Help-seeking Behaviours of University Students in a Northern Ontario Community

by

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Abstract

Prevalence rates for mental illness are high for Canadian youth 15-24 years old and for those living in northern and rural populations; however, a concerning portion of youth in need do not access mental health services. Although university student populations have higher prevalence rates than the general population, little is known about how Canadian university students seek help for mental health issues and the barriers they may face. This mixed-methods study examined the help-seeking attitudes, intentions, barriers-to-care, depressive symptomology, and help-seeking experiences of a sample of 61 undergraduate university students in the Northern Ontario community of Sudbury, Ontario. There was a total of 61 participants for this study. All participants completed a questionnaire package and seven of the participants volunteered to engage in an additional semi-structured interview. The overall sample had moderately positive attitudes toward help-seeking. Students who had accessed services were more likely to seek help from professional mental health services, had experienced more barriers-to-care, and had higher BDI-II scores than students who had not accessed services. Students not accessing care were more likely to seek help from their parents. There were no differences in the types of barriers faced between users vs. non-users of mental health services. Using thematic analysis, three primary themes were identified from the interview data: 1) Important factors in mental health care; 2) Experiences with mental health professionals and services; and 3) Barriers to accessing mental health care. The findings may help direct future research and endorse the need to further refine outreach interventions and available mental health services to promote student engagement with treatment at universities across Ontario.

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Help-seeking Behaviours of University Students in a Northern Ontario Community

Treatment rates for mental health problems have increased over the past decade according to the World Health Organization (WHO; Mackenzie, Erickson, Deane & Wright, 2014; Jagdeo & Stein, 2009). It has been estimated that approximately 20-24% of Canadians will experience a mental disorder at one point during their life time (Canadian Mental Health Association [CMHA], 2015; Mental Health Commission of Canada [MHCC], 2015). The most common are depression, anxiety, and substance abuse disorders (CMHA, 2015). These disorders are considered to be treatable and to have the potential for positive outcomes with early intervention and adequate service implementation (Gulliver, Griffiths, Christensen & Brewer, 2012). However, research has consistently demonstrated that a large portion of the population living with mental health problems do not access services (Gulliver et al., 2012; Clement et al., 2015; Vasiliadis, Lesage, Adair, & Boyer, 2005; Bergeron, Poirier, Fournier & Barrette, 2005; Sunderland & Findlay, 2013; Findlay & Sunderland, 2014; CMHA, 2015; MHCC, 2015). In 2004 the WHO conducted a mental health survey across 14 countries and found that 35.5% to 50.3% of individuals with serious cases of mental illness in developed countries did not receive treatment in the past 12 months (Demyttenaere et al., 2004). Mental disorders that go untreated can lead to an array of negative outcomes and have the potential to become life-threatening (Gulliver et al., 2012; MHCC, 2015; CMHA, 2015). Studies of youth who have committed suicide and their family members have found that the majority of these youth did not access mental health services in the year before their death (Hom, Stanley, & Joiner, 2015).

Research has also found that prevalence rates for mental health problems are higher in university student populations than the general population of young adults (Tamboly & Gauvin, 2013; Thomas, Caputi, & Wilson, 2013; Potvin-Boucher, Szumilas, Sheikh, & Kutcher, 2010; Eisenberg, Gollust, Golberstein & Hefner, 2007), however, research regarding help-seeking and mental illness in university students is limited (Golberstein, Eisenberg, & Gollust, 2008; Thomas, Caputi, &Wilson, 2013; Hussain et al., 2013). Holmes and Silvestri (2015) stated that Canada's shortage of research on help-seeking and mental illness in post-secondary student when compared to the United States' is "disconcerting" and underscored the need for further Canadian research. Furthermore, little is known about help-seeking in university students and the barriers they face while attending campuses in rural and northern communities where prevalence rates for suicide and mental health disorders are reportedly higher than in urban centers (Smith, Humphreys, & Wilson, 2006; Findlay & Sunderland, 2014; Dunn, 2014; Lin & Parikh, 1999; Potvin-Boucher et al., 2010; Hussain et al., 2013; Dyck & Hardy, 2013; Boydell et al., 2006; Thomas, Caputi, & Wilson, 2013). As such, help-seeking behaviours have been a primary focus in research to better understand the variables involved with seeking and accessing mental health services (Findlay & Sunderland, 2014; Sunderland & Findlay, 2014; Kauer, Mangan & Sanci, 2014).

This current study was conducted to examine the help-seeking attitudes, intentions, barriers-to-care, and personal experiences of a sample of undergraduate university students in a Northern Ontario community. This paper begins with a review of the literature regarding the state of mental health in youth – particularly Canadian youth – and university students. The review will then discuss help-seeking for mental health services and the most common theoretical models of help-seeking behaviour in research. Help-seeking attitudes, barriers to accessing mental health services, help-seeking for university students, as well as mental health care and help-seeking in northern and rural populations of Canada will also be reviewed. From there, the hypotheses, research question, and rationale for the present study will be described for a mixed-methods study followed by a discussion of results.

Mental Health in Canadian Youth and University Students

Youth are a particularly vulnerable population when it comes to mental illness. The onsets of various mental disorders (e.g. depression, anxiety disorders, bipolar disorder, and schizophrenia) most often take place during young adulthood, especially between 18-25 years of age (Leanne & Sunderland, 2014; Nunes et al., 2014; Stuart et al., 2014; Tamboly & Gauvin, 2013; MacLeod & Brownlie, 2014). Prevalence rates for mental illnesses are high among Canadian youth between the ages of 15 - 24 years, with one in five youth meeting the criteria for a mental disorder each year (Findlay & Sunderland, 2014; Nunes et al., 2014; Stuart et al., 2014; Tamboly & Gauvin, 2013, Lin & Parikh, 1999; Vasiliadis et al., 2005). Individuals in this age group have been found to be more likely to report mental health problems than other age groups, particularly for concurrent mental health and substance abuse disorders (MacLeod & Brownlie, 2014; Canadian Centre for Addiction and Mental Health [CAMH], 2012). Concurrent disorders such as these have been associated with a higher risk for incarceration and involvement in the criminal justice system, homelessness, decreased school attendance, difficulties with social relationships, HIV infection, and suicide (MacLeod & Brownlie, 2014; Fortney et al, 2016). If not addressed, mental health problems can lead to a wide-ranging, negative impact on youth, their families, and communities, which may continue into adulthood (MacLeod & Brownlie, 2014).

Rates for mental health disorders that reportedly result in significant impairment or symptomology can range from 15% to 21% in children and youth (Tilleczek et al., 2014). In terms of Canadian students, some estimates suggest that rates of psychological distress range from 15% to 30% (Tilleczek et al., 2014). Given this, it is important to note that these estimates do not include subclinical or undiagnosed mental health problems, and that the level of underreported mental health issues could indicate more distress in these populations than is formally documented (MacLeod & Brownlie, 2014).

The most commonly reported mental health problems for youth are depression, anxiety, and substance abuse (MacLeod & Brownlie, 2014). A cross-sectional survey – Canadian Community Health Survey—Mental Health (CCHS – MH) – was conducted in 2012 by the government of Canada, which surveyed individuals 15 years and older in 10 provinces. The purpose was to gather national estimates of the prevalence of mental health disorders, the functioning of individuals with mental illness, and service estimates (Findlay & Sunderland, 2014). It was found that youth of 15-24 years had the highest rates of mood and anxiety disorders when compared to all other age groups (Findlay, 2017). Approximately 7% of youth surveyed reported having depression in the past year (Findlay, 2017). Furthermore, the Mental Health Commission of Canada (MHCC; 2013) has reported that approximately 12% of female and 5% of male Canadian youth between the ages of 12-19 years had experienced a major depressive episode. Regarding anxiety disorders, it was estimated that 5% of youth and young adults were diagnosed with an anxiety disorder in 2009 (Butler & Pang, 2014). Prevalence rates for depression and anxiety disorders have been found to be higher among young women than men, and for Indigenous populations in Canada (Butler & Pang, 2014).

Findings from the CCHS – MH (2012) also showed that youth between 15-24 years had the highest rate (11.9%) of substance use disorders when compared to all other age groups (Findlay, 2017). Prevalence rates for symptoms of substance use disorder were higher among young men (6.4%) than women (2.5%; Findlay, 2017). According to the Centre for Addiction and Mental Health (CAMH), individuals with mental health problems are also two times more likely to have problems with substance use when compared to the general population (CAMH, 2012).

A population-based, repeated annual cross-sectional study was conducted between 2006 and 2011 in Ontario to examine mental health service use over time (i.e. mental health related emergency department visits, psychiatric hospitalizations, and mental health related outpatient visits) (Gandhi et al., 2016). Participants were residents of Ontario between the ages of 10 and 24 years. It was found that the most common reason for emergency department visits were for anxiety disorders while the most common reason for hospitalizations were mood and affective disorders (Gandhi et al., 2016). Furthermore, results demonstrated a 32.5% increase in emergency department visits, a 53.7% increase of hospitalizations and a 15.8% increase in outpatient visits for mental health issues (mostly to family physicians; Gandhi et al., 2016). This study has shown that over time there has been an increase in the use of acute mental health services in Canadian youth.

Regarding self-harm, MacLeod and Brownlie (2014) reported that 14% to 39% of Canadian adolescents have engaged in some form of self-harm, with adolescent girls reporting higher rates than adolescent boys. However, when it comes to college student populations, 17% of students reported that they had self-harmed with no difference in rates between genders.

Statistics Canada reported that approximately 10.8 per 100 000 Canadians committed suicide in 2011 (MHCC, 2015). Suicide is the second leading cause of death among Canadian youth, second only to accidental death (CMHA, 2015; CAMH, 2012; Nunes et al., 2014; Tamboly & Gauvin, 2013; MacLeod & Brownlie, 2014). According to CAMH (2012), 28% of deaths among individuals 15 - 19 years old and 25% of deaths among those 20 - 24 years old were attributed to suicide in 2012. Among First Nations youth, suicide rates are 5 to 6 times greater than that of non-Indigenous youth, with Inuit youth having suicide rates that are 11 times that of the national average and among the highest in the world (CAMH, 2012). Canadian suicide rates are considered the third highest of the industrialized nations in the world (CMHA, 2015) with Canadian youth also experiencing higher levels of distress than other nations (Stuart et al., 2014).

Research on prevalence rates of mental disorders in youth in the United States has generally found that post-secondary students screen at higher rates of mental disorders than the general population of non-students (Eisenberg et al., 2007a; Eisenberg, Speer & Hunt, 2012; Golberstein, Eisenberg, & Gollust, 2008). Eisenberg et al. (2007a) studied a sample of undergraduate and graduate students from a large, public university in the U.S., and found that students screened positive for depression, panic disorder, generalized anxiety disorder, and suicidal thoughts at rates higher than those reported by the U.S. National Comorbidity Survey-Replication. The researchers randomly selected 2,843 undergraduate and graduate students for their study. The Patient Health Questionnaire-9 (PHQ-9) was the screening instrument used to estimate prevalence of depressive and anxiety disorders. Questions from The National Comorbidity Survey Replication (NCS-R) were also used to assess suicidal thoughts and behaviour. This was a community household survey that assessed the prevalence and correlates of mental health disorders in the U.S. and was deemed to be nationally representative (Kessler & Merikangas, 2004). Eisenberg et al. (2007a) reported that their study was the first in 30 years to use a random population-based sample as well as validated measures while also accounting for nonresponse bias to examine the mental health of students.

The researchers found that 15.6% of undergraduate students screened positive for a depressive or anxiety disorder, 13.8% for depression (both major or minor), 2.9% for generalized anxiety disorder, and 1.8% for panic disorder. Regarding graduate students, 13% screened positive for a depressive or anxiety disorder, 11.3% for depression (both major or minor), 3.1% for generalized anxiety disorder, and 1.1% for panic disorder. Regarding suicidality, 2.5% of undergraduate students and 1.6% of graduate students reported thinking of suicide in the last month while less than 1% of each group reported having made a suicide plan in the last month. One student had reported a suicide attempt (Eisenberg et al., 2007a).

When compared to data for youth of 18-24 years from the NCS-R, Eisenberg et al. (2007a) reported that their sample had higher rates of both depression and anxiety. For depression, this study found 5.2% of students had a current major depressive disorder as compared to the general population of individuals of the same age (2.4%). Regarding anxiety disorders, the researchers found 2.9% of students experienced generalized anxiety disorder and 1.8% experienced panic disorder, both of which were higher than the NCS-R's estimate of 1% for each.

Mental health and transitioning to adulthood.

Emerging adulthood is a time in one's life where a young person becomes responsible for managing their own life independently (Thurber & Walton, 2012) and transitions to the "real world" (Dunn, 2014). With this newfound autonomy also comes responsibility for tasks that were typically handled by their parents/guardians, such as managing finances and monitoring one's own overall health, along with arranging and keeping appointments.

Research has shown that this transitioning to adulthood is becoming prolonged and more complex for youth (Tilleczek et al., 2014). With increasing pressure to obtain more education and the lack of available work, Canadian youth are leaning on social supports and delaying meeting major markers of adulthood, such as living on their own, obtaining post-secondary education, obtaining economic independence, owning a house, having a life partner, and having children (Kroes & Watling, 2009). The transition to employment in Canada is taking longer, approximately eight years in 2009 compared to six years in 1990 (Kroes & Watling, 2009). In addition, more and more youth are living with their parents for longer (Kroes & Watling, 2009).

For young adults entering post-secondary education for the first time, university comes at a pivotal time in which individuals face an array of new experiences and the role transition from adolescence to young adulthood (Thurber & Walton, 2012; Dunn, 2014). With increasing demands for more education in society, school continues to play an increasingly important role for youth (Tilleczek et al., 2014). Some students attend university away from home, which has the potential to lead to new challenges wherein their support systems are not as easily accessible, and homesickness can develop (Thurber & Walton, 2012; Potvin-Boucher, Szumilas, Sheikh, & Kutcher, 2010). Some students are also faced with a cultural contrast, which can also lead to homesickness and difficulties in adjustment to university (Thurber & Walton, 2012).

From an academic standpoint, students are now faced with responsibilities and challenges in having to adjust to new schedules, heavy course loads, and pressure to be successful in all their academic-related pursuits (Thurber & Walton, 2012). For first year students, Thurber and Walton (2012) explained that this transition can be stimulating and exciting for some and overwhelming and distressing for others. The new challenges students face while transitioning to university can perpetuate pre-existing conditions or trigger the onset of physical and mental health problems in a generally high risk, youth population (Thurber & Walton, 2012; Hussain, Guppy, Robertson, & Temple, 2013; MacLeod et al., 2014).

Coupled with this is that with transitioning to adulthood and turning 18 years old, there is also a transition in health care (Tilleczek et al., 2014). The Ontario Ministry of Children and Youth Services is responsible for mental health services for children to 18 years, after which service gets transferred to the Ministry of Health and Long-Term Care. Service eligibility based on age, has been found to lead to problems for youth, such as a decrease of available service provisions as they age out of children's services (Tilleczek et al., 2014). Some of these problems may stem from the fact that the mental health system is based on pediatric and adult health care models, however, these services tend to be ill-equipped to address the unique needs of youth in transition, who are either too young to be treated in the adult system or are too old for children's mental health care (Kroes & Watling, 2009; Macleod & Brownlie, 2014). Furthermore, these services also tend to be fragmented across several departments and levels of government, which often have service criteria that are inconsistent across programs (Kroes & Watling, 2009).

Those experiencing mental illness or having difficulties in transitioning to university and adulthood may adopt maladaptive coping mechanisms such as binge drinking, substance abuse and/or dependence, self-mutilating behaviours, and excessively engaging in behaviours like exercise, sleeping, or spending (Tamboly & Gauvin, 2013; Thomas, Caputi, & Wilson, 2013). Research has found that negative outcomes for university students experiencing mental health problems are similar across the U.S., Europe, and Australia (Hussain et al., 2013). These outcomes may persist into later life and can include: Risk taking behaviour, insomnia/hypersomnia, physical illnesses, excessive weight gain or loss, poor academic performance, academic attrition, antisocial behaviour, poor employment performance, and suicide (Hussain et al., 2013; Tamboly & Gauvin, 2013; Eisenberg et al., 2007b).

Academic impacts of mental illness.

Mental illness can also have negative academic impacts for post-secondary students. Holmes and Silvestri (2015) examined the academic impacts of specific mental illnesses for Ontario college students accessing campus-based counselling and disability centres across 15 community colleges. The authors reported that both Canadian and American counselors at colleges and universities are reporting that are being diagnosed with mental health disorders and seeking counselling in recent years. This study reports on 1,964 students who completed a survey that assessed DSM-IV Axis I and Axis II diagnoses, and mental health problems, subjective academic performance difficulties, as well as thinking, learning, and psychosocial skills. It was found that 45.5% of students had one mental health disorder while 15.3% had comorbid diagnoses according to DSM-IV criteria (Holmes & Silvestri, 2015). The most frequent mental disorders were mood and anxiety disorders (37.2% and 24.5% respectively), followed by substance abuse, psychotic, eating, and personality disorders. Of those who reported meeting criteria for comorbid disorders, 51.8% had depression and anxiety.

Students with a diagnosed mental illness, when compared to students without a diagnosis, reported experiencing significantly more academic challenges in terms of their performance after having controlled for the effects of gender and age. These challenges were related to alertness, attention, memory and executive functions, and problems with peer relationships. The specific academic challenges Ontario college students reported were related to the symptoms of their disorders (Holmes & Silvestri, 2015). Those diagnosed with comorbid disorders reported more academic challenges than those with single diagnoses. Academic challenges related to attention and alertness were more likely to be experienced by students with mood disorders while those related to memory/executive functions were more likely to be experienced by students with anxiety. Students with anxiety disorders reported going “blank” on tests and experiencing panic when faced with deadlines or tests. Students with mood disorders reported experiencing a lack of energy and frequent absences. They also reported more pervasive challenges with their peer relationships than students with anxiety disorders.

Studies such as this help to both shed light on the broad range of academic challenges that postsecondary students with mental illness may experience. These challenges can hinder the progress of students in their academic careers. Without access to adequate services, it is possible that students may fall behind or be unable to complete the requirements of their programs. This not only has implications towards the successful completion of post-secondary education but also the ability to find and maintain future employment. At a time where help-seeking on campus for mental health related problems is on the rise, Holmes and Silvestri (2015) underscored the need for young adult-oriented, on and off campus mental health services that can keep up with the rising demand.

University campus services.

Research has demonstrated that, with mental illness, there is a better chance for a healthy prognosis the earlier that intervention and treatment plans are implemented, which makes youth populations a popular target for research and government initiatives (Stuart et al., 2014; MHCC, 2015; Findlay & Sunderland, 2014; Tamboly & Gauvin, 2013). As such, campus programs have been introduced in various universities across Canada to address the issue of high rates of mental disorders among students, many of which have been aimed at first year students and the transition to university. Some programs are part of the university’s orientation process for new students and can be arranged prior to one’s arrival with continuation once the student is on campus for those who need help navigating this new environment (Tamboly & Gauvin, 2013; Dunn, 2014).

There has been a recent increase reported in the number of Ontario college students diagnosed with mental disorders who are seeking access to campus counselling centres (Holmes & Silvestri, 2015). Staff campus-based counselling and disability centres at 15 of 24 Ontario community colleges reported an increase in the complexity of mental illness these students present with which, in turn, has led to progressive difficulties in staff caseloads (Holmes & Silvestri, 2015). The primary role of counselling and disability centres is to support students with direct, short-term treatment interventions to target presenting mental health issues that may be hindering their ability to be successful in the academic setting (Marsh & Wilcoxon, 2015). The increasing rates of help-seeking coupled with comorbid mental health problems can present difficulties such as large caseloads, the requirement of long-term, specialized treatment, and a lack of resources to meet these needs.

University campus-based mental health services as well as community services have implemented various strategies in an attempt to engage and encourage university students to access their counselling services. These programs, however, tend to vary from institution to institution thereby resulting in a lack of standardization that makes it difficult to assess their overall effectiveness (Eisenberg, Hunt, & Speer, 2012a). Eisenberg et al. (2012a) noted that there was a lack of formal data and research about the intervention practices on campus, but that many universities in the U.S. have indicated they have some form of program directed to encourage help-seeking in students. Due to limited research and the lack of standardization in programs across universities, there is little empirical evidence to support the effectiveness of these programs (Eisenberg et al.2012a).

Eisenberg, Hunt, and Speer (2012a) reported that the three main common intervention strategies they found that were implemented by universities and their communities to encourage post-secondary students to seek treatment are (a) stigma reduction and education programs, (b) screening and linkage programs, and (c) gatekeeper training programs. Stigma reduction and educational campaigns have been the most common approach made by universities to encourage their students to seek help (Eisenberg et al., 2012a). These programs can be referred to as "outreach" in that they use a variety of methods to reach out and connect with students, often with the help of students themselves (e.g. guest speakers and presentations, flyers, newsletters, posters, etc.). There is the potential to reach many students since these programs tend to be based on-campus. Other psycho-education-based campaigns have been developed to specifically address and educate students about suicide (Hom, Stanley, & Joiner, 2015). Hom, Stanley, and Joiner (2015) found that there was an overall improvement in knowledge and attitudes about suicide in a review of eight campus-based suicide prevention programs.

Screenage and linkage programs also have the potential to reach a large population of students (Eisenberg et al., 2012a). These programs involve emailing students and inviting them to participate in a brief online questionnaire that screens for suicidal risk factors, screening students who participate, and then directing those who screen as distressed towards the appropriate on-campus or community-based services. In these screening programs – such as the American Foundation for Suicide Prevention's Interactive Screening program that uses a web-based screener – the screeners are used to identify those who are at a high risk for suicide or mental illnesses (Hom, Stanley, & Joiner, 2015). Those who score at a high risk are be contacted online by a counsellor who then invites them for face-to-face evaluation so that they may link them with appropriate services (Eisenberg et al, 2012a). As of 2012 in the U.S., 25 colleges and universities were using a refined screenage program called the Interactive Screening Program. Another screening program used in the U.S. is the National College Depression Partnership. This program involves the collaboration of several colleges across the U.S. and was designed to provide screening, early intervention, and a more integrated treatment of depression.

A program evaluation of the National College Depression Partnership at eight campuses found that 801 students who were identified with clinical depression obtained treatment through the program over a period of 17 months (Eisenberg et al., 2012a). The students were followed for 12 weeks during treatment and it was found that 86% of students had continued with treatment, 58% had met an agreed upon goal with their clinician, and 52% had experienced improvement in their overall functioning. Preliminary research has shown that these programs can be helpful in providing at-risk students with information to connect with mental health services, however, it has also been shown that there has been a very low percentage (8%) of students who ended up participating in the initial screening questionnaires (Eisenberg et al., 2012a; Hom, Stanley, & Joiner, 2015). Furthermore, for these programs to effectively transition students to needed services, the universities themselves must first have the required infrastructure to facilitate this transition of students to services (Hom, Stanley, & Joiner, 2015).

Gatekeeper training programs, on the other hand, target people (e.g. faculty members, residence personnel, peers, or advisors) who have frequent contact with students on campus and in the community, to provide them with education and skills to help those who may be in crisis (Eisenberg et al., 2012a). Like psycho-educational programs, these training programs address general mental health issues and/or suicidality. What sets them apart is that gatekeeper training programs work to train people so that they can recognize, safely respond to signs of illness or suicide, and appropriately refer people to available services.

The Applied Suicide Intervention Skills Training (ASIST), which is based on educating students and staff on suicide first aid, is an example of these programs (Living Works, 2014). ASIST is a two-day interactive workshop that focuses on teaching participants how to recognize warning signs and suicide risk factors, and how to help them form a plan to support their immediate safety (Living Works, 2014). ASIST was first developed in 1983 and has continued to be updated according to the National Action Alliance for Suicide Prevention guidelines for training (Living Works, 2014).

Programs such as ASIST were first introduced in workplaces and the general community and have since been applied to post-secondary institutions (Eisenberg et al., 2012). Eisenberg et al., (2012) suggest that further research is needed to better understand who the best gatekeepers are on campus for optimal effectiveness as well as the level of intensiveness is required to have a significant effect on supportive behaviour in real-life situations.

Campus mental health services as well as programs to engage students in accessing these services have been growing over the past years. The introduction of these programs has been regarded as promising; however, research has consistently demonstrated that university students have patterns of underuse of mental health services similar to that of the general, young adult population (Eisenberg, Golberstein, Gollust, 2007b; Tamboly & Gauvin, 2013; Golberstein, Eisenberg, & Gollust, 2008). Hussain et al. (2013) explained that for this high-risk age group, stressors specific to university compounded with this stage of transition into adulthood can increase the likelihood that students will manifest with symptoms of mental illness.

Eisenberg et al. (2007b) conducted a web-based survey of 2,785 graduate and undergraduate students at a large public university. The survey measured symptoms of depression (with the PHQ-9), symptoms of generalized anxiety and panic (with the PHQ anxiety module), impairments of academic functioning because of mental health problems, and perceived need for mental health services in the past year. Results showed that 15% of the students reported having obtained psychotherapy or medication for a mental condition in the past year. Ninety-four percent of students had health insurance, however, only half of these students were aware of the mental health related services that this covered. This highlighted the issue of unmet needs in this sample that Eisenberg et al. (2007b) reported was similar to that the general population. Of those who screened positive for major depression without anxiety, only 36% of students had received therapy or medication in the past year. A lack of perceived need for services, a belief that stress was “normal in school”, and a reported lack of time were the reasons reported by students to account for this discrepancy between need and service use.

Help-seeking Behaviour: Primary Models

Help-seeking behaviour has been defined as the complex process of behaviours by which an individual becomes aware of a problem, identifies a need, and then willingly and actively seeks to access either formal or informal services from which to receive help (Kauer et al., 2014; Rickwood & Thomas, 2012).

Different models have been developed to explain help-seeking behaviour, such as the Health Belief Model (HBM), the Network Episode Model (NEM) (Eisenburg et al., 2012a; Pescosolido & Boyer, 2010), and Anderson’s Behavioural Model for Health Service Use (BMHSU).

The HBM was developed in the 1950s by a group of psychologists working for the U.S. Public Health Service in order to address the high prevalence of underutilization of health services and disease preventative strategies (Janz & Becker, 1984). It has since been adjusted and applied to better understand patient responses to health symptoms, adherence to medication

(Janz & Becker, 1984), and more recently in the mental health field to understand perceived need and help seeking from an individualistic approach (Eisenburg et al., 2012a). In the HBM, it is hypothesized that one's health behaviour depends upon the individual's desire to avoid illness/to get well and the individual's belief that a certain health action can prevent or treat an illness (Janz & Becker, 1984). There is a focus on the meaning of predisposing characteristics behind general and specific beliefs about health (i.e. an individual's belief about the state of their mental health; Pescosolido & Boyer, 2010). The limitation with the use of this model has been that it is primarily focused on individuals' knowledge, attitudes, and beliefs (Eisenburg, Hunt, & Speer, 2012; Janz & Becker, 1984), which may overlook external factors associated with help-seeking behaviour.

The NEM is a recent conceptual model that emphasizes social networks and informal sources of help-seeking that may influence an individual's knowledge and attitudes about mental illness, help-seeking, and accessing mental health care (Eisenburg et al., 2012a). This model is based on the concept that help-seeking is a "social process" that involves the various social networks of individuals, such as their community, the treatment system, and social service agencies (Pescosolido & Boyer, 2010). There are four components to the NEM: the illness career, the social support system, the treatment system, and the social context (Pescosolido & Boyer, 2010).

According to the NEM, help-seeking and accessing services is viewed as pathways of that individuals traverse throughout episodes of mental illness, as opposed to a single, one-time decision to seek help (Pescosolido & Boyer, 2010). The NEM was also developed on the premise that help-seeking models need to account for informal sources of help-seeking (e.g. from non-professionals) as well as formal sources (Eisenburg et al., 2012a). This premise was based upon research that has shown that individuals tend to seek help from non-professionals, such as family and peers more often than professionals, for mental health issues. As such, the NEM suggests that social contacts and networks have an important role in help-seeking and that mental health interventions and education should address these factors.

Anderson's BMHSU is the most frequently used theoretical model in the help-seeking literature (Babitsch et al., 2012; Pagura et al., 2009). It has been applied to a wide range of health sectors and diseases and accounts for a broad variety of factors that may influence help-seeking (Babitsch et al., 2012). Anderson first developed this model for understanding help-seeking behaviour in 1968. Since then, there have been various revisions and versions of the model developed for different populations (such as the vulnerable and families) (Babitsch et al., 2012; Anderson, 2008; Jagdeo et al., 2009).

The BMHSU is a multilevel model that focuses on contextual (e.g. social and structural factors) and individual determinants of help-seeking behaviour (Anderson, 2008; Anderson & Davidson, 2007). Contextual factors are typically described as including community characteristics, organizations, health care providers, and other social and structural factors that can also be measured at the individual level (Anderson, 2008; Anderson & Davidson, 2007). Individual factors consist of socio-demographic factors such as age, gender, ethnicity/race, geographic location, marital status, problem type, etc. (Anderson, 2008; Anderson & Davidson, 2007; Babitsch et al., 2012;). Contextual and individual factors are divided into three sub-factors, all of which can be overlapping in the model (Anderson, 2008), and are proposed influence service use and health outcomes (Pagura et al., 2009). These sub-factors are predisposing, enabling, and need factors (Anderson, 2008; Anderson & Davidson, 2007).

Predisposing factors at the individual level include demographic characteristics (both biological and social), attitudes, beliefs and knowledge regarding health, all of which may play an indirect role in predisposing people to use or not use health services (Anderson & Davidson, 2007; Babitsch et al., 2012; Eisenburg et al., 2012a). At the contextual level, these factors include demographic and social characteristics of the community as well as the community's beliefs, values, and cultural norms regarding health services (Anderson & Davidson, 2007; Babitsch et al., 2012).

Enabling factors at the individual level include a person's financial means (e.g. income, insurance, ability to pay, etc.), transportation availability, and travel and wait time for health care, all of which may facilitate or hinder an individual's use of services. (Babitsch et al., 2012; Eisenburg et al., 2012a). At the contextual level, these factors include health policies at all levels of government, the finances and resources available in the community, and the availability, organization, and structure of health care services within the community (Anderson & Davidson, 2007; Babitsch et al., 2012). Pagura et al. (2009) noted that enabling factors, at the contextual level, have been infrequently focused upon and studied in help-seeking research.

Need factors at the individual level include perceived need for services (a person's perspective of their own health) and evaluated need for services (professional, objective assessments of the person's health) (Anderson & Davidson, 2007; Babitsch et al., 2012). The need factor has been considered a central determinant of help-seeking (Pagura et al., 2009). It is important to note that evaluated and perceived need are different (Pagura et al., 2009). Evaluated need can be dependent upon perceived need in that without the presence of a perceived need, an individual may not voluntarily peruse or access services to receive an evaluated need for services. A lack of perceived need by an individual can hinder help-seeking as well as make it difficult for general practitioners who are faced with the task of assessing for the possible presence of mental health issues in patients. At the contextual level, need factors include environmental need (the environment's health-related conditions, such as injury and death rates) and population health indices (that indicate the community's overall health) (Anderson & Davidson, 2007).

For the purposes of this research, Anderson's BMHSU was used as a guiding theoretical model to identify factors that may influence help-seeking and to assist in the interpretation of results. Seeing as this study focused on help-seeking behaviours at the individual level (i.e. attitudes, intentions, actual help-seeking, barriers to service use, and personal experiences) as well as at the societal and structural level (i.e. barriers to service use and personal experiences), a model that emphasizes both individual and contextual factors, like Anderson's BMSHSU, was thought to be the most useful to inform this research. For example, using measures to assess attitudes, intentions to seek help, and actual help-seeking history would provide scores that indicate the likelihood and patterns of seeking help while measures of symptoms of depression would provide scores that indicate the need of the participant. At the individual level, high scores for depression would indicate a higher need for mental health services than low scores. At the structural level, high scores on measures of subjective experiencing of barriers to accessing mental health care would indicate a higher need for easier access to services than low scores.

Help-seeking: Attitudes, Intentions, and Actual Help-seeking

Researchers have conducted studies that focus on examining variables that are proposed to influence the help-seeking process and whether a person ultimately seeks help. Consistent with the BMHSU, attitudes, intentions, and actual help-seeking are the foci of this study; these have increasingly been examined in the literature as influencing factors in help-seeking (Gulliver et al., 2012). Barriers have also been assessed (Mojtabai et al., 2011), but the current study amalgamates the proposed determinants in a mixed-methods approach to develop a greater understanding of the experiences and qualities involved in university students' help-seeking.

Gulliver et al. (2012) identified three broad categories from which researchers have studied help-seeking behaviour: attitudes, intentions, and actual behaviour. Evidence suggests that attitudes and intentions may be the strongest determinants of actual help-seeking behavioural patterns (Gulliver et al., 2012; Ballon et al., 2004; Mackenzie et al., 2014; Clement et al., 2015; Mackenzie, Gekoski, & Knox, 2006) and can be considered as either barriers or facilitators to accessing treatment (Boydell et al., 2006). Attitudes are considered the strongest predictor of intentions, which in turn are considered the strongest and most immediate predictor of actual help-seeking (Mackenzie, Gekoski, & Knox, 2006; Marsh & Wilcoxon, 2015). Marsh and Wilcoxon (2015) noted that there is still a need to better understand this link between intentions and actual behaviours, especially in the context of help-seeking for postsecondary students.

Barriers-to-care

Mojtabai et al., (2011) highlighted the importance of understanding why individuals do not seek help as a step in working towards unmet need for care. Examining barriers to service use is thus an important focus in help-seeking research as these include a wide variety of factors that may influence an individual to not seek professional help (Mojtabai et al., 2011; Urbanoski, Cairney, Bassani, & Rush, 2008; Craske, Edlund, Sullivan, Roy-Byrne, Sherbourne, & Bystristsky, 2005). Barriers have often been studied using interviews and surveys as well as analyzing data obtained from national surveys, such as those conducted in the U.S. and Canada (e.g. the National Comorbidity Survey Replication in the U.S) during the last 15 years (Mojtabai et al., 2011; Sareen, Jagdeo, Cox, Clara, Have, Belik, de Graaf, & Stein, 2007; Oleski, Mota, Cox, & Sareen, 2010).

Researchers examining barriers-to-care have typically focused on individuals who have not sought help. Ojeda and Bergstresser (2008) examined barriers-to-care in persons who identified having unmet needs and had not sought help. The researchers explained that they focused on just those who have not sought help and that this was a limitation as others (such as those who have sought help) may identify different needs and barriers that could be helpful in understanding help-seeking behaviours and barriers-to-care. Although research has been conducted that has focused on the experiences of individuals who have sought help and the barriers-to-care they faced, it is thus also important to understand the experiences of those who have not sought help as well as for post-secondary students in particular.

Barriers have been described and largely categorized into two primary types: attitudinal and structural (Sareen et al., 2007; Oleski et al., 2010; Mojtabai et al., 2011; Marsh & Wilcoxon, 2015). Attitudinal barriers include personal factors that may impede access to services, such as a person’s perceptions of a problem or situation (Oleski et al., 2010; Marsh & Wilcoxon, 2015). Attitudinal barriers have also been called “perceived” or “person-related” barriers in some of the literature (Craske et al., 2005; Urbanoski et al., 2008; Marsh & Wilcoxon, 2015). Attitudinal barriers commonly found to impede service use are lack of a perceived need, fear of stigma, negative attitudes and beliefs about help-seeking, negative attitudes toward doctors/health services, lack of knowledge of disorders and/or where to go for treatment, and mistrust or fear of the health system (e.g. a disliking of hospitals and/or doctors, a fear of being committed, negative previous experiences, etc.) (Sareen et al., 2007; Oleski et al., 2010; Sturm &

Sherbourne, 2001; Mojtabai et al., 2011, Golberstein et al., 2008; Ballon, et al., 2004; Bergeron et al., 2005; Eysenbach, 2014).

Structural barriers have also been referred to as “system”, “contextual”, or “system-related” barriers within the literature (Marsh & Wilcoxon, 2015; Anderson, 2008). These barriers include external, system-level factors that may exist in a person’s environment and impede their ability to seek and access services (Sareen et al., 2007). As cited by Marsh and Wilcoxon (2015), Penchansky and Thomas (1981) characterized structural barriers in terms of four distinct categories: affordability; availability (e.g. proximal location); accessibility (e.g. time and transportation); and acceptability (e.g. social and cultural acceptability or stigma). Examples of frequently identified structural barriers are financial factors (e.g. inability to pay for services and lack of insurance coverage) and accessibility factors (e.g. no access to specialists in immediate family, transportation, long waitlists, lack of resources in the community, and service unavailability at the time it’s required) (Craske et al., 2005; Urbanoski et al., 2008; Mojtabai et al., 2011; Sareen et al., 2007; Oleski et al., 2010; Sturm & Sherbourne, 2001). Research regarding structural barriers, especially within postsecondary student populations, is limited (Marsh & Wilcoxon, 2015).

Prior research has consistently demonstrated that attitudinal barriers are more frequently reported as reasons for not seeking help than structural barriers (Craske et al., 2005; Sareen et al., 2007; Mojtabai et al., 2011; Vasiliadis, Lesage, Adair, & Boyer, 2005. Sareen et al. (2007) assessed barriers in the U.S., Ontario, and the Netherlands and found that the most commonly reported perceived barriers were “I wanted to solve the problem on my own” and “I thought that the problem would get better by itself”. In a recent study by Slaunwhite (2015), the most frequently cited reasons for not seeking help were that participants “wanted to self-manage”

(28.4%) and “thought nothing of the issue” (12.4%). In another study, 72% of participants who did not access services and 58% of those who withdrew from services believed that the “disorder would go away by itself” or “wanted to manage on their own” (Vasiliadis et al., 2005). A study of suicidal patients in Canada showed that the most commonly reported barrier by those with past suicide attempts was a lack of knowledge of where to access services and that those with suicidal ideation reported a preference to manage their symptoms on their own (Pagura et al., 2009). Eisenberg, Speer, and Hunt (2012b) discussed similar attitudinal barriers in their literature review wherein studies with college and graduate students were found to report beliefs that “the problem would get better by itself”, “stress is normal [in school]”, and that they “did not have the time to seek treatment”.

Hom, Stanley, and Joiner (2015) conducted a literature review that explored the help-seeking and service use of suicidal individuals and identified seven primary barriers to help-seeking. A lack of perceived need was a common barrier found in the literature. The WHO’s World Mental Health Surveys found that this low perceived need was a significant reason why individuals did not seek treatment in 58% of the surveyed sample (Hom et al., 2015). For participants in a study of college students with suicidal ideation, low perceived need was once again echoed in the findings that the majority of participants did not believe their needs were serious enough to warrant service use, and that they believed this was “a normal part of college life” (Hom et al., 2015). A preference for self-management of symptoms tended to overlap with low perceptions of severity in symptoms and stigma emerged as a commonly reported barrier on its own.

Fear of hospitalization or a mistrust of service providers was also found, in that although a sample of adolescents had completed a suicide prevention program, 48% of participants still reported a fear of hospitalization that may prevent them from seeking help for themselves in the future (Hom et al., 2015). This fear was also found to extend to the encouraging of or seeking help for friends in 40% of the sample. Sareen et al. (2007) had similar findings, in that their sample of youth reported more concerns about stigma (i.e. embarrassment) and involuntary hospitalization. It was hypothesized that this finding possibly indicated a lack of mental health literacy and knowledge among these youth. Along with this fear of hospitalization, Hom, Stanley, and Joiner (2015) also found that negative beliefs about treatment effectiveness are often cited as a significant barrier in the literature.

Socio-demographic risk factors were a category of related barriers found in the literature review. Barriers within this category pertained to risk for non-service use based on age, gender, race and ethnicity. They found that ethnic minority populations often reported concerns with service providers' cultural competency and limited cultural familiarity as barriers to seeking and continuing treatment (Hom et al., 2015).

Hom and colleagues (2015) also reported structural barriers in their review of suicide and college students. In this manner, a perceived lack of time to seek services and a lack of financial resources were reported as significant barriers to accessing care. The researchers cited the WHO's World Mental Health Surveys, which revealed that structural barriers were of concern in that, worldwide, 15% of adults reported financial concerns, lack of available resources, difficulties with transportation, and general inconveniences (e.g. geographical) as hindering their help-seeking and service utilization. Eisenberg et al. (2012b) found similar barriers reported by college students in their review where medical students reported a lack of time as well as a fear of a negative effect on careers and academic records as deterring them from help-seeking.

In addition to identifying barriers, Hom et al. (2015) also found that a few studies have examined facilitators to care (i.e. factors that enable individuals to seek help). These included positive attitudes toward care from mental health services, family and friend support systems, and a history of prior service use. Interestingly, these factors have dual influences in either promoting or hindering future service use, thereby qualifying them as both possible facilitators and barriers-to-care. It was noted that facilitators that are more attitude-based as opposed to structural or demographic have the potential to be more dynamic and modifiable, and therefore are important to consider in further research.

Summerhurst et al. (2016) conducted a study of youth who have sought treatment from the First Episode Mood and Anxiety Program (FEMAP), which is an outpatient psychiatric clinic affiliated with the London Health Sciences Centre in London, Ontario. There were 283 youth that participated in this study, and their experiences with mental health services were explored. The youth participated in a clinical intake assessment to see if their symptoms met inclusion criteria. Three months after the intake they completed a survey that asked what the most helpful and most difficult aspects of their recovery from their mental health problems were. Youth between 19-26 years were found to be significantly more likely to report access to services as a barrier than youth between 16-18 years. These results were hypothesized as being related to the greater degree of contact younger youth may have with their parents and other adults as opposed to older youth who may have less contact with these sources and may not be aware of where to go to access services. Overall, a frustration with long wait lists and redirections to several services within their local mental health care community were discussed. Summerhurst and colleagues (2016) indicated that further research is warranted in the areas of students and barriers-to-care, especially to better investigate the differences found between younger and older youth populations.

Marsh and Wilcoxon (2015) examined structural barriers to seeking mental health service use in a sample of clinical and non-clinical college students in the United States. A regression analysis identified five system-related barriers that significantly predicted help-seeking behaviour: cost, not knowing about resources, stigma, lack of transportation, and lack of time. Cost was found to be the strongest predictor of help-seeking in the study and had greater impact on behaviour than stigma and attitudes toward help-seeking. The researchers discussed that the perception of cost as opposed to the true cost of services may be the actual treatment barrier being measured, this being demonstrated in the finding that students were deterred from seeking help even when the cost for treatment was low. It is important to note that these findings may not be generalizable to Canadian post-secondary students considering the differences in healthcare systems between Canada and the U.S. While perception of cost may still be a barrier reported among Canadians, it may not necessarily hold the same predicative value as demonstrated in this study.

Stigma has been a commonly examined barrier throughout the help-seeking literature. Dockery et al. (2015) studied barriers to seeking mental health care in service users and their caregivers in the U.K. The researchers reported that stigma-related barriers were most frequently identified with 83.2% of service users expressing that they delayed seeking treatment because they were concerned that this would present challenges when applying for employment. In the previously cited review of help-seeking on college campuses in the U.S., Eisenberg et al. (2012b) discussed how self-stigma (negative attitudes held by and about one’s self about help-seeking and mental health) and public-stigma (perceived negative attitudes held by others about help-seeking and mental health) can hinder access to mental health care. It was discussed that public-stigma is often perceived to exist at levels that are higher than self-stigma, which the researchers suggested could be a result of over-exaggerated beliefs about public-stigma. Eisenberg et al. (2012b) explained that this could represent an area in which educational intervention may help to reduce the perception of this barrier and thereby increase the likelihood of help-seeking.

Understanding what barriers exist in Canadian student populations and the effects these barriers may have on help-seeking for mental health services is a critical part of understanding overall help-seeking in these populations. Attitudinal barriers have been shown to have a significant negative impact on help-seeking for post-secondary students (Sareen et al., 2007), however, research regarding structural barriers – especially for these student populations – remains limited (Marsh & Wilcoxon, 2015). It is therefore imperative that further research be conducted to explore how structural barriers relate to help-seeking in Canadian university students.

Help-seeking Behaviours in University Students

Despite the potential for positive outcomes for mental illness, research has consistently demonstrated that, across North America and Europe, nearly half of all youth who have experienced mental illness did not access mental health services and had needs that went unmet (Clement et al., 2015; CMHA, 2015; MHCC, 2015; Gulliver et al., 2012). Data from the WHO's World Mental Health Surveys on 55,302 individuals 18 years of age and older across 21 countries revealed that only 40% of those who reported having a history of suicidal thoughts received a form of treatment for emotional difficulties in the past year (Hom, Stanley, & Joiner, 2015). Clement et al., (2015) found that 53-74% of those in need of help across Europe and the U.S. did not receive treatment. The CMHA (2015) reported that almost 49% of individuals experiencing depression and/or anxiety did not receive professional treatment for their mental health problems.

Mackenzie et al. (2014) conducted a 40-year cross-temporal meta-analysis that reviewed help-seeking data for American youth. Studies that used and/or cited Fischer and Turner's (1970) attitudes toward help-seeking measure (Attitudes Toward Seeking Professional Psychological Help Scale, the ATSPPHS) were included in the meta-analysis. Also included were search terms such as “help-seeking”, “attitudes”, “beliefs”, and “psychological help” etc. The researchers found a trend of increasingly negative attitudes toward seeking help from mental health services over the past 30 years. Findlay and Sunderland (2014) found that youth were less likely to use services and were more likely to have negative attitudes towards service use than older populations, which is also consistent with prior research (Mackenzie, Gekoski, & Knox, 2006; Tamboly & Gauvin, 2013; Golberstein, Eisenberg, & Gollust, 2008). In addition, the CMHA (2015) cited that one of five youth in need of psychological services did not receive professional help.

As previously discussed, service use can have a significant impact on the trajectory of mental illness in a person's life, which also applies to the specific cohort of university students (Eisenberg et al., 2007a). Research has demonstrated that there are high levels of unmet needs in university student populations (Eisenberg et al., 2007a; Tamboly & Gauvin, 2013; Golberstein, Eisenberg, & Gollust, 2008; Thomas, Caputi, & Wilson, 2013). For example, Eisenberg et al., (2007a) examined help-seeking in a sample of undergraduate and graduate students and found that only 36% of those that had screened positive for a mental disorder (e.g. depression and/or anxiety) had accessed services for medication or therapy in the past 12 months. The most commonly reported reason for not accessing services in this study was that there was no perceived need for treatment despite a positive screen. A possible explanation is that not all participants with a positive screen may have met diagnostic criteria for a mental disorder. The reasons reported, however, still follow a trend in the literature whereby the most commonly reported reasons for not seeking help revolve around not recognizing a need for treatment. Other reasons reported were being unaware or unfamiliar with available service options, skepticism regarding the efficacy of treatment, concerns about privacy, financial constraints, and lack of time.

Gender differences have been well documented in the help-seeking literature for mental and physical health care as well as in the symptomology for mental disorders (Summerhurst et al., 2016; Pattyn, Verhaeghe, & Bracke, 2015; Mackenzie et al., 2014). A gender gap for service use has been discussed where men have been found less likely to use mental health services than women (Pattyn et al., 2015; Mackenzie et al., 2014). This pattern in help-seeking for men and women has remained consistent through out the literature, even in adolescent and young adult populations. Summerhurst et al. (2016) reported that adolescent females were two to three times more likely to develop mood disorders and subsequently seek mental health services than adolescent males. In a Canadian sample of youth between 19-24 years of age, Cheung et al. (2009) found that female participants were more likely to seek services for mental health issues than male participants.

In a recent study by Pattyn, Verhaeghe, and Bracke (2015), gender and help-seeking were researched using a social constructionist perspective of gender differences. The researchers found that male participants had higher levels of shame and attributed more shame and blame to having mental illness than female participants. Furthermore, men were more likely to suggest self-care in response to mental health issues and were less likely to perceive psychotherapy as useful for treating mental illness as compared to women. Men were also found to be more likely to seek medical treatments (e.g. medication) and prefer a quick solution to their problem than women. The researchers postulated that seeking help represents a gendered role conflict wherein men are socially expected to appear strong, self-reliant, and in control, which could thereby lead to reluctance and a fear of stigma around seeking and accessing mental health services. Women were also found to perpetuate gender role expectations in that they were more likely to suggest self-care to men than to women and were more likely to suggest help-seeking to women than to men.

Dockery et al. (2015) further discussed contradictions in research regarding stigma and gender differences in help-seeking. For example, while Pattyn et al. (2015) suggested that men experience higher levels of personal stigma in the form of shame and blame, a study by Hom et al. (2015) found that women were more likely to report stigma-related barriers than men when analyzed with a service user regression model. Overall, these contradictions may indicate that the experience of stigma in help-seeking in men and women is complex, and an area in which further research is needed in order to better understand stigma as an influencing factor in help-seeking and how this affects the gender gap in service use.

As previously discussed, youth have been identified as holding more negative attitudes toward help-seeking and are less likely to seek help from formal mental health services than older populations. Similar trends have been found for post-secondary students. Golberstein, Eisenberg, and Gollust (2008) examined perceived public stigma in university students, which was described as a “newly studied population for this topic”, and found that perceived stigma was negatively associated with perceived need for help for students aged 18-22 years, but not for older, graduate-level students. The researchers discussed their findings, explaining it is possible that the younger students were less likely to have already experienced a mental disorder and were therefore less accepting of this label and experience (Golberstein, Eisenberg, & Gollust, 2008). It was also explained that the older, graduate students might possibly have been a unique population in and of itself wherein they have already experienced the transition from undergraduate studies, have been successful, have obtained a higher education level, and have experienced other unknown variables that may account for these differences (Golberstein, Eisenberg, & Gollust, 2008).

In a study on homesickness and adjustment by Thurber and Walton (2012), age differences in adjustment were discussed, and it was suggested that older students were less likely to experience intense homesickness due to having had more experiences away from home and feeling more supported by their families. Tamboly and Gauvin (2013) discussed their review of mental health literature and explained that students transitioning to university tended to believe that the stress and symptoms they were experiencing was normal in a post-secondary setting or that they feared seeking help for mental health problems would lead to public stigmatization and could affect their ability to progress with their education and career.

Golberstein, Eisenberg, and Gollust (2008) stated that further research is needed to understand this variation in help-seeking for younger and older students, and that interventions aimed at improving the knowledge of and availability of services for university students may be the most promising way to help improve service use on campuses (Golberstein, Eisenberg, & Gollust, 2008). Thomas, Caputi, and Wilson (2013) suggested the implementation of early intervention programs as part of undergraduate (psychology) programs to promote help-seeking and mental health well-being may be effective, considering that there has already been a push toward this in graduate (psychology) programs. The literature discussed herein tends to indicate a greater need for research to understand the unique dynamics of help-seeking in undergraduate university students so that proper prevention and intervention strategies can be designed and implemented for this unique, vulnerable, and at-risk population.

Northern and Rural Mental Health in Ontario

There is mounting concern regarding the mental health status of northern and rural populations, as poverty, unemployment, mental health issues, and suicide rates in Canada increase in relation to the rurality of the region, and especially for First Nations communities (CMHA, 2009; O'Neill et al., 2016; Smith, Humphreys, & Wilson, 2008; Caxaj, 2016). A similar pattern of poor mental health statuses and increased suicide rates in rural and northern communities has been documented across the globe (Caxaj, 2016). Still, Canadian-based research is needed to better understand the unique living conditions and health requirements of Canadian communities so that a greater improvement in overall health quality can be achieved.

Canada, a northern country, is home to a rich diversity of geography that affects the health services of its varying communities. It is well documented that northern and rural regions of northern countries, such as Canada, face considerable health disparities when compared to their more urbanized and southern regions (O'Neill et al., 2016; MHCC, 2012; CMHA, 2009; Caxaj, 2016). Despite the large geographical area of Northern Ontario (nearly 400,000 square miles), the population is relatively small in comparison (780, 140). Northern Ontario is considered to have its own distinct economic and social characteristics when compared to Southern Ontario (Strasser et al., 2009). What makes it even more unique is that approximately 60% of the population of Northern Ontario resides in rural and/or remote communities, while 30% of the population resides among Northern Ontario's two largest urban centers, Thunder Bay

(107,909; Statistics Canada, 2017) and the City of Greater Sudbury (161, 531; Statistics Canada, 2017).

For this study, it is important to note that definitions of “rural areas” and “rural and small towns” are based upon those provided by Statistics Canada. According to Statistics Canada, a “rural area” refers to a population that is living outside of a community of 1,000 people or more and that “rural and small town” refers to a population that is living outside of commuting zones of Census Metropolitan Areas that have a total population of 100,000 or more (du Plessis et al., 2001). For this study, the term “rural” will be used to describe both “rural areas” and “rural and small towns”.

Regarding the definition of “northern” in relation to Ontario, the typical point of division between Northern and Southern Ontario is Parry Sound, Ontario. As cited by the Northern and Rural Health Care Panel in their report for the Ontario Ministry of Health and Long-Term Care (2011), as well as by the CMHA (2009), the Canadian government’s definition of Northern Ontario stretches from the southern boundary of the District of Parry Sound and extends as far north as Hudson Bay and James Bay, also extending from the eastern border of Quebec to the western border of Manitoba, consisting of 10 territorial districts. North Bay, Sault Ste. Marie, Sudbury, Timmins, and Thunder Bay are considered the five urban centres of Northern Ontario. Furthermore, the geography of Northern Ontario ranges from the “near” north to the “far” north. The Northern and Rural Health Care Panel (2009) explained that the availability and accessibility of resources and services along with the needs of these communities differ across the unique geographies of Northern Ontario.

The literature that will be presented herein is guided by the concept that, in general, Northern Ontario has different needs, resources, and services than that of Southern Ontario. The following literature review for mental health in northern and rural areas of Northern Ontario will therefore include that of both the near and far north as well as its urban, rural, and remote communities.

The City of Greater Sudbury was used for this study. Sudbury itself is considered an urban center and is the largest Northern Ontario community with a population of 161, 531 with rural settlements outside of the city (Boydell et al., 2006). Sudbury is also home to several post-secondary institutions to which students from local as well as outside rural and urban communities come to study, such as Laurentian University, Collège Boréal, Cambrian College, and the Northern Ontario School of Medicine (NOSM). With Sudbury being a prime Northern Ontario location for post-secondary education, it was thought that a sample of undergraduate students at Laurentian University may be a group with diverse hometowns in terms of geographic location and population density.

Health in Northern and Rural Populations of Canada

Approximately 6-10 million Canadians live in rural and northern communities and experience difficulties in accessing mental health services (Dyck & Hardy, 2013; Boydell et al., 2006; O'Neill et al., 2016). Many communities in Northern Ontario, especially those in the far north, tend to be isolated both geographically and economically from urban centres and have limited local health resources to meet these smaller, sparser populations (Dyck & Hardy, 2013; O'Neil, 2016).

For those living in rural and/or northern communities, there are similar challenges expressed with the state of mental health services. Limited resources are a primary issue (Caxaj, 2016) that can lead to further challenges and barriers-to-care. The state of rural and northern economic factors can have direct impacts on a community's overall health. Many of these regions' economies involve agriculture, mining, forestry, and fishing. A decrease in local resources coupled with isolation in rural areas can lead to poor socio-economic conditions that correlate with high rates of alcohol use, increased stress, and a decreased physical activity (Caxaj, 2016; Smith et al., 2008).

Also noted is that there are limited services and practitioners, especially specialized practitioners, available in these communities. This lack of availability can pose a challenge, as those with mental health issues are faced with long, expensive travels to access specialized services and long wait lists and wait times (Caxaj, 2016). This lack of specialists in some regions of Northern Ontario has also resulted in family doctors being the source of first contact and, oftentimes, treatment for those with mental disorders (Komiti, Judd, & Jackson, 2006). A lack of knowledge about mental health and mental health services has been documented in the research (Komiti et al., 2006; Caxaj, 2016; Dyck & Hardy, 2013) and, as such, could present itself as a significant barrier to seeking help from local family doctors who, in Northern Ontario, tend to be a critical part of the detection, prevention, and intervention for mental disorders. In addition, the close-knit nature of some of these communities can pose as a challenge. Inhabitants tend to experience difficulties with protecting privacy and maintaining anonymity in smaller communities (Caxaj, 2016; Dyck & Hardy, 2013; O'Neill et al., 2016). This lack of anonymity can perpetuate a fear of public stigma, perceived or not, that can hinder service use (Caxaj, 2016; Komiti, et al., 2006).

The Mental Health Strategy for Canada, released by the Mental Health Commission of Canada in 2012 (MHCC), emphasized the importance of working with community resources to reduce these disparities and respond to the unique and varying needs of the population of Northern Ontario. There have been efforts made in Ontario to address the mental health disparities between rural and northern communities and urban centres. Tele-psychiatry, for example, has been developed to better connect those in rural or northern communities with urban resources, services, and practitioners (Caxaj, 2016). As of 2012, the Ontario Telemedicine Network reported that mental health care accounted for 67% of the clinical fields for which they provided support. The benefits of these videoconferencing programs as that it allows service users to meet with specialists without having to travel or relocate, protects patient anonymity, facilitates staff education, and reduces a sense of isolation for local service providers. Disadvantages to this strategy involve inequality between different communities where there will be those that do not have the funding and resources to support the technical requirements of tele-psychiatry.

Help-seeking research in Canada's northern and rural populations.

Undergraduate students attending universities in some Northern Ontario communities may experience barriers and help-seeking differently than students attending universities in larger, urban centres, such as those found in Southern Ontario. Although help-seeking research has become more specific to Canadian populations, there is still relatively little research that has been conducted regarding how Canadian youth – particularly undergraduate university students – access mental health resources and services in a northern geographical context (Findlay & Sunderland, 2014; Dunn, 2014; Lin & Parikh, 1999; Potvin-Boucher et al., 2010; Hussain et al., 2013; Dyck & Hardy, 2013; Boydell et al., 2006). The majority of Canadian research has been conducted in large, urban centres, such as in Southern Ontario as opposed to smaller communities in Northern Ontario (Findlay & Sunderland, 2014; Ballon, et al., 2004; Hippe et al., 2014; Dunn, 2014; Angus et al., 2012; Potvin-Boucher et al., 2010; Hussain et al., 2013).

Northern communities are considered vulnerable to mental illness (e.g. mood, anxiety, and substance abuse disorders) on account of the unique barriers these communities face in terms of social and economic disparities (e.g. increased financial costs, stigma and/or lack of anonymity related to smaller social networks, poorer overall health, and high suicide rates), limited and/or unavailable health resources (e.g. services, physicians, etc.), need for culture-specific services, and transportation challenges (MHCC, 2015; Hippe et al., 2014; Dyck & Hardy, 2013; Angus et al., 2012; Stuart et al., 2014)

Boydell et al. (2006) conducted a study that examined the experiences of parents who sought help for their children in two rural communities in Ontario, Canada to address the lack of research regarding help-seeking and rural communities in regard to youth. The two communities were Owen Sound, (Southern) Ontario and Sudbury, (Northern) Ontario. The researchers used definitions of rurality based on Statistics Canada. They recruited participants from at least 50 km outside of Census Agglomerations (one or more municipalities with a core population density of 10,000-99,999) and the commuting zones outside Census Metropolitan Areas (one or more municipalities with a core population density of 100,000 or more) (Boydell et al., 2006; Statistics Canada, 2015).

Thirty parents of 35 children formally diagnosed with a mental disorder and who were between 3 and 17 years of age participated in qualitative, in-depth interviews. The majority of family members interviewed were mothers. Half of the sample included children with mood disorders, anxiety-related disorders, and oppositional-defiant disorders. Approximately half of the children were diagnosed with comorbid disorders and the other half with a single disorder. The interviews captured parental experiences with barriers and facilitators to accessing care for youth.

Barriers-to-care were categorized as personal, systemic, and environmental. Boydell et al. (2006) found that the barriers reported by participants were often also reported to be facilitators to care. Participants reported that perceived stigma and lack of anonymity in the small, rural communities made it difficult to seek care as they were concerned about their child being “labelled”. This lack of anonymity, however, also contributed to the feeling of a close-knit community where word of mouth was reported as helping participants find services in the community and feel supported. The participants reported difficulties with affording travel out of town for specific services, of rigid intake criteria by programs to account for policy and funding issues, the “invisibility” of mental illness, and lengthy wait times (the average length of time being on a wait list being reported as anywhere from a few months to two years’). As for facilitators to care, participants also reported that the small size of the community helped them receive personalized delivery of care (such as home visits), that allowed service providers and workers to see unique aspects of their family life and therefore provide unique services in their local communities. Boydell et al. (2006) concluded that the rural communities studied demonstrated differences between barriers and facilitators in rural and urban communities, and cautioned that solutions to address access barriers in an urban community may not necessarily work in more rural areas.

The limited availability of research for help-seeking particularly in undergraduate students in rural communities was addressed in an American study by Hussain et al. (2013). The researchers stated that undergraduate students at rural campuses can face unique advantages and challenges, such as limited anonymity in rural communities that can deter students from seeking mental health services (Hussain et al., 2013). It was found that the most common barriers reported were “perceived stigma” and a lack of privacy. Participants responded that they were concerned with being perceived by peers as being unable to keep up with academic demands and that, as a result of feeling guilty, embarrassed, and mistrusting of others, they didn't access on-campus services. The unique circumstances of mental health services and help-seeking in rural and northern communities in Canada and among undergraduate university students as well as the limited research in this area indicates a need for further exploration and comprehension.

Purpose

Although there are high levels of unmet need for mental health treatment in undergraduate student populations, the research is limited (Golberstein, Eisenberg, & Gollust, 2008). The purpose of this mixed-methods master's thesis was to study the attitudes, intentions, barriers-to-care, and experiences of a sample of undergraduate students enrolled at a university in a Northern Ontario community. A standardized measure of depression was used to determine if this sample differed from the general population of this age group with regard to depressive symptoms. Furthermore, understanding whether this group of students were experiencing symptoms of depression during the time they were participating in the study was considered useful in determining if need for service, attitudes, and intentions to seek help, perceived barriers, and prior use of services varied by symptoms.

This study was undertaken in two parts. Part I examined undergraduate students' attitudes, intentions, actual help-seeking, and barriers to accessing services through quantitative measures. Part II examined students' personal experiences with mental health services by way of a semi-structured qualitative interview.

Hypotheses

The hypotheses for Part I of this study were:

1) Participants who have sought and accessed help from professional mental health services will have attitudes that are more positive toward help-seeking than those who have not.

This hypothesis was based upon previous research that has found that attitudes may be predictive of future help-seeking behaviour and that those who have negative attitudes toward help-seeking are less likely to have sought help or seek help in the future than those who have positive attitudes (Gulliver et al., 2012; Ballon et al., 2004; Mackenzie et al., 2014; Clement et al., 2015; Mackenzie, Gekoski, & Knox, 2006).

2) Participants who have sought and accessed help from professional mental health services will report more positive intentions toward future help-seeking than those who have not. Additionally, participants who have sought and accessed help from professional mental health services will report being more likely to seek help from professional sources of help than those who have not.

This hypothesis was based upon previous research that has found intentions may be strong predictors of actual help-seeking behaviour (Gulliver et al., 2012; Ballon et al., 2004; Mackenzie et al., 2014; Clement et al., 2015; Mackenzie, Gekoski, & Knox, 2006). Furthermore, past help-seeking may also increase the likelihood that someone will once again seek help in the future. Rickwood et al. (2005) reported that young people tend to seek help from informal sources (e.g. friends and family) more than formal sources (e.g. psychologist, counsellor, etc.).

3) Participants who have sought and accessed help from professional mental health services will report having faced more barriers to seeking and accessing services than those who have not.

This hypothesis suggests that those who have sought help will report more barriers and a greater frequency of these barriers than participants who have not sought help. Students have not sought help may not have actively faced some of the barriers to accessing care that those who have sought help (e.g. tried to or succeeded in accessing services).

Part I: A Look at Specific Help-seeking Behaviours in Students

Methods

Participants

A total of 61 undergraduate students from a northern university who were between the ages of 18 to 25 years (*M* = 20.4, *SD* = 1.6) participated in the study. There were 50 female and 11 male students. Based on the demographic self-reported data, 22 students had accessed professional mental health services (16 females and six males) and 39 had not (34 females and five males).

In terms of education, participants ranged from being in their first to fifth (one student) year of study in an undergraduate program (*M* = 2.5, *SD* = 0.9). The most frequently reported program of study was psychology (41.0%). In terms of employment, 44.8% of participants reported being unemployed, 11.5% reported being employed, 24.6% reported being employed part-time, 9.8% reported having summer employment, and 6.6% reported being a full-time student. It is most likely that the participants who reported being unemployed and those who reported being full-time students were within the same category of having a primary student status and being otherwise unemployed.

In terms of living situation, most participants were living in Sudbury, Ontario at the time of the study (88.5%) and most participants reported that their hometown was Sudbury (21.3%): 37.7% of participants reported living in residence, 26.2% reported living with their parents, and 16.4% reported living off campus and with a roommate. Regarding relationship status, 93.4% of participants reported being single, 4.9% reported being in a common-law relationship, and 1.6% chose not to respond. Two participants reported having dependent children.

Measures

Demographic Questionnaire.

A demographic questionnaire (Appendix A) was developed that comprised 28 items regarding gender, age, hometown and current place of residence, education, living situation, and mental health history. Professional mental health services were defined as “services that are provided by licensed mental health care practitioners, such as a registered psychologist, a registered psychiatrist, a family doctor, or a registered counsellor (who works for a mental health clinic or organization such as the Canadian Mental Health Association, Health Sciences North, Crisis Intervention, etc.)”.

The Inventory of Attitudes toward Seeking Mental Health Services (IASMHS).

The IASMHS is a 24-item attitude measure with three factor subscales: Psychological Openness, Help-seeking Propensity, and Indifference to Stigma (Mackenzie et al., 2004; Mackenzie, Gekoski, & Knox, 2006). The questionnaire takes approximately five to ten minutes to complete. In the IASMHS, participants are provided with statements regarding psychological problems and are prompted to rate whether they agree with the statements on a 5-point Likert scale ranging from zero (disagree) to four (agree). Higher scores indicate more positive attitudes towards help-seeking while lower scores indicate more negative attitudes towards help-seeking. The IASMHS has been replicated with an undergraduate student sample and was therefore deemed appropriate for the population of this study. The IASMHS defined professionals in mental health services as “individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers and family physicians” (Mackenzie et al., 2004).

The Psychological Openness subscale measured the participants' willingness to acknowledge and seek help for their psychological problems. An example item of this is "Psychological problems, like many things, tend to work out by themselves". The Help-Seeking Propensity subscale measured the participants' belief that they are willing and able to seek mental health services. An example item is "I would want to get professional help if I were worried or upset for a long period of time". The Indifference to Stigma subscale measured the participants' concern about what others' may think if they discovered they were seeking professional mental help. An example of this item is "Having been mentally ill carries with it a burden of shame".

Test-retest reliabilities for the IASMHS were: Total IAMSHS score, $r = 0.85$, $p < 0.01$; psychological openness, $r = .86$, $p < 0.01$; help-seeking propensity, $r = 0.64$, $p < 0.01$, and indifference to stigma, $r = 0.91$, $p < 0 .01$ (Mackenzie et al., 2004). Alpha coefficients for the subscales are from 0.76 to 0.82 (Mackenzie, Gekoski, & Knox, 2006). Internal consistency for the entire measure is 0.87 (Mackenzie, Gekoski, & Knox, 2006). It was found that this measure can differentiate between those who have and have not previously accessed mental health services as well as those who would and would not use them in the future, thereby demonstrating its convergent validity (Mackenzie, Gekoski, & Knox, 2006).

The General Help-Seeking Questionnaire (GHSQ).

The GHSQ was developed by Wilson et al. (2005) to address problems researchers found with prior scales, where-in attitudes and intentions were not accounted for as separate variables (Wilson, Deane, Ciarrochi, & Rickwood, 2005). The GHSQ is used to measure intentions and provide researchers with the ability to adjust the probe and sources of help specific to the purpose of their own study (Wilson et al., 2005; Rickwood & Thomas, 2012). It is open for use and reproduction for research purposes. The questionnaire takes approximately five to ten minutes to complete.

The GHSQ is comprised of a probe regarding the problem (e.g. “If you were having [problem-type], how likely is it that you would seek help from the following people?”), and that may also include a time-frame by which one identifies they’ll seek help in the future, which is then followed by a list of sources for help (both informal and professional) that are rated on a seven-point Likert scale (Wilson et al., 2005; Rickwood & Thomas, 2012).

For this study, the standard probe of how likely it would be for the participant to seek help from each of the people listed for a personal or emotional problem was used (Wilson et al., 2005). A time frame of four weeks was used. Sources of professional help were a mental health professional (e.g. school counsellor, psychologist, psychiatrist and a family doctor/General-Practitioner). Informal sources of help were a partner (e.g. significant boyfriend or girlfriend), a friend (not related to you)”, a parent, another relative/family member, phone help line (e.g. Lifeline, Kids Help Line), a teacher (year advisor, classroom teacher), and someone else not listed above. For the option of someone else, the participant was prompted to describe who this was in a space provided. An alternate option was provided of “I would not seek help from anyone”. The 7-point Likert scale ranged from one (extremely unlikely) to seven (extremely likely).

The GHSQ in this study was also used with the Actual Help-Seeking Questionnaire (the AHSQ) which, originated from an earlier measure by Rickwood and Braithwaite in 1994 and was specifically developed for use with the GHSQ by Wilson et al. (2005). It was developed to measure actual, past help-seeking behaviour from a list of sources within a specified time frame (Wilson et al., 2005; Thomas & Rickwood, 2012). This measure contains a “yes” or “no” response scale and asks if the participant has ever seen a mental health professional (with examples of a school counsellor, counsellor, or psychologist) to get help for personal problems. Participants were asked to answer three additional questions if their answer was yes. For the first question of the AHSQ, participants are prompted to write down how many visits they had with a mental health professional. The second question prompts participants to write down the title of the mental health professional if they knew what type of professional they had seen. The last question asks how helpful the participant thought the visit to the mental health professional was. This was to be answered on a 5-point Likert scale ranging from one (extremely unhelpful) to five (extremely helpful).

The Barriers to Access to Care Evaluation (BACE-3).

The BACE-3 was developed to assess the barriers to accessing mental healthcare in adults who accessed or were currently accessing secondary mental health services. It is suggested that this measure may be useful in general populations by helping to identify what barriers may need to be targeted with interventions to make accessing mental health services easier (Clement et al., 2012). Preliminary research has demonstrated acceptable internal consistency, test-retest reliability, and convergent validity, although further research has been recommended to determine population norms and to test the scale’s factor analytic structure (Clement et al., 2012).

The BACE-3 is a 30-item measure with a 12-item Treatment Stigma subscale. The questionnaire takes approximately five minutes to complete. In the BACE-3, barriers are defined as issues that have ever “stopped, delayed, or discouraged” someone from “getting or continuing with professional care for a mental health problem”. Professional care is also defined as care from persons such as a “GP (family doctor), member of a community mental health team (e.g.

care coordinator, mental health nurse or mental health social worker), psychiatrist, counsellor, psychologist or psychotherapist" (Clement et al., 2012). Participants are provided with a variety of potential barriers as items on which they are to rate as having stopped, delayed, or discouraged help-seeking on a 4-point Likert scale ranging from zero (not a t all) to three (a lot). Higher scores indicate experiencing more barriers, while lower scores indicate experiencing fewer barriers when seeking help.

In addition to the 12-item Treatment Stigma subscale, the BACE-3 can be further broken into two additional non-stigma related subscales: An 8-item Instrumental Barriers subscale and a 10-item Attitudinal Barriers subscale (Clement et al., 2012). An example item from the Treatment Stigma subscale is "Concern that I might be seen as weak for having a mental health problem". An example item from the Instrumental Barriers subscale is "Not being able to afford the financial costs involved". An example item from the Attitudinal Barriers subscale is "Thinking that professional care probably would not help".

The Beck-Depression Inventory II (BDI-II).

The BDI-II is a widely used self-report measure of assessing the severity of depressive symptoms in adults (Beck, Ward, & Mendelson, 1961). It is a 21-item measure wherein each item consists of a group of statements. The measure takes approximately five to ten minutes to complete. Participants are asked to pick one statement from each group that best describes the way they have felt during the past two weeks, which also includes the day on which they are completing the measure (Beck et al., 1961). For example, the group item of "Sadness" has four statements that the participant chooses from on a 4-point Likert scale ranging from zero ("I do not feel sad") to three ("I am so sad or unhappy that I can't stand it"). Appetite and sleep are two groups that have some statements broken down into two sub-groups to choose from as they may experience increases or decreases in these items. Lower scores on the BDI-II indicate minimal to mild depressive symptoms while higher scores indicate moderate to severe symptoms. Total scores for the BDI-II range from 0-63. Regarding depressive symptoms, a total score ranging from 0-13 is considered *minimal*, 14-19 is *mild*, 20-18 is *moderate*, and 29-63 is *severe*.

The BDI-II's criterion validity, severity cut scores, and test-retest reliability were examined with a sample of 137 university students who were receiving treatment from a university counseling center (Sprinkle et al., 2002). A strong correlation of $r = 0.83$ was found between the BDI-II student scores and the threshold for depressive mood symptoms from the *major depressive episode* portion from the Structured Clinical Interview for DSM-IV Axis 1 Disorders, also known as the SCID (Sprinkle et al., 2002). Regarding the BDI-II cut off score, a sensitivity rate of 84% was found. In terms of test-retest reliability, the researchers found a short-term test-retest reliability of $r = 0.96$, which they noted was similar to that found by Beck, Steer, and Brown in 1996 ($r = 0.93$), who examined its test-retest reliability in a sample of 26 outpatients. As such, the BDI-II was deemed appropriate for measuring depressive symptoms in this study's sample of undergraduate university students.

Procedure

This study was approved by the Laurentian University Research Ethics Board to ensure that the Tri-Council Policy was upheld regarding ethical research practices with human participants (Appendix B). Participants were recruited via posters shared on social media, such as Facebook, and in-class recruiting presentations from October 2016 to April 2017 (Appendix C). The study was completed either individually or with other students (with space provided for anonymity) dependent upon the participants' availability. They were provided with two consent forms (Appendix D): One for participation in Part I of the study and one for consenting to be contacted to participate in Part II of the study (Consent for Contact). Participants were then given a questionnaire package with the study measures. The questionnaires were placed in random order within the package. The package took from 15 to 30 minutes to complete.

Those who were participating and could receive credit in their university courses had their appropriate paperwork filled out for them. Before leaving, participants were thanked for their time and debriefed regarding possible discomfort they may experience as a result of thinking about possible mental health issues. Participants were provided with a list of community resources for mental health services (Appendix E).

Results

Results from the demographic questionnaire were separated into two primary sections: the overall sample and the grouped samples (those who had ever accessed mental health services and those who had not). Following this, the results from the study's measures are presented.

Population Demographics

As can be seen in Table 1, 24.6% of participants reported that they had accessed professional mental health services in the last year, and seven participants (11.5%) reported that they were currently accessing services. Of those with professional contact, he most frequently reported mental health service was counselling (4.9%). Regarding informal sources of help, 46 participants reported that they had sought and received such help. The most frequently reported informal source of help was friends (11.5%), while a combination of family and friends (6.6%) were the next most frequently reported.

Participants were also asked whether they thought they had a mental health disorder. The majority of participants (55%) did not report thinking they had a disorder. Regarding being diagnosed with a mental disorder in the past, 68% of participants reported that they had not, and 31% participants had been diagnosed. When asked if they currently had a mental health diagnosis, 72% participants reported they did not, and 26% participants reported that they did. The most frequently reported diagnoses were depression and anxiety. For additional demographic information regarding this sample, see Appendix F.

Table 1

Participants who Reported Accessing Mental Health Services and When as a Percentage of the Sample

Services and Time Frame	Percent
Ever Accessed Professional	
Yes	36.1
No	63.9
Professional in the Last Year	
Yes	24.6
No	75.4
Currently Accessing Professional	
Yes	11.5
No	86.9
Not Answered	1.6
Ever Accessed Informal Help*	
Yes	75.4
No	24.6

Note: *Informal sources of help were defined as friends, family members, spouse or romantic partners, a telephone hotline, teachers/professors, etc.

Attitudes toward Help-Seeking

The first hypothesis predicted that there would be differences in attitudes toward help-seeking between those who have accessed services and those who had not. Independent samples t tests were conducted between groups for the total IASMHS score as well as the subscales. There were no significant differences found in total IASMHS scores between those who had ($M = 59.22$, $SD = 15.79$) and had not ($M = 58.15$, $SD = 12.36$) ever accessed professional mental health services ($t_{59} = -0.294$, $p = 0.77$). There were no significant differences between groups on any of the subscales for the IASMHS. The mean IASMHS total score for the entire sample was 58.54 (*SD* = 13.46), which indicates moderately positive attitudes.

Intentions toward Help-Seeking

The second hypothesis predicted that there would be differences in intentions to seek help from professional mental health services between those who have ever sought and accessed these services in the past and those who have not. An independent sample t-test on the GHSQ scores showed that those who had accessed professional mental health services (*M* = 4.86, *SD* = 1.85) had reported more positive intentions toward seeking help from professional services than those who had not (*M* = 3.07, *SD* = 2.08) at $t_{59} = -3.341$, *p* = 0.001. It was also found that those who had not accessed professional mental health services (*M* = 5.21, *SD* = 2) reported more positive intentions toward seeking help from parents than those who had not received some form of service (*M* = 3.07, *SD* = 2) at $\mathrm{t}_{58} = 2.54$, *p* = 0.014.

Pearson correlations were conducted to compare all the sources of help on the GHSQ. Only parents and a mental health professional showed significant results. Pearson correlations were then conducted to compare the likelihood of seeking help from parents and a mental health professional. Intentions to seek help from mental health professionals were positively correlated with having accessed services in the past (*r* = 0.399, *p* = 0.001). Intentions to seek help from parents were negatively correlated with having accessed services in the past (*r* = -0.316, *p* = 0.014).

Table 2

Means of GHSQ Scores of Undergraduate University Students*

Sources of Help	Group 1 *n* = 22		Group 2 *n* = 39	
	M	*SD*	*M*	*SD*
Partner	4.85	2.18	4.71	2.27
Friend	5	1.95	5	1.73
Parent*	3.9	1.74	5.21	2
Other Related Family Member	2.86	1.75	3.73	2
Mental Health Professional*	4.86	1.85	3.07	2.08
Phone Help Line	2.5	1.89	1.92	1.52
General Practitioner	3.54	2.1	2.76	1.85
Teacher	1.77	1.19	2.33	1.49
Someone Else Not Listed Above	2.2	2.33	1.53	1.36
No one	3.05	2.08	2.56	1.77

Note: Means (*M)* and standard deviations (*SD*) of rating scores on the GHSQ* (General Help-Seeking Questionnaire) for intentions to seek help from a variety of sources of help for mental health issues. The participants' intent to seek help from each source was rated on a 7-point Likert scale. Scores range from 1 (*extremely unlikely*) to 7 (*extremely likely*). Group 1 refers to those who reported having ever accessed professional mental health services and Group 2 refers to those who have not. Mean ratings for each source of help can be seen along with a comparison of mean ratings from each group.

Actual Help-Seeking.

Responses for the AHSQ were analyzed with descriptive statistics. Twenty-six participants reported having ever seen a mental health professional, and 35 participants reported that they had not. For those who had seen a mental health professional, the most frequently reported type of professional was a counsellor (19.3%), followed by a counsellor/social worker (7.7%), a psychologist (7.7%). When asked how helpful the visit was on a 5-point Likert scale, 14.8% of participants reported "extremely helpful", and 9.8% reported "helpful", as presented in Table 3.

Table 3

How Helpful the Visit to a Mental Health Professional was as a Frequency Percentage of the Overall Sample

Rating	Frequency
1	3
2	2
3	5
4	6
5	9
Not Applicable	34
Not Answered	1
Psychologist 4 / Psychiatrist 2	1

Note: This table displays the frequency with which each rating was endorsed by participants regarding how helpful they perceived their visit to a mental health professional had been. Answers were rated on a 5-point Likert scale ranging from 1 (*extremely unhelpful*) to 5 (*extremely helpful*). Answers are from the Actual Help-Seeking Questionnaire (AHSQ).

Barriers to Accessing Mental Health Care

To assess the hypothesis that there would be differences in the barriers faced between groups, an independent samples t-test was conducted. Those who had accessed professional mental health services had higher total BACE scores (M = 30.36, SD = 16.74) than those who had not (M = 29.4, SD = 13.40) at t_{58}= -2.178, p = 0.034. There were no significant differences between groups on the individual subscales of the BACE.

Symptoms of Depression

To assess the symptoms of depression between groups in this sample of participants, an independent samples t test was conducted for BDI-II scores between those who had accessed professional mental health services and those who have not. A significant difference was found between groups. Those who accessed services (M = 25.45, SD = 14.09) had significantly higher depression scores than those who had not (M = 14.35, SD = 8) at t_{59} = 3.97, $p < 0.001$. The mean depression score for the entire sample was 18.29 (SD = 11.71), which is categorized as “mild depression” on this measure and close to the clinical cut-off for “moderate depression”.

Discussion

This part of the study was designed to test three hypotheses regarding attitudes and intentions towards help-seeking and barriers to seeking and accessing mental health services for a sample of undergraduate post-secondary students. Symptoms of depression were also measured to verify levels of depressive symptomology for this sample. Differences were examined between students who reported having ever sought and accessed services and students who had not. The results are discussed in terms help-seeking behaviours, barriers, and depressive symptoms.

Attitudes. It was hypothesized that students who had accessed professional mental health services in the past would have more positive attitudes toward help-seeking than those who had not accessed (Jagdeo et al., 2009; Mackenzie et al., 2014). It was therefore predicted those who had accessed services would have higher total scores on the IASMHS, as well as on its subscales. This hypothesis was not supported; there were no statistical differences found between the groups on the attitudinal measure. Furthermore, despite previous research that has demonstrated a decline over time in youth's attitudes toward help-seeking for professional mental health services (Mackenzie et al., 2014), this sample of university students had moderately positive attitudes toward help-seeking overall.

Mackenzie and colleagues' (2014) cross-temporal meta-analysis examined the help-seeking attitudes of American youth between 1968 to 2008 and cited other studies which demonstrated prevalence rates of negative attitudes among American and Canadian youth. One of the studies was by Jagdeo et al. (2009) in which two population surveys (the US National Comorbidity Survey and the Ontario Health Survey) were examined. The authors found that negative attitudes toward help-seeking were prevalent among Ontarians (18%), and that a younger age was associated with more negative attitudes. It also found that those who had previously accessed mental health services were more likely to have positive attitudes. Jagdeo et al. (2009) explained that it is unknown whether these positive attitudes were already present in these individuals prior to service use, or if the use of these services enhanced attitudes. Furthermore, the American results of this study were found to have similar trends despite differences in the two nations. Although the researchers noted an increase in positive attitudes in the last decade in the United States – which juxtaposed the later findings by Mackenzie et al. (2014) – it was also explained that there was a paucity of Canadian research to suggest that a similar trend has taken place in Canada. Jagdeo et al. (2009) suggested that future studies assessing current attitudes toward help-seeking in the Canadian population would be useful and important.

The current hypothesis regarding attitudes was developed and based upon research such as that by Jagdeo et al. (2009) and Mackenzie et al. (2014). The presence of moderately positive attitudes toward help-seeking found among post-secondary youth in the current study could be explained by a possible increasing trend of positive attitudes amongst Canadians, similar to that in the United States, which was described by Jagdeo et al. (2009). This could be associated with increasing initiatives toward reducing stigma in various areas (e.g. campus advertisements, increased education, media anti-stigma campaigns such as Bell Lets Talk; Jagdeo et al., 2009).

For this sample, the subscale of Indifference to Stigma had the highest scores on the IASMHS, suggesting that these students had positive attitudes that weren’t negatively influenced by stigma. This study’s findings could also be explained by the possibility that this particular sample of students, the majority of whom were enrolled in undergraduate psychology programs, were more educated about and more accepting of mental health, in general. It is also possible that these students answered in a way in which they thought was most acceptable, thereby representing a bias toward responding with answers associated with positive views of mental health problems. The anonymity of participation is thought to mostly negate this nervous bias.

It is important to also note that the majority of previous studies on attitudes toward help-seeking, as well as the Mackenzie et al. (2014) meta-analysis, had used or were based on studies that had used the ATSPPHS as opposed to the IASMHS. The IASMHS is a relatively new measure that was adapted from the ATSPPHS and was determined to have high test-retest reliabilities, internal consistency, and demonstrated validity (Mackenzie, Gekoski, & Knox, 2006). The primary reason to use the IASMHS in this study was to use a measure that had been adapted from another that's already been widely used throughout research, but that has also addressed concerns regarding conceptual and methodological limitations of the prior measure. As discussed by Mackenzie et al. (2006) as well as Hammer, Parent, and Spiker (2018), concerns about the ATSPPHS had been raised over the past decades regarding its outdated language, predated factor analysis, poor subscale reliability, lack of internal consistency, lack of theoretical grounding, and construct-irrelevant variance.

Mackenzie et al. (2006) explained that the development and use of the ATSPPHS had brought benefits to research on help-seeking attitudes, in that its development with psychometric accuracy was unique at the time and that its use increased consistency in the study of attitudes towards help-seeking from mental health services. The researchers argued that despite these benefits, however, the ATSPPHS required revision after 30 years of use. A 10-item short-form of the measure had been developed in 1995 by Fisher and Farina (ATSPPHS-SF) in an effort to address the recognized internal inconsistencies of the ATSPPHS; however, conceptual and methodological limitations were believed to remain in the short-form (Mackenzie et al., 2006), as well as contradictory evidence of the desired unidimensionality of the measure and continuingly low internal consistency (Hammer et al., 2018).

With the IASMHS, Mackenzie et al. (2006) decided to ground their scale in the theoretical background of Ajzen's Theory of Planned Behaviour (TPB) from 1985. The TPB had a specific emphasis on attitudes which postulated that behavioural intent toward help-seeking can be predicted by a combination of help-seeking attitudes, subjective norms (i.e. perceived social pressure), and perceived behaviour control (i.e. one's perceived control and ability about seeking help; Hammer et al., 2018). Mackenzie et al. (2006) reasoned that Anderson and Newman's framework of health service use from 1973 – which is essentially based upon Anderson's Behavioural Model for Health Service Use (BMHSU) – didn't have a direct focus on attitudes, and therefore was not chosen to guide the development of the IASMHS. This use of the TPB in the IASMHS addressed the concern that the ATSPPHS lacked theoretical grounding while also addressing the researchers' second goal of extending the ATSPPHS with the inclusion of items based upon TPB, which was believed to improve the scale's predictive ability (Mackenzie et al., 2006). Items were developed to measure the constructs of subjective norms and perceived behavioural control. These items assessed perceptions of what various individuals or groups that were considered important would think about or how they would react, to help-seeking behaviours, perceptions of control that was believed to be had over obstacles to seeking help (both within and out of one's control), and perceptions of one's ability to successfully attain services if these were sought.

A key adaptation to the scale was the change in language believed to limit the ATSPPHS's relevance and validity. Gender-specific language was replaced with gender-neutral pronouns and the terms "psychiatrist" and "psychologist" were replaced with a more generic term of “professionals” to reflect the fact that various health professionals are often involved in mental health services. In addition, it was believed that the use of various terminology to refer to mental health problems resulted in a lack of consistency throughout the items. As such, the term “psychological problems” was used to replace the variety of terminology found in the ATSPPHS. Also adapted was the 4-point Likert rating scale, which was changed to a 5-point Likert rating scale. It was argued that scales with 5 or 7-point rating scales were considered more reliable, more valid, and less likely to have Type II errors than those with less than 5 points.

It was believed that the IASMHS addressed the concerns of the ATSPPHS and ATSPPHS-SF. The use of the IASMHS in this study was believed to also contribute to help-seeking research in that it had already begun to be used in newer research as a way to examine its effectiveness and to measure attitudes in differing populations. As such, it was also thought that the use of the IASMHS in this particular research with a university student population may also contribute to existing help-seeking literature.

There is the possibility, however, that the use of the IASMHS was perhaps a limitation in this study as the validity and effectiveness of this measure has recently come into question. In a 2018 study conducted by Hammer et al., the ATSPPHS and IASMHS were compared and it was argued that both of these scales were flawed when it came to accurately measuring attitudes toward help-seeking for mental health services. Due to this perceived absence of valid measures, these researchers developed their own measure of help-seeking attitudes: The Mental Help Seeking Attitudes Scale (MHSAS). This scale was considered necessary by the researchers as it was thought that the limitations of the ATSPPHS and IASMHS were significant and compounded by the fact that the IASMHS was an adaptation of a scale that was considered an inherently invalid measure of attitudes toward help-seeking.

Hammer et al. (2018) stated that the IASMHS was susceptible to construct-irrelevant variance in that, while it was intended to measure three factors of help-seeking attitudes (Psychological Openness, Help-seeking Propensity, and Indifference to Stigma), each factor was argued to measure multiple distinct constructs unrelated to attitudes (i.e. mental health literacy and self-disclosure of mental illness). The IASMHS was considered an invalid measure as it was believed that it did not purely measures attitudes, which it was designed to do. It was argued that the IASMHS, which was grounded in TPB, strayed from the TPB’s strict definition of attitudes (how “good” or “bad” an individual evaluates the act of seeking help from mental health services) by measuring multiple irrelevant constructs and not clearly measuring help-seeking attitudes, which was referred to as construct underrepresentation. Hammer et al. (2018) explained that some items were not clearly defined and that, as a result, participants with differing thoughts on help-seeking might both agree to the same item, therefore invalidating the scores. In addition to the above concerns, the researchers suggested that the evidence for it’s ability to be used cross-culturally has been contradictory.

With the development and psychometric evaluation of the MHSAS, there is the possibility that the results found in this study for help-seeking attitudes may not replicable if conducted with the MHSAS, or even the ATSPPHS. Future research is needed to further evaluate and compare the validity, reliability, and cross-cultural applicability of the IASMHS and the MHSAS in both student and non-student populations.

Intentions. It was hypothesized that students who had sought and accessed professional mental health services in the past would have more positive intentions toward future help-seeking than those who had not. It was therefore predicted that those who have used services would have higher total GHSQ scores than those who had not. This hypothesis was supported. It was found that participants who ever accessed professional mental health services were more likely to intend to seek help from professional mental health services than those who had not. Additionally, participants who had never accessed these services were more likely to intend to seek help from their parents – an informal source of help – than those who had. There were no other significant differences found regarding intentions to seek help from other informal sources indicated on the GHSQ.

These results are generally consistent with prior research regarding intentions for seeking help from professional mental health services. It has been reported that young people in general tend to seek more help for mental health problems from informal sources rather than formal sources (Thomas et al., 2014; Rickwood et al., 2005) and that they access these informal sources first before professional sources of help (Rickwood et al., 2005). Thomas et al. (2014) also reported that research involving undergraduate psychology students has found that this population has been found to prefer seeking informal sources of help, with talking to family and friends being the most preferred coping strategy.

Rickwood and colleagues (2005) explained that although it is a positive sign that youth are willing to discuss their mental health problems, it can be problematic if the informal sources of help – such as friends and family – do not provide the necessary type of support that is needed. In addition, it was reported that whether friends and family tend to provide support that is actually helpful remains unclear. It is generally accepted that friends and family may be ill-equipped and/or poorly trained to address the mental health problems that youth may seek help for and that mental health professionals are well-equipped and trained, providing a protective factor against mental health risks (such as the risk for suicide; Rickwood et al., 2005).

Rickwood et al. (2005) examined the results of 19 research studies conducted on help-seeking attitudes, intentions, and barriers in high school and first-year university students. The researchers found that parents and friends were the primary informal sources of help from which youth between the ages of 14 - 24 years had sought help (2005). Differences were found between genders in that, as girls got older they became more likely to seek help from friends than their parents, while boys tended to remain stable in their help-seeking sources of friends as they aged. Both groups were found to have intentions to seek help from parents that declined over the years. This finding was generally limited to the high school years and did not specifically explain whether these differences continued into post-secondary education.

In this study, parents were the only form of informal sources of help identified by students. Any differences between genders were not investigated due to low sample size. Friends were not found to be a statistically significant source of informal help, which contrasts with Rickwood and colleagues' (2005) findings. It was suggested by Rickwood and colleagues (2005) that, as youth become more independent from their family, their peer-groups begin to have a more significant role in their lives. Furthermore, was explained was that help sought from these main sources of informal help were also dependent upon the type of help being sought. For instance, help for personal-emotional and relationship problems were preferred from friends as opposed to family. Different types of problems were not investigated in this study. This study focused upon only "personal" and/or "emotional problems" for the GHSQ. It is possible that this may account for some differences in findings, however, it is important to note that this study found family to be a more likely source of future help than friends for personal/emotional problems as opposed to what Rickwood et al. (2005) reported.

In addition, these results indicate that the prior experience of having accessed formal services for youth may have an influence on the likelihood that they would go to certain sources for help, considering that mental health professionals and parents were the only sources of help found to be clinically significant in the GHSQ results for this sample of undergraduate students. As reported by Rickwood et al. (2005), youth that had prior positive experiences with mental health professionals were more likely to intend to seek help from these sources again in the future. This is consistent with the results of the present study which found that those who had ever accessed professional mental health services were more likely to intend to seek help from professional services again than those who had not. Also consistent with Rickwood and colleagues' (2005) findings, is that the AHSQ results in of the present study demonstrated that the majority of those who reported seeking help in the past rated their visit to a mental health professional as being helpful to extremely helpful. This finding may have had an impact on how these individuals reported their intentions to seek help from these types of services again.

Also consistent with Rickwood et al. (2005) is that, in the present study, those who had not sought help from professional mental health services in the past were more likely to intend to seek help from informal sources than formal sources in the future. As was mentioned in this section, Rickwood et al. (2005) explained that informal sources of help are typically the first that are sought by youth. As such, it is logical that the undergraduate students in this study who had not accessed mental health services in the past would report higher levels of intentions to seek help from informal sources (i.e. their parents) than formal.

While interpreting the results from this study and how they relate to previous research, it is important to note that Rickwood et al. (2005) and Thomas et al. (2014) conducted their research in Australia. Furthermore, the 19 studies that Rickwood et al. 2005) examined were also conducted in Australia. It is possible that Canadian youth may have different relationships with their parents and peers than Australian youth and therefore have different help-seeking attitudes and intentions. This emphasizes the need for further research on Canadian youth's help-seeking intentions.

Barriers. It was hypothesized that students who had ever sought and accessed professional mental health services in the past would report experiencing more barriers to seeking and accessing these services than those who had not. It was predicted that participants who had accessed services would therefore have higher total scores on the BACE-3 than those who had not. This hypothesis was supported regarding the BACE-3 full scores, but not regarding the subscales scores.

In general, those who reported having ever accessed professional mental health services reported facing more barriers to service use than those who had not. This could be explained by the fact that those who reported having never accessed services may have: 1) never faced any barriers to help-seeking, 2) may have faced but not recognized facing barriers, or 3) may have never sought help to begin with. It is possible that there were individuals in this study who did not recognize they had a mental health problem and therefore a lack of perceived need could have presented as a barrier to help-seeking in the group who reported having never accessed professional help. In addition, it was not specifically asked whether participants had sought help from mental health services but did not receive it. Seeing that this potential subgroup of individuals was not directly examined in this study, it is not known if this may have also had an impact on the reporting of barriers by those who reported having never accessed help.

That being stated, it is important to note that while this subgroup was not directly studied, the fact that those who reported having never accessed professional services did in fact report having faced barriers on the BACE-3 suggests that this subgroup was present in the overall population sampled in this master's thesis study. Possible full-scores for the BACE-3 range from 0 – 99. In this study, the lowest overall full-score measured was five and the overall highest full-score measured was 63. This means that despite the group they belonged to, all of the participants reported having experienced at least one of the barrier-related items measured by the BACE-3, but also that variability was high.

Prior research regarding barriers to seeking help has typically focused on these populations that have not accessed professional mental health services (i.e. those who have identified unmet needs and had not sought help), and research regarding those who have sought help is limited (Ojeda & Bergstresser, 2008). Ojeda and Bergstresser (2008) studied unmet needs in adults. They cited that their failure to ask about perceived barriers-to-care in those who did not perceive unmet needs was a limitation. This study addressed this limitation in providing the BACE-3 to all participants. Regardless, considering this paucity of research as well as the discussed considerations regarding the results of this study, future research is needed that further examines barriers to help-seeking in those who have sought and accessed professional services, those who have sought but not received any services, and those who have never sought professional services.

The BACE-3 consists of three subscales that measure three separate types of barriers: Instrumental barriers (i.e. structural), attitudinal barriers, and treatment-stigma related barriers.

That there were no significant differences in the BACE-3 subscales between groups is inconsistent with previous research that has found attitudinal barriers to be more commonly reported as reasons for not seeking and/or accessing help than structural barriers in student populations (Craske et al., 2005; Sareen et al., 2007; Mojtabai et al., 2011). It has also been suggested that there is limited research regarding structural barriers in Canadian student populations (Marsh & Wilcoxon, 2015). It is possible that this lack of knowledge about the effect of and reporting of structural barriers for Canadian university students may account for the above contrast between this study's findings and prior research about experiences with specific types of barriers to help-seeking.

Depressive symptoms. Depressive symptoms were measured across the entire sample as well as between groups. This was done to determine if discrepancies existed between need for services based upon participants' scores and the results when testing the study hypotheses.

This sample of students was found to be in the clinical range of mild depression, on average, based upon BDI-II scores at the time of completing the measure. In addition to the overall sample demonstrating mild depressive symptomology, differences in BDI-II scores were found between groups. Those who reported having ever accessed professional mental health services in the past had significantly higher BDI-II scores than those who had not, verifying that there were higher levels of depressive symptomology among the group that had sought and required access to help. The group that had accessed services in the past had, on average, a moderate level of depression. The group that had not accessed services in the past had an average score that was at the cut-off/threshold for mild levels of depression.

It is possible that those had not accessed professional mental health services in the past did not perceive a need for help for their depressive symptoms. The fact that the results were in the mild clinical range for this group could explain why students may not have recognized a need for help or may have sought to deal with their distress informally. Previous research on attitudinal barriers to help-seeking in post-secondary students may help to explain this finding. Several studies have found that students often demonstrated a perceived lack of need in that they prefer to deal with their problems on their own, they question the severity of their problems, and that they hold a belief that stress is “normal” in college, university, and/or graduate school settings (Eisenberg, Hunt, & Speer, 2012; Tamboly & Gauvin, 2013; Eisenberg, Speer, & Hunt, 2012; Hom et al., 2015). In addition to these attitudes and beliefs, students have also reported thinking that they didn’t have the time to seek professional help (Eisenberg, Hunt, & Speer, 2012; Eisenberg, Speer, & Hunt, 2012; Hom et al., 2015) as well as the belief that seeking help for their mental health problems could negatively impact their educational and vocational progression (Tamboly and Gauvin, 2013). It is possible that with depressive symptoms ranging from minimal to mild in this group, participants may have experienced some of these attitudinal barriers, and therefore have not accessed professional mental health services.

Participants were recruited and participated from October to April, across two academic terms. If the majority of students that participated did so during high stress times of the term, this may have impacted their scores. Considering that the incentive of marks for participation in this study were provided by professors, it’s a possibility that students may have waited until later in the semester for their courses to accumulate marks for participation in various studies being conducted at Laurentian University. This effect was expected to be minimized by sampling across two terms from October (providing students time to adjust to the school year routine and their new schedules) to April (the end of courses and start of exams).

The results are consistent with prior literature on depression and mental illness in undergraduate students. As Tamboly and Gauvin (2013) reported in an issue brief intended to address mental health concerns in students at McMaster University, Ontario youth between the ages of 15–25 years are at a higher risk for depression and anxiety than other age groups, with Ontario students reporting significant mental distress. In the Canadian Campus Survey 2004 for the Centre for Addiction and Mental Health (CAMH), it was stated that one third of undergraduate students that participated reported having four or more symptoms of elevated distress (Adlaf, Demers, & Gliksman, 2005). The most commonly reported of these symptoms were a feeling of significant stress (47% of students), loss of sleep attributed to worry (32%), and feelings of unhappiness or depression (31%; Adlaf et al., 2005).

The mental health of university students across countries has become increasingly problematic in the last few decades. In a systematic review of 11 articles, Storrie, Ahern, and Tuckett (2010) assessed the global state of university students and mental illness. The researchers found that since 1994, stress and anxiety problems became the most frequently reported problems at global university counselling centres. They found that within this population, students with depression had doubled in over a decade. It was reported that emotional health was a more significant issue than physical health for students and that, in comparison with the general population, student health was poorer overall (Storrie et al., 2010).

Although the results of this study support prior research, it is unclear whether the levels of depressive symptomology in this sample of university students differed significantly from other university students in Canada. Future research would be needed to explore whether student populations at different universities across Canada, particularly in northern and southern Ontario, have similar depression scores as found in the current study. In addition, exploring relationships between depression and help-seeking attitudes, intentions, and barriers may be helpful in order to better understanding the unique needs of Canadian undergraduate university students who have and have not sought and/or accessed professional mental health services.

Part II: Student Experiences when Accessing Mental Health Care

The purpose of this part of the study was to further explore undergraduate students' experiences of seeking and accessing professional mental health services. While the first part of the study examined help-seeking behaviours of those who had and had not engaged in service use, the second part of this study intended to expand upon these results through an in-depth examination of participants' personal experiences with accessing services. It is important to note that professional mental health services were defined as services that are provided by licensed mental health care practitioners, such as a registered psychologist, a psychiatrist, or a counsellor (who works for a mental health clinic or organization such as the Canadian Mental Health Association, Health Sciences North, Crisis Intervention, etc.).

The research question was as follows:

1) What are the help-seeking experiences of undergraduate students at a university in a Northern Ontario community?

This question was exploratory and based upon previous research that has explored the experiences of help-seeking for mental health problems or disorders in different populations.

Methods

Participants

Participants were recruited from the Part I sample by indicating their interest to participate in Part II of the study. Those who indicated that they met the criteria of having previously sought help from professional mental health services were invited via email to participate.

Seven undergraduate students with a mean age of 21.4 years (*SD* = 1.9) participated; five females and two males. One participant reported having dependent children. Five participants reported being single and two reported being in a common-law relationship. Participants were in their 2nd and 3rd years of study with the majority being in psychology programs. Two participants reported living in residence, three reported living off campus, and two reported living with their parents.

Measures

A semi-structured interview (Appendix G) was developed to address the research question "What are the help-seeking experiences of undergraduate students at a university in a Northern Ontario community?". The 21 questions were divided into four parts: What mental health care meant to the participant, their personal experiences with seeking mental health care, their experiences with mental health services with a focus on their needs and the treatment they received, and any barriers and/or facilitators to accessing mental health care that the participants may have experienced. There were also questions regarding their opinion and thoughts about mental health services in Sudbury, on campus, in northern Ontario, and in southern Ontario.

Procedure

Participants were informed of the purpose of the study upon their arrival and provided with a consent form (Appendix H) for participation. Private interviews were recorded with a Sony digital voice recorder (ICD-PX333). The semi-structured nature of the interview allowed for the interviewer to ask any additional questions that may have arisen from the participants' responses. Interviews were between 14 minutes and 28 minutes in duration. The average interview length was 20 minutes. Upon completion of the interview, participants were debriefed regarding any discomfort they may have experienced as a result of discussing their personal mental health issues. For example, the students were allowed to take any time they needed before leaving the room. They were also provided with the same list of community resources for mental health services (see Appendix E).

Results

A deductive Thematic Analysis, following Braun and Clarke (2006), was conducted to address the broad research question regarding personal experiences of help-seeking for mental health services. A contextualist theoretical framework of critical realism was the position from which this analysis took place. How the individuals made sense of their experiences while considering the social contexts that surrounded their realities were taken into consideration while analyzing the data set (Braun & Clarke, 2006).

Interview recordings were transcribed verbatim. The interview transcriptions were then read and reread so that the researcher could become familiarized with the data set. From there, sections of text were highlighted that were deemed relevant to the overall research question. Notes regarding initial analytic observations were made in the margins of the transcripts. These analytic observations of the data set were then coded.

After these codes and their data extracts were organized, they were sorted into relevant groups. Patterns throughout the coded data were identified. Codes that were similar to each other were grouped into emerging themes based upon these patterns in the data. Visual representations were used throughout this process. Coded data within these “candidate themes” were reviewed to ensure that they formed coherent and meaningful themes (Braun & Clarke, 2006).

Next, the entire data set was reread to ensure validity of the themes in relation to the overall data set and to refine emerging themes and search for any additional codes or themes. Themes were then defined and named. Detailed analysis of each theme was written up and then an integrated report of the findings of the analysis was produced.

Three primary themes were developed from the semi-structured interview analysis. Throughout the interviews, participants discussed their perceptions and opinions of the mental health care they received and what they expect from these services. Their most recent and, if applicable, past help-seeking and treatment experiences were explored throughout the interview. The three themes were: Important factors in mental health care, experiences with mental health care, and barriers to accessing mental health care.

Theme One: Factors in mental health care.

Participants described mental health care in a broad scope as well as in more specific terms relating to their own experiences. They were asked what mental health care meant to them. This was directly answered at the beginning of the interviews and found to be indirectly answered throughout each interview as the participants continued to report their own personal experiences with seeking and accessing mental health services. There were common perceptions of what participants felt were important factors in mental health care in general. This demonstrated the qualities that participants felt were essential to mental health care as well as what they would expect from it. The subthemes identified were Openness, being Non-Judgemental, Being heard, Confidentiality, and having Qualified professionals (Figure 1).

Openness. Openness was considered to mean that health care was available and accessible to all those seeking help as well as being an attribute that promoted a perceived willingness to provide care in an open-minded and inclusive atmosphere. In terms of openness, one participant described accessibility related to knowledge of services when seeking and accessing mental health care. Participant 1 stated:

> "It's important to me on…how easy they are to find. If they [mental health care services] are known that may be easier to find them […] If they're affiliated with like, um, like an organization or something that is very known then it's easier to find them."

Theme 1: Important Factors in Mental Health Care

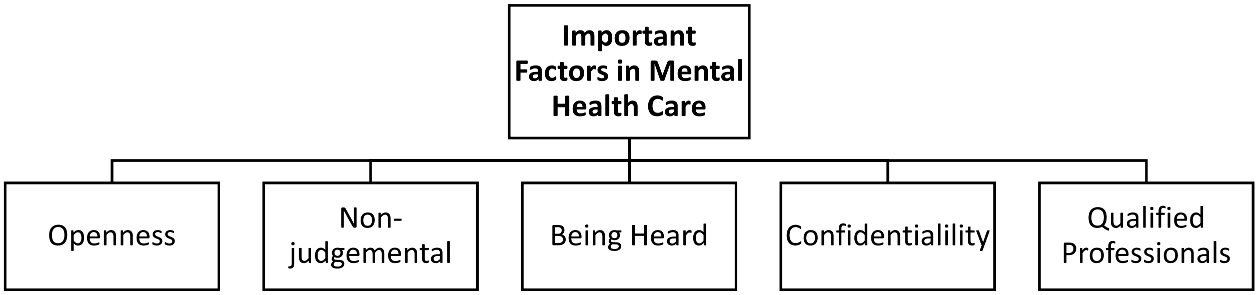

Figure 1: A representation of Theme 1 developed from deductive thematic analysis of seven interviews.

Participant 2 described how accessibility is important to seeking mental health care, explaining that "[…] it's always good to have, like, that open door because sometimes I need that little…mmm…guidance, I guess I'd say.". This participant also continued to emphasize the importance of this factor, stating that the northern community in which the individual experienced accessing mental health care in was "pretty open and convenient in the sense of mental health".

Non-judgemental. In terms of mental health care being non-judgemental, some participants addressed this factor as being an important part of what mental health care meant to them. For example, participant 3 described "Just having someone who understands what you're going through and doesn't judge" when asked what mental health care meant to them. Participant 2 also addressed this characteristic and related it to her positive experience with the mental health care services she had received while also explaining how the environment felt open, which helped to foster a non-judgmental atmosphere. This individual explained:

> "I feel pretty comfortable. I never felt judged when I walked into the counseling office there because I feel like anybody who's been in there and was there for the same reason I am...and I feel like it's not like any negative connotation around counselling here, I feel like it's just super open and so I've never felt it or anything like that."

Participant 4 also addressed non-judgment by stating "Yeah, I would expect non-judgement. You know, like, openness, honesty, kind of like an understanding…". This association between openness and non-judgement can be observed in these two statements, with both described as a positive feature in mental health care. For participant 2, the environment the participant encountered was what participant 4 expected in services. Non-judgement as well as the associated openness were common threads throughout the interview data.

Being heard. The importance of feeling as if one was being heard when they sought and accessed mental health care was emphasized throughout the interview data. Being heard in the context of help-seeking and accessing services refers to the concept of opening up about personal difficulties while asking for help and getting a response that addresses these concerns and considers what the individual is trying to convey when moving forward with a treatment plan, making referrals, and providing treatment. For the participants in this study, being heard was an important aspect of what they expected from mental health care in general. Being heard was observed to underlie both the feeling of being taken seriously and not being ignored.

For example, participant 4 discussed her frustration with the response that a family member had received when they tried to access mental health services. This individual stated that:

> "…she [family member] was a little bit younger when she started, and her social worker was completely like, 'Oh, you're just a kid and you're still going to grow out of it and you don't know what it is yet' and stuff, so…yeah. Which of course turned her off a lot, so she didn't, she doesn't even want to try now."

This described a situation in which a person was seeking help and felt like they were not being heard, which was also highly related to not being taken seriously. Following this perceived negative experience, the person withdrew from seeking further help from mental health services, which frustrated and saddened the participant. This emphasized the importance of being heard – and in conjunction, being taken seriously – when seeking and accessing mental health care.

Confidentiality. Throughout the interview data, the importance of confidentiality in mental health care was highlighted by participants. When asked what mental health care meant to them, participant 5 responded "Confidentiality is the main thing." And participant 6 responded "Trust and confidentiality between you and the one you're speaking to. And that's the biggest thing for me.". Along with confidentiality is the desire for anonymity when receiving mental health care, which can be difficult to uphold in small communities. In these situations, the need for confidentiality is emphasized. Participant 1 described being in a helping profession course when a teacher discussed that, in small towns, mental health care providers would sometimes see clients in the community, "in real life". He commented that situations such as the one he had described hearing "was weird". This demonstrated the unease that may be felt when encountering a mental health provider or patient in one's own community. It also demonstrated a mental health professional's need to ensure that patient confidentiality is upheld in both clinical and community settings.

Qualified Professionals. The expectation that there be qualified professionals who were educated and trained for their varying positions in mental health care was noted across interviews. The concept of mental health professionals being trained and thus qualified for their positions can be observed in the following statements. For participant 7, the idea of mental health care meant "Someone who is having an issue […] and who seeks care from a trained individual" and, for participant 5 it meant "them [mental health care professionals] actually being qualified, knowledgeable, to actually help you with the problems, the conditions, you're like going through.". Participant 4 explained that she would expect professionals to understand your situation and be knowledgeable in setting up treatment plans, stating, "[…] not just understanding, but like, understand what could be underlying, understanding what your saying but also what – understanding what that would mean and how to treat it, kind of thing.". The expressed need and expectations for qualified mental health professionals was also observed through negative experiences that some participants had with these providers. These experiences will be addressed as part of Theme Two in the following section.

Theme Two: Experiences with mental health care.

All participants had at least one experience with services, ranging from one experience to several experiences. In the latter case, the most recent experience was primarily explored, and the prior experiences were also addressed. Those who had known someone close to them who had sought and/or accessed services (e.g. a friend, family member, or significant other) disclosed their emotions related to their close others' time with these services as well as their perceptions regarding the helpfulness of the care that person received.

A pattern of dichotomy was noted throughout all these experiences in which the participants described having negative and positive perceptions of the care they and their close others received. While some participants' close others had helpful experiences with treatment, others had not. This pattern was also observed with the participants' own experiences. Some had encounters they considered helpful and others that were not. The two subthemes developed were "Mental Health Care Providers" and "Mental Health Care Services". The pattern of dichotomy was consistent in both subthemes with there being "positive" and "negative" perceptions of what the participants considered to be beneficial or aversive to their experiences as well "positive aspects" and "negative aspects" of their perceptions regarding their expectations of service providers. There was not enough data regarding close others' experiences for the development of a theme or subtheme.

It should also be noted that several of the qualities identified tended to also cross subthemes in that some qualities were noted in experiences with mental health care providers as well as the mental health care services in general. In addition, aspects of mental health care services as a whole often encompassed experiences with mental health care providers that had an effect on the participants' overall encounter with these services. Although the two are separate subthemes, it is important to recognize that they are also connected. What affects an experience with mental health care services may have an impact on a person's perception of their experience with professionals providing the mental health care, and vice versa.

Mental Health Care Providers.

Positive.

Regarding mental health care providers, participants described various characteristics and qualities of those who provided their care. As can be seen in Figure 2, these characteristics were either positive – and therefore perceived to be beneficial or important in participants' experiences with mental health care providers; or negative – and therefore perceived to be aversive to their experiences. Positive qualities were being caring and nice, taking the patient seriously, being qualified, helpful, and non-judgemental.

Theme 2: Experiences with Mental Health Care

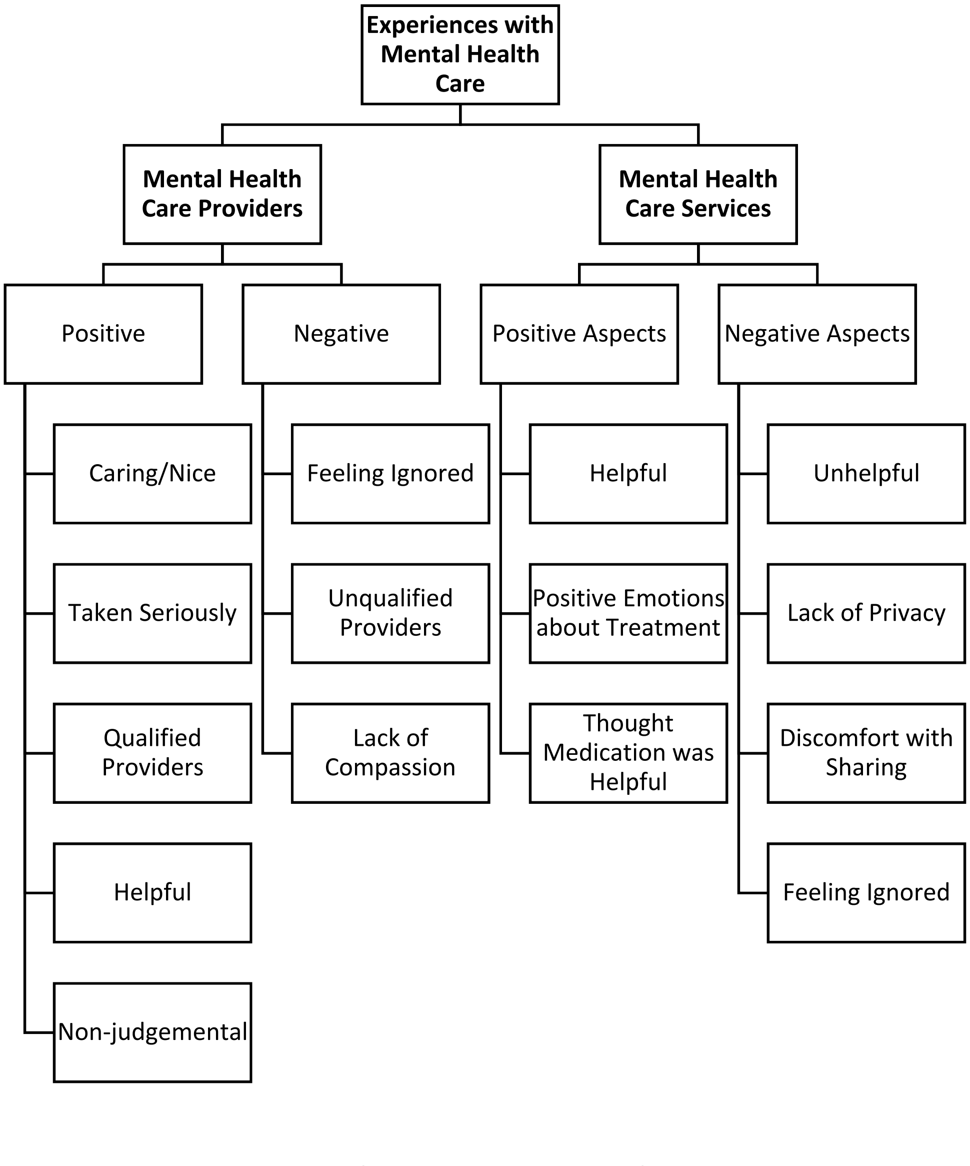

Figure 6: A representation of Theme 2 developed from deductive thematic analysis of seven interviews.

Participant 2 commented “[…] I believe that the people who were there for me fully believed in me and wanted to help me.” This description spoke to the caring aspect of their provider. In another interview, participant 6 described the characteristics of a provider as being both qualified and helpful, stating that the doctor seen “spent a lot of time asking me questions and getting to know me […] I feel the doctor gave me a thorough explanation of what I am going through. And she, she was great.” Participant 7 described their provider as being helpful and qualified despite there being an identified therapist-client incompatibility regarding age. He stated that “[…] she definitely had the techniques down. Might not be as relatable because she was so old, but she knew how to, uh, kinda the right questions to ask, the key indicators of everything. So I felt it was pretty good.”

As discussed in the previous theme about important factors in mental health care, non-judgement was once again emphasized by participants in discussions of mental health care providers and the participants’ experiences with them. Participant 3 explained how they thought being non-judgemental was important for mental health care providers to exhibit: “[…] just having someone that understands what you’re going through and doesn’t judge…”. Participant 4 also stated “I would expect non-judgement” regarding seeking and accessing help.

Being taken seriously was a positive characteristic of mental health care providers that also emerged in the interviews through discussion of participants’ negative experiences with professionals. In describing the opposite, more negatively perceived characteristic of being ignored, the importance of mental health care providers taking their patients seriously was illustrated. Participant 4 described a need to be taken seriously in terms of the severity of their distress and a belief that this may only happen if they were in a crisis:

> "I wish I'd of done it sooner. But at the same time, if I would have went sooner people probably wouldn't have taken me as seriously because I wasn't at that breaking point, right? You'd see someone and they'd be like 'oh, you're depressed, everyone's depressed' or whatever, you know? But if you're actually at the point where you're going to do something then people act. Or that's just my perspective.".

Negative.

Common qualities related to negative perceptions of mental health care providers were identified and included being unqualified, having a lack of compassion, and ignoring the patient. Regarding qualifications, participant 4 explained that she would want "someone qualified in actual diagnosis", explaining that "at first I was hooked up with like, uh like a social worker who had no idea of what actual mental disorder, she just kind of tried to work with my situation, you know? But that's not really someone who actually knows the disorders". The participant went further to explain that the provider was "really nice, she tried" but that "she was doing what she could but she wasn't knowledgeable in that [psychiatric disorders] so she couldn't do more" and "it's not what she was trained in, you know?".

Participant 3 described a contrast between her recent and past experiences with mental health providers; previous providers were perceived as being uncaring, and recent providers were perceived as being compassionate:

> "It seemed to be more beneficial this time for me. It didn't seem like, they're like 'Oh, she's another patient, you've got to fix her.'. Like, that's how I usually, when I go into a hospital that's usually how they kind of treat you. It's the same with the nurses. They kind of talk down to you and think that they're better than you are. But this time they seemed to be a little more caring"

This participant also explained an experience she had while visiting her friend who was a patient in a mental health facility: "I was overhearing the nurses, how they were talking to people like they were dogs really. It was…I guess you don't really notice it while you're there because you're not really noticing much, but I found it really embarrassing, almost".

Regarding the perception of being ignored, participants described situations in which they felt they had not been taken seriously and were thereby also being ignored. Conversely, this feeling of having been ignored by mental health providers was also often associated with the perception of not being taken seriously. This association was briefly discussed in the previous section with "being taken seriously" as the phrase utilized for the positive characteristic. As such, the primary negative characteristic is being ignored and the perception of not being taken seriously is associated with it.

Participant 5 described an experience where they felt as if they weren't being heard and thereby ignored. The following statement demonstrates the frustration with being ignored by a mental health provider when one seeks help: "[…]it just upset me, just 'cause like, I don't know… you're telling somebody that you want help from them and they don't really do anything. It's kind of upsetting." When asked what the participant thought could have been done or changed to make her experience better, she responded "Yeah, probably instead of just diagnosing somebody with something, maybe actually listen more. And they could have actually seemed more involved, I guess you could say".

Participant 3 described an experience where they had sought help at a hospital and had to wait for a bed to become available. In the recounting of this experience, their perceptions of the staff and how the person felt were expressed as follows:

> "I think that, like, if you go to the hospital for mental health issues I feel like they don't really see you as being sick, so they kind of just push you off to the side and deal with you later […] this past time I went, I had went to [hospital] to emerg and they kind of just put me in a bed…into a bed off in the corner, just 'We're just going to wait until we can find a spot for you.'. So I think that's basically what they do for people that are actually sick, but they didn't really seem to check up on me to make sure I was okay or talk with me or anything. They were just…they just kind of push off to the side and wait until a bed's available for you and then other people can deal with you after."

As can be seen in the quotation, there was a perception that the staff were not taking her mental health condition seriously as well as a feeling of being ignored by staff by pushing the participant "off to the side" so that other staff members could then take them into their care. In another section of the interview, this participant described mental health care providers in her community as seeing people with mental health issues as a "burden". Participant 3 stated that "they seem to think that we're kind of a burden to the people that are actually sick. So…I, it might just be me thinking that but, I…it's kind of what I experienced".

Also noted was a pattern whereby the qualities of mental health care providers that were considered "positive" were the same qualities considered to be lacking in the participants' negative experiences with mental health care providers. These qualities were helpfulness, taking the patient seriously and thereby not ignoring the patient, being caring, and being qualified. For the participants in this part of the study, these were characteristics that were associated with the participant's overall perception of their experience with their service providers.

Mental Health Care Services.

The same dichotomy of negative and positive perceptions of participants’ experiences was identified regarding the mental health services provided. These were categorized into positive and negative aspects of the experiences. Participants elaborated upon their treatment and expressed what they considered was beneficial and/or challenging, as well as their overall perception of the services they were provided.

Positive aspects.

“Positive aspects” of mental health services that were common across the interviews were that the services were considered helpful, the participants had positive emotions about their treatment, and that participants thought medication was helpful.

Regarding being helpful, one participant described a positive experience with mental health services and explained “They were very helpful to myself and, um, I don’t know, it made me get to like know myself even more […]” (participant 6). Participant 7 explained how their views of how helpful the services they received had changed over time. He said that “at the time I thought it [counseling] was kind of unnecessary and kind of took it as a joke, but now I see that it was helpful”. When this participant was asked whether his needs were met, he stated that “because it did improve on the situation, it…I’d say that needs were met.”. A situation in which previous experiences were perceived as being aversive and a more recent experience perceived as beneficial, participant 3 said that “it seemed to be more beneficial this time for me”. Another participant had described the treatment protocol they received and identified a therapeutic task as having been helpful, explaining that it “never crossed my mind that I could do that or felt like I should do that [therapeutic task]. Um, and it helped and yeah.” (participant 1). These statements are examples of ways in which participants believed that the mental health services they experienced were helpful.

In terms of positive emotions about their treatment, some participants described various positive emotions (e.g. pride and happiness) about having sought and accessed mental health services. When asked about their decision to seek and receive mental health services, participant 2 stated: “I’m happy about it. Like I said before, I don’t think I’d be here today”. This statement not only spoke to the happiness regarding her decision for treatment, but the effectiveness of the services as well. Participant 6, who was referred to services by someone else, said that it wasn’t something they would have done on their own, and stated “I am thankful that I did do it.”. Participant 7 described two positive emotions about the services they received even though they were not the one who sought help for themselves. He explained his emotions with the following statements: “I’d say happiness because like it did, it did help at the time.” and “Maybe a little bit of pride, too; that I did, that I was able to go and do it and stick with it.”

Some participants received medication as part of their treatment plans. Throughout the interviews it was noted that participants who received medication tended to view this part of their experience as helpful. Participant 4 described being prescribed medication and that once the right dosage was established, “it was fine”. She later went on to discuss her emotions regarding this aspect of mental health care, explaining: “I’m really happy for Zoloft. Like…very happy. I was really scared to get on it ‘cause people, like, there’s so many horror stories about it and stuff. And I’m like ‘oh, it’s chemicals in your brain’, eh, you know? But I’m so happy I tried it.” Participant 2 described their belief that medication was helpful for their treatment in the following statement: “…I’ve gone through the medication side of things, as well. But overall I think that was really beneficial.”. Regarding medical treatment, participant 3 explained the following: "…he [psychiatrist] got my medications sorted out. So I'm on a pretty good combination of medication. And, um, I think that's a really big factor for feeling a little bit better.".

In addition to this, it was noted that some participants who were not on medication also held positive emotions regarding medication in mental health care. For example, Participant 1 described what it felt like to have a friend(s) on medication for mental health problems. He explained, "I know some of them do need medication, but at the same time don't like taking it. But then other time they'll say 'I need my meds'. […] And when they take their meds I feel good for them because they're helping themselves.".

Negative aspects.

"Negative aspects" of mental health services that were common across interviews were that services were considered unhelpful, there was a lack of privacy, participants felt discomfort with sharing personal information, and felt ignored. In some situations, participants described feeling as though their needs were not fully met, disappointment with services they received, and thereby an overall sense that the services were unhelpful. This can be seen in participant 5's negative experience with a mental health care professional and their frustration with not being heard or having their needs met. When asked how they felt about the treatment they received, this participant responded "I was actually not very satisfied. I was kind of disappointed really.". The participant went on to explain that there was "nothing really" helpful about their treatment, and that it "kind of felt annoying because it didn't really help or do anything. So it was kinda, I felt like it was a waste of my time…".

For participant 4, it was an accumulation of experiences that were perceived to be unhelpful that were described throughout the interview. Many of these experiences were related to a belief that the mental health care professionals seen were not fully qualified as they did not have a background in diagnosis or psychological disorders. This participant explained her belief that these professionals were focusing more on getting the participant to fit into society as opposed to providing coping mechanisms through counselling. This was demonstrated in the following statement:

> "…they all kind of told me 'like, oh, this is just to help you with, like you know, like your ways.', like not even coping, like your ways of not even reacting, just fitting into society kind-of-thing so it's not exactly mental health, it's just trying to get along with it, you know? […] So it's like not as good, I guess.".

A similar pattern of prior negative experiences leading to a belief that past treatment was not very helpful was found in an interview with another participant. This participant described situations in which they felt the mental health care providers were uncaring, and that previous experiences with more compassionate providers was more helpful.

A lack of perceived privacy was another situation observed. Participant 4 stated further that confidentiality was very important and described a time when they felt the place they attended for services did not fully ensure that patients could not be heard when with their provider. When asked what was important to her when looking for help, the participant answered:

> "Confidentiality. Like, I've been in an office where you can easily hear on the other side…like, easily; like there are people sitting out there and they can hear everything 'cause when I was siting there I could hear everything in here. So as much as it's like, okay, you can close the door but it's not doing very much.".

For some participants there was discomfort with sharing personal information. Participant 6 described that she had grown up in a family where these types of personal problems were not openly discussed in public. She explained that “We kind of have the idea at home not to air out, like, dirty laundry, so you know, like whatever happens it only stays at home and you don’t talk about it outside of home”. Talking openly about personal information with mental health care providers was identified as challenging for this participant because of that “mentality”. Participant 7 depicted discomfort with sharing personal information during treatment. He stated “…just having to kind of replay events. It is kind of, you are sad or it makes you angry depending on the event. [..] she [mental health care provider] gives the techniques, but just like, going through the events, you are a little depressed after.” Participant 1 elaborated upon discomfort they felt with speaking freely to providers of a certain gender and that he felt he “really could talk more easier to the male counsellor.” as opposed to a female counselor. This highlighted the need for compatibility between patient and the service provider. Participant 6 discussed how, despite being a “really talkative person”, they thought it was “challenging” to open up and talk to someone about “personal issues that [they’ve] kept to [themselves]”.

Another factor that was found to be associated with perceived negative experiences with mental health services was the feeling of being ignored. As previously discussed, being ignored was connected to the feeling of not being heard and not being taken seriously. Negative experiences of feeling ignored by mental health professionals was also discussed and is related to the overall sense that one has been ignored by mental health services, in general, from which they sought help. As mentioned in previous sections, participant 3 described a situation seeking help from a hospital’s emergency department and was sat in the hallway to await a bed. This participant described feeling that the nurses did not check up on them enough and that they were being “pushed aside” – and in an underlying sense, ignored – for “other people to deal with [you] later”. Participant 5 explained a situation where they sought help and felt that the provider didn’t “really do anything”, thereby ignoring the needs they expressed.

Theme Three: Barriers to accessing mental health care.

A complex theme regarding the barriers to accessing mental health care was developed. Throughout the interviews, participants described their experiences with mental health services, challenges they or their close others experienced when seeking and/or accessing help, and their opinions on what may have made their experiences more beneficial. A number of barriers were identified and categorized under two subthemes: “Individual” and “Structural” (Figure 3). These themes represented barriers experienced at the individual or personal level as well as those experienced at the structural or societal level.

Individual. At the individual level, two common barriers were identified: Attitudes toward seeking and accessing mental health care and a lack of perceived need for mental health care. The attitudinal barrier of perceived public stigma was observed as having a common impact across for participants. Perceived public stigma regarding mental health and help-seeking refers to an individual’s beliefs that the public/others will or are viewing them negatively for having sought or accessed mental health care. Specific kinds of perceived public stigma observed across interviews were shame and a fear of judgement.

Perceived shame for needing to get help in the first place as well as the belief of bringing shame to their family through service use were expressed by participants. Participant 3 identified the following as a challenge to seeking services: “Fear of judgement and the disappointment to my family, and the shame.”. This participant elaborated upon their fear and shame when they described being unsure about whether they would access services on their university campus. She explained, "[…]I don't like the judgement that the teachers -I, I'm sure they're not judging me, but it feels like it, and I just don't want anybody at the school to know really that I would be accessing them.". There was also a belief that, if people were to know about the person getting mental health care that they would be seen differently. This was apparent with the statement: "[…] because I feel that's what they really see you as…they don't see you as anything other than being…sick, I guess.".

Theme 3: Barriers to Accessing Mental Health Care

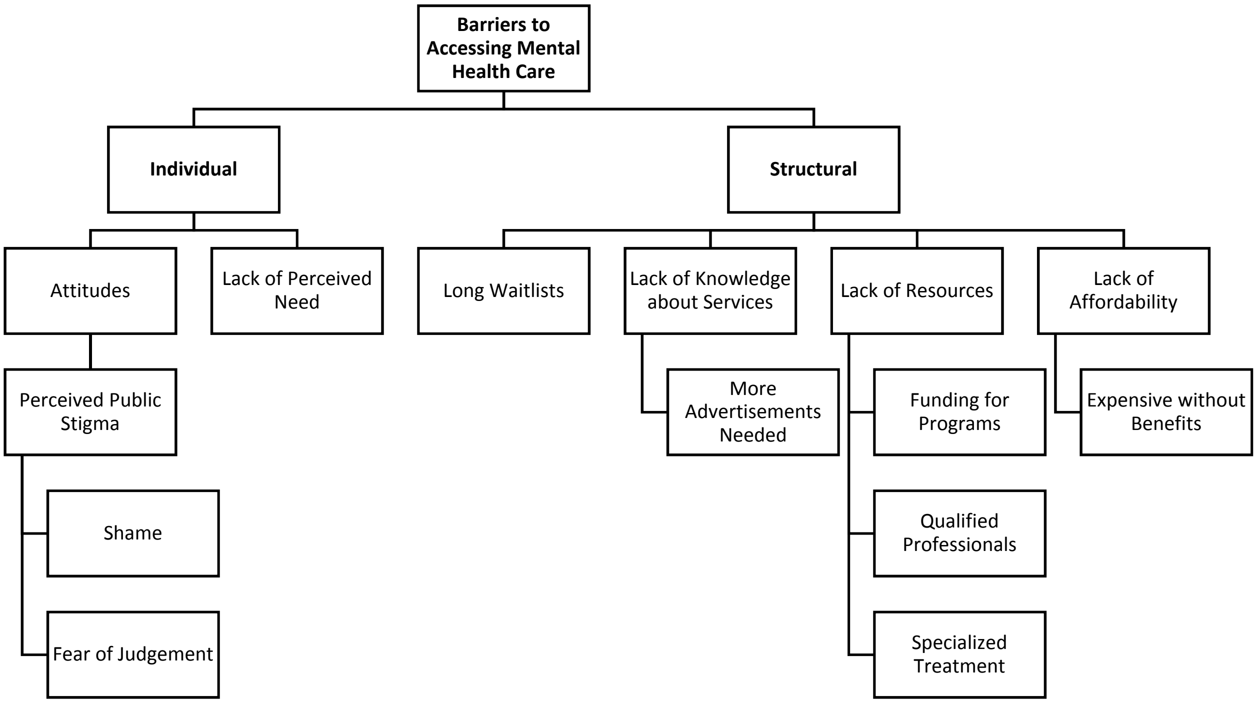

Figure 3. A representation of Theme Three developed from deductive thematic analysis of seven interviews.

Participant 5 described feeling shame in a variety of ways. It was explained that they felt "shame that [they] even went", elaborating that the "shame is just more of a 'I hurt my pride' kind of thing to do that so I felt shameful having to seek something like that, that I was feeling actually that sad…". The participant then stated that this shame made it "tough to even tell anybody" and that it was "then even more shameful when you have to go speak to someone about it…".

Participant 7 discussed the idea that talking about getting help from mental health care services could lead to being stereotyped or judged as well as the shame that is connected to it. Regarding his own perceived shame for receiving mental health services, this participant explained "But no one else I knew was attending at the time. So, I was kind of like 'you're the odd man out'. You don't really know how, and you might feel a little embarrassed that you're going…don't want to talk about it.". Regarding a fear of judgement from others, he stated: "As a grown up I just kind of realized that there's a taboo or a thought that anyone who seeks mental health is a crazy person and like, just isn't fit for society. And, unfortunately, that stereotype still kind of exists today."

Participant 2 explained a sense of not wanting to expose a vulnerable side of themselves due to an "embarrassment to show who [they] really were.". While this embarrassment can be considered similar to shame for having mental health difficulties, it can also accompany a fear of judgement as can be seen with their following statement of being guarded about their personal mental health struggles: "'Cause you don't want to be vulnerable in front of the…not the wrong type of people, but kind of the wrong type of people." (participant 2).

Fear of being judged by others can also pose as a barrier to seeking and accessing help when this perceived public stigma is held by the person's family members. Participant 4 discussed a situation such as this and identified it as being a challenging part of getting treatment. The participant said that her parents were "not exactly open" to the idea of psychiatric medication and "kind of blew up and made a big scene", but that she had to go through her parents' benefits to afford the medication so it was still something that had to be addressed. Although the participant explained that her parents were now more accepting of the therapy and medication required, her parents still held a perceived public stigma regarding her medication. Participant 4 recounted how she must hide her medication and be "sure not to take it in front of everyone." She said, "I left the prescription out once and my grandma came over and my mom's like rushing to hide it, so it's still kind of a negative thing, like no one should know you need this kind of thing."

A lack of perceived need was identified as a personal barrier to seeking and accessing mental health services. Not perceiving a need for help refers to a person not recognizing that there is a problem or an issue in the first place. In these cases, individuals who do not perceive a need themselves may end up being referred to seek help by others (e.g. family members and friends).

Some participants in the interviews explained that others had convinced them to seek help. Participant 6 explained that someone else suggested they talk to a counselor, stating: "Again, it's not something that I would have done on my own had I not spoken to an academic adviser.". Participant 7 was referred to seek help by their parents and explained "I felt fine, but they thought I should seek mental help." and that they thought it was "unnecessary" and "took it as a joke". Another case in which parents perceived a need for mental health care and suggested a participant attend services was with participant 5, who said "It was more so my parents sayin' it ‘cause I was kinda depressed for, well um, a varying amount of time. So, I was kind of pretty much depressed, so my parents wanted me to talk to somebody.”.

In another situation, it was not a family member who referred participant 3 for help, but teachers and a counselor at their high school. Participant 3 said that this was their first experience with mental health services. She depicted the situation with the following statement: “[…]A few of the teachers and the counselor had some together and then kind of sat me down and said, like, ‘Okay, you need to go to the hospital or you need to get help’ because I was…I wasn’t eating very much.”.

Another participant illustrated how one’s own perceived need for help can change with time. Participant 1 stated that he wasn’t comfortable attending mental health services because he felt like he was “in-between”. He elaborated upon this with stating, “I feel good now. Like I feel like I don’t need, but I don’t know. It’s like, it’s like I go through waves of ‘I need it’, ‘I don’t need it’, ‘I need it’, ‘I don’t need it’.” As this individual demonstrated, people can sometimes feel confused about whether they require mental health services and that their perceptions can change and can be a barrier to seeking help.

Structural. At the structural or societal level, there were four primary barriers identified in the analysis: Long waitlists, a lack of knowledge about services, a lack of resources, and a lack of affordability. Participants explained throughout the interviews how some of these barriers may have made it difficult for them to seek and access services as well as how they believe these barriers may make it difficult for others to seek and access services. Some participants also discussed having accessed mental health services in a northern Ontario community and the challenges they believed may have existed in these communities while some participants had also accessed services elsewhere (typically Southern Ontario).

Long waitlists. Waitlists for services are common in health care in general. For mental health services, these can sometimes be lengthy and hinder the ability for individuals to get the mental health care they need in a timely manner. Participant 1 discussed their frustration with experiencing having to wait for services and wait longer than they had wanted in-between appointments, and explained:

> "[…] at first when like you make an appointment it's like, you need it now. It's like when you go up to the desk and ask for an appointment you want it now but then they tell you the next availability. So it's like, 'you're going to make me wait a month?'. So that just sucks because […] you expect it to be like soon."

In terms of having a longer than desired time between appointments, Participant 1 described this as a challenge, saying that "[…] What I'd prefer is like go every week"; however, the participant went on the explain that they were given a month to wait between appointments and that they "pushed" to make it sooner.

Participant 4 discussed being on a waitlist for a specialist (i.e. psychiatrist) after being referred by their family doctor. This individual explained that "It's been a year and a half and I still have not even gotten a call and he's [general practitioner] told me that when I get the call not to get too excited over it 'cause there's still, will be a long wait, so I have no idea.". The participant also added that "[…]the helplines, too, a few times that I call they've put me on hold, so that's not very good.". Another participant identified waitlists as being a barrier to seeking mental health care. Although this participant did not actively seek help for themselves and couldn't recall if he was on a waitlist or not, he did mention having heard of "some people [taking] months to get a booking" for an appointment (participant 7).

Lack of knowledge about services. Throughout the interview data there was a lack of knowledge about available mental health services. Some participants were surprised to learn that there were services on campus while others were knowledgeable. A common recommendation among participants was that there needed to be more advertisements of available mental health services in general. For example, participant 6 who was from southern Ontario stated, "[…] going to school here in [northern Ontario], it's not – not that it's not so much a bigger deal – but just not so much advertised, if that makes sense."

Participant 4 recognized that they were not knowledgeable about available services.in their own community. They explained that these services were "hard to access" and stated "Like I couldn't even tell you like where to actually go, like I have no idea.". Participant 4 was also unaware of services available at their undergraduate campus, stating "It'd be really good to tell people about it…". When asked if there was anything that could have been changed to make their experience seeking help any better they replied, "Maybe if I knew even on campus, like who to talk to, who to go see, where that is. Like, do you go to registrar? Do you go, like, I have no idea…who do you talk to to know where they are?"

Another participant also recommended there be more advertisements for campus services "because [they] find that would be something more sort of for university students just 'cause of all the stress and all…"; however, they did express that they thought there was enough advertising in the community to make people aware of the available services. Regarding their own knowledge of campus services, Participant 5 said, "I briefly heard of them, but I don't really know any of the details or where it is.". Participant 6 described having little knowledge about where to go to seek help, saying: "[…]had it not been for her [academic adviser] I wouldn't even know these services were available."

Lack of resources. Some participants described a need for more funding for programs, more qualified professionals, and more specialized treatment (Figure 8). In terms of funding for programs, participant 7 explained that although he hadn't had to "seek mental health care in an emergency situation", he'd heard about the mental health wing at his local hospital being "overfilled" with "people having to wait for hours or days". This individual also stated that, in his community, "We probably have too few mental clinics or too few doctors in the mental health wings of various hospitals". Participant 3 described a situation where there was a lack of resources related to possible funding issues, stating that, "They do have groups and re-activation workers at the hospital, but they don't come as often as some patients need them to.". Also addressed by participant 3 as possible challenges to accessing mental health care, particularly in northern Ontario communities, was the need for "ongoing" specialized treatment provided by qualified professionals on a regular basis as well as a possible lack of funding for these specialists and this type of care.

Regarding qualified professionals, the perceived need for these in mental health care throughout the interviews has been discussed in the previous sections and themes. Participant 4 addressed the need for more qualified professionals throughout the interview. She described a situation where they accessed help from social workers who were restricted to providing only short-term services and therefore saw several workers and never really received the long-term treatment they said they required. This individual explained,

> "After six [sessions] you're done and there was no other, like, I would have had to stay longer, but she legit told me 'Well, you're six weeks are up; I can't do anything else' s I had to be transferred to someone else, which is why I've had like four or five […] and you have to kind of restart and try to tell them what the other one did…".

An additional point that one participant made as a recommendation for what is needed is increased competence of mental health care providers in relation to the discharge of patients. This participant explained that some patients may only be saying they are ready to leave in order to be discharged, regardless of their mental health stability. They recommended that more in-depth follow ups with patients who've been discharged were needed.

Lack of affordability. The issue of affordability of treatment for mental health problems was brought up several times throughout the interviews. The participants described mental health care as being expensive based upon their experiences regarding others and articulated that they were able to afford their care through government funded programs such as university services, their parents' benefit plans, and work benefits. Participants 4, 5, and 7 explained that they were able to receive treatment services without detrimental costs due to their parents' benefits. Participant 1 stated that their treatment was free at their university's campus services and that he had also received treatment before under his work benefits.

When participant 4 depicted her difficulties with her parents perceived social stigma and their understanding of mental health care, she explained that her medication was obtained through her parents' benefits. She stated that, "meds are expensive if I don't go under their benefits.". Participant 5 described their personal situation with the following:

> "Well…it's expensive if you want to go, in that regard, like to seek help because you have to pay for it. If you don't have benefits then it's kind of, you know you have to pay a lot of money to go talk to somebody. My parents had some benefits for it, but if I were to go more than what I did then we would have been paying out of pocket…".

Participant 7 was asked about their emotions when they reflected upon their experiences with mental health services. He responded with the following: "[…] gratitude, I guess, toward my parents that they were able to afford and accommodate me to actually go because I know a lot of people wouldn't be able to go. And I know people who currently can't go because they can't afford it.". In this statement he indicated that he knew people who were adversely affected by the barrier of affordability. The participant also indicated the cost of his treatment as being "a hundred dollars a session or more if you don't have coverage.".

In regard to work benefits, participant 1 their employer funded counselling and that their mental health care was thus paid for. They stated that "it's free, which is helpful.". The participant went on to explain that counselors outside of their school were knowledgeable that "universities provide these [services] for free, too.", and appeared happy to have been referred to an affordable source of care.

Discussion

Three primary themes emerged from the analysis of seven interviews. While qualitative findings in the literature have typically revealed themes related to barriers and facilitators for help-seeking in youth (Gulliver, Griffiths, & Christensen, 2010), results of this current study's revealed themes related to participants' own beliefs about mental health care, their own personal experiences with services and providers, and their perceived barriers to accessing care. Although facilitators to help-seeking from mental health services were addressed in the interviews, there was not enough data across the entire data set to justify this as a theme. As such, this study has focused upon the aforementioned aspects of mental health care as experienced by this group of undergraduate students who had previously sought and accessed mental health services.

To better understand how this interview group relates to the entire sample as well as to compare the responses of this group from quantitative and qualitative portions of this study, the means and standard deviations of the interview sample were interpreted. In congruence with the overall sample, the interview group was found to have moderately positive attitudes toward help-seeking from professional mental health services.

A difference was found between this group and the overall sample regarding depression scores on the BDI-II. While the overall sample scored within the mild clinical range of depressive symptoms, this group scores within the moderate clinical range on average. This would make sense considering that the overall sample was comprised of both those who have and have not ever accessed professional mental health services while the interview group was a select sample of students who had accessed services at least once in the past. It is possible that some participants who reported having not sought or accessed services may have still had unrecognized depressive symptomology while participating in the study; however, it is also possible that some did not, and therefore the presence of scores lower than that observed in the interview group is reasonable. It is still important to note that, even though some participants may not have had any mental health problems at the time of the study, the overall sample on average had depressive symptoms within a clinical range.

Themes

In terms of the theme regarding factors that participants identified as important in mental health care, five subthemes were developed from the data: Openness, being Non-judgemental, Being Heard, Confidentiality, and having Qualified professionals. It is important to note that Openness and being Non-judgemental were two characteristics found to be associated with one another throughout the interviews but were categorized as separate subthemes. Being Non-judgemental was considered to mean that those seeking and accessing mental health care would not feel discriminated against or judged in any way, thereby also promoting an open-minded and inclusive atmosphere. In some interviews, participants tended to use the term “open” while others referred to “non-judgemental” or “no judgement” while still describing a similar meaning of an important quality in mental health care. Seeing as these two characteristics were both related and separate in meaning when dependent upon context, they were categorized as two factors within the primary theme; however, it should also be noted that the term “open” was observed in the non-judgemental factor as a description of this factor’s characteristics.

For participants, “being heard” meant that they were being taken seriously and listened to when they sought and accessed mental health care. It also meant that their concerns were being appropriately addressed by professionals. Summerhurst et al. (2016) examined Ontarian youth perspectives of facilitators and barriers to mental health care and found that “support” and “being understood” were two of the themes considered most helpful in treatment. Support consisted of safety, comfort, non-judgement, understanding, and confidentiality. These are consistent with subthemes identified in this current study regarding important factors of mental health care as well as experiences with mental health services.

Feeling understood in Summerhurst et al.'s (2016) study consisted of having others understand what was happening with one's mental health. This theme is congruent with having qualified mental health professionals and being taken seriously, which were factors found in sub-themes of mental health care expectations and previous experiences with services and professionals. For the participants in this study, having a professional understand their mental health concerns, understand the etiology and treatment of mental illness, and address their concerns were crucial to what they expected from the services they accessed. The value of the above can be demonstrated in the following quote: "Just having someone who understands what you're going through and doesn't judge".

As was previously stated in this thesis, prior experiences have been found to have a predictive impact on future help-seeking (Rickwood et al., 2005). Negative experiences with mental health care services and professionals have been negatively associated with future help-seeking (Rickwood et al., 2005). One participant described their experience with mental health services, stating "I felt like it was a waste of my time". This kind of belief stemming from negative experiences illustrates how it is possible for future help-seeking to be hindered. Conversely, it is also logical that positive experiences are positively associated with seeking help in the future. This underscores the importance of further exploring the expectations and experiences that university students have with mental health services beyond the scope of this thesis study.

For this group of undergraduate university students in northern Ontario, negative experiences with mental health care providers encompassed feeling ignored, perceiving a lack of compassion, and a belief that the providers were unqualified in their role while positive experiences encompassed the belief that the providers were qualified, were caring, took them seriously, were helpful, and non-judgemental. In terms of mental health services over all, what left participants with a sense of a negative experience were that the services were unhelpful, lacked privacy, and tended to ignore the service users who also felt a great deal of discomfort with sharing their concerns. Conversely, participants with a sense of positive experience with services described having positive emotions about their treatment, having the belief that medication was helpful, and the belief that the services in whole were helpful in regard to their needs. Summerhurst et al. (2016) also identified a theme related to perspectives of medication, where having the right medication was deemed helpful in their population. Throughout the interviews in this thesis study, medication being helpful was related to whether the participants felt they were on the right combination of medication or that they had been stabilized after having not been on a beneficial medication. These beliefs were similar to that discussed by Summerhurst et al. (2016).

A dichotomy of positive and negative aspects was noted and discussed in the theme of experiences with mental health care wherein, often, the factors that participants attributed to a positive experience with professionals and services were also what participants believed was lacking and therefore resulted in more negative experiences. This makes logical sense considering that the opposite of what was valued in mental health care may have the reverse effect.

A similar dichotomy can also be found in Summerhurst et al. (2016) regarding the theme of medication, which was considered both helpful and difficult in the recovery from emotional or mental health concerns. In a qualitative study conducted by Boydell et al. (2006) that used a family perspective to examine access to mental health services for children and youth in rural Ontario communities, a dichotomy like that found in this present study was also noted, however, this dichotomy demonstrated that barriers to accessing care were also facilitators under different circumstances. For example, the barrier of "stigma" meant that, in a small community, it was hard to remain anonymous and that the fear of perceived public stigma was pervasive. At the same time, this lack of anonymity was crucial to the facilitator of "word of mouth" where families learned about ways to access appropriate services for their children from the experiences of other families within their community.

In previous sections of this research, it was explained that there has been relatively less focus on structural barriers as opposed to attitudinal (or otherwise known as or grouped under the term individual) barriers in help-seeking research (Craske et al., 2005; Sareen et al., 2007; Mojtabai et al., 2011). Furthermore, even less is known about the impact of structural barriers on help-seeking in university student populations, especially in Canadian research literature (Marsh & Wilcoxon, 2015). Although there was little data regarding facilitators to help-seeking in the current study, there was enough data regarding barriers to accessing mental health care to develop an individual theme of barriers-to-care. It was found that within this theme, participants tended to discuss more structural barriers to accessing mental health care than individual barriers. As such, the qualitative portion of this study supplements prior research with additional insight into the structural barriers that Canadian students have identified as hindering their ability to access professional mental health care in Ontario.

Barriers in this study were divided into individual-based and structural-based barriers. The individual barriers that were discussed in the interviews were categorized as attitudinal barriers, which was further subdivided into perceived public stigma and a lack of perceived need. Previous research has identified stigma as being a significant barrier to help-seeking (Tamboly & Gauvin, 2013; Sareen et al., 2007; Eisenberg et al., 2012; Dockery et al., 2015; Ojeda & Bergstresser, 2008). Self-stigma and perceived public stigma are two primary forms of stigma that have been addressed in help-seeking literature. The main difference between the two is that in self-stigma, negative attitudes towards help-seeking for mental health are held by the individual while in perceived public stigma, the individual believes that the public or close others have negative attitudes (Eisenberg et al, 2012). In both cases, stigma presents as a deterrent for individuals to seek help for their mental health problems.

In this study, perceived public stigma was discussed more than self-stigma. Feelings of shame about seeking help and a fear of being judged by others for seeking help were identified throughout the interviews. As Eisenberg and colleagues (2012) explained, perceived public stigma may stem from an exaggeration of one’s beliefs about public stigma, and have suggested that this may be an area of which to target when preparing educational interventions regarding stigma. The presence of perceived public stigma as being a significant concern among some of the interview participants further supports this area of research as well as Eisenberg and colleagues’ (2012) suggestions.

Golberstein, Eisenberg, and Gollust (2008) found a negative association between perceived public stigma and the likelihood of perceived need for mental health services in university students. This association was found in younger students between the ages of 18 and 22 years, but was not found in the older, graduate students that were studied. The researchers suggested that the younger students may have been less likely to perceive a need for help as this may have been the first time they were experiencing symptoms of mental illness and that there may have been a reluctance to accept this possibility and the perceived label associated with it. Furthermore, the authors also explained that older students being in graduate studies may have modified the relationship due to their higher levels of education and the possibility of other unique qualities that were not observed in the study. The lack of perceived need as well as perceived public stigma found in the current study is consistent with Golberstein, Eisenberg, and Gollust's (2008) findings.

As previously discussed, a lack of perceived need for mental health services has been consistently found in help-seeking research in post-secondary students (Eisenberg, Hunt, & Speer, 2012; Tamboly & Gauvin, 2013; Eisenberg, Speer, & Hunt, 2012). This study's finding related to a lack of perceived need is congruent with this previous research. In the interviews, some participants described not thinking that they had a mental health problem, either directly stating it or explaining that they did not seek services for themselves. In most cases, the participants' parents had been the ones who identified a need and sought help for their children, except for two participants who had school-related personnel advise them to access services. In hindsight, most of these participants acknowledged that they had in fact been struggling with mental illness and some even expressed happiness that they had received treatment. Regarding service use, one participant stated, "I wish I'd of done it sooner". As was found by Vasiliadis et al. (2005) in a cross-provincial study of service use, one's perceived health and need for services was significantly predictive of future service use across all provinces in Canada. The researchers concluded that awareness of mental health issues has an important role in service use. This, along with the findings from the current study, emphasize the need for educational strategies that enhance mental health literacy in order for individuals to be more aware of and more likely to detect symptoms of mental illness within themselves.

Regarding structural barriers, this study's findings of factors that hindered access to mental health services was consistent with previous help-seeking literature. Participants in this study identified long wait times, lack of knowledge about mental health services, lack of available resources, and a lack of affordability for services as significant barriers to seeking and accessing these services. There have been several studies in the United States and Canada that have identified similar structural barriers to mental health care (Craske et al., 2005; Marsh & Wilcoxon, 2015; Sareen et al., 2007; Summerhurst et al., 2016; Pagura et al., 2009; Slaunwhite, 2015)

Summerhurst and colleagues (2016) examined what youth in Ontario believed were facilitators and barriers to accessing mental health services. This thesis study's findings in an Ontario population of undergraduate students are consistent with that of Summerhurst et al. (2016), in that participants in both studies did not know exactly how to navigate the mental health care system or where to go for appropriate treatment. In addition, having to wait to see professionals for their mental health concerns was indicated as a difficulty in accessing services. Craske et al. (2005) identified similar barriers of long wait times for appointments and not knowing where to go for help in their American population. The above barriers were also found in Slaunwhite's (2015) study of barriers to service use in Canada. Slaunwhite (2015) found that participants reported waiting too long to access services, not being able to obtain help because a mental health professional was unavailable to them at the time, and an inability to afford services as significant accessibility barriers. These factors were also identified by the Ontarian participants in this present study.

The issue of affordability was addressed in Sareen and colleagues' (2007) study of barriers-to-care in Ontario, the United States, and the Netherlands. The researchers found it "noteworthy" that financial barriers were reported by Ontarian participants who were part of a "single-payer universal health care system" (Sareen et al., 2007). In the American study conducted by Craske et al. (2005), participants reported difficulty affording services that were not covered by their health care plan. Marsh and Wilcoxon (2015) found in their study of structural barriers in American college students that cost of services was the strongest predictor of help-seeking. The researchers explained that although many colleges had free or low-cost campus services available to students, their sample of college students perceived that these low-costs were still unaffordable and deterred them from seeking help. Marsh and Wilcoxon (2015) suggested that it is perhaps the perception of cost as a barrier that should be studied instead of the actual costs of services.

Most of the participants in this study expressed feeling gratitude that their (or their parents') health insurance covered the costs of their therapy and/or medication. Some participants also described knowing of people who could not access services in Ontario because they could not afford the costs for services as they were not covered by the Ontario Health Insurance Plan (OHIP). It is certainly important to recognize that individuals in Canada, experience many of the same barriers discussed here that those in the United States do, despite the differing health care systems between the two countries. Future research of structural barriers in Canadian university students may want to explore Marsh and Wilcoxon's (2015) suggestion that the perceived cost of mental health services may help to better explain findings such as these.

Conclusion

Canadian prevalence rates for mental health problems have been regarded as highest in youth populations between the ages of 15 and 24 years (MacLeod & Brownlie, 2014; Vasiliadis et al., 2005; Findlay & Sunderland, 2014). When compared to the general population of young adults, university students have been found to be an especially vulnerable population, however, there has been a paucity of research conducted in regard to the mental health of Canadian university students (Tamboly & Gauvin, 2013; Thomas, Caputi, & Wilson, 2013; Eisenberg, Gollust, Golberstein & Hefner, 2007). It is widely recognized that, despite the treatability of mental health disorders such as depression and anxiety, a substantial portion of those living with mental health problems do not access services (Gulliver, Griffiths, Christensen, & Brewer, 2012; Clement et al., 2015; Gulliver et al., 2013; CMHA, 201 MHCC, 2015). Considering the negative outcomes possible when mental health disorders are left untreated (Gulliver et al., 2012), it is important to better understand the factors that influence how mental health services are sought out and accessed. As such, research has focused on help-seeking behaviours of youth and university students to identify and address the variables associated with the seeking and accessing of mental health services.

This study sought to examine differences in the help-seeking behaviours of undergraduate university students who have and have not sought help from mental health services in the past. Attitudes and intentions toward help-seeking, past help-seeking, experiences with barriers to accessing services, and depressive symptomology were studied. Seven students who reported previous experiences with mental health services participated in semi-structured interviews to explore these personal experiences with mental health care.

The results demonstrated that the students had moderately positive attitudes overall towards help-seeking for mental heath problems. While there have been conflicting findings regarding trends in attitudes toward seeking help from mental health professionals, the majority of this research has focused on American university students (Jagdeo et al., 2009; Mackenzie et al., 2014). The finding of moderately positive attitudes in this population of university students in northern Ontario provides an addition to Canadian based-research in this area considering that attitudes and intentions are regarded as predictive variables in future help-seeking.

Intentions to seek help were found to differ between students who reported having ever accessed mental health services and those who had not. It was found that those who had previous experiences with mental health professionals reported that they were more likely to intend to seek help from formal sources in the future, while those who didn't have prior contact with professions reported that they were more likely to intend to seek help from their parents in the future. This finding is consistent with that of Jadgeo et al. (2009) and Rickwood et al. (2005) in that those with prior experience with service use had more positive attitudes towards using these services, which in turn would suggest that they would have greater intentions to access these formal sources of help. When asked about their previous help-seeking, students who reported having accessed services rated their experiences as being helpful to extremely helpful.

This study also found that students who had previously sought help from professional mental health services had a tendency to report facing more barriers to accessing mental health care than those who had not. This finding makes intuitive sense in that those who have accessed services would have a greater likelihood of facing barriers; however, it is important to recognize that research has found that a large portion of the population that live with mental health problems go untreated (Gulliver et al., 2012; Clement et al 2015; Sunderland & Findlay, 2013).

Barriers can be experiences at the personal level (negative beliefs) as well as the structural level (lack of resources) and can have an impact whether the individual identifies it or not. Previous research has tended to focus on barriers in untreated populations, and therefore this study (both the quantitative and qualitative portions) provides additional insight to the literature regarding the experience of barriers in both those who have and have not reported accessing professional mental health services.

The results have also demonstrated that undergraduate students reported depressive symptoms at a mild (approaching moderate) clinical level, signifying a need for service use for mental health problems. Although there are free counselling services at the university, approximately 81% of participants reported knowing about the services while 19% did not. Of those who were interviewed, several either did not know that the services existed, or they did know but were not sure where or how to access them. This lack of knowledge may very well be a situation common across universities in Ontario – a notion that was behind the reasoning for Tamboly and Gauvin's (2013) review of students' mental health at McMaster University. It also emphasizes an area of research that requires further study. Mental health literacy of undergraduate students is of high importance due to the vulnerable nature of this population. Knowing about free services on campus as well as where they are and how to access them is critical. From the interviews, it was clear that the majority of participants thought that more advertisement was needed – in general – for mental health services in this community.

Three primary themes emerged when exploring experiences with mental health care: 1) Five common factors deemed to be important in mental health care, 2) A dichotomy of positive and negative aspects experienced with mental health care services and mental health professionals, and 3) The experience of individual and structural barriers to accessing mental health care. It was found that characteristics participants thought were important to mental health care tended to expand into the second theme, being qualities that made experiences with services and/or professional positive or, when lacking, negative. Openness, being non-judgemental, confidentiality, being heard, and having qualified professionals were considered essential to the participants and coincided with the overall perceptive evaluation of services provided. Having positive emotions about treatment, believing that medication was helpful, feeling a sense of non-judgement, confidence in the qualifications of the services/providers, feeling like one is being heard and taken seriously, as well as a general sense of compassion provided were associated with positive overall experiences. Meanwhile, the opposite of these factors as well as a discomfort with disclosing personal information and a global assessment that services were unhelpful were associated with negative experiences.

The third theme encompassed challenges that the participants reported facing when they sought and accessed help for their mental health problems. There tended to be an emphasis on structural barriers amongst this group of participants. For these students, attitudes about perceived public stigma and a lack of perceived need for services were prevalent as individual level barriers. As for structural barriers, participants identified long waitlists, not knowing about available services along with a need for more advertisement, a lack of resources (i.e. specialists and/or funding in their communities), and a lack of affordability. This study thereby added to the help-seeking literature in that structural barriers experienced by those who had accessed professional services were examined, both of which were previously discussed as being underrepresented in prior research.

Within the subtheme of structural barriers was found a discussion regarding the participants' experiences of help-seeking in northern and/or southern Ontario. The barriers identified by participants were those that have been focused upon in northern and rural mental health research (e.g. long waitlists and lack of resources). Participants expressed concern that, in their community, there was a lack of specialized practitioners and programs available to them, which resulted in their care being primarily with family doctors, and them being on long waitlists to see specialists. These specific difficulties were addressed by Komiti et al. (2006) and Caxaj (2016), with lack of resources being identified as a primary issue facing northern and rural communities. Furthermore, a lack of knowledge about what resources were available was identified as a barrier-to-care within this sample of interviewed students, which has also been found in the literature as being a significant hindrance in northern and rural populations (Komiti et al., 2006; Caxaj, 2016; Dyck & Hardy, 2013). These findings indicate that there are some similarities regarding barriers-to-care between the northern Ontario community within which this study was conducted and the northern and rural help-seeking research. As such, this study added to the literature in this area while also demonstrating a need for further exploration of help-seeking in northern Ontario communities.

General Limitations and Future Directions

There are several possible limitations to this research. A larger, more diverse sample would help to minimize the influence of possible confounding variables (such as advanced mental health literacy) and provide future studies with a more accurate reflection of the help-seeking attitudes, intentions toward help-seeking, perceived barriers-to-care, depressive symptomology, and experiences with mental health services of Canadian undergraduate students.

It is important to recognize that most studies which examine barriers to accessing mental health services, this present study included, tend to do so in a manner which only provides a snapshot of the barriers and facilitators individuals may have faced. This is because they often examine these at one single point in time (Hom et al., 2015). Hom et al. (2015) explained that barriers and facilitators should be thought of as dynamic as they may change over the course of an individual’s life. The influence of actual or perceived barriers on help-seeking at one time may not have the same influence at a later point, with some becoming irrelevant or having been overcome with facilitators. It would be beneficial to study how barriers and facilitators to care may change over time and how this dynamic nature can affect service utilization. As Hom et al., (2015) explained, it would be helpful for treatment service providers to understand what barriers may be modifiable and what facilitators may have the most beneficial impact, thereby allowing for interventions to be implemented in a way that encourages more successful engagement with treatment.

Future research is encouraged to explore help-seeking behaviours and experiences with mental health services in post-secondary students from rural and/or northern Canadian communities, whether it be from smaller universities or colleges. By sampling from these post-secondary schools, it is more likely to obtain a student population that is truly representative of rural and northern communities and therefore better understand the needs and perspectives of these unique populations. With this information, interventions and services targeted to these populations could be developed to address treatment resistance and increase the likelihood of engagement on and off campus. Additionally, services that are tailored to these populations may be better equipped to navigate the unique challenges of the rural, northern, and remote communities they’re in as well as improve upon possible treatment outcomes.

The ethnicity of participants should also be addressed in future research. It is generally accepted that depression and suicide is more prevalent in certain ethnic populations than others (e.g. Indigenous Peoples; Adelson, 2005). Ethnic differences have also been found regarding attitudes towards help-seeking in Canadian students, with Caucasian students having more positive attitudes than non-Caucasian students (Kuo, Kwantes, Towson, & Nanson, 2006; Morgan et al., 2003). As such, future research should also address the fact that many rural, northern, and remote communities across Canada have higher Indigenous populations.

According to the Constitution Act of 1982, there are three Indigenous groups recognized in Canada: First Nations, Inuit, and Métis. It is important to recognize the differences in ability that these groups have regarding their access to different agencies within Canada (King, Smith, & Gracey, 2009). In Canada, mental health problems are generally higher among Indigenous peoples, but it is important to consider that these rates can vary dramatically across communities (King, Smith, & Gracey, 2009). Bearing in mind the higher rates of physical and mental health problems, increased risk of suicide, and financial disparities of Indigenous peoples in Canada, it is important to better understand the mental health services that are available to them as well as their attitudes and intentions towards help-seeking. It would be additionally helpful to explore the impact that a lack of Indigenous-centred health services as well as the impact that intergenerational trauma may have on Indigenous mental health and service utilization. Nelson and Wilson (2017) found that there is a paucity of research focused on the mental health of Indigenous peoples in Canada. They advised that future research needs to use a more critical approach to the concepts of colonialism and historical trauma while also focusing on underrepresented populations.

Clinical Implications

This research adds to the body of research literature in help-seeking through its focus on Canadian students, its use of joint quantitative and qualitative analyses, its use of a more recently developed measure of attitudes toward help-seeking (IASMHS), and its examination of those who have and have not accessed professional mental health services. The findings of this research may help to inform university campuses across Ontario and provide a starting point for more in depth research to better understand the nature of mental health in Ontarian university students and the factors that influence their seeking of help for mental health problems.

The results of this study suggest a possible shift toward more positive attitudes toward mental health service utilization, however, this study also adds to the conflicting research of Canadian and American youth, emphasizing the need for further exploration of Canadian university students' attitudes toward help-seeking. With attitudes and intentions being considered predictors of actual help-seeking behaviour, better understanding of students' attitudes and intentions to seek help from formal and informal sources can help universities to better evaluate the effectiveness of their outreach programs for mental health. In addition, knowing what types of barriers-to-care are most relevant to different student populations can help to advise current service implementation and intervention strategies.

These university students reported having moderately positive attitudes toward seeking help. It is intriguing to note that, although this sample had populations known to be more likely to have enhanced mental health literacy (i.e. psychology students), depressive symptoms were reported within a low clinical range and yet the majority of the participants were not currently receiving and/or had never received services. This highlights the necessity of researchers and clinicians to investigate the factors that may prevent service utilization in those who would otherwise be considered likely to seek help. From the current research as well as previous literature, it is clear that risk factors for unmet needs are complex, interconnected with facilitating factors, and dynamic. As research has demonstrated, the progression from positive attitudes to positive intentions to active help-seeking behaviour is not fluid. For universities, communities, and clinicians to better engage and successfully treat university students in Canada, additional knowledge is needed about how these help-seeking factors and barriers-to-care interact to influence the way in which students seek out and access professional services for their mental health problems.

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Appendix A

Demographic Questionnaire

Demographic Questionnaire

Note: *For this study, professional* ***mental health*** **services** *are defined as services that are provided by* *<u>licensed mental health care practitioners</u>, such as a registered psychologist, a registered psychiatrist, a family doctor, or a registered counsellor (who works for a mental health clinic or organization such as the Canadian Mental Health Association, Health Sciences North, Crisis Intervention, etc.).*

The following questions are designed to provide additional information regarding demographics of the participants for the study. You have to right not to answer any questions you may be uncomfortable with or do not want to answer. You may stop participating at any time. You may stop the questionnaire at any time.

1) Age _______________

2) Gender _______________

3) Marital status

Single	☐	Common-law partner	☐	Married	☐
Divorced	☐	Separated	☐	Sole Support Parent	☐

4) Number of dependents/children

0 ☐ 1 ☐ 2 ☐ 3 or more ☐

5) Current city of residence ____

6) Are you an international student?

Yes ☐ No ☐

7) Living situation

With parents ☐ In residence ☐
Off campus & live alone ☐ Off campus & live with roommate(s) ☐
Off campus & live with romantic partner ☐

8) Do you:

Rent ☐ Own your own home ☐
Other _________________

9) Hometown (city, province/state/country) ____________________________

10) Year graduated from high school ____________________________

11) Program of study _________________________

12) Year in the program

1 ☐ 2 ☐ 3 ☐ 4 ☐
Other _______________

13) Employment status _____________________________

14) Do you know about available counselling services at Laurentian University?

Yes ☐ No ☐

15) Have you ever accessed counselling services at Laurentian University?

Yes ☐ No ☐

16) Have you ever been diagnosed with a mental health disorder?

Yes ☐ No ☐
If so, what is the disorder? ____

17) Do you currently have a diagnosis for a mental health disorder?

Yes ☐ No ☐

If so, what is the disorder? ______________________________

If so, who made the diagnosis? ______________________________

18) Do you think you may currently have a mental health disorder?

Yes ☐ No ☐

If so, what do you think it may be? ______________________________

19) Have you ever accessed informal sources of help for a mental health issue? (e.g. friends, family members, spouse or romantic partner, a telephone hotline, teacher/professor, etc.)

Yes ☐ No ☐

If so, what source(s)? ______________________________

20) Have you ever accessed professional mental health services?

Yes ☐ No ☐

If so, what services? ______________________________

21) Have you accessed professional mental health services in the past 12 months?

Yes ☐ No ☐

If so, what services? ______________________________

22) Have you ever receive medication as part of your mental health treatment?

Yes ☐ No ☐

If so, what kind? ______________________________

23) Have you ever received therapy?

Yes ☐ No ☐

If so, what kind? ____

How often? (e.g. sessions per week) ________________________________

Did you attend individual or group sessions (or both)? ____________________

24) Are you currently accessing professional mental health services?

Yes ☐ No ☐

If so, what services? ____

25) Have you ever had to travel outside of Sudbury to access mental health care services?

Yes ☐ No ☐

If so, where? ____

26) Have you ever been put on a wait list for mental health care services?

Yes ☐ No ☐

If so, what services? ____

27) Have you ever had to pay for your mental health care services?

Yes ☐ No ☐

If so, what services? ____

28) Have you ever had problems with privacy when accessing mental health care services?

Yes ☐ No ☐

If so, what services? ____

Appendix B

LaurentianUniversity
UniversitéLaurentienne

APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS

Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

TYPE OF APPROVAL / New X / Modifications to project / Time extension

Name of Principal Investigator and school/department	Sophie Nash, supervisor Elizabeth Levin, Psychology
Title of Project	Help-seeking Behaviours of University Students in a Northern Ontario Community
REB file number	2016-06-03
Date of original approval of project	July 15, 2016
Date of approval of project modifications or extension *(if applicable)*	
Final/Interim report due on: *(You may request an extension)*	July 15, 2017
Conditions placed on project	

During the course of your research, no deviations from, or changes to, the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please refer to the Research Ethics website to complete the appropriate REB form.

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g. you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate LU REB form. In all cases, please ensure that your research complies with Tri-Council Policy Statement (TCPS). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations and best wishes in conducting your research.

Rosanna Langer

Rosanna Langer, PHD, Chair, *Laurentian University Research Ethics Board*

Appendix C

Recruitment Poster

LaurentianUniversity
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"Help-seeking Behaviours of University Students in a Northern Ontario Community"

Are you an **undergraduate** student enrolled at Laurentian University?
Are you **under 25 years old**?

You are invited to participate in a two-part, Master's thesis study examining university students' attitudes towards and experiences of seeking help from mental health services.

Volunteers who participate in Part I of the study **may also have** the opportunity to participate in Part II.

PART 1

Volunteers who participate will be asked to fill out a questionnaire package. This will take approximately 30-45 minutes to complete.

(You **DO NOT** need to have sought help for mental health services to participate.)

PART 2

Volunteers will be asked to participate in a semi-structured interview where they may share their own past experiences with seeking mental health services. The interview will take approximately 1 hour to complete.

(Only those who **HAVE** sought mental health services in the past may participate in part 2.)

For more information, please contact **Sophie Nash** at sx_nash@laurentian.ca

Recruiting Script

LaurentianUniversity
UniversitéLaurentienne

Recruiting script for
"Help-seeking Behaviours of University Students in a Northern Ontario Community"

Hello. I am looking for volunteers to participate in my master's thesis study titled "Help-seeking Behaviours of University Students in a Northern Ontario Community". Undergraduate students who are between the ages of 18-25 years and are enrolled at Laurentian University are invited to participate in this two-part study examining university students' attitudes towards and experiences of seeking help from mental health services.

In PART I of this study, participants will be asked to fill out a questionnaire package. This will take approximately 30-45 minutes to complete. Volunteers who participate in Part 1 of the study **may also have** the opportunity to participate in Part 2.

In PART II of this study, volunteers will be asked to participate in a semi-structured interview where they may share their own past experiences with seeking mental health services. The interview will take approximately 1 hour to complete. Only those who **HAVE** sought mental health services in the past may participate in part 2 of this study.

For more information, please contact **Sophie Nash** at sx_nash@laurentian.ca

Appendix D

Consent Form for Part I

LaurentianUniversity
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Part I Consent Form

I agree to participate in the research project entitled "Help-seeking Behaviours of University Students in a Northern Ontario Community".

I understand that the goals of this research are to explore the help-seeking attitudes, intentions, barriers to care, and experiences of undergraduate university students for mental health services in the Northern Ontario community of Sudbury, Ontario. I understand that this is a two-part study and that I am consenting to participate in Part I.

I understand that I will be asked to participate in filling out a questionnaire package. I understand this will take approximately 30 to 45 minutes to complete. I will also be asked to participate in a semi-structured interview that will be audio recorded. I understand I will be asked questions about my experiences with mental health services in my community such as those provided by: licensed mental health care practitioners, such as psychologist, a registered psychiatrist, a family doctor, or a registered counsellor (who works for a mental health clinic or organization such as the Canadian Mental Health Association, Health Sciences North, Crisis Intervention, etc.).

I understand that I do not have to participate in this study. I understand that I do not have to agree to participate in the interview part in order to participate in the first part of the study. **I may stop participating at any time**. I understand that the questionnaires/interview may bring up topics that I may be uncomfortable with discussing. I can choose not to answer any questions. If I feel uncomfortable, I can take a break or stop the questionnaire/interview at any time. After the study, I understand there will be a debriefing where I will be provided with a list of general and mental health resources should I need them.

I understand that all information collected will be used for research purposes only. I understand that my anonymity will be protected. Any personal information collected during the study will stay private and confidential. I understand that any identifying information about me, such as my name, will be entered as numbers to ensure confidentiality. I understand that the data will be stored on a secure, password protected computer enhanced with encryption. I understand that all data will be destroyed 5 years after the end of this project. If I want, I may receive a summary of the results at the end of the study (please check below).

I understand that there are limits to confidentiality. Should at any point during the interview I disclose the risk of imminent harm to myself or to others, the researcher is obligated to contact the appropriate authorities and therefore break confidentiality.

If I have any questions regarding the purpose or nature of the study, I can contact Sophie Nash, M.A. Candidate, by e mail at sx_nash@laurentian.ca, or Elizabeth Levin, Ph.D., by phone at 705-or 1-800-461-4030, extension 4242, or by e-mail at elevin@laurentian.ca . If I have concerns regarding the ethics of the study, I may contact the Research Ethics Officer, Laurentian University Research Office, by phone at 705-675-1151 or 1-800-461-4030, extension 3213, or by e-mail at ethics@laurentian.ca

After reviewing this consent form, I agree to participate in this research project.

PARTICIPANT: ______________________________

(Signature)

DATE: ______________________________

Name: ______________________________

Daytime phone number: ______________________________

E-mail address: ______________________________

I would like to receive a copy of the results at the end of this study. ☐ **Yes** ☐ **No**

Consent Form for Contact

Consent Form for Contact

I have just participated in the questionnaire portion (Part I) of a research project where the goals are to explore the help-seeking attitudes, intentions, barriers to care, and experiences of undergraduate university students for mental health services in the Northern Ontario community of Sudbury, Ontario.

I understand that I am being asked if I am willing to participate in an interview portion of this research project (Part II) to further explore the topic of first-hand help-seeking experiences.

I understand that the interview will be audio recorded for transcription purposes. The interview will take approximately one hour to complete. I understand I will be asked questions about my experiences with mental health services in my community such as those provided by: licensed mental health care practitioners, such as psychologist, a registered psychiatrist, a family doctor, or a registered counsellor (who works for a mental health clinic or organization such as the Canadian Mental Health Association, Health Sciences North, Crisis Intervention, etc.).

I understand that I do not have to consent to being contacted. **I may stop participating at any time**.

I understand that all information collected will be used for research purposes only. I understand that my anonymity will be protected. Any identifying information about me, such as my name, will be changed to numbers to ensure confidentiality. I understand that the data will be stored on a secure, password protected computer enhanced with encryption.

If I have any questions regarding the purpose or nature of the study, I can contact Sophie Nash, M.A. Candidate, by e-mail at sx_nash@laurentian.ca, or Elizabeth Levin, Ph.D., by phone at 705-or 1-800-461-4030, extension 4242, or by e-mail at elevin@laurentian.ca . If I have concerns regarding the ethics of the study, I may contact the Research Ethics Officer, Laurentian University Research Office, by phone at 705-675-1151 or 1-800-461-4030, extension 3213, or by e-mail at ethics@laurentian.ca

Do you consent to being contacted in the near future so that you may be asked to participate in the interview portion of this research project about your help-seeking experiences?

Yes ☐ No ☐

PARTICIPANT: ____

(Signature)

DATE: ____

Name: ____

Daytime phone number: ____

E-mail address: ____

Appendix E

Community Resource List

Sudbury Mental Health Resources

Laurentian University Counselling and Support Services…………………...……705-673-6506
Email………………………………………………… supportprograms@laurentian.ca
G-7-Student Street, Single Student Residence (SSR)

Canadian Mental Health Association……………………………………………705-675-7252
Toll free……………………………………………………………………..1-866-285-8642

Crisis Intervention……………………………………………………………………705-6754760
127 Cedar Street, in HSN – Sudbury Mental Health & Addictions Centre building

Appendix F

Table 1

Programs of Study as a Frequency Percentage of the Overall Sample

Program of Study	Frequency
Behavioural Neuroscience	3
Biochemistry	1
Biology/Psychology	1
Biomedical Biology	2
Concurrent Ed. (Jr./Int.), SPED	1
Concurrent Ed.	1
Concurrent Ed. with Phys. Ed.	1
Concurrent Ed./Psychology	1
Environmental Studies	2
Health Promotion	3
Health Promotion/Concurrent Ed.	1
Labour Studies	1
Nursing	2
Orthophonie	1
Psychology	25
Radiation Therapy	4
Social Work	2
Sociology/Psychology	1
SPAD	1
Sports and Phys. Ed.	2
Sports and Phys. Ed. with Concurrent Ed.	1
Sports Psychology	3
Zoology	1

Note: Demographic information is self-reported, and participants had the opportunity to write in their own response. Phys. Ed. = Physical Education. Ed. = Education. SPED = Special Education Program. SPAD = Sports Administration Program at Laurentian.

Table 2

Current City/Town as a Frequency Percentage of the Overall Sample

City/Town	Frequency
Azilda, ON*	1
Barrie, ON/Sudbury**	1
Belleville, ON/Sudbury**	1
Orillia, ON***/Sudbury**	1
Sudbury, ON	54
Toronto, ON	1
Val Caron, ON*	1
Wasaga Beach, ON***/Sudbury**	1

Note: *These are rural communities in town(s) that are part of the municipality of the Greater City of Sudbury. **Demographic information is self-reported, and participants had the opportunity to write in their own response. These participants considered themselves as currently living in two cities at once. *** These are rural communities or towns with populations below 100, 000 as of 2016 census data from Statistics Canada.

Table 3

Living Situation as a Frequency Percentage of the Overall Sample

Living Situation	Frequency
In Residence	23
With Parents	16
In Residence and with Parents	1
Off Campus and with Parents and Romantic Partner	1
Off Campus	
Alone	3
With Romantic Partner	4
With Roommate	13

Note: Demographic information is self-reported, and participants had the opportunity to write in their own responses.

Table 4

Frequencies of Group Demographic Characteristics

Characteristic	Group 1 (*n* = 22) Frequency	Group 2 (*n* = 39) Frequency
Gender		
Female	16	34
Male	6	5
Age		
18 years old	1	1
19 years old	5	15
20 years old	2	12
21 years old	4	6
22 years old	6	3
23 years old	1	2
24 years old	1	0
25 years old	2	0
Marital Status		
Single	19	38
Common-law	3	0
Unanswered	0	1
Employment Status*		
Employed	3	4
Unemployed	10	10
Employed Part-time	5	10
Summer Employment	1	5
Full-time Student	2	2
None	0	4
N/A**	1	4

Year in Program		
1	2	3
2	11	20
3	2	10
4	5	6
5	1	0
Graduation Year***		
2009	2	0
2010	1	0
2011	1	1
2012	3	2
2013	7	7
2014	2	10
2015	3	17
2016	2	2

Note: The two groups are those who have reported ever accessing professional mental health services (Group 1) and those who have not (Group 2). *n* = sample size of each group. *Demographic information was self-reported, and participants had the opportunity to write in their own response. **N/A = Not Applicable. ***Graduation year refers to the year the participants graduated from high school.

Table 5

Programs of Study of Groups as Frequencies

Program of Study	Group 1 (*n* = 22)	Group 2 (*n* = 39)
	Frequency	Frequency
Behavioural Neuroscience	0	3
Biochemistry	0	1
Biology/Psychology	1	0
Biomedical Biology	1	1
Concurrent Ed. (Jr./Int.),	1	0

SPED		
Concurrent Ed.	1	0
Concurrent Ed. with Phys. Ed.	0	1
Concurrent Ed./Psychology	1	0
Environmental Studies	2	0
Health Promotion	0	3
Health Promotion/Concurrent Ed.	0	1
Labour Studies	0	1
Nursing	0	2
Orthophonie	0	1
Psychology	10	15
Radiation Therapy	1	3
Social Work	1	1
Sociology/Psychology	1	0
SPAD	0	1
Sports and Phys. Ed.	1	1
Sports and Phys. Ed. with Concurrent Ed.	1	0
Sports Psychology	0	3
Zoology	0	1

Note: The two groups are those who have reported ever accessing professional mental health services (Group 1) and those who have not (Group 2). *n* = sample size of each group. Demographic information is self-reported, and participants had the opportunity to write in their own response. Phys. Ed. = Physical Education. Ed. = Education. SPED = Special Education Program. SPAD = Sports Administration Program at Laurentian.

Table 6

Current City/Town as a Frequency of Group Samples

City/Town	Group 1 (*n* = 22) Frequency	Group 2 (*n* = 39) Frequency
Azilda, ON*	1	0
Barrie, ON/Sudbury**	0	1
Belleville, ON/Sudbury**	0	1
Orillia, ON***/Sudbury**	1	0
Sudbury, ON	17	37
Toronto, ON	1	0
Val Caron, ON*	1	0
Wasaga Beach, ON***/Sudbury**	1	0

Note: The two groups are those who have reported ever accessing professional mental health services (Group 1) and those who have not (Group 2). *n* = sample size of each group. *These are rural communities in town(s) that are part of the municipality of the Greater City of Sudbury. **Demographic information is self-reported, and participants had the opportunity to write in their own response. These participants considered themselves as currently living in two cities at once. *** These are rural communities or towns with populations below 100, 000 as of 2016 census data from Statistics Canada.

Table 7

Living Situation as a Frequency Group Samples

Living Situation	Group 1 (*n* = 22) Frequency	Group 2 (*n* = 39) Frequency
In Residence	8	15
With Parents	7	9
In Residence and with Parents	0	1
Off Campus and with Parents and Romantic Partner	1	0
Off Campus		
Alone	1	1
With Romantic Partner	3	1
With Roommate	0	8

Note: The two groups are those who have reported ever accessing professional mental health services (Group 1) and those who have not (Group 2). *n* = sample size of each group. Demographic information is self-reported, and participants had the opportunity to write in their own responses

Appendix G

Semi-structured Interview

Read to Interviewee

You indicated in the first part of this study that you have previously accessed professional mental health services and would like to participate in this interview process. The following questions are designed to explore your personal experiences with these services.

For this study, professional **mental health services** are defined as those provided by licensed mental health care practitioners, such as a registered psychologist, a psychiatrist, a family physician, or a registered counsellor (who works for a mental health clinic or organization such as the Canadian Mental Health Association, Health Sciences North, Crisis Intervention, etc.).

You have to right not to answer any questions you may be uncomfortable with or do not want to answer. You may stop participating at any time. You may stop the interview at any time.

PART 1: What does mental health care mean to the interviewee

1) **What does 'mental health care' mean to you?**
   Prompt: What kinds of things are important to you?
   Probes: Do you have anything you would like to add?
   Could you give me an example of this?

2) **What does seeking help from mental health services mean to you?**
   Prompt: What kinds of things are important to you when seeking help?
   Probe: Could you tell me more about that?

3) **Have you ever known someone close to you who has accessed mental health care services? (e.g. family member, friend, significant other)**

   a) **If so, how does this make you feel when you think about it today?**
      Prompt: Tell me about any emotions you have about this person accessing services.
      Probe: Tell me more
      Could you give me an example?

PART 2: Experience with Seeking Mental Health Care

You indicated in your consent form that you have accessed mental health care services before. Let’s discuss your most recent experience with mental health care services:

4) **When did this experience happen?**

5) **Have you ever accessed mental health care services before the time you just described?**

6) **Why did you decide to seek mental health care?**
Prompt: Were there any particular problems or distress that you were experiencing?
Probe: Could you tell me more?
Could you give me an example?

7) **How do you feel about your decision to seek help?**
Prompt: Are there any particular emotions that you experience when you look back at your decision?
Probe: *Tell me more*

PART 3: Experience with Services (Needs and Treatment)

8) **What did your treatment look like?**
Prompt: What services were involved with your treatment?
Probe: Could you give me an example of this?
Can you think of anything else that was involved with your treatment?

9) **Do you still experience any of the issues that lead you to seek help?**

10) **Do you feel like your needs were met?**
Probe: Tell me more

11) **How do you feel about the treatment you received from these services?**

Prompt: What is your overall opinion or feeling about your treatment?
Probe: Can you think of anything else to add?

12) **How do you feel about the people who provided these services?**
Prompt: Were there any particularly positive and/or negative experiences you had with any people involved with your treatment or services?
Probes: Can you think of anything else to add?
Could you give me any examples?

13) **Tell me about anything that you think was helpful and/or challenging about your treatment.**
Prompt: Were there any particularly positive and/or negative experiences you had with treatment?
Probes: Can you think of anything else to add?
Could you give me any examples?

14) **What are some emotions you feel when you reflect upon your experiences with these services?**
Prompt: For example, do you feel any emotions like happiness, sadness, pride, anger, gratitude fear, shame, hopefulness etc.)
Probe: Tell me more

a) **Is there anything in particular that makes you feel this way about your experiences?**
Probe: Is there anything else you would like to add?
Could you give me an example?

PART 4: Barriers and/or facilitators to accessing care from these services

15) **How did you go about finding and accessing these mental health services?**
Prompt: For example, did you call or go anywhere specific?
Probe: Could you give me an example?

16) **Was there anything that made it difficult for you to seek and access help?**

Prompt: E.g. waitlists, financial costs, concerns for privacy, out of town travel etc.

Probe: Is there anything else you would like to add?
Could you give me any examples?

17) Was there anything that made it easier for you to seek and access help?
Prompt: E.g. wait-times, financial aid, community supports etc.
Probe: Is there anything else you would like to add?
Could you give me any examples?

18) What are your thoughts about mental health care in Northern and Southern Ontario communities? (e.g. Sudbury)

Prompt: Do you think there are any differences or similarities between mental health care in Northern and Southern Ontario?

Probe: Tell me more
Could you give me any examples?

a) Tell me about any pros or cons you feel there are to seeking and receiving mental health care in the North versus the South.
Probes: Could you give me any examples?

19) What are your feelings or thoughts about the mental health services here in Sudbury?
Prompt: Is there anything you do or do not like about the mental health care here in Sudbury?
Probes: Tell me more
Could you give me any examples or reasons why you think you feel this way?

20) How do you feel about accessing mental health services on campus?
Probe: Is there anything else you would like to add?
Could you give me any examples or reasons why you think you feel this way?

a) Were you or are you aware of these services here on campus?
Probe: How do you feel about your awareness of these?

21) Is there anything you think could have been done or changed that may have made your experience better?

Probe: Is there anything else you would like to add?
Could you give me any examples?

Appendix H

Part II Consent Form

I agree to participate in the research project entitled "Help-seeking Behaviours of University Students in a Northern Ontario Community".

I understand that the goal of this research is to explore the help-seeking attitudes, intentions, barriers to care, and experiences of undergraduate university students for mental health services in the Northern Ontario community of Sudbury, Ontario. I understand that this is a two-part study and that I am consenting to participate in Part II.

I understand that I will be asked to participate in a semi-structured interview that will be audio recorded for transcription purposes. This will take approximately one hour to complete. I understand I will be asked questions about my experiences with mental health services in my community such as those provided by: licensed mental health care practitioners, such as psychologist, a registered psychiatrist, a family doctor, or a registered counsellor (who works for a mental health clinic or organization such as the Canadian Mental Health Association, Health Sciences North, Crisis Intervention, etc.).

I understand that I do not have to participate in this study. **I may stop participating at any time**. I understand that the interview may bring up topics that I may be uncomfortable with discussing. I can choose not to answer any questions. If I feel uncomfortable, I can take a break or stop the questionnaire/interview at any time. After the study, I understand there will be a debriefing where I will be provided with a list of general and mental health resources should I need them.

I understand that all information collected will be used for research purposes only. I understand that my anonymity will be protected. Any personal information collected during the study will stay private and confidential. I understand that any identifying information about me, such as my name, will be changed to numbers to ensure confidentiality. I understand that the data will be stored on a secure, password protected computer enhanced with encryption. I understand that all interview transcripts will be destroyed 5 years after the end of this project. I understand that my audio files will be destroyed immediately following transcription. I also understand that I will have a chance to look at my interview transcript to make sure it accurately shows what I have said during the interview. By reviewing my interview transcript, I will have an opportunity to inform the researcher of any information I gave that I might be uncomfortable with having shared or may provide further clarification information on what I have said. I also understand that I may be contacted again to clarify my responses or answer any follow up questions. If I want, I may receive a summary of the results at the end of the study (please check below).

I understand that there are limits to confidentiality. Should at any point during the interview I disclose the risk of imminent harm to myself or to others, the researcher is obligated to contact the appropriate authorities and therefore break confidentiality.

If I have any questions regarding the purpose or nature of the study, I can contact Sophie Nash, M.A. Candidate, by e-mail at sx_nash@laurentian.ca, or Elizabeth Levin, Ph.D., by phone at 705-or 1-800-461-4030, extension 4242, or by e-mail at elevin@laurentian.ca . If I have concerns regarding the ethics of the study, I may contact the Research Ethics Officer, Laurentian University Research Office, by phone at 705-675-1151 or 1-800-461-4030, extension 3213, or by e-mail at ethics@laurentian.ca

After reviewing this consent form, I agree to participate in this research project.

PARTICIPANT: ______________________________

(Signature)

DATE: ______________________________

Name: ______________________________

Daytime phone number: ______________________________

E-mail address: ______________________________

I would like to receive a copy of the results at the end of this study. ☐ **Yes** ☐ **No**