi/10.3316/informit.437880529384286.

Splett, J. W., Fowler, J., Weist, M. D., McDaniel, H., & Dvorsky, M. (2013). The critical role of school psychology in the school mental health movement. *Psychology in the Schools, 50*(3), 245–258. https://doi.org/10.1002/pits.21677

Weist, M. D., Hoover, S. A., Daly, B. P., Short, K. H., & Bruns, E. J. (2023). Propelling the global advancement of school mental health. *Clinical Child and Family Psychology Review, 26*(4), 851–864. https://doi.org/10.1007/s10567-023-00434-7

Western NSW Primary Health Network. (2018). *Western NSW Primary Health Network Needs Assessment*. W. N. P. H. Network, 2019–2022.

Western NSW Primary Health Network, (2020). Western NSW primary health network needs assessment, 2019-2022 W. N. P. H. Network. www.WNSWPHN.org.au/about-us/our-region/needs-assessment.