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Adolescents' Help-seeking for Mental Health Problems: Development and Evaluation of a School-based Intervention

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Adolescents' Help-seeking for Mental Health Problems: Development and Evaluation of a School-based Intervention

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THESIS CERTIFICATION

I, Janaki Rughani, declare that this thesis, submitted in partial fulfilment of the requirements for the award of Doctor of Psychology (Clinical), in the School of Psychology, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

Janaki Rughani

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Abstract

Help-seeking is defined as a request for assistance with problems that the individual does not have the personal resources to solve on their own (Barker, et al., 2005). While it is well established that help-seeking is a protective factor for many significant health and developmental outcomes (Barker, et al., 2005; Kalafat, 1997; Rickwood, et al., 2005), adolescents' use of professional health services compared to the rest of the population is disturbingly low. The current research aimed to investigate factors that influence adolescent help-seeking from formal sources in order to develop, implement and evaluate a school-based intervention to improve adolescents' use of professional services for mental health problems.

Study 1 investigated the extent to which perceived benefits of help-seeking, stoicism, gender and symptoms of psychological distress were associated with intentions to seek professional help for mental health problems. A total of 778 adolescents between the ages of 13 and 18 living in regional areas of New South Wales completed a self-report questionnaire. Results from multiple regression analysis suggested that adolescents were more likely to seek help from professionals if they perceived help-seeking as beneficial. Female participants reported that they were more likely to seek help than male participants. Findings from study 1 suggest that improving adolescents' beliefs about the benefits of professional help seeking might be a key strategy for increasing their use of professional health services to address mental health problems.

Study 2 aimed to design and implement an intervention that addressed adolescent barriers to seeking help, promoted the benefits of seeking help and provided education about the process of seeking help. Two hundred and sixty Year 11 students from two schools in the Illawarra and South East Region of New South Wales participated in the study. Students were randomised to control and intervention groups and completed questionnaires immediately before and after the presentations, and at 3-months follow-up. The primary outcome variables measured were helpseeking intentions, perceived benefits of help-seeking and perceived barriers to helpseeking.

Hierarchical linear modelling was performed to evaluate the effectiveness of the intervention on outcome variables. Findings revealed short-term improvements in help-seeking intentions, perceived benefits of help-seeking and perceived barriers to help-seeking as a result of the intervention. However, students' help-seeking intentions remained in the "unlikely" range of help seeking, and improvements in perceived barriers to help-seeking and perceived benefits to help seeking were only apparent in one of the two schools in the study. Results also revealed that improvements were not maintained at 3-months follow-up, suggesting that the intervention did not facilitate successful long term improvement in help-seeking intentions.

These findings indicate a need to re-consider the design, structure and timing of future interventions so that immediate improvements in help-seeking can be sustained. It will also be useful to measure the level of support provided by school staff to students in regards to health behaviour, and accordingly encourage greater levels of school support and engagement around implementation of an intervention.

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I would like to dedicate this thesis to my parents, Subhash and Ajita Rughani, who have consistently provided loving encouragement through all the years I have been working on this thesis. Their genuine interest and pride in my studies has helped provide me with the high levels of motivation required to complete this work.

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Finally I would like to thank all of the individuals involved in the implementation of the intervention, including: individuals involved in DVD development and design, the facilitators of the intervention, as well as the head of welfare teachers and school counsellors that were involved in the research. I would like to acknowledge and thank all of the high school students who agreed to take part in the study.

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The Importance of Help-seeking in Adolescence

Adolescence has been identified as a peak period for the onset of mental health problems, with half of all lifetime cases of mental disorders starting by 14 years of age (Kessler et al. 2005; Newman, et al., 1996). Adolescents are faced with numerous struggles as they strive to develop a sense of autonomy and independence, as well as establish their own identity (Erikson, 1968). The significant biological, cognitive, social, emotional and interpersonal transitions that occur during this phase of life increase adolescents' vulnerability to the development of mental health problems (Evans, et al., 2005).

Although these transitions are a normal part of life, the way an adolescent experiences and copes with these struggles can have a major impact on their development into adulthood (Schonert-Reichl & Muller, 1996). Specifically, the methods used by adolescents to cope with difficulties contribute to forming a foundation for the coping methods they use throughout adulthood (Schonert-Reichl, 2003). During this phase of life, adolescents begin to learn to make independent decisions and become responsible for their own behaviour. It is therefore a critical time to ensure that adolescents develop effective and appropriate strategies to cope with arising difficulties. In particular, it is crucial that adolescents experiencing difficulties learn to seek appropriate help.

Informal and formal sources of help. Generally, help-seeking is defined as a request for assistance with problems that the individual does not have the personal resources to solve on their own (G. Barker, Olukoya, & Aggleton, 2005). Research has consistently reported that adolescents prefer to seek help from informal sources such as family and friends, rather than from formal sources such as GPs, school counsellors and psychologists (Raviv, Sills, Raviv, & Wilansky, 2000; Schonert-Reichl & Muller, 1996; Sheffield, Fiorenza, & Sofronoff, 2004; Tishby, et al., 2001; Zwaanswijk, Verhaak, Bensing, van der Ende, & Verhulst, 2003).

Although informal help-seeking may provide some support for adolescents who are experiencing distress, it may not be the most effective source of help (Offer, Howard, Schonert, & Ostrov, 1991). Adolescents may not receive the support that they require from family and friends who have limited training or experience in dealing with mental health problems. Same-aged peers may be poorly equipped to provide adequate responses to a distressed friend. Also, distressed adolescents are often involved in unsupportive relationships that involve conflict (Marcus, 1996), and they tend to form friendships with peers who are similarly distressed (Sarbornie & Kauffman, 1985). Therefore, informal sources of help may not always be appropriate for adolescents experiencing mental health related problems (Offer, et al., 1991; Rickwood, 1995).

In contrast to informal help-seeking, formal help-seeking is widely recognised as a protective factor, and is vital for early treatment and prevention of mental health problems during adolescence (Wilson, Deane, Marshall & Dalley, 2010). Seeking and receiving help from mental health professionals can assist in the reduction of distressing psychological symptoms (Bergin & Garfield, 1994; Rudd, et al., 1996), as well as successfully reduce the long term impact of many mental health problems (Rickwood, Deane & Wilson, 2007)

Long term effects of untreated mental health problems. Adolescents experiencing mental health problems are at an increased risk of developing further mental health problems. For example, the risk of developing an anxiety or substance abuse disorder is elevated for adolescents that are experiencing depression (Wisdom, Clarke, & Green, 2006). Furthermore, these problems have the potential to lead to serious and at times life threatening consequences, such as suicide (Fombonne, 1998). Seeking appropriate help for these problems, before they become severe, can reduce adolescents' risk for developing comorbid difficulties and potentially reduce the risk of suicide (Gould, et al., 2004; Kalafat, 1997).

As well as increasing the risk of developing comorbid difficulties, untreated mental health problems can have a profound impact on adolescents' academic, social and independent

functioning. Even somewhat minor mental health problems can cause disruption to education, the formation of peer relationships, and the establishment of identity (Wolfe & Mash, 2006). Specifically, depression amongst adolescents has been associated with academic failure, school absences, difficulties with occupational adjustment and peer rejection (Wolfe & Mash, 2006). Due to the highly changing developmental nature of adolescence, all of these experiences have a major long term effect on various areas of adult life, including employment opportunities (Kessler, Foster, Saunders & Stand, 1995) and the establishment of adult roles (Raphael, 1986).

Importantly, evidence suggests that the presence of mental health problems in adolescence is a risk factor for mental health problems in adulthood (Orvaschel, Lewinsohn, & Seeley, 1995). For example, the experience of symptoms of major depression during adolescence, if left untreated, can lead to the development of depressive and substance use disorders that continue into adulthood (Wisdom, et al., 2006). These disorders comprise a large proportion of mental health problems amongst adult populations. Appropriate mental health support during adolescence is therefore vital in order to reduce the potential impact of these issues in later life.

The service gap. While it is well established that help-seeking is a protective factor for many significant health and developmental outcomes (Barker et al., 2005; Kalafat, 1997; Rickwood, Deane, Wilson & Ciarrochi, 2005) adolescents' use of professional health services compared to the rest of the population is disturbingly low. The Child and Adolescent version of the National Survey of Mental Health and Wellbeing conducted in 2000 reported that more than 20% of Australian 12-16 yr olds had a mental health problem (Sawyer, Miller-Lewis & Clark, 2007). Only one out of every four adolescents' with mental health problems had received professional help. Given the high occurrence of mental health problems (Sawyer et al., 2007) amongst adolescents, this finding is cause for serious concern. The disparity between the number of adolescents requiring services and the number of adolescents accessing services has therefore been

a focus of recent research and is commonly referred to as the "service gap" phenomenon (Kushner & Sher, 1989; Raviv, Raviv, Vago-Gefen, & Fink, 2009; Stefl & Prosperi, 1985).

In an effort to understand the service gap phenomenon, researchers have identified a number of factors that influence the likelihood that adolescents will engage in formal help-seeking behaviour. A clearer understanding of the factors influencing help-seeking behaviour can be obtained by using health behaviour models to guide research.

Theories of Help-seeking Behaviour

In order to address the problem of the service gap, it is useful to consider theoretical models that attempt to identify and understand the factors that affect help-seeking behaviour. A number of researchers have designed and tested models of help-seeking behaviour, and some common factors involved in the help-seeking process are apparent. For example, most of the models described below claim that before deciding to seek help, an individual will make some sort of evaluation of the outcome of seeking help. This will include asking questions about the benefits and barriers to seeking help. It is still useful to examine each model, as each provides its own unique conceptualisation of the help-seeking process.

Anderson's model of Health Care Utilization (Andersen, 1995) purports that help-seeking is determined by predisposing characteristics, enabling resources and need. Predisposing characteristics include demographic characteristics such as age and gender, beliefs or attitudes about services, and social structure characteristics such as culture, education and social networks. Enabling resources include characteristics such as income and access to transportation, while need refers to the individual or a professional's assessment of need. Aspects of this model correspond to components of the Social Network Model, which highlights the influence of sociodemographic characteristics, illness characteristics, illness history, and social networks to the health related decisions an individual makes (Pescosolido, 1992). Both models highlight the influence of

background factors such as age and gender, as well as the importance of social networks, specifically, the support provided by an individual's social network.

In contrast, the Stages of Change model focuses on the individual, rather than the influence of social and environmental issues on help-seeking behaviour. The Stages of Change model has been extensively applied to health related behaviour change, and highlights that change is a cyclical process that varies for each individual. The model has five stages: (1) pre-contemplation, (2) contemplation, (3) preparation for action, (4) action, and (5) maintenance. When applied to help-seeking behaviour, pre-contemplation corresponds to the stage when the individual is not thinking about seeking help. During the contemplation stage, the individual has begun to consider seeking help, before preparing to seek help (preparation for action). The action phase corresponds to consistent engagement in help-seeking behaviour and the maintenance stage corresponds to maintenance of help-seeking behaviour over time. Consistent with the "need" component of Andersen's model of Health Care Utilisation, the Stages of Change model implies that an intervention targeting help-seeking behaviour may need to be tailored to the needs of an individual, depending on where they are in the change process.

More recently, the Information Processing Model of Help-seeking describes help-seeking as a decision making process comprising of a series of steps (Vogel, Wester, Larson, & Wade, 2006). The four steps outlined in this model are (1) encoding and interpreting internal and external cues, (2) generating and evaluating behavioural options, (3) deciding on and enacting a selected response, and (4) responding to personal and peer evaluations of the selected behaviour. Similarly, Saunders (1993) identified four steps involved in making the decision to seek help: (1) recognizing the problem, (2) deciding therapy might help, (3) deciding to seek therapy, and (4) contacting the mental health system.

The Health Belief Model (Rosenstock, 1966) and the Theory of Planned Behaviour (TPB; Ajzen, 1985) have been applied to a range of health behaviours. Whilst neither of these models

have been designed specifically for help-seeking behaviour, they have received support for their utility in predicting health behaviours (Ajzen, 1991; Armitage & Conner, 2001; Godin, 1996). Both models provide a useful framework for understanding help-seeking behaviour and will therefore be considered in detail. The Theory of Planned Behaviour was designed as a general model for predicting behaviour and was not designed specifically to predict health related behaviour. Therefore, if applied on its own, it may not capture important factors specific to health related behaviour. For example, the Theory of Planned Behaviour does not accommodate high versus low levels of severity of symptoms, whereas the Health Belief Model does include severity as a distinct factor. Both of these models will be described in detail and applied to help-seeking behaviour.

Health Belief Model (HBM; Rosenstock, 1966). Help-seeking behaviour has not been investigated explicitly using the HBM, however, much of the existing literature can be conceptualised using the components of this model. The HBM proposes that health behaviour is determined by an individual's personal beliefs or perceptions about the problem, and their beliefs about the options available to reduce the problem. The model describes four main perceptions that can be used individually, or in combination to explain health behaviour: (1) Perceived Severity, (2) Perceived Susceptibility, (3) Perceived Benefits and (4) Perceived Barriers.

(1) Perceived Severity also referred to as Perceived Seriousness, refers to the individual's opinion of the level of seriousness of a problem or its consequences. This belief can be based on factual knowledge about the problem, as well as on the individual's own beliefs about the difficulties the particular problem would create and the effects it would have on their life.

(2) Perceived Susceptibility/Perceived Risk refers to the individual's belief about their susceptibility to the problem. If an individual does not believe that they are susceptible to a particular problem, they are unlikely to engage in behaviours to reduce the risk of having the problem. However, if an individual perceives that he or she is susceptible to a problem, he or she is more likely to engage in behaviours that will reduce the risk.

When the perception of susceptibility and perception of seriousness are combined, it results in perceived threat. The model states that a perception of increased threat does not always lead to behaviour change.

(3) Perceived benefit refers to the person's opinion about the value or usefulness of a new behaviour in reducing the risk of a problem. Individuals must believe that there is a benefit in adopting a particular behaviour in order to engage in the behaviour.

(4) Perceived barriers to change refer to an individual's own evaluation of the obstacles in the way of him or her adopting a new behaviour. For an adolescent to seek help, they need to believe that the benefits of seeking help outweigh the consequences of continuing to try and handle the problem on their own. An important barrier identified in the HBM is self-efficacy, which refers to the belief of confidence in one's own ability to do something. The model asserts that an individual is less likely to engage in a particular behaviour if they do not believe they have the capability to carry out the behaviour.

Based on the HBM, these four major constructs of perception are modified by individual characteristics that influence personal perceptions, (e.g. culture, age, past experiences). In addition, behaviour is also influenced by Cues to Action. Cues to Action refer to incidents that may prompt an individual to engage in the behaviour. For example, feeling depressed may act as a cue to seeking help.

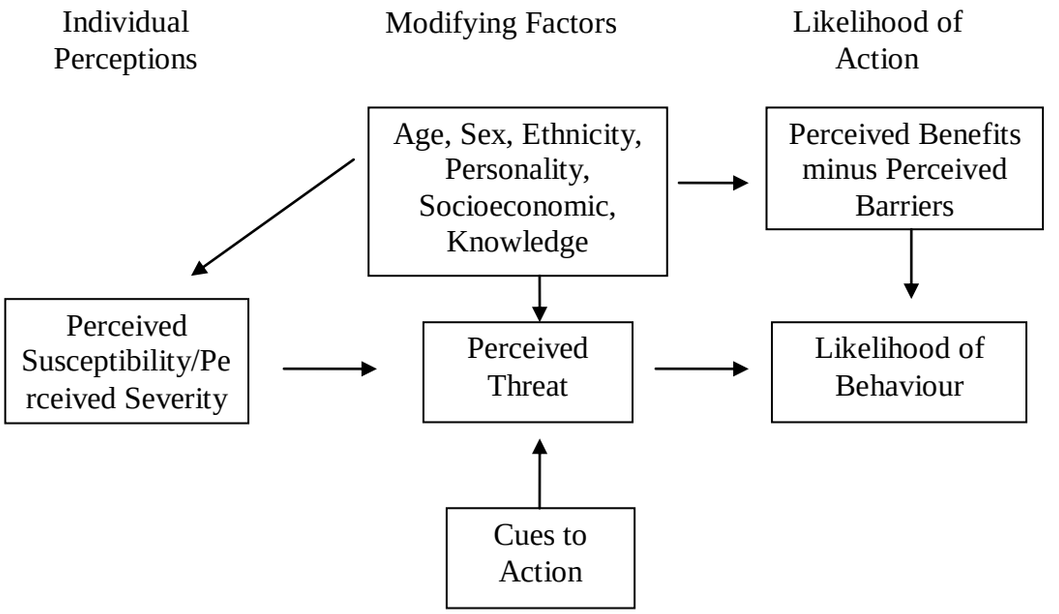

Figure 1. Diagram of the Health Belief Model (Rosenstock, 1966)

Based on the HBM, for individuals experiencing significant psychological distress, help-seeking behaviour can be facilitated by accurate information to answer these basic decision-making questions: (a) severity: when are my symptoms ‘‘bad enough’’ to seek professional help? (b) benefits: does professional help increase my chances of feeling better soon? (c) barriers: are the financial, emotional, or other costs of seeking professional help worth the possible benefits? and (d) self-efficacy: am I capable of making the changes necessary to improve how I feel?

The Theory of Planned Behaviour (TPB; Ajzen, 1985). The TPB asserts that the most important determinant of behaviour is an individual’s intention to perform the behaviour. Intention is an indication of a person's readiness to perform a given behaviour. The direct determinants of behavioural intention are Attitude toward the behaviour, Subjective norm, and Perceived behavioural control.

Attitude toward the behaviour refers to the degree to which engaging in the behaviour is positively or negatively valued. Attitudes, in turn, are predicted by a person’s behavioural beliefs linking the behaviour to expected outcomes (Ajzen & Fishbein, 1980). Consistent with this idea, research has shown that outcome expectations are associated with help-seeking attitudes (Kelly &

Achter, 1995; Vogel & Wester, 2003). When applied to help-seeking behaviour, this suggests that if a person anticipates a constructive outcome from seeking help (e.g., seeking help will lead to not feeling sad anymore), they will have a positive attitude (e.g., seeking help is a good thing). Conversely, if a person anticipates a harmful outcome from seeking help (e.g., "If I seek help, others will think I am crazy"), then they will have a more negative attitude (e.g., seeking help is a bad thing).

Subjective norm refers to the perceived social pressure to engage in, or not to engage in a particular behaviour. Subjective norm, in turn, is determined by normative beliefs - the perceived behavioural expectations of significant others (e.g. parents, peers) and the individual's motivation to comply with these expectations.

Perceived behavioural control refers to an individual's perception of their ability to perform a given behaviour. Perceived behavioural control, in turn, is determined by control beliefs - beliefs about the presence of factors that may facilitate or impede performance of the behaviour. For example, an adolescent may believe that he or she is not capable of describing their problem effectively to a health professional, and may therefore be less likely to seek help.

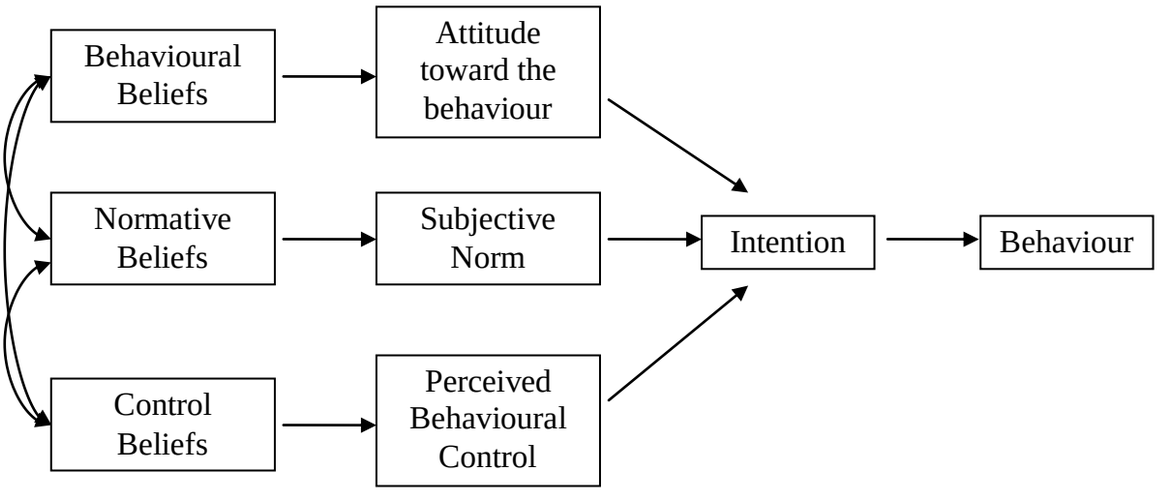

Figure 2. Diagram of the Theory of Planned Behaviour (Ajzen, 1985)

Health Behaviour Models applied to help-seeking research. Whilst the models described overlap in a number of areas, a significant limitation is the lack of a unifying theory of help-seeking

behaviour. Both the HBM and TPB focus on attitudes and perceptions related to help-seeking. The models suggest that research directed towards identifying individuals' attitudes towards help-seeking may provide guidance for the development of interventions addressing help-seeking. Specifically, health professionals may develop interventions to address maladaptive attitudes or inaccurate beliefs that influence help-seeking behaviour. Consistent with these models, many studies have found that the singles best predictor of help-seeking intentions is the person's attitude toward seeking professional help (Cepeda-Benito & Short, 1998; Kelly & Achter, 1995; Vogel & Wester, 2003). The models indicate that an individual's attitude towards help-seeking behaviour is determined by their beliefs about the outcomes of performing the behaviour (Ajzen, 1985), that is, their perception of both the perceived benefits and the perceived barriers of carrying out the behaviour. For example, if an individual expects that seeking help will reduce feelings of distress, they are likely to have a positive attitude towards help-seeking. On the other hand, if the individual expects that seeking help will lead to others perceiving them as weak, they are likely to have a more negative attitude towards help-seeking. Consistent with this perspective, research has shown that positive or negative outcome expectations influence attitudes and intentions to seek help (Vogel & Wester, 2003). Therefore, a closer examination of adolescents' beliefs about the outcomes of seeking help is likely to provide guidance on how to facilitate their help-seeking behaviour.

Factors Influencing Help-seeking for Emotional Problems

Consideration of theoretical models allows for factors influencing help-seeking to be understood and organised in a structured manner. Understanding how these factors relate to each other allows for effective design of interventions to target help-seeking. In line with the aforementioned models of health behaviour, research has identified a number of factors that influence adolescents' help-seeking for psychological problems. Gender, an influencing factor identified in all models described above, has empirically been one of the most consistent predictors of help-seeking (e.g. Addis & Mahalik, 2003). Research has also identified a number of perceived

barriers to help-seeking, with some barriers being consistently identified amongst adolescent populations (e.g. Booth, et al., 2004; Sheffield, et al., 2004; Wilson & Deane, 2001). A review of help-seeking literature also reveals that the perceived benefits of seeking help influence adolescents' help-seeking from a health professional (e.g. Vogel, Wester, Wei, & Boysen, 2005).

Gender and help-seeking. Gender differences in formal help-seeking for mental health problems are widely accepted amongst adult and adolescent populations, with females seeking help more than males (Addis & Mahalik, 2003; Garland & Zigler, 1994; Gonzalez, Alegria, & Prihoda, 2005; Grinstein-Weiss, Fishman, & Eisikovits, 2005; Hauenstein, et al., 2006; Mackenzie, Gekoski, & Knox, 2006; Raviv, et al., 2000; Rhodes, Goering, To, & Williams, 2002; Rickwood & Braithwaite, 1994; Rule & Gandy, 1994; Schonert-Reichl & Muller, 1996; Tishby, et al., 2001). It has been found that females report fewer reservations to seeking help than their male peers (Raviv, et al., 2009) and that men are more likely to have negative attitudes about mental health services, which contributes to lower rates of help-seeking (Mackenzie, et al., 2006).

While it is well established that females are more likely to seek help than males, the reasons underlying this gender difference remain unclear. It has been suggested that female adolescents are more likely to express feelings of distress and are therefore more open to seeking help than male adolescents (Hauenstein, et al., 2006; Mackenzie, et al., 2006; Rhodes, et al., 2002; Schonert-Reichl & Muller, 1996; Tishby, et al., 2001). Women may also be better at identifying problems and believe more in the effectiveness of seeking help (Corney, 1990; Garland & Zigler, 1994), whereas men have been found to deny or lack insight into their problems (Timlin-Scalera, Ponterotto, Blumberg, & Jackson, 2003). Men perceive stigma to be a greater barrier to seeking treatment than women (Mackenzie, et al., 2006) and experience concerns about expressing emotions or affection toward other men (Good, Dell, & Mintz, 1989). Seeking help may cause men to feel a sense of failure and fear about losing their autonomy (Addis & Mahalik, 2003). Further, men may

experience feelings of shame about being seen as weak if they cannot handle a problem on their own (Vogel, Wade, & Haake, 2006).

To date, differences in male and female attitudes towards help-seeking are predominantly conceptualised as occurring due to gender role socialisation (Grinstein-Weiss, et al., 2005). In particular, common characteristics of the male gender role, such as restricted emotionality, independence, invulnerability and self-reliance may be related to negative attitudes toward seeking help (Blazina & Watkins, 1996). Further, it is thought that males hold stoic beliefs such as needing to project a strong, autonomous image (Timlin-Scalera, et al., 2003), which they may view as inconsistent with help-seeking. These male gender role characteristics may lead men to perceive themselves as autonomous problem solvers, rather than help seekers (Mackenzie, et al., 2006), because seeking help may mean admitting an inability to handle things on one's own. On the other hand, female gender role socialisation emphasises emotional expression, collaboration and dependence, which are characteristics that appear to be more consistent with seeking help from others for problems (Mackenzie, et al., 2006).

Consistent with these theories, recent research suggests that individuals who adhere to more traditionally masculine gender roles may be more likely to perceive help-seeking as stigmatising (Addis & Mahalik, 2003; McKelley & Rochlen, 2010; Vogel & Wade, 2009). While stoicism has been associated with a decreased likelihood of seeking help, it has also been found to be more prominent amongst males than females (Bruch, 2002; Fischer & Good, 1997). In a sample of rural adults, men were found to have higher levels of stoicism than women (Judd, Komiti, & Jackson, 2008). Amongst adolescents, males felt they could not seek help for their own problems because it would be perceived by both themselves and others as a sign of weakness (Timlin-Scalera, et al., 2003). The perception that males who seek help are weak was a primary barrier to help-seeking for males in this study. Similarly, Quine et al (2003) reported that amongst Australian adolescents, the rural culture of self reliance made it more difficult for rural males to seek help than urban males.

Research findings suggest that lower rates of help-seeking for mental health problems by men may be due to higher levels of stoicism in men compared to women (Judd, et al., 2008). Further exploration of gender differences in stoicism amongst adolescents, and the effect of these attitudes on help-seeking intentions may facilitate understanding of possible factors underlying gender differences in help-seeking.

Perceived barriers to help-seeking. Based on theory (e.g. HBM; Rosenstock, 1966), for adolescents to seek help, they need to believe that the benefits of seeking help outweigh the barriers to seeking help. Empirically, numerous barriers to adolescents' accessing professional help have been identified. Common barriers identified across the literature include: lack of time, financial difficulties, unavailability of services, lack of knowledge about where and how to seek help, feeling too embarrassed to seek help, believing that help-seeking is a sign of weakness, fear of being stigmatised as a consequence of seeking help, concerns about confidentiality, and negative past experiences of help-seeking.

Saunders, Zygowicz and D'Angelo, (2006) distinguish between treatment related barriers and person related barriers. Treatment related barriers refer to aspects of treatment that deter help-seeking, such as unavailability of services, lack of time or financial difficulties (Davies, Stankov, & Roberts, 1998; Wilson, Deane, Biro & Ciarrochi, 2003). Person related barriers refer to cognitive and emotional factors that prevent the individual from deciding to seek help, such as negative attitudes towards treatment or failure to realise the severity of the problem (Saunders et al., 2006). These two general categories of barriers are broadly consistent with attitudinal and structural barriers identified by other authors (Issakidis & Andrews, 2002; Wells, Robins, Bushnell, Jarosz, & et al., 1994).

Whilst both categories of barriers have been found to influence help-seeking behaviour, research has found that person-related barriers are more salient than treatment-related barriers. Within a sample of individuals with problems related to alcohol use, person-related barriers were

more commonly identified than treatment-related barriers as reasons for not seeking treatment (Saunders, et al., 2006). Consistent with these findings, patients with anxiety identified attitudinal barriers to seeking help, such as "I preferred to manage myself" as more important than structural barriers such as "I couldn't afford the money" (Issakidis & Andrews, 2002; Wells, et al., 1994). Amongst British adolescents, structural factors seemed far less relevant than personal concerns about confidentiality and embarrassment (Booth, et al., 2004), and personal barriers were considered to be more problematic than logistical barriers amongst rural adolescents aged 14-16 years when seeking help (Hernan, Philpot, Edmonds, & Reddy, 2010). Similarly, in a sample of 101 fifteen to twenty-one year old American Indians who had thought about or attempted suicide but who avoided seeking help, most commonly endorsed person-related barriers such as embarrassment and self-reliance as reasons for not seeking help. Within this sample, treatment-related barriers, such as lack of money or service availability were only rarely cited as reasons for not seeking help (Freedenthal & Stiffman, 2007). The apparent importance of person-related barriers over treatment-related barriers may be due to the large numbers of adolescents who do not actually access services, and therefore never face the potential structural or treatment-related barriers (Booth, et al., 2004). That is, if larger numbers of adolescents attempted to access professional health services, treatment related barriers may potentially become a more prominent issue. Current research findings emphasise the importance of effectively identifying and understanding person-related barriers to adolescent help-seeking in order to facilitate adolescents' use of professional health services.

Person-related barriers to help-seeking. A vast amount of research into adolescent help-seeking has led to a large number of potential person-related barriers being described in the literature. The current study aims to review and present the most commonly cited barriers to adolescent help-seeking. A psycINFO database search was conducted using combinations of the following search terms: help-seeking, barriers and adolescent, with search results restricted to

between years 2000-2010. Of the 32 search results, 11 journal articles identified specific barriers to help-seeking as identified by adolescents, and were therefore retained. An additional 8 studies were located through hand-searching the reference lists of reviews and key papers found through the systematic search. A summary of the 19 studies is presented in Table 1 (see page 26). Barriers that are consistently mentioned across these studies include: symptoms of psychological distress, confidentiality concerns, fear of being stigmatised, stoicism and the desire to appear independent.

Symptoms of psychological distress and help-seeking. Perceived severity of symptoms is a main component of the health belief model (Rosenstock, 1966). The model asserts that symptoms of distress serve as cues to action, in that they motivate individuals to engage in behaviour aimed at reducing their distress (Rosenstock, 1966). In line with these models, symptoms of psychological distress can be conceptualised as an *approach* variable, so that as symptoms of distress increase, the likelihood of seeking help increases (Barker & Adelman, 1994; Offer, et al., 1991; Rickwood & Braithwaite, 1994). However, a review of help-seeking literature indicates that even when distressed, adolescents rarely ask professionals for help (Timlin-Scalera et al., 2003). Although a number of studies suggest that symptoms of psychological distress influence the likelihood of help-seeking, findings regarding the direction of the relationship between distress and help-seeking are contradictory.

Consistent with health behaviour models, a number of studies have found higher psychological distress is related to an increase the likelihood of help-seeking (e.g., Barker & Adelman, 1994; Judd et al., 2006; Offer, Howard, Schonert, & Ostrov, 1991). Amongst a sample of adults living in rural areas, symptoms of distress as measured by the Kessler Psychological Distress Scale (K-10) significantly predicted help-seeking, with higher distress scores associated with greater likelihood of seeking help (Judd et al., 2006). Higher levels of psychological symptom distress facilitate recognition of the problem, and hence increase the individual's perceived need for help (Thompson, Hunt, & Issakidis, 2004; Wilson, Rickwood & Deane, 2007). In line with these

findings, increases in symptom severity have been shown to prompt patients with anxiety or mood disorders to seek help (Thompson et al., 2004). Similarly, adolescents experiencing higher levels of psychological distress have expressed a greater willingness to seek help from both formal and informal sources (Sheffield, et al., 2004). Specifically, amongst a sample of 254 Australian high school students aged 15-17, those with higher levels of co-morbid depression, anxiety and stress were more likely to seek help (Sheffield, et al., 2004). It is important to note that conclusions are limited by the co-morbid nature of presenting problems in the study. Co-morbid presentations mean that the effects of depressive symptoms cannot be separated from the effects of stress and anxiety, making it difficult to determine whether participants' greater willingness to seek help was due to experiencing a particular problem type (Sheffield, et al., 2004).

This is an important limitation, as existing research suggests that the influence of symptoms of psychological distress on help-seeking may be dependent on the problem type. Specifically, adolescents who are at potentially increased risk for depression and suicide are often less likely to seek help (e.g. Carlton & Deane, 2000; Wilson, Rickwood & Deane, 2007; Garland and Zigler, 1994). The refusal to accept or access sources of help when distressed has been referred to as the process of "help-negation" (Rudd et al., 1995).

Garland and Zigler (1994) found that adolescents with higher depressive symptoms were more likely to have negative attitudes toward seeking help. Similarly, in a sample of Australian high school students, as depressive symptoms increased, students reported they were more likely to seek help from no one (Wilson, Rickwood & Deane, 2007). In this study, adolescents with the most clinically relevant levels of depressive symptoms were significantly less likely to intend to seek help from their parents and significantly more likely to seek help from no one, when compared to those with lower levels of depression (Wilson et al., 2007). Likewise, studies conducted amongst large samples of high school students in the US found that a quarter of adolescents with depression reported that they would not disclose their feelings to anyone (Gould et al. 2004) and that higher

levels of depression were related to 'not seeking help from anyone' (Sen, 2004). In an effort to explain this help negation effect for depression, it has been suggested that symptoms typical of depression may actually act as barriers to seeking help. For example, as levels of depression increase, adolescents may experience increased levels of apathy and hopelessness, leading to an indifference towards help-seeking and reduced motivation towards seeking help (Wilson et al., 2007).

The help negation process has also been found to occur amongst adolescents experiencing suicidal ideation. Specifically, Carlton and Deane (2000) found that as suicidal ideation increased in adolescents, their willingness to seek help decreased. As with depression, it has been suggested that even though the individual is likely to be distressed, symptoms typical of suicidality may actually act as barriers to seeking help. Evidence that suicidal adolescents find it difficult to generate new ideas and identify solutions suggests that they may also avoid engaging in active problem solving, such as seeking help (Carlton & Deane, 2000).

These findings are consistent with health behaviour models, which highlight that a number of factors are involved in the process of deciding to seek help. Symptoms of psychological distress, although influential in the decision making process, may not be sufficient to lead an individual to make the decision to seek help. In line with this, research has found that moderate to severe symptoms of distress are not sufficient on their own for adolescents to engage in help-seeking (Boldero & Fallon, 1995; Whitaker, et al., 1990). Inconsistent and contradictory findings regarding the relationship between psychological distress and help-seeking highlight the need for further research in order to better understand their role in the process of help-seeking.

Confidentiality concerns. Adolescents commonly raise concerns regarding the maintenance of confidentiality when seeking help from a health professional (Aisbett, Boyd, Francis, & Newnham, 2007; Quine, et al., 2003). Amongst a sample of refugee adolescents, concerns regarding confidentiality and distrust of services were seen as significant barriers to help-seeking

(de Anstiss & Ziaian, 2010). British (Booth, et al., 2004) and Israeli (Raviv, et al., 2009) adolescents indicated that an important barrier to seeking help is the fear that confidentiality will not be kept. Amongst the British sample, adolescents also expressed concern about the possibility of being seen attending a service (Booth, et al., 2004). American high school students attending a suicide education program raised concerns about confidentiality and privacy (Cigularov, Chen, Thurber, & Stallones, 2008), and Australian adolescents have also reported confidentiality to be a significant concern with regard to seeking help from a professional (Kuhl, Jarkon-Horlick, & Morrissey, 1997; Sheffield, et al., 2004). Concerns regarding confidentiality may be influenced by factors such as the proximity of the service provider to the adolescent's local environment, the relationship of the service provider with others (e.g., school staff, parents), legal obligations of the service provider, and severity of the condition (Booth, et al., 2004). Concerns about confidentiality could potentially be related to concerns about the reactions and opinions of others should they discover an individual has mental health problems. These concerns are closely related to perceived stigma.

Stigma concerns. The fear of stigma often associated with having a mental illness may also deter individuals experiencing mental health problems from acknowledging their symptoms and thereby seeking appropriate help (Barney, Griffiths, Jorm, & Christensen, 2006). Stigma towards individuals with mental illness leads to the individual being associated with undesirable characteristics (Mojtabai, 2010). The individual may therefore hide mental health concerns and avoid treatment in an attempt to reduce the negative consequences associated with stigma (Corrigan, 2004). It is understandable that adolescents, during this vulnerable period of life, may be more likely to avoid seeking help if they believe that it will lead to being stigmatised and rejected by peers or others in society.

Studies that have investigated the relationship between stigma and help-seeking distinguish between self stigma and perceived stigma. Self stigma refers to an individual's own response to

mental health problems and help-seeking, whereas perceived stigma refers to perceptions of others' negative responses towards mental health problems and help-seeking (Barney, et al., 2006). Research findings into the relationship between stigma and help-seeking has also had mixed results. Barney et al., (2006) found that amongst adults, the likelihood of seeking help from a professional source was predicted by embarrassment and the expectation that others would respond negatively. Similar findings have been reported amongst young adults, who expressed feeling too embarrassed to discuss their problems with anyone (Vanheusden, et al., 2008). In line with these findings, adolescents who had previously sought help were more likely to report being stigmatised by others than adolescents who had not sought help (Jorm & Wright, 2007). In contrast, in a sample of rural adults, perceived stigma did not influence help-seeking (Komiti, Judd, & Jackson, 2006). Similarly, stigma was reported to be of relatively little significance amongst a sample of Australian adolescents (Sheffield, et al., 2004). A recent study conducted amongst university students found no evidence that linked perceived stigma and help-seeking for mental health problems (Golberstein, Eisenberg, & Gollust, 2009).

Currently, research suggests that self stigma may be a more important barrier to help-seeking than perceived stigma (Vogel & Wade, 2009). In general, self stigma can be described as an internal form of stigma (Vogel & Wade, 2009). Self stigma related to help-seeking may involve an individual's own belief that they are unacceptable due to having a mental health problem, and that they are weak if they seek help (Corrigan, 2004; Vogel, Wade, et al., 2006). Therefore, the more a person perceives seeking help as a weakness or threat to their sense of worth and confidence the less likely they would be to seek help (Vogel & Wade, 2009).

Stoicism. The perception that help-seeking is a sign of weakness and self-reliance is a sign of strength corresponds with the concept of stoicism. Stoicism is an ancient Greek philosophy that teaches the development of self-control and fortitude. Individuals who adhered to the stoic doctrine believed that people who experienced hardship did not deserve sympathy and that compassionate

acts toward them were to be avoided (Wagstaff & Rowledge, 1995). The modern concept of stoicism involves the denial, suppression and control of emotions (Wagstaff & Rowledge, 1995). As an attempt to be self-reliant, tolerant and mentally and emotionally tough, individuals that are stoic may exercise emotional restraint in the face of adversity (Sherman, 2005). Some examples of stoic attitudes in relation to seeking help for problems are: "I preferred to manage it myself" and "I think it is important to remain strong and silent in the face of hardship, even if you are hurting inside".

Stoic attitudes are prevalent throughout the general community (Komiti, et al., 2006) and are often endorsed as reasons for not accessing mental health treatment (Andrews, Issakidis, & Carter, 2001; Meltzer, et al., 2000; Wells, et al., 1994). Individuals who hold stoic attitudes may perceive help-seeking as a sign of dependence and weakness. In order to preserve a sense of independence and strength, these individuals may avoid seeking help (Nadler, 1990).

A core developmental process during adolescence involves establishing autonomy and identity formation (Erikson, 1968). As a result, adolescents may want or attempt to rely more on their own coping resources when faced with problems. In order to appear independent and self-reliant, adolescents may feel the need to avoid overt expressions of feelings and displays of emotion, as well as have a greater desire to solve their problems alone. Stoicism may serve the function of preserving a core belief such as, "I must be independent or I am a failure". Adolescents may be reluctant to seek professional help, because help-seeking might be punished by negative feelings associated with violating the rule "I must show I am independent".

Although there has been little investigation into the relationship between stoicism and help-seeking intentions amongst the adolescent population, beliefs about self-sufficiency and enduring hardship have been associated with reluctance to seek help (Kuhl, et al., 1997; Nada-Raja, Morrison, & Skegg, 2003). Gould et al., (2004) found that approximately one third of adolescents believed people should be able to handle their own problems without outside help. Similarly, beliefs

that one can or should handle their problems on their own was the second most highly rated barrier to seeking help amongst high school students attending a suicide education program (Cigularov, et al., 2008). A study involving adolescent males found that the stigma of being weak due to needing someone else's help was a primary barrier to seeking help (Timlin-Scalera, et al., 2003).

The majority of research on stoicism and help-seeking has focused on males, partly because males have been shown to display higher levels of stoicism than females (Bruch, 2002). For example, Komiti et al., (2006) found that males were more likely than females to show admiration for individuals that were able to solve their problems without needing help from a professional. Similarly, in a study of white male high school students, participants expressed that they felt the need to project a strong, autonomous image, and that the stigma of being weak and troubled was one of the main factors that prevented them from seeking help for problems (Timlin-Scalera, et al., 2003). In fact, many male adolescents viewed going to someone for help as a type of failure (Timlin-Scalera, et al., 2003).

Person related barriers in rural areas. While person-related barriers have been shown to influence the help-seeking behaviour of adolescents living in urban and rural areas, it has been suggested that there are particular barriers that are more prominent in rural areas (Jackson, et al., 2007). This is supported by findings indicating that rates of help-seeking for mental health problems are lower amongst rural residents than urban residents (Caldwell, Jorm, & Dear, 2004; Parslow & Jorm, 2000). Gunnell and Martin, (2004) examined differences in the number of consultations to a GP between rural and urban young people in the United Kingdom. The study found that rural male participants were less likely to seek help from GPs for mental health problems when compared to urban male participants. Actual consultations with a GP were reported to be 30% lower for males and 16% lower for females living in rural areas, when compared to urban participants (Gunnell & Martin, 2004).

Stoic attitudes have also been identified as being particularly prevalent in rural communities, where self-sufficiency and the ability to deal with hardship is highly valued (Elliot-Schmidt & Strong, 1997; Fuller, Edwards, Procter, & Moss, 2000; Rost, Smith, & Taylor, 1993). Amongst adults living in rural areas, stoic attitudes such as self-reliance have been associated with willingness to seek help (Hoyt, Conger, Valde, & Weihs, 1997). Consistent with this finding, 80% of adults living in rural areas held the belief that a person should work problems out on their own (Komiti, et al., 2006). Further, participants expressed that there is something admirable about a person who is willing to cope with their problems without resorting to professional help, and that getting professional help would be a last resort (Komiti, et al., 2006).

Research suggests that the socially proximate nature of rural communities may create a fear of social stigma, gossip and social exclusion amongst help seekers. Living in a small, rural community as opposed to a more populated urban area may mean that residents have greater concerns about the level of anonymity and confidentiality associated with seeing a professional for help with a mental health problem (Komiti, et al., 2006). This is supported by research reporting that, in rural areas, stigmatising attitudes towards mental illness are barriers to help-seeking from professionals (Fox, Blank, Berman, & Rovnyak, 1999; Fuller, et al., 2000).

Boyd et al., (2007) found that first year psychology undergraduate students living in a rural area were reluctant to seek help due to concerns about privacy and anonymity. In this study, participants stated: 'you couldn't go anywhere without people knowing who you were' and, 'the whole area that I lived in everyone basically sort of had an idea of who everyone else was and their business' (Boyd, et al., 2007). The rural culture of self reliance was also a barrier to help-seeking (Boyd, et al., 2007). During interviews, participants described the expression of emotions as a sign of weakness in character, and an indication that an individual is unable to handle their own problems (Boyd, et al., 2007). Participants emphasised a need to present as tough and self-reliant when living in the country (Boyd, et al., 2007), where a culture that values people taking care of

themselves predominates (Francis, Boyd, Aisbett, Newnham, & Newnham, 2006). Seeking external help may therefore be avoided, and findings from focus groups amongst rural adolescents reveal a frequently reported perception that seeking help for mental health problems is a sign of weakness (Francis, et al., 2006). In fact, some adolescents reported that they would prefer to suffer from a mental illness than to be perceived as weak (Francis et al., 2006).

As well as a culture of self-reliance, factors such as stigma, social visibility (lack of anonymity), lack of qualified local professionals, and logistical problems such as lack of transport have been identified as barriers to seeking help for mental health problems by rural adolescents (Boyd, et al., 2007). For adolescents living in rural areas, person-related barriers, such as a lack of anonymity and a culture of self reliance have been considered as more problematic than logistical barriers (Hernan, et al., 2010).

Current research into help-seeking barriers indicates that beliefs about the outcomes of help-seeking appear to have an important influence on the likelihood that adolescents will seek help. In line with these findings, adolescents' beliefs about the benefits of seeking help have also been found to influence their help-seeking intentions.

Perceived benefits of help-seeking. According to theory (e.g. HBM; Rosenstock, 1966), an individual must perceive help-seeking as beneficial, in order to engage in the behaviour. Consistent with theory, the belief that "nothing could help" was the second most endorsed barrier by adolescents, as reported in the National Survey of Mental Health and Well-Being (Sawyer et al., 2001). A number of studies have identified a relationship between the belief that treatment is helpful and future help-seeking intentions (Bayer & Peay, 1997; Deane, Skogstad, & Williams, 1999; Deane & Todd, 1996; Vogel, et al., 2005).

Amongst 142 adult patients attending a community based general practice, it was found that the belief that health professionals are unable to provide a sufficient level of help for personal problems significantly influenced the decision to seek professional help for mental health problems

(Bayer & Peay, 1997). Specifically, individuals who indicated that they were likely to seek help believed that they would benefit from professional help, whereas those that were unlikely to seek professional help were uncertain about whether the help would be beneficial (Bayer & Peay, 1997). Similarly, Kelly and Achter (1995) found that of the participants in their study who did not seek help when needed, many of them believed that a mental health professional could not do anything to help and was inappropriate for the their problems. Other studies conducted amongst adult populations have also found that perceptions of treatment helpfulness influence intentions to seek help from a mental health professional, with helpful prior help-seeking experiences being associated with future help-seeking intentions (Deane, et al., 1999; Deane & Todd, 1996). In line with these findings, a study conducted with university students found that the belief that seeking help is beneficial uniquely predicted intentions to seek psychological services (Vogel, et al., 2005).

Although there has been limited investigation into the direct relationship between perceived benefits of help-seeking and help-seeking intentions amongst adolescents, existing research suggests that adolescents may also be reluctant to seek professional help because they do not perceive it as beneficial. For example, interviews with parents of youth aged 13-21 years that had completed suicide, the belief that "nothing could help" was identified as a predominant barrier to help-seeking (Moskos, Olson, Halbern, & Gray, 2007). It was argued that this belief may have been related to a lack of knowledge regarding the effectiveness of receiving professional help (Moskos, et al., 2007). Similarly, a self report questionnaire administered to approximately 600 high school students between 12-21 years of age revealed that the belief that "nothing will help" was associated with lower help-seeking intentions (Wilson, Fogarty & Deane, 2002). Freedenthal and Stiffman, (2007) reported that about one in five American Indians aged 15-21 years, avoided seeking help because they believed that nobody could help them. For example, in response to why they avoided seeking help, one adolescent stated, "I didn't think it would do anything". Other less frequently cited reasons were related to unhelpful prior help-seeking experiences, for example, "I

don't think it works. I've gone before and the doctor didn't do his job right". Research suggests that the degree to which talking to others has helped in the past may be a clear indicator of whether an individual would decide to seek help (Vogel & Wester, 2003).

Consistent with these findings, beliefs about professional help being unhelpful have also been associated with reluctance to seek formal help amongst non clinical adolescent populations. Further, beliefs associated with prior help-seeking being unhelpful were important barriers to formal help-seeking for emotional and suicidal problems (Wilson, et al. 2002).

Support for an association between the perceived benefits of help-seeking and help-seeking intentions also comes from qualitative research conducted amongst high school students. Focus group discussions conducted amongst a small group of adolescents between 14-17 years of age revealed that students who reported having successful prior help-seeking experiences seemed more likely to seek help from the same source again (Wilson & Deane, 2001). Focus group comments on seeking help from mental health professionals, such as, "I've seen one before and they don't do anything" and "I couldn't be bothered, it wouldn't help anyway", suggest that participants are unlikely to engage in help-seeking behaviour as they do not anticipate it as likely to be beneficial (Rickwood et al., 2005). While these focus group discussions provide insight into adolescents' beliefs about help-seeking, generalisation of the findings is limited by their qualitative nature and small sample size. There remains a need to conduct quantitative studies, utilising larger adolescent samples in order to determine whether there is a direct relationship between the perceived benefits of help-seeking and help-seeking intentions.

Table 1

Summary of Barriers to Adolescent Help-seeking

Author, year	**Sample size**	**Gender (% female)**	**Age range (years)**	**Culture**	**Design**	**Barriers Identified**
Carlton & Deane, 2000	221	51	14-18	New Zealander	Survey	• suicidal ideation
Wilson & Deane, 2001	23	52	14-17	Australian	Focus Groups	• confidentiality concerns • fear of being stigmatised
Ciarrochi, Wilson, Deane, & Rickwood, 2003	217	67	Years 8-11	Australian	Survey	• limited mental health literacy • low emotional competence
Timlin-Scalera, Ponterotto, Blumberg, & Jackson, 2003	22	0	14-18	European-American	Semi-structured interview	• stoicism • desire to be independent
Ballon, Kirst, & Smith, 2004	24	29	14-21	Canadian	Focus groups	• lack of self-motivation to seek help • shame, fear and lack of confidence in treatment effectiveness • confidentiality concerns • symptoms of mental illness
Booth et al., 2004	unknown	Unknown	12-17	English	Focus Groups	• confidentiality concerns
Gould et al., 2004	2,419	42	13-19	American	Survey	• stoicism • desire to be independent

Table 1 continued

Summary of Barriers to Adolescent Help-seeking

Author, year	**Sample size**	**Gender (% female)**	**Age range (years)**	**Culture**	**Design**	**Barriers Identified**
Rickwood, Cavanagh, Curtis & Sakrouge, 2004	457	57	14-18	Australian	Focus Groups	• confidentiality concerns
Sheffield, Fiorenza, & Sofronoff., 2004	254	51	15-17	Australian	Survey	• confidentiality concerns
Wilson, Deane & Ciarrochi, 2005	269	64	12-18	Australian	Survey	• suicidal ideation
Francis, et al., 2006	52	71	Years 9-10	Australian	Focus Groups	• stoicism • desire to be independent
Freedenthal & Stiffman, 2007	101	72	15-21	American Indian	Interview	• embarrassment • self-reliance
Wilson, Rickwood & Deane, 2008	1497	53	Years 7-12	Australian	Survey	• depressive symptoms
Cigularov, Chen, Thurber, & Stallones, 2008	854	47	Grades 9-12	American	Intervention	• stoicism • desire to be independent

Table 1 continued

Summary of Barriers to Adolescent Help-seeking

Author, year	Sample size	Gender (% female)	Age range (years)	Culture	Design	Barriers Identified
Gould, et al., 2009	317	58	13-19	American	Interview	• thinking the problem was not serious enough to warrant services • thinking the problem would get better on its own • wanting to solve the problem by oneself • not believing that any real problem existed
Raviv, Raviv, Vago-Gefen & Fink, 2009	662	54	grades 10 & 12	Jewish Israeli	Survey	• confidentiality concerns
de Antiss & Ziaian, 2010	85	48	13–17	Mixed culture refugees	Focus Groups	• confidentiality concerns
Guterman, Haj-Yahia, Vorhies, Ismayilova, & Leshem, 2010	1,835	55	Grades 9-12	Arab & Jewish Israeli	Survey	• minimisation of problems • confidentiality concerns • desire to be independent • embarrassment in relation to sharing problems with health professional • talking to someone would not help
Hernan, Philpot, Edmonds & Reddy, 2010	74	55	14-16	Australian	Survey	• fear, anxiety and embarrassment in relation to seeing a health professional

Increasing Help-seeking Intentions in Adolescents

Although a vast amount of research into factors influencing adolescent help-seeking behaviour exists, there is a relative paucity of research aimed at addressing these factors in order to increase adolescents' help-seeking for mental health problems. This is an important area of help-seeking research that needs to be pursued, as improvements in help-seeking can be made by designing an intervention based on relevant theory and research (Wilson, Deane, Marshall & Dalley, 2008). The success of campaigns utilising combinations of multimedia, websites and telephone information services to raise community awareness of mental health problems provides evidence that such interventions can alter adolescents' knowledge of and attitudes towards help-seeking (Jorm, Christensen, & Griffiths, 2005; Wright, 2006).

Community and school based programs that aim to raise mental health awareness and promote available services may facilitate appropriate help-seeking in rural adolescents who are experiencing mental health problems (Aisbett, et al., 2007). Further, such programs can be tailored to the needs of rural communities by obtaining a refined understanding of attitudes of the community and specific perceived barriers to help-seeking that exist amongst adolescents within a community (Mojtabai, 2010). Findings from research, as reviewed in previous sections, suggests that in order to change the help-seeking behaviour of adolescents, interventions should aim to increase adolescents' awareness of the benefits of seeking help (Jorm & Wright, 2007; Raviv, et al., 2009). Also, adolescents in need of treatment might seek help earlier if interventions aimed to identify and lower perceived barriers to help-seeking (Kalafat, 1997; Sheffield, et al., 2004; Silverman & Felner, 1995; Webb, 2006). There is a need to identify effective strategies to address these factors and outline how such strategies can be successfully implemented in order to increase adolescents' use of professional services for mental health problems (Wilson & Deane, 2001).

Although the number of mental health promotion programs being developed is growing, a review of research identifies relatively few programs that specifically focus on improving

adolescents' help-seeking from professional sources. The majority of interventions that target adolescent help-seeking have focussed on facilitating help-seeking for suicide (Aseltine & DeMartino, 2004; e.g. Cigularov, et al., 2008; Kalafat & Elias, 1994). Suicide prevention programs have aimed to target help-seeking barriers, with an attempt to reduce the barriers and thereby facilitate help-seeking. These programs have utilised various methods to promote help-seeking, including: peer support programs (Kalafat & Elias, 1994), providing general suicide education (Cigularov, et al., 2008; Kalafat & Elias, 1994), community awareness campaigns (Farberman, 1997; Jorm, et al., 2005), and school based interventions (e.g. Wilson et al., 2008).

Campaigns to target help-seeking. Based on findings from focus groups, the American Psychological Association launched a campaign that addressed the potential benefits of seeking help (Farberman, 1997). The campaign involved the use of television, radio and print advertisements that portrayed individuals who had benefited from seeking psychological help. Participants were also provided with avenues to seek help, including a referral service phone number, information brochure and website address. Results of the study aimed at assessing the effectiveness of the campaign found that within the first six months of campaign activity, phone calls to referral services doubled in one state, and quadrupled in another state (Farberman, 1997).

In a study conducted amongst the Australian public, Jorm et al., (2005) evaluated whether "beyondblue: the national depression initiative" campaign increased knowledge about depression. Data from national surveys of mental health literacy from 2,164 participants in 1995 and 3,998 participants in 2003–2004 were analysed in order to compare States that funded the campaign to those that did not fund the campaign. Results reported that States which funded the campaign had a greater change in beliefs about the benefits of help-seeking (Jorm, et al., 2005).

Wright et al., (2006) utilised multimedia, a website and an information telephone service to design and implement a campaign that aimed to improve mental health literacy and help-seeking amongst adolescents. The campaign was evaluated using a quasi-experimental design, with six

hundred 12-25 year olds from one region forming the experimental group, and six hundred 12-25 year olds from another region forming the comparison group. All participants completed a telephone survey of mental health literacy before the campaign and 14 months after the campaign. Amongst the experimental group, results revealed a significant reduction in perceived barriers to help-seeking, an increase in knowledge of mental health problems and an increase in help-seeking for depression. Specifically "Thinking that nothing can help" decreased as a barrier to help-seeking in the experimental group, whilst it either increased or stabilised in the comparison group. It is important to note however, that in this study, there was no apparent control for the large number of comparisons (38) that were included in analyses evaluating the impact of the campaign. For example, if a Bonferroni adjustment was used, then for 38 comparisons an adjusted p-value of .001 would be applied. In this case, only 2 out of the 38 comparisons can be reliably taken as significant, whereas, without the Bonferroni adjustment, 7 out of the 38 comparisons were reported to be significant. Therefore, whilst the researchers suggest that participants exposed to the campaign became more positive toward the potential benefits of treatment, the number of domains where this occurred is likely more limited than suggested.

Findings from these studies suggest that national awareness campaigns can be effective in improving community beliefs about help-seeking, and therefore may be an effective means to increase help-seeking for mental health problems. In particular, it seems important to provide individuals who have never sought help before with information that describes realistic expectations for treatment and its potential benefits, so that they can make informed decisions about whether to seek help (Henshaw & Freedman-Doan, 2009). Whilst these public health campaigns have the benefit of being able to reach a wide audience in order to raise public awareness of help-seeking, they may not be the most effective means of specifically addressing adolescents' help-seeking behaviour. This is highlighted by the results of a campaign aimed at increasing physical activity where it was found that the public health campaign was more effective at increasing knowledge,

awareness and attitudes about certain behaviour than at changing the actual behaviour (Hillsdon, Cavill, Nanchahal, Diamond, & White, 2001). A notable finding from at least one study investigating the effects of public service announcements promoting help-seeking for suicide was that adolescents at high-risk of suicide held less favourable attitudes towards help-seeking after exposure to the public service announcement (Klimes-Dougan, Yuan, Lee, & Houri, 2009). This finding strongly suggests that messages around help-seeking for mental health problems should be carefully tailored to the needs of particular groups of individuals. In order to target the adolescent population, the current intervention will be delivered in a school setting, and will be tailored to the needs of the individuals in this setting.

School-based interventions to target help-seeking. The school environment provides an important location to implement health promotion programs targeting adolescent populations (e.g. Rickwood, Wilson & Deane, 2006). Adolescents spend a large proportion of their lives in the school setting, making school an ideal location to promote services to manage social, emotional and behavioural problems (Vanheusden et al., 2008). Further, it has been found that schools are generally supportive of mental health promotion efforts (Sheehan et al., 2002). A summary of school based intervention studies targeting help-seeking is presented in Table 2. The studies included in Table 2 were derived by first conducting a psycINFO database search using combinations of the search terms: help-seeking, intervention and school. The abstracts of the searched studies were then screened to eliminate studies that did not specifically aim to evaluate a school based interventions. Studies that focussed on university samples were also eliminated. After screening, 4 studies were retained. An additional 3 studies were located through hand-searching the reference lists of reviews and key papers found through the systematic search. Table 2 presents the details of the final 7 studies. Consideration of the design, outcome and limitations of these studies is important when designing and implementing school based interventions targeting help-seeking.

Examination of findings shows that across all seven studies, individuals that received a help-seeking intervention showed improvements in at least some of the help-seeking outcome variables targeted by the intervention. This lends support to the use of brief school based interventions to influence help-seeking behaviour amongst adolescents. It is also useful to note that findings from these studies provide useful directions for improvement to guide the design of future interventions. For example, an important finding from one study was that while knowledge increased for most of the indicators of mental health literacy, it was lowest for understanding the benefits of seeking help early (Rickwood, Cavanagh, Curtis & Sakrouge, 2004). As highlighted by the authors, this finding suggests a need for future interventions to emphasise the benefits of seeking help, and in particular, the benefits of seeking help early. In the same study, post intervention discussion with participants indicated that students would have liked a focused outline of the specific steps involved in seeking help for different types of problems, information that may be incorporated into future help-seeking interventions. Future interventions can also provide information on the different types of health professionals that adolescents can approach when feeling mentally or emotionally distressed.

For adolescents, general practitioners are often the first point of contact in the help-seeking process (Wilson et al., 2008). Therefore, the program, Building Bridges to General Practice (Wilson, Deane & Fogarty, 2004) was designed to target and promote general practitioners as a professional group who could facilitate access to specialist mental health care services.

Building Bridges to General Practice (BBGP; Wilson et al., 2004.) The BBGP includes professional development training for GPs and school staff as well as an interactive GP delivered classroom presentation. The program was developed, delivered and evaluated on the basis of two theoretical models: the Theory of Planned Behaviour (Ajzen, 1985)and the Stages of Change Model (Prochaska & DiClemente, 1986). The classroom presentation targeted adolescents' perceived barriers to seeking help for physical and psychological problems, with the aim to increase their intentions to seek help from general practitioners. Specifically, various barriers to help-seeking

were identified, and the presentation involved normalising the process of seeking help from a GP, examining previous experiences students had with GPs, discussing these negative experiences and explaining this is not necessarily going to be a universal response and that it is worth trying to seek help again. The presentation also provided information about practical issues related to consulting a GP, such as the structure of a consultation and rules regarding confidentiality. Students were also given the opportunity to ask the presenter any health related questions.

The intervention was carried out amongst urban and rural adolescent populations. For the urban sample, the intervention involved a 45 minute GP lesson (Wilson et al., 2004). For the rural sample where other health professionals are often the first point of access, due to limited access to GP services, a GP and another health professional (e.g. drug and alcohol case worker) presented a 90 minute lesson (Wilson et al., 2004). Evaluation amongst both populations involved a non randomised control design. The urban sample was formed by students from three Public high schools in the Illawarra region of NSW. Questionnaires of perceived barriers, intentions and self-reported consultations with a GP were completed by both groups 1 week before the intervention, 5 then 10 weeks post-intervention. The rural sample was formed by students from 7 different schools in the Riverina region of New South Wales. Questionnaires were completed before the intervention and at 4 then 8 weeks post-intervention.

Findings from both studies found that the BBGP program led to an increase in help-seeking intentions (Deane, Wilson, & Russell, 2007; Wilson et al., 2008). Specifically, in both the rural and urban samples, there was a significant increase in help-seeking intentions for psychological problems for those receiving the intervention but not for those in the control group. However, overall adolescents still reported that they were *unlikely* to seek professional help for psychological problems. Amongst the urban population, results for the treatment group showed a significant reduction in perceived barriers to consulting a GP and a significant increase in the number of self-reported actual consultations for psychological problems for the ten week follow-up period. For the

rural sample, it was found that relationships between help-seeking intentions and actual consultations varied considerably, dependent on the source of help. Help-seeking from General Practitioners was relatively low and this may reflect the low levels of access to GPs in rural settings.

These findings are promising and lend support for utilisation of interventions such as BBGP as a way to influence variables associated with adolescents' help-seeking from GPs. Although the influence of the BBGP presentation has been found to increase intentions to consult a GP for psychological problems, students' intentions to seek help for psychological problems were still rated to be in the ''unlikely'' end of the rating scale measuring intentions. This indicates a need to further refine interventions in order to increase the strength of help-seeking intentions. Health behaviour models and previous research suggest that as well as addressing barriers to help-seeking, improving young people's beliefs about the benefits of professional psychological help-seeking may be an important strategy for increasing their use of mental health services. Importantly, in order to improve the effectiveness of school based interventions, future research should aim to address the limitations of previous intervention based studies.

Design Limitations. As can be seen in Table 2, there are also a number of limitations to the design of presented intervention studies. Importantly, four out of five controlled trial studies lack randomisation of participants to control and intervention groups. Further, three of these studies did not include the administration of baseline measures, raising the possibility that group differences may have existed prior to implementation of the intervention. This may be particularly applicable amongst those studies that utilised different school year groups for comparison (Santor, Poulin, LeBlanc, & Kusumakar, 2007; Wilson et al., 2008). Importantly, three out of seven studies did not include the administration of any follow-up measures, meaning that although interventions may appear to have a short term impact on help-seeking variables, the long term impact of these interventions cannot be ascertained. In three of the four studies where follow-up measures were

included, baseline measures were not included (e.g. Nicholas, Oliver, Lee, & O'Brien, 2004). In all five studies that included a control group, there is no mention of the administration of an alternative control presentation. This raises the possibility that attentional factors rather than the actual help-seeking content may contribute to differences between treatment and control groups. Future research should aim to account for these limitations.

Specifically, a controlled trial with random allocation and an attention control condition is required. Baseline, post-test and follow-up measures should be administered in order to thoroughly explore the effects of the intervention.

Table 2

Summary of School Based Help-seeking Intervention Studies

Author, year	n, age	Intervention	Study design	Outcomes measured	Findings	Limitations
Kalafat & Elias, 1994	253, grade 10	3x45 minute classroom lessons on suicide	• non randomised controlled trial • surveys 3 weeks follow-up	• knowledge about suicide • attitudes toward suicide, help-seeking and talking about suicide in class • self-reported responses to the awareness of potential suicide in peers • reactions to suicide awareness classes	• significant knowledge gains in intervention group compared to control group • attitudes unaffected by intervention • greater likelihood to take effective action in response to troubled peers for intervention group compared to control group • 64% of participants indicated that the classes will make it easier to deal with their friends' problems	• no randomisation to groups • no distinction between help-seeking from informal and formal sources
Aseltine & deMartino, 2004	2,100, grades 9-12	school based suicide prevention program, video and discussion	• randomised controlled trial • surveys 3 months follow-up	• self reported suicide attempts and ideation • knowledge and attitudes about depression and suicide • help-seeking behaviour	• intervention group 40% less likely to report a suicide attempt in past 3 months compared to control group • intervention group had greater knowledge of depression and suicide compared to control group • intervention group had more adaptive attitudes towards depression and suicide compared to control group • No significant differences in help-seeking behaviour between control and intervention groups	• 1 out of 5 schools not randomised to groups • no baseline measures

Table 2 continued

Summary of School Based Help-seeking Intervention Studies

Author, year	n, age	Intervention	Study design	Outcomes measured	Findings	Limitations
Nicholas, Oliver, Lee & O'Brien, 2004	243, 13-18 years	20 min classroom presentation on help-seeking website	• survey 6 months follow-up	• help-seeking knowledge • help-seeking intentions • help-seeking behaviour	• 45% of participants had visited help-seeking website • 63% of participants stated they would use help-seeking website if going through a tough time	• no baseline measures • no control group
Rickwood, Cavanagh, Curtis & Sakrouge, 2004	457, 14-17 years	50-90 minute classroom presentation by volunteers who had experienced mental illness	• non-randomised controlled trial • survey pre-test and post-test	• stigma • knowledge • help-seeking intentions	• program had a strong impact on knowledge • program had a moderate impact on stigma • program had a weak impact on help-seeking intentions	• no randomisation to groups • no follow-up measure
Santor, Poulin, LeBlanc & Kusukumar, 2007	1,124, grades 7-9	2x45 minute classroom workshops on distress and help-seeking + access to help-seeking website	• non randomised controlled trial • survey post-test	• help-seeking attitudes • level of distress and duration of problems • website utilisation	• more individuals in the intervention group visited school health clinics than control group • total number of visits greater for intervention group • intervention more effective for students experiencing distress compared to those not experiencing distress	• no randomisation to groups • no baseline measures

Table 2 continued

Summary of School Based Help-seeking Intervention Studies

Author, year	n, age	Intervention	Study design	Outcomes measured	Findings	Limitations
Wilson, Deane, Marshall & Dalley, 2008	Urban sample: 173, rural sample: 118, 15-16 years	45-90 minute classroom presentation	• non-randomised controlled trial • survey at pre, post and follow-up	• perceived barriers • help-seeking intentions • self-reported consultations with a GP	• significant increase in help-seeking intentions for intervention group • no change in help-seeking intentions for control group • urban sample: intervention group showed reduction in perceived barriers and increase in number of self-reported consultations with a GP	• no randomisation to groups • no control group presentation
Cigularov, Chen, Thurber & Stallones, 2008	854, grades 9-12	classroom presentation on signs of depression and suicide with teaching and practicing the skills required to ask for help	• Survey at post-test	• barriers to help-seeking for self or friend	• improved skills and self efficacy associated with seeking help • barriers to seeking help remained	• no baseline measures • no control group

Summary of the Literature Review

The importance of help-seeking. The Child and Adolescent version of the National Survey of Mental Health and Wellbeing conducted in 2000 reported that more than 20% of 12-16 yr olds had a mental health problem (Sawyer et al., 2007). Yet, research has consistently found that adolescents' use of professional health services is low compared to the rest of the population (Sawyer et al., 2007). Given the high prevalence of mental health problems amongst adolescents (Sawyer et al., 2001), these findings indicate that adolescent help-seeking is an important public health problem.

Perceived benefits, perceived barriers and help-seeking. The Theory of Planned Behaviour states that attitude is determined by the individual's beliefs about outcomes of performing the behaviour (Ajzen, 1985). This is consistent with other health behaviour models such as the Health Belief Model (HBM; Rosenstock, 1966), which asserts that the likelihood of carrying out health related behaviour is influenced by the individual's perception of both the perceived benefits/value and the perceived barriers of carrying out the behaviour.

The perception that treatment is helpful is one factor that appears to be related to greater future help-seeking intentions (Bayer & Peay, 1997; Deane et al., 1999). The anticipated benefits of seeking help have been found to uniquely predict intentions to seek psychological services (Vogel et al., 2005), and negative past experiences of seeking help have been identified as substantial barriers to future help-seeking intentions (Rickwood et al., 2005). Qualitative data from focus groups conducted amongst high school students suggests that perceptions of help-seeking as unhelpful may prevent adolescents from seeking help (Rickwood et al., 2005). Barriers to help-seeking that are consistently mentioned across studies include: symptoms of psychological distress (e.g. Wilson, Rickwood & Deane, 2007), confidentiality concerns (e.g. Raviv, et al., 2009), fear of being stigmatised (e.g. Wilson & Deane, 2001), stoicism and the desire to appear independent (e.g. Gould et al., 2004).

Gender differences in help-seeking. Gender differences in help-seeking have been consistently found, with women and girls seeking help more than men and boys (Addis & Mahalik, 2003; D. Rickwood & Braithwaite, 1994; Rule & Gandy, 1994). There appears to be a lack of research into the factors that may contribute to gender differences in help-seeking. Considering that research and theory have linked stoic attitudes to the male gender (Bruch, 2002; Fischer & Good, 1997), it seems useful to investigate the potential role of stoicism in contributing to gender differences.

Increasing help-seeking intentions in adolescents. A review of seven studies aimed at evaluating the effectiveness of school-based interventions in improving adolescent help-seeking lends support to the use of brief school based interventions to influence help-seeking behaviour. Importantly, the review of these studies highlights several limitations that future research should address. Specifically, a controlled trial with random allocation and an attention control condition is required. Baseline, post-test and follow-up assessments should be administered in order to test how sustainable any effects might be.

Aims of the Current Research

The aims of the current research is to increase the likelihood that adolescents will implement appropriate help-seeking from professional sources. Specifically, the aims of the current research are:

1. to investigate factors that influence adolescent help-seeking from formal sources such as doctors, school counsellors and psychologists;
2. to develop an intervention aimed at improving adolescents' help-seeking for mental health problems;
3. to implement the intervention across schools in the Illawarra region of New South Wales; and
4. to test the effectiveness of the intervention.

The current research will address these aims through conducting two studies. Specific hypotheses will be noted at the beginning of each study.

Study One

Rural Adolescents' Help-seeking Intentions for Emotional Problems: The Influence of Perceived Benefits and Stoicism

Aspects of this study have been published:

Rughani, J., Deane, F. P., & Wilson, C. J. (2011). Rural adolescents' help-seeking intentions for emotional problems: The influence of perceived benefits and stoicism. *Australian Journal of Rural Health, 19*, 64-69.

Aims and Hypotheses

Study one aims to build on existing research by using un-analysed archival data to investigate factors that influence adolescent help-seeking from formal sources such as doctors, school counsellors and psychologists. The focus is on help-seeking for emotional or psychological problems. The study will investigate the extent to which symptoms of psychological distress, perceived benefits of help-seeking, stoicism and gender are associated with help-seeking intentions. Specifically, the following hypotheses will be tested:

1. Females will have higher help-seeking intentions for emotional problems than males.
2. Symptoms of psychological distress will predict help-seeking intentions for emotional problems, in that higher levels of psychological distress will lead to higher intentions to seek help for emotional problems.
3. Stoicism and restrictive emotionality will inhibit help-seeking intentions for emotional problems.
4. Perceived benefits of help-seeking will predict help-seeking intentions for emotional problems, in that higher perceived benefits of help-seeking will lead to higher intentions to seek help for emotional problems.

Method

Participants

Participants were a total of 778 adolescents from years 9-12 recruited from two public high schools from a regional city (population = 57,557), one Catholic and public high school from a medium sized rural town (population = 11,228) and three public high schools from separate small rural towns (population < 7,000), all in the Riverina region of New South Wales, Australia. The average age of participants was 15 years (range = 13-18 years), and the sample included 374 (48%) males and 403 (52%) females. The majority of participants (*n* = 773, 94%) identified themselves as "Australian" when asked about their cultural affiliation. The remaining groups were Aboriginal, Asian, European, New Zealander, African and American.

Measures

(For a copy of the full survey questionnaire administered, see Appendix A)

Help-seeking intentions. Help-seeking intentions were assessed by 2 items that were adapted from the General Help-seeking Questionnaire (GHSQ; Wilson, Deane, Ciarrochi & Rickwood, 2005). The first item was: "If you have an emotional problem like being depressed or stressed out, how likely are you to talk to a doctor about it?". The second item was: "If you have an emotional problem, how likely are you to talk to a health professional other than a doctor about it? Write the type of professional:". Items are rated on a 7- point scale ranging from 1 = *extremely unlikely* to 7 = *extremely likely* so that higher scores reflect greater intentions to seek help. In the present study the mean of both intentions items was used as a scale to represent intentions to seek help for emotional problems. Cronbach's alpha for this scale in the current study was .79.

Perceived benefits of help-seeking. Perceived benefits of consulting a health care professional was measured by 4 items that make up the Anticipated Utility subscale of the 8-item Disclosure Expectations Scale (DES; Vogel & Wester, 2003). The 4 items are designed to assess participants' expectations about how beneficial it would be to talk to a health professional about an

emotional problem. Items are rated on a 5-point Likert-type scale ranging from 1 = *not at all* to 5 = *very*. Responses are summed such that higher scores reflect higher anticipated benefits. A sample item is, "Would you feel better if you told a counsellor about personal feelings of sadness or anxiety?". The anticipated utility subscale has been found to correlate positively with the tendency to self disclose distressing information and intentions to seek therapy (Vogel, et al., 2005). The internal consistency for the anticipated utility subscale has previously ranged from .81-.83 (Vogel & Wester, 2003; Vogel, et al., 2005). Cronbach's alpha for the subscale in the current study was .83.

Stoicism. Stoicism was measured by two separate scales. The component of stoicism corresponding to emotional control and restraint was measured by 10 items comprising the Restrictive Emotionality Scale (RE-GRCS; O'Neil, Gable, & Wrightsman, 1986). Items were rated on a 6-point scale ranging from 1 = *strongly disagree* to 6 = *strongly agree* so that higher scores reflected greater restrictive emotionality. A sample item from this scale is, "I do not like to show my emotions to other people". The RE-GRCS has been significantly related to help-seeking attitudes (Good, et al., 1989). Cronbach's alpha for the RE-GRCS in the current study was .86. The component of stoicism corresponding to an attitude of toughness and self-reliance was captured by 5 items from the Wollongong University Stoicism Scale (WUSS; Phillips, 2005). The WUSS was first developed in order to target the "toughness" construct of stoicism, which seemed underemphasised in previously designed measures which tended to solely focus on the refusal to express emotions (e.g. O'Neil, et al., 1986; Wagstaff & Rowledge, 1995). Items were rated on a 6- point scale ranging from 1 = *strongly disagree* to 6 = *strongly agree* so that higher scores reflected higher levels of stoicism. A sample item from the WUSS is, "When the going gets tough I just grin and bear it". The WUSS has been found to correlate significantly with the Liverpool Stoicism Scale (LSS; Wagstaff & Rowledge, 1995) (r = .70). Cronbach's alpha for the WUSS in the current study was .78.

Symptoms of psychological distress. Symptoms of psychological distress were assessed by the Hopkins Symptom Checklist 21 (HSCL-21; Green, Walkey, McCormick, & Taylor, 1988). The items are designed to assess the level of distress participants have experienced over the past 7 days. The scale measures 3 factors of distress: general feelings of distress, somatic distress and performance difficulty. Items are rated on a 4-point scale ranging from 1 = *not at all* to 4 = *extremely*. Responses are summed such that higher scores reflect greater levels of distress. The HSCL-21 is appropriate for use with adolescents to the extent that other variants of the HSCL have been used and normed extensively with adolescent non-clinical samples (e.g. Carlton & Deane, 2000; Derogatis, 1994). Cronbach's alpha for the HSCL-21 in the current study was .91.

Procedure

Permission to conduct the research in schools and ethical review was provided by the New South Wales and Riverina District Department of Education and Training Strategic Research Directorate. Permission and ethical review was also granted by the Riverina Catholic Education Office and University of Wollongong Human Ethics Committee (See Appendix B). A parent/caregiver informed consent form was sent out to homes two weeks before the survey was administered and students were required to bring the signed consents back to school prior to participation. On the day of the survey, students were provided with an information sheet outlining that the information they provided would be confidential and anonymous. Supervising teachers read a standard procedure script outlining that participation was voluntary and that students held the right to withdraw from the study at any time. Students were also required to provide their own consent on the day of the survey. Students with caregiver permission and who provided their own consent completed an anonymous but coded questionnaire during class. Once students completed the questionnaire, they were given a debrief form that was reviewed with their teacher. The form provided information about different sources of help for mental health issues.

Results

Prior to analysis scores for the WUSS, RES, HSCL-21, DES and GHSQ were examined through SPSS for accuracy of data entry, missing values and fit between their distributions and the assumptions of the multivariate analyses utilised. A substantial positive skew in the HSCL-21 scores (indicating that most participants had low levels of psychological distress) led to logarithmic transformation of this variable to obtain a normal distribution. Consequently, log HSCL-21 was used in all multivariate analyses. A substantial positive skew in the GHSQ scores (indicating that most participants had low intentions to seek help from professionals for emotional problems) and a square-root transformation of this variable resulted in an acceptable normal distribution. Consequently, square-root GHSQ was used in all multivariate analyses. All other variables met the assumptions of the analyses used. Within the sample, only cases where 80% or more of items on a scale were answered were included in the analyses. As a result 25 (3.2%) cases were excluded from analyses involving WUSS, 28 (3.6%) were excluded from analyses involving RES, 22 (1.8%) cases were excluded from analyses involving HSCL-21 and 14 (1.8%) from analyses involving DES. A prorated score (proportional score based on the number of items completed) was calculated for those measures with at least 80% of available data.

Help-seeking intentions

In order to describe the overall help-seeking intentions of participants, frequencies for different levels of intentions were calculated. Examination of the frequencies of help-seeking intentions by gender and help source (see Table 3) indicate that only 17% of males and 29% of females were likely to seek help from a doctor when experiencing emotional problems. Similarly, only 15% of males and 23% of females were likely to seek help from a health care professional other than a doctor when experiencing emotional problems.

Table 3

Frequencies and Percentages of Adolescents' Intentions to Seek Help for Emotional Problems by Gender and Professional Help-seeking Source

Gender	Health Professional	Unlikely *n* (%)	Not sure *n* (%)	Likely *n* (%)
Male	Doctor	237 (63%)	71 (19%)	62(17%)
	Other[a]	229(61%)	83 (22%)	56 (15%)
Female	Doctor	227(56%)	56 (14%)	117 (29%)
	Other[a]	225 (56%)	69 (17%)	93 (23%)

[a]Other refers to health care professional other than a doctor

A standard multiple regression analysis was performed using help-seeking intentions as the dependent variable, and gender, symptoms of psychological distress, stoicism and perceived benefits of help-seeking as independent variables. Analysis was performed using SPSS REGRESSION. The correlations between variables and regression coefficients are provided in Table 4. The results of the regression indicate that the model was significant $F(5, 721) = 38.87$, $p = .00$ and explained 21% of variance in intentions to seek help. Perceived benefits of help-seeking and gender were significant unique predictors of help-seeking intentions for emotional problems. Specifically, higher perceived benefits of help-seeking were associated with higher intentions to seek help and female adolescents were more likely to seek help when compared with male adolescents.

Post hoc analyses

To better understand the nature of gender differences in help-seeking intentions, a series of t-tests comparing males and females on symptoms of psychological distress, stoicism, and perceived benefits means were conducted (Table 5). Results of the t-tests indicated that female participants scored significantly higher than male participants on psychological distress, $t(752) = -3.62$, $p = .000$ and intentions to seek help for emotional problems, $t(774) = -3.38$, $p = .001$. There were no significant gender differences on stoicism and perceived benefits of help-seeking.

Table 4

Multiple Regression Analyses Predicting Help-seeking Intentions from Symptoms of Psychological Distress, Stoicism, Perceived Benefits of Help-seeking and Gender

Variable	2	3	4	5	6	*β*	*t*	*p*
1. Help-seeking Intentions	.03	-.10*	-.10*	.44*	.10*			
2. Symptoms of psychological distress		.30	.36*	.01*	.10	.02	.66	.51
3. Stoicism (WUSS)			.64*	-.09*	-.03	-.06	-1.42	.16
4. Stoicism (RES)				-.10*	.01	-.04	-.88	.38
5. Perceived benefits of help-seeking					.03	.43*	12.91	.00
6. Gender						.09*	2.69	.01

Note. WUSS = Wollongong University Stoicism Scale; RES = Restrictive Emotionality Scale

*$p < .05$

Table 5

Means, Standard Deviations and t-values for Females and Males on Help-seeking Outcome Variables

Variable	Female		Male		
	M	*SD*	*M*	*SD*	*t*
Stoicism (WUSS)	3.48	1.16	3.58	1.14	1.13
Stoicism (RE-GRCS)	3.66	1.27	3.63	1.30	-0.32
Perceived benefits of help-seeking	2.63	1.01	2.56	1.03	-0.1
Symptoms of psychological distress	1.89	.56	1.76	.58	-3.62*
Help-seeking intentions	1.71	.45	1.60	.46	-3.38*

Note. WUSS = Wollongong University Stoicism Scale; RE-GRCS = Restrictive Emotionality Scale

*$p < .05$

Discussion

Main Findings

Study one investigated the extent to which symptoms of psychological distress, perceived benefits of help-seeking, stoicism and gender are associated with help-seeking intentions. In the current study only 23% of male adolescents and 29% of female adolescents indicated that they were likely to seek help from a health care professional other than their doctor when experiencing emotional problems. These percentages are very similar to the actual rate of help-seeking reported in the Child and Adolescent Version of the National Survey of Mental Health and Wellbeing (CA-NSMHWB, 2000). The CA-NSMHWB found that 25% of young people with mental disorders received professional care (Sawyer et al., 2007). Whilst the CA-NSMHWB reported statistics on adolescents that were actually diagnosed with a mental disorder, findings from the current study are consistent with evidence indicating the existence of a gap between the number of adolescents requiring mental health services and the number of adolescents accessing mental health services.

Perceived benefits of help-seeking. A central finding of the current study was that the perceived benefits of help-seeking were significantly associated with adolescents' help-seeking intentions. Consistent with cognitive models of health behaviour (e.g. Ajzen, 1985; Rosenstock, 1966), findings from the current study indicate that adolescents are more likely to seek help from professionals if they perceive benefits from seeking help. This is in keeping with findings from help-seeking research conducted amongst university students and adult populations (e.g. Bayer & Peay, 1997; Vogel, et al., 2005). Importantly, the current study strengthens findings obtained from focus groups conducted amongst high school students (Rickwood et al., 2005) by establishing a direct link between perceived benefits of

help-seeking and help-seeking intentions amongst adolescents. Although help-seeking is a protective factor for many health and developmental outcomes (G. Barker, et al., 2005), the majority of adolescents in the current study indicated that they do not believe that professional help-seeking is beneficial (mean perceived benefits score = 1.02 out of 5). Further, this lack of perceived benefit is related to lower intentions to seek professional help when experiencing emotional problems.

Symptoms of psychological distress and help-seeking. Contrary to predictions, symptoms of psychological distress did not significantly predict help-seeking intentions when all other variables were controlled, and psychological distress was not significantly correlated with help-seeking intentions (r = .01) Findings from the current study indicate that participants' intentions to seek professional help do not increase as they experience higher levels of psychological distress. The correlation between symptoms of psychological distress and perceived benefits of help-seeking was also low (r=.01), suggesting that as participants' experience higher levels of psychological distress, they do not perceive help seeking as more beneficial. The low correlations between these variables and symptoms of psychological distress may be explained by the lack of variability between participants on self-reported symptoms of psychological distress, with most participants reporting low levels of psychological distress. This finding is not unexpected, considering the investigation was carried out amongst a non-clinical population. Although the self-reported levels of psychological distress in the present study were relatively low, the lack of relationship between symptoms of psychological distress and intentions to seek help is in line with research indicating that even moderate to severe symptoms of distress are not sufficient for adolescents to engage in help-seeking (Kelly & Achter, 1995; Vogel & Wester, 2003). On examination of gender differences in psychological distress, female participants

reported experiencing greater symptoms of psychological distress than males. This is in keeping with previous findings indicating that female adolescents are more likely than males to report feelings of distress (Schonert-Reichl & Muller, 1996; Tishby, et al., 2001).

Gender, stoicism and help-seeking. In line with well established findings, in the current study gender was significantly related to help-seeking intentions for emotional problems, with female participants indicating that they are more likely to seek professional help than males. However, the only other difference between males and females was in symptoms of psychological distress.

Contrary to predictions, stoicism did not significantly account for differences in help-seeking intentions. While past research has linked stoic attitudes of toughness and self-reliance to help-seeking intentions, findings from the current study indicate that although WUSS and RES measures were associated with help-seeking intentions, stoicism does not appear to be a main barrier to adolescents' help-seeking intentions. Also contrary to expectations, there were no significant differences in stoicism between male and female participants in the current study. This indicates that although male adolescents in the current study are less likely to seek help than females, their lower help-seeking intentions do not appear to be due to higher levels of stoic attitudes. Although there is a small but significant bivariate relationship between aspects of stoicism and help-seeking intentions these are not significant when the effects of gender are controlled.

Limitations

Since the current study was conducted using a non-clinical sample, adolescents experiencing low levels of psychological distress were overrepresented. Therefore the results may not generalise to groups of adolescents that are

experiencing significant emotional difficulties. It is important to note the limited range of help sources and problem types that were addressed by the help-seeking intentions measure administered in the current study. In order to increase the completion rate of questionnaires and minimise time demands, the full version of the GHSQ was not administered, placing limitations on the psychometric data that could be obtained for the current measure. Further, although intentions are thought to be the most proximal predictor of actual behaviour (Ajzen, 1985), there is still a considerable gap between intentions to act and actual help-seeking behaviour (Bayer & Peay, 1997). Further research may include measures of actual help-seeking through the use of observational methods as well as longitudinal measurements of actual help-seeking. The focus of the study was on adolescents from rural and regional Australia. Thus, it may not reflect the help-seeking intentions of young people in larger metropolitan areas.

Implications

Despite these limitations, the current study furthers our understanding of factors influencing adolescent help-seeking intentions, particularly in regional and rural areas. The relationship between the perceived benefits of help-seeking and help-seeking intentions provides an important insight into the reasons underlying the service gap phenomenon. This finding suggests that improving adolescents' beliefs about the benefits of professional help-seeking may be a key universal strategy for increasing their use of professional health services to address mental health problems.

Although classroom based interventions involving adolescents have led to an increase in help-seeking intentions (e.g. Wilson et al., 2008) findings from the current study suggest that an important component of such interventions should be to increase awareness of the benefits of seeking professional help.

Although the current study provides further evidence that females are more likely to seek professional help than males, the reasons behind this gender difference are not fully explained. Gender differences in psychological distress and help-seeking have been consistently reported in prior research. An understanding of why this gender difference exists is likely to provide significant guidance into factors to target when designing interventions that aim to increase help-seeking intentions in adolescents. The current study did not find differences between males and females in stoicism. It is possible that in rural and regional areas males and females are equally stoic. Future research should explore other factors that might explain the gender differences in help-seeking intentions. This may include investigation of the relationship between gender-role socialisation and help-seeking amongst adolescents (Grinstein-Weiss, et al., 2005). Gender differences in factors such as emotional competence (Ciarrochi, Deane, Wilson, & Rickwood, 2002) and coping styles (Frydenberg & Lewis, 1993) may also provide insight into reasons underlying gender differences in help-seeking intentions.

Study Two

Improving Adolescents' Help-seeking for Mental Health Problems: Development and evaluation of a school-based intervention conducted by health professionals

Development of Study Two

Based on health behaviour models, previous research, and findings from Study one, study two aims to design and run an intervention to increase help-seeking intentions and help-seeking behaviour for emotional problems in high school students.

Consistent with the Health Belief Model (Rosenstock, 1966) and previous research (e.g. Bayer & Peay, 1997; Vogel, et al., 2005), results from Study one indicated that higher perceived benefits lead to an increase in help-seeking intentions. This suggests that improving young people's beliefs about the benefits of professional psychological help-seeking may be an important strategy for increasing their use of mental health services. Further, health behaviour models and past research indicate that barriers to help-seeking are associated with help-seeking intentions. Although results from Study one did not find that barriers significantly predicted help-seeking intentions for emotional problems, the barriers variable approached significance (p = .06) and is therefore barriers are worth addressing as part of the intervention.

Findings from seven studies evaluating school-based help-seeking interventions suggest that brief school based interventions can influence help-seeking behaviour amongst adolescents. The Building Bridges to General Practice (BBGP) program involved an interactive high school classroom presentation that was found to increase high school students' intentions to consult a GP for psychological problems. Although the BBGP presentation led to an increase in help-seeking intentions, overall, adolescents still reported that they were unlikely to seek professional help for psychological problems. This suggests the need for further refinement of interventions with an aim to increase the strength of help-seeking intentions (Wilson et al., 2008).

Study two aims to design and implement an intervention that addresses adolescent barriers to seeking help, promotes the benefits of seeking help and provides education about the process of seeking help. Further, in order to demonstrate a unified and multidisciplinary approach to health care, the study will integrate health care professionals other than a GP into the help-seeking intervention.

Aims and Hypotheses

Study 2 investigates the effectiveness of an intervention designed to increase adolescents' professional help-seeking for mental health problems. The study will assess the influence of the designed intervention on three help-seeking outcome variables: help-seeking intentions, perceived benefits of help-seeking and perceived barriers to help-seeking. Specifically, the following hypotheses were tested:

1. **Effect of the intervention on perceived benefits of help-seeking**

   Participants in the intervention group will have significantly higher perceived benefits to help-seeking post-intervention and at follow-up compared to baseline. There will be no significant change in perceived benefits to help-seeking over time for participants in the control group.

2. **Effect of the intervention on perceived barriers to help-seeking**

   Participants in the intervention group will have significantly lower perceived barriers to help-seeking post-intervention and at follow-up compared to baseline. There will be no significant change in perceived barriers to help-seeking over time for participants in the control group.

3. **Effect of the intervention on help-seeking intentions**

   Participants in the intervention group will have significantly higher help-seeking intentions post-intervention and at follow-up compared to baseline. There

will be no significant change in help-seeking intentions over time for participants in the control group.

Method

Participants

Initially, five high schools in the Illawarra and South East Region of New South Wales were approached to participate in the study. The five selected schools were chosen on the basis that they had previously been involved in the Building Bridges to General Practice program (Wilson et al., 2004), and therefore had an ongoing working relationship with the research team. A letter was sent to the principals of each school providing them with a background to the study and informing them of what would be required of the school and its studentsth. Out of the five schools, four indicated an interest in being involved in the current study. Due to practical constraints, two of the four schools were unable to allow for the implementation of an appropriate control condition and the randomisation of students to groups. Therefore only two of the four schools were able to be included in the current study.

Three hundred and sixty Year 11 students from the remaining two schools were approached to participate in the current study. Of these students, 74% (n = 267) provided the appropriate written parental consent and chose to participate in the study. The mean age of participants was 15.94 (SD = 45), with 13% (n = 29) of students aged 15, 80% (n = 179) of students aged 16, and 7% (n = 16) of students aged 17. Fifty four percent of students were female (n = 122), and 95% (n = 213) of students described their cultural affiliation as Australian. The remainder described their culture as European, Asian, or "other". Both schools served students coming from a range of socioeconomic backgrounds with the majority coming from what would be

characterised as "middle class" families, although no formal measures of socioeconomic status were obtained from participants.

Research Design

The current study used a randomised controlled trial design to test the impact of the help-seeking intervention on high school students' intentions to seek help from a health professional. A computerised random integer generator (see http://www.random.org/integers/) was used to allocate students to one of two conditions. Year 11 roll lists for each school were obtained by the primary researcher, who allocated each student to "Group 1" (Treatment condition), or "Group 2" (Control condition) based on the computer generated randomisation. As shown in Figure 3, students assigned to the treatment condition received the designed intervention titled "Promoting Access and Support Seeking" (PASS!), and students assigned to the control condition received alternative presentations of the same length. Students in both conditions completed measures immediately before the presentation (Time 1), immediately after the presentation (Time 2), and at three months follow-up (Time 3).

Condition	Time 1	Presentation	Time 2		Time 3
Control	Measures	Start out Right Safe Partying	Measures	3 months	Measures
Treatment	Measures	PASS!	Measures		Measures

Figure 3. Outline of Randomised-Control Design for Study 2

Primary Outcome Measures

Intentions to seek help from a health professional. Intentions to seek help from a health professional were measured at Time 1, Time 2 and Time 3 by 4-items that were adapted from the General Help Seeking Questionnaire (GHSQ; Wilson, Deane, Ciarrochi et al., 2005). These items have been used in other studies with adolescents (Deane, et al., 2007; Wilson, Bignell & Clancy, 2003; Wilson et al., 2010). Items ask participants to rate how likely it is that they would seek help from a professional if they were experiencing emotional problems. A sample item is, "If you were to have an emotional problem like being depressed or stressed out, how likely are you to see a health professional about it?". Items are rated on a 7-point scale, where 1 = *Extremely Unlikely* and 7 = *Extremely Likely*. Responses are summed so that higher scores reflect higher intentions to seek help from a health professional. In the current study, the mean of the 4 items was used to represent each individual's help-seeking intentions score. These items have been related to perceived barriers to help-seeking and to engaging in treatment with a General Practitioner (Deane, et al., 2007). Cronbach's alpha coefficients for the scale have previously ranged from .70 to .90 (Wilson et al., 2008). In the current study Cronbach's alpha coefficients for the scale were .96, .97 and .97 at Time 1, Time 2 and Time 3 respectively.

Perceived benefits of help-seeking. Perceived benefits of help-seeking were measured at Time 1, Time 2 and Time 3 by the anticipated benefits subscale of the Disclosure Expectations Scale (DES; Vogel & Wester, 2003). The scale comprises 4 items, designed to assess participants' expectations about how beneficial it would be to talk to a health professional about an emotional problem. Participants are asked to rate their own opinion of statements such as, "Would you feel better if you revealed feelings of sadness or anxiety to a health professional?" Items are rated on a 5-point

scale where 1 = *not at all* and 5 = *very*. Higher scores reflect higher perceived benefits of help-seeking. In the current study, the mean of the 4 items forming the anticipated utility subscale of the DES was used to represent each individual's perceived benefits of help-seeking score. The anticipated utility subscale has been found to correlate positively with the tendency to self disclose distressing information and intentions to seek therapy (Vogel, et al., 2005). In Study one, Cronbach's alpha for the anticipated utility subscale was .83.

In the current study Cronbach's alpha was .86, .85 and .80 at Time 1, Time 2 and Time 3 respectively. As part of the DES (Vogel & Wester, 2003), the anticipated risks subscale was administered at all three time points but was not included in the analyses.

Perceived barriers to help-seeking. Perceived barriers to help-seeking were measured at Time 1, Time 2 and Time 3 by the 12-item Barriers to Engagement in Treatment Screen (BETS; Deane, et al., 2007; Wilson et al., 2002). Items are designed to assess participants' perceived knowledge- and belief-based barriers to consulting a health professional, by asking them to rate how different statements reflect their own opinion. A sample item is, "If I tell a health professional about my emotional problems, I believe they will keep it a secret". Items are rated on a 4-point scale, where 0 = *disagree* and 3 = *agree*. In the current study, responses were reverse coded so that higher scores reflect higher perceived barriers to help-seeking. The mean of the 11 items was used to represent each individual's perceived barriers to help-seeking score. BETS scores have been negatively related to Year 11 adolescents' intentions to consult a GP for psychological problems ($r = -.57$, $p < .001$; C. J. Wilson, et al., 2003). In the current study, Cronbach's alpha was .81, .82 and .82 at Time 1, Time 2 and Time 3 respectively.

Secondary Measures

Demographic information. Basic demographic information including age, date of birth, gender, country of birth and cultural affiliation was collected at Time 1. (see Appendix C for full measure).

Help-seeking behaviour for emotional or mental health problems. Help-seeking behaviour was not a primary outcome variable in the current study because rates of help-seeking are overall relatively low (Sawyer et al., 2007) and, over the short follow-up period of 3 months the rates were not expected to be particularly high. Help-seeking behaviour for emotional or mental health problems was measured at Time 1 and Time 3 by items adapted from the Actual Help Seeking Questionnaire (AHSQ; Rickwood & Braithwaite, 1994). At Time 1, four items were administered to address participants past help-seeking behaviour for emotional or mental health problems. Item 1 required participants to indicate whether they had sought professional help in the past, and Item 2 required participants to indicate the frequency of visits to a health professional in the last 3 months. Participants that responded "yes" to item 1 were required to rate how helpful their professional help-seeking experience had been. Item 4 required participants to indicate how often they had sought help from a family member or friend for emotional or mental health problems. At Time three, items 2, 3 and 4 were administered to address participants' help-seeking behaviour in the past 3 months, since participation in the intervention or control presentation. This measure was collected and included in secondary analyses.

Symptoms of psychological distress. Symptoms of psychological distress were measured at Time 1 and Time 3 by the Kessler Psychological Distress Scale 6-item version (K-6; Kessler et al., 2002). Items ask participants to rate how often they have experienced different symptoms of distress in the last thirty days. A sample item

is, “During the last 30 days, about how often did you feel worthless?”. Items are rated on a 5-point scale where 1 = *none of the time* and 5 = *all of the time*. Higher scores reflect higher levels of psychological distress. In the current study, the mean of all six items was used to represent each individual’s psychological distress score. The K-6 has been shown to have high discriminatory power in detecting DSM-IV depressive and anxiety disorders (Kessler et al., 2002). In an adolescent sample, Cronbach’s alpha for the 10 item version of the scale, (K-10), was .90. In the current study, Cronbach’s alpha was .78 and .83 at Time 1 and Time 3 respectively.

Knowledge of the intervention. Knowledge of the intervention was measured at Time 1 and Time 2 for individuals assigned to the intervention group only. Five multiple choice questions were developed specifically for the current study, in order to assess participants’ understanding of the content of the presentation. A sample question is “Under what circumstances would a psychologist usually need to break confidentiality?”. The number of correct items were summed to provide the knowledge score (range 0-5).

Intervention: Promoting-Access-and-Support-Seeking (headspace PASS!)

Facilitator training. Prior to implementation of the intervention, facilitators were provided with a copy of two workbooks that provided: (1) background research and information on help-seeking, and (2) detailed instructions regarding implementation of the PASS!. Facilitators then attended a two hour training session facilitated by Dr Coralie Wilson, the author of PASS!. Staff from a local youth mental health service known as Headspace Illawarra, along with associated welfare school staff were involved in facilitation of PASS!. In School 1, due to the school staff’s unavailability, the intervention was conducted by Headspace staff, namely the Project Officer and Project manager of Headspace Illawarra. In School 2, the

intervention was facilitated by a Care Coordinator, a Clinical Psychologist and the Headspace Illawarra Project Officer with the school counsellor.

Structure and timing. The PASS! program consisted of two 50 minute sessions separated by a 30 minute computer activity and a 30 minute break. The sessions were composed of PowerPoint slideshow presentations, interactive group discussions and DVD clips. See Appendix D for a copy of the PowerPoint slides and scripts for the DVD clips.

Instructions given to participants. All students participating in the intervention heard a brief introduction prior to commencement of session one. Instructions were read out by either the class teacher who supervised the class, or one of the presentation facilitators. The script provided a brief overview of the aims and structure of the intervention and detailed information regarding completion of questionnaires to evaluate the program. See Appendix D for a full version of the introduction to PASS! evaluation script.

Content. In general, session one focused on relationship building, addressing attitudinal and belief-based barriers to help-seeking and highlighting the benefits of seeking help. As described in detail below, session two targeted emotional and mental health literacy, skill building and information giving. Throughout the presentation, students were encouraged to interact and ask questions. The main components of the program are described below. For a full description and structured outline of program content, see Appendix D.

The intervention began with a general introduction to the PASS! program, followed by an open discussion to explore what students currently knew about consulting a health care professional and what they would like to know. Students were also given some time to express their attitudes and beliefs about consulting a

health care professional in the group setting. General components addressed in the program included: (1) normalizing of the process of consulting health care professionals for physical and mental health problems, (2) describing the ways health care professionals can help with different types of problems, (3) examining previous experiences that students have had with health care professionals, and (4) discussing how to overcome experiences that students perceive as unhelpful when seeing a health care professional in the future.

Also, practical information was provided about: (1) the structure of typical consultations, (2) rules about confidentiality, (3) obtaining and using Medicare cards, (4) specific costs and billing for consultations, (5) ways to find your own health care professional, (6) how to communicate with health care professionals, (7) responsibilities as a patient, (8) ways to make the most out of a consultation and, (9) feelings that stop young people visiting a health care professional. A component of Session 2 also included information about the signs indicative of anxiety, depression and drug/alcohol abuse.

Session one and two included presentation of DVD clips from the Support Seeking Skills Program (S3) that was developed to accompany PASS!. Three short film clips that portray young people accessing help for emotional problems were included in the presentation. The clips were titled "Getting Help", "Making the most of a consultation", and "Summary of support seeking skills". Discussion after each clip was encouraged, with a focus on the perceived help-seeking barriers for young people that can be changed.

The website activity required students to explore the Headspace website and answer a series of specified questions. See Appendix D for a copy of the website activity worksheet provided to students.

Control Presentations

Two 60 minute control presentations were conducted in both schools. Each presentation was separated by a 30 minute break. One presentation was titled "Safe Partying" and was conducted by two members of the police force. The aim of the presentation was to educate students about safe partying, including drug and alcohol use. The other presentation was titled "Start out Right" and was conducted by two members from a legal aid team. The presentation provided students information regarding their legal rights and responsibilities in relation to consumer contracts for mobile phones and other age relevant purchases.

Procedure

Prior to approaching potential participants, ethics approval from the New South Wales Department of Education and Training (DET) and the University of Wollongong Human Ethics Research Committee (HREC) was obtained. A critical incident procedure and incident log was developed with the schools involved in case any student needed support following the presentations (see Appendix D).

Prior to implementation, researchers met with the head of welfare teachers from all interested four schools, in order to arrange for effective implementation and evaluation of the intervention. Teachers were provided with a background and rationale for the current research, as well as familiarised with the process required for implementing the current research. This included an understanding of the importance and process of random allocation, and the need for an appropriate control condition. In order to ensure that the control presentation did not overlap in content with the intervention presentation, welfare teachers were provided with a checklist of topic areas that should not be included in control presentations (See Appendix C). Implementation dates and procedures were discussed with the remaining two schools.

In order to minimise any disruption to academic learning, students received the presentations as part of "CrossRoads", an existing student health and welfare program that is part of the curriculum. The two schools were provided with a set of information sheets and consent forms to be distributed to relevant school staff and parents of year 11 students (see Appendix C).

One week prior to implementation, parent information sheets and consent forms were distributed to year 11 students at both schools. At this time, researchers spoke briefly to year 11 students from both schools to provide information regarding the study and to distribute written student information sheets (see Appendix C).

Control and intervention presentations were conducted in the school setting. Locations within the school included classrooms, school library and gymnasium. A school teacher was present in each classroom to supervise students. Within the respective schools, the control and intervention groups were broken down into class sizes of approximately 30 students in order to facilitate appropriate implementation of the presentations. In School 1, the groups were divided into two smaller groups, with approximately 30 students in each classroom. In School 2, each group was divided into three classes, with approximately 35 students in each classroom.

Students with parental consent were required to provide their own written consent to participate in the study (see Appendix C for a copy of consent forms). On the day, students were provided the opportunity to ask any questions, and were verbally informed that their participation in the study was voluntary, and that they would not be penalised in any way if they declined to participate. They were also informed that the questionnaires were anonymous. All students who agreed to participate were provided with the option to withdraw from the study at any time. Students in both intervention and control groups who had parental consent and

provided their own consent were given 15 minutes to complete an anonymous self-report questionnaire, comprised of the measures described above. A unique code for each participant was derived based on their date of birth and each parents' first initial. Immediately after the presentations, students were required to complete a similar anonymous but questionnaire using the same self-generated code. This coded questionnaire was re-administered by school staff to participating students three months after implementation. Coded questionnaires were matched for analysis.

Data Analysis

Exploratory analyses. Means and standard deviations were generated to describe participants' scores on help-seeking outcome variables at each measurement time point. Paired t-tests comparing Actual help-seeking items were conducted to investigate whether there were any differences in the frequency of visits to a health professional as a result of the intervention. Individual item analyses were conducted for participants' help-seeking intentions at Time 1, Time 2 and Time 3. Due to a significant positive skew on the help-seeking intentions items, scores for each participant on these items were recoded into the likely to seek help or unlikely to seek help category. Help-seeking intentions scores ranging from 1 = *extremely unlikely* to 3 = *a little unlikely* were placed in the *unlikely* category; and help-seeking intentions scores ranging from 4 = *unsure* to 7 *extremely likely*, were placed in the *likely* category. Frequencies were generated to describe the proportion of participants in each group that were in the likely category of help-seeking, at each measurement time point.

The relationship between participation in the help-seeking intervention and outcome variables. Data was analysed using hierarchical linear modelling (HLM; Raudenbush & Bryk, 2002), also referred to as multilevel modelling (Snijders

& Bosker, 1999) and mixed effects modelling (Pinheiro & Bates, 2000). HLM does not require complete data on every participant and thus, flexibly handles missing data that can be assumed to be missing at random (Atkins, 2005). Data from all 267 participants was used. A detailed participant flow diagram is presented on page 73 .

A two level model was used, where measurement times (N = 3, level 1) were nested within individual students (N = 267, level 2). In level 1, the intercept was allowed to vary between individuals in level 2 and *Time* was fixed at the same value for all individuals in level 2. In level 2, the fixed effects include *Gender* (Male and Female), *Group* (Intervention and Control) and *School* (School 1 and School 2). Furthermore, the model included two cross-level interactions to explore if the relationship between participation in the intervention and help-seeking outcomes was moderated by *Group* and *School*.

The model consisted of the following equations:

Level 1 $Y_{ij} = \beta_{0j} + \beta_1(Time)_{ij} + \varepsilon_{ij}$

where

Time 0 = pre-intervention, 1 = post-intervention, 2 = follow up

i Measurement

j Individual

ε_{ij} Residual

Level 2 $\beta_{0j} = \gamma_{00} + \gamma_{01}(Group) + \gamma_{02}(Gender) + \gamma_{03}(School) + u_{0j}$

where

Group 0 = control, 1 = intervention

Gender 1 = male, 2 = female

School 1 = school 1, 2 = school 2

Cross-level Interactions $\beta_{1j} = \gamma_{10} + \gamma_{11}(Time \times Group) + u_{1j}$

$B_{2j} = \gamma_{20} + \gamma_{21}(Time \times Group \times School) + u_{2j}$

The three help-seeking outcomes were Help-seeking Intentions, Perceived Benefits of Help-seeking, and Perceived Barriers to Help-seeking.

Number of Participants Included in each Analysis

As recommended by the Consolidated Standards of Reporting Trials (CONSORT) Statement (Schulz, Altman, & Moher, 2010), a detailed participant flow diagram is presented in Figure 1. The diagram shows the number of participants assigned to intervention and control groups, and depicts the passage of participants through each stage of data collection (enrolment, pre-intervention, post-intervention, follow-up and analysis). The primary analysis involved all patients who completed measures at any time point (pre, post or follow-up).

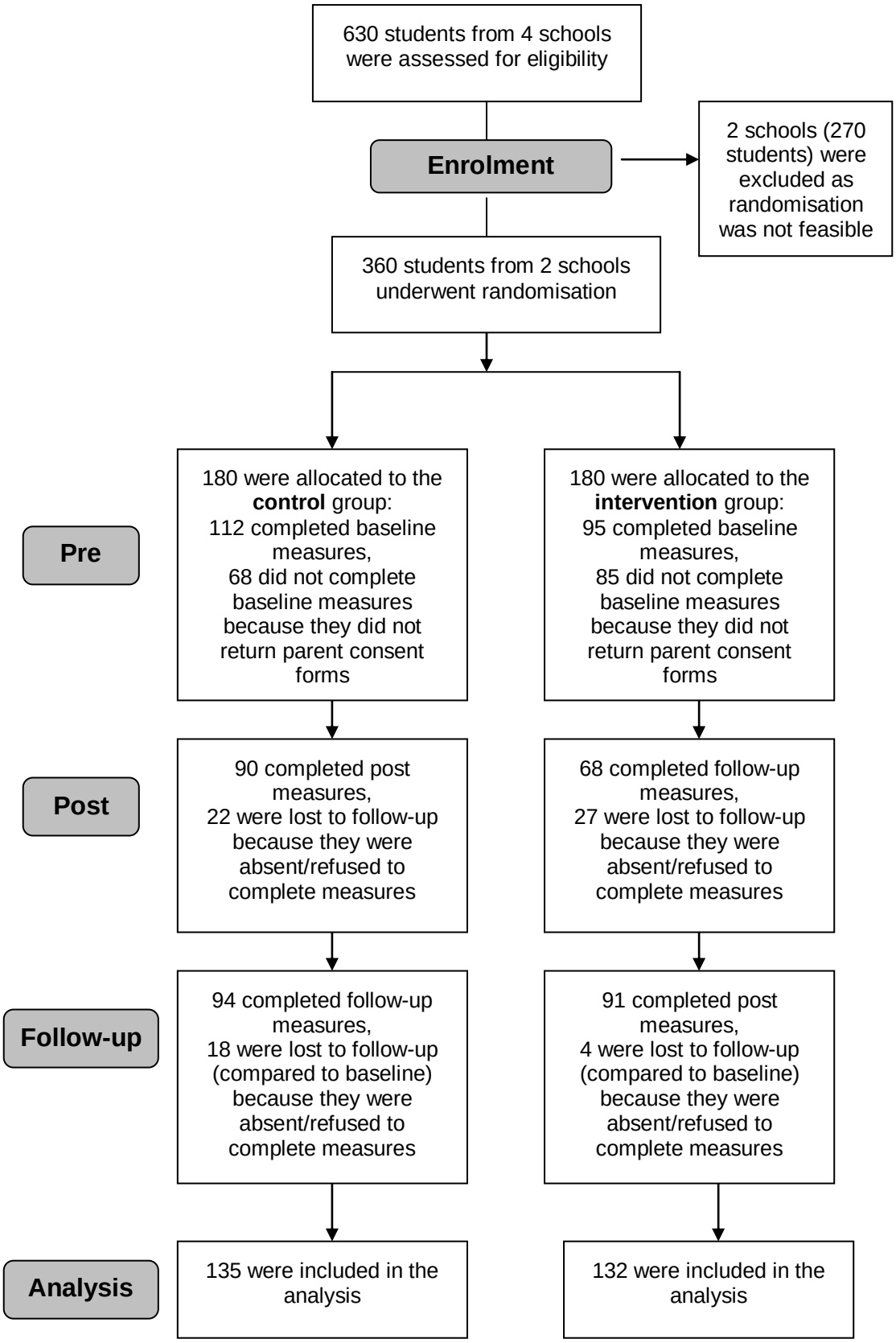

Figure 4. Flow of Participants through recruitment, intervention and analysis stages

Recruitment: Dates defining the Period of Recruitment and Follow-up

Year 11 high school students from the Illawarra region of New South Wales were recruited from October 2008 to February 2009. Students participated in the intervention or control presentations at the time of randomisation (baseline). Students completed measures immediately prior to the presentation (Time 1), immediately after the presentation (Time 2), and 3 months after the presentation (Time 3).

Data Screening and Preparation

All statistical analyses were conducted using SPSS Statistics 17.0 for Windows. Prior to analysis, scores on measures of symptoms of psychological distress, perceived benefits, perceived barriers, help-seeking intentions and knowledge were examined to check for the accuracy of data entry, missing values and fit between their distributions and the assumptions of the analyses utilised. Since hierarchical linear modelling does not require complete data on every participant, data from participants who had completed measures during at least one of the three measurement time points were included in the analyses (N = 267). Of these participants, 43 (16%) did not provide information on their age, 42 (16%) did not indicate their gender, 41 (15%) did not specify their country of birth and 42 (16%) did not state their cultural affiliation.

Due to a substantial positive skew on help-seeking intentions items, scores on help-seeking intentions items were recoded into two categories (as described earlier), so that 0 = unlikely to seek help and 1 = likely to seek help. Exploratory analyses using the recoded variables were conducted.

For ease of interpretation, items on the Barriers to Engagement in Treatment Scale (BETS) were recoded, so that higher scores correspond to higher barriers to help-seeking. To best represent individual respondents, the mean of the items on

measures of symptoms of psychological distress, perceived benefits, perceived barriers, help-seeking intentions and knowledge were calculated for each participant. Dummy coding was used for time (0 = pre, 1 = post, 2 = follow up), Group (0 = control, 1 = intervention) and Gender (1 = female, 2 = male).

In order to utilise multilevel analyses to investigate differences in help-seeking outcomes over time, the original data set was restructured. In time-varying models, data is analysed using vertical rather than horizontal data structures (Heck, Thomas, & Tabata, 2010). The original data set was restructured using the SPSS VARSTOCASES routine that is contained in the SPSS Restructure Data Wizard. The resulting data set was vertically structured, so that each individual student had three records corresponding to each measurement time point for each help-seeking outcome variable.

Results

Descriptive Analyses

Table 6 and Table 7 provide a summary of demographic statistics by group, for students in School 1 and School 2 respectively. Means and standard deviations on measures of help-seeking intentions, perceived benefits of help-seeking and perceived barriers to help-seeking taken at pre, post and follow-up are presented in Table 8.

Table 6

Demographic Statistics of School 1 Students for the Control and Intervention Group taken at Baseline

Group	*N*	Age *M (SD)*	Female *n* (%)	Born in Australia *n* (%)	Australian culture *n* (%)	Symptoms of Psychological Distress *M (SD)*
Control	74	15.92 (.53)	35 (49)	62 (86)	65 (92)	2.00 (.64)
Intervention	75	15.85 (.49)	30 (56)	53 (96)	51 (93)	1.78 (.61)

Table 7

Demographic Statistics of School 2 Students for the Control and Intervention Group taken at Baseline

Group	*N*	Age *M (SD)*	Female *n* (%)	Born in Australia *n* (%)	Australian culture *n* (%)	Symptoms of Psychological Distress *M (SD)*
Control	61	16.03(.37)	33(56)	57 (97)	57 (97)	2.02 (.67)
Intervention	57	15.98 (.28)	24 (60)	40 (100)	40 (100)	2.11 (.70)

Table 8

Descriptive Statistics for Help-seeking Intentions, Perceived Benefits and Perceived Barriers for Control and Intervention Group at each Measurement Time Point

Outcome Variable	Control									Intervention									Mean difference (95% CI) at post
	Pre			Post			Follow-up			Pre			Post			Follow-up			
	M	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*	
Help-seeking Intentions	3.45	1.66	109	3.42	1.67	88	3.24	1.70	94	3.24	1.52	94	3.96	1.7	89	3.26	1.58	67	-0.54 (-1.04, 0.04)
Perceived Benefits	2.84	0.98	112	2.79	0.88	90	2.67	0.88	94	2.85	0.99	95	3.03	1.01	91	2.89	0.85	68	-0.24 (-0.52, 0.04)
Perceived Barriers	1.18	0.52	111	1.17	0.55	90	1.18	0.59	94	1.17	0.6	95	1.12	0.57	91	1.1	0.49	67	0.04 (-0.12, 0.21)

To investigate differences in Actual help-seeking, paired sample t-tests comparing Item 2 (frequency of visits to a health professional in the last 3 months) at Time 1 and Time 3 were conducted. Results for the intervention group revealed a significant difference in the number of visits to a health professional $t(48) = -2.07$, $p = .04$, with a greater number of visits at Time 3 ($M = .10$, $SD = .37$) compared to Time 1 ($M = .02$, $SD = .14$). For the control group, there was no significant difference in the number of visits to a health professional at Time 3 compared to Time1, $t(71) = -1.40$, $p = .17$.

In order to explore changes in likelihood to seek help from pre to post intervention, exploratory analyses examined the proportion of students that moved from the unlikely range pre-intervention into the unsure or likely range post-intervention (contemplation).

Individual item analyses on all four items addressing intentions to seek help from a health professional showed differences in help-seeking intentions over time for the intervention group. Specifically, for the intervention group, there was an increase in the percentage of students who were in the *likely* category of between 13% and 17% from pre to post-intervention across all four items. The mean percentage increase across the four items was 15.25%. For the control group, the increase in the percentage of students in the *likely* category from pre to post-intervention was between 1% and 9%, with a mean percentage increase across the four items of 4.25%. At three months follow-up, the percentage of students in the likely category dropped back to baseline levels for participants in the intervention and control group. See Appendix E for results from the item level analysis for each group, across all three time points

Hierarchical Linear Modelling on the Relationship between Participation in PASS! and Primary Outcome Variables

Help-seeking intentions. In order to first assess whether or not any of the variation in individual help-seeking intentions could be attributed to individual-level factors, an intraclass coefficient (ICC) was calculated, and the resulting ICC was 0.64. The ICC indicates that approximately 64% of the total variation in individual help-seeking intentions occurred between individuals and supports the usefulness of HLM analysis to assess the relative contribution of measurement and individual-level factors to the outcome variable.

Main effects. At the measurement level (level 1), the main effect of time on help-seeking intentions was significant $F(2, 313) = 7.66$, $p = .001$. Specifically, there was a significant difference between help-seeking intentions measured post-intervention when compared to help-seeking intentions measured pre-intervention $t(304) = 4.00$, $p = .00$. Help-seeking intentions post-intervention were significantly higher ($M = 3.73$, $SE = .12$) than help-seeking intentions pre-intervention ($M = 3.37$, $SE = .11$). At the individual level (level 2), the main effect of school on help-seeking intentions was significant $F(1, 226) = 15.98$, $p = .00$, with higher help-seeking intentions in School 2 ($M = 3.88$, $SE = .15$) than School 1 ($M = 3.08$, $SE = .13$). gender and group were not significantly associated with help-seeking intentions ($p > .05$).

Interactions. The cross-level interaction between time and group was significant $F(2, 313) = 5.30$, $p = .01$, implying that the change in help-seeking intentions over time was different for the control and intervention group (Figure 5). Specifically, there was a significant difference between the control and intervention group for help-seeking intentions measured post-intervention compared to pre-

intervention $t(308) = 2.64$, $p = .01$. For individuals in the intervention group help-seeking intentions measured post-intervention ($M = 3.91$, $SE = 0.17$) were higher than help-seeking intentions measured pre-intervention ($M = 3.22$, $SE = 0.16$), and help-seeking intentions measured at follow-up ($M = 3.29$, $SE = 0.21$) were significantly lower than help-seeking intentions measured immediately after the intervention. For individuals in the control group, time had no effect on help-seeking intentions.

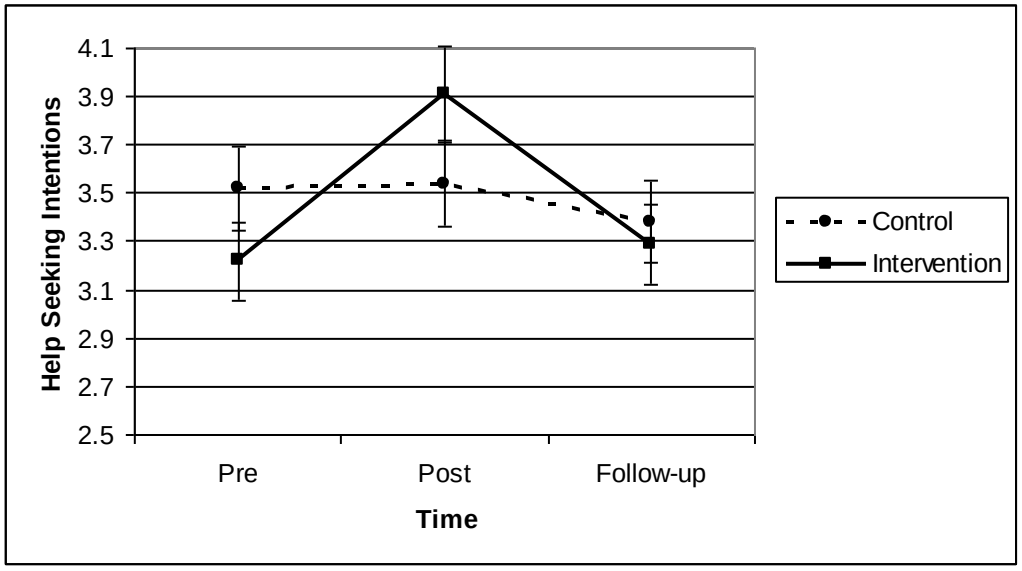

Figure 5. Help-seeking intentions: Time X Group interaction. Error bars represent 95% confidence intervals.

Perceived benefits of help-seeking. In order to first assess whether or not any of the variation in individual Perceived Benefits could be attributed to individual-level factors, an intraclass coefficient (ICC) was calculated, and the resulting ICC was 0.55. The ICC indicates that approximately 55% of the total variation in individual Perceived Benefits occurred between individuals and supports the usefulness of HLM analysis to assess the relative contribution of measurement and individual-level factors to the outcome variable.

Main effects. At the measurement level (level 1), the main effect of time on perceived benefits was not significant ($p > .05$). Analysis of differences between individual time points revealed significant differences between perceived benefits measured pre-intervention when compared to perceived benefits measured post-intervention $t(314) = 3.27$, $p = .00$ and follow-up $t(336) = 2.30$, $p = .02$. Specifically, perceived benefits measured post-intervention ($M = 2.96$, $SE = .07$) and at follow-up ($M = 2.86$, $SE = .08$) were significantly higher than perceived benefits measured pre-intervention ($M = 2.86$, $SE = .06$). At the individual level (level 2), the main effect of group on perceived benefits was significant $F(1, 272) = 4.07$, $p = .05$, with higher perceived benefits for the intervention group ($M = 3.00$, $SE = .08$) compared to the control group ($M = 2.8$, $SE = .07$). Also, the main effect of school on perceived benefits was significant $F(1, 229) = 28.09$, $p = .00$, with higher perceived benefits for School 2 ($M = 3.19$, $SE = .08$) compared to School 1 ($M=2.60$, $SE=.07$). Gender was not significantly associated with perceived benefits ($p > .05$).

Interactions. The main effect for the cross level interaction between time and group was not significant ($p > .05$), however consideration of individual time points revealed significant differences between the control and intervention group in perceived benefits measured post-intervention $t(316) = 2.97$, $p = .00$) and at follow-up

$t(429) = 2.16$, $p = .03$ when compared to perceived benefits measured pre-intervention. The cross-level interaction between time, group and school was significant $F(5, 374) = 2.70$, $p = .02$, implying that the change in perceived benefits over time was different for the control and intervention group for each school (Figure 6). Specifically, for individuals attending School 2, those in the intervention group scored higher on perceived benefits measured post-intervention ($M = 3.45$, $SE = 0.15$) and at follow-up ($M = 3.43$, $SE = 0.20$) than perceived benefits measured pre-intervention ($M = 2.99$, $SE = 0.14$). In School 2, for individuals in the control group, time had no effect on perceived benefits. For individuals attending School 1, those in the control group scored lower on perceived benefits at follow-up ($M = 2.33$, $SE = .12$) than perceived benefits post-intervention ($M = 2.60$, $SE = .12$). In School 2, time had no effect on perceived benefits for the intervention group.

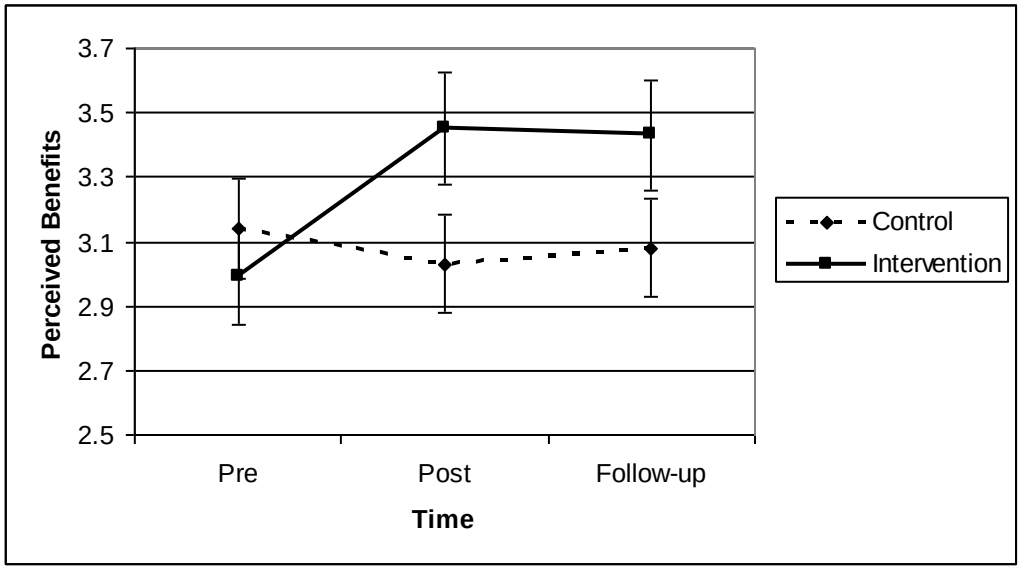

Figure 6. Perceived benefits of help-seeking: Time X Group interaction for School 2. Error bars represent 95% confidence intervals.

Perceived barriers to help-seeking. In order to first assess whether or not any of the variation in individual perceived barriers could be attributed to individual-level factors, an intraclass coefficient (ICC) was calculated, and the resulting ICC was 0.29. The ICC indicates that approximately 29% of the total variation in individual perceived barriers occurred between individuals and supports the usefulness of HLM analysis to assess the relative contribution of measurement and individual-level factors to the outcome variable.

Main effects. At the measurement level (level 1), the main effect of time on perceived barriers was not significant ($p > .05$). Consideration of individual time points revealed significant differences between perceived barriers measured post-intervention compared to perceived barriers measured pre intervention $t(302) = 2.62$, $p = .01$. Specifically, perceived barriers post-intervention were significantly lower ($M = 1.10$, $SE = .04$) than perceived barriers pre-intervention ($M = 1.16$, $SE = .04$). At the individual level (level 2), the main effect of school on perceived barriers was significant $F(1, 221) = 10.60$, $p = .00$, with significantly lower perceived barriers in School 2 ($M = 1.02$, $SE = .05$) compared to School 1 ($M = 1.25$, $SE = .05$). Group and gender were not significantly associated with perceived barriers ($p > .05$).

Interactions. The cross-level interaction between time, group and school was significant $F(5, 339) = 2.35$, $p = .04$, implying that the change in help-seeking intentions over time was different for the control and intervention group for each school (Figure 7). For individuals attending School 2, those in the intervention group scored lower on perceived barriers measured immediately after the intervention ($M = .85$, $SE = 0.09$) than perceived barriers measured immediately before the intervention ($M = 1.04$, $SE = 0.09$). Furthermore, within School 2, those in the intervention group scored higher on perceived barriers at follow-up ($M = 1.02$, $SE =$

.11) than Perceived Barriers measured post-intervention. In School 2, for individuals in the control group, time had no effect on perceived barriers. For individuals attending School 1, time had no effect on perceived barriers for the control and intervention groups.

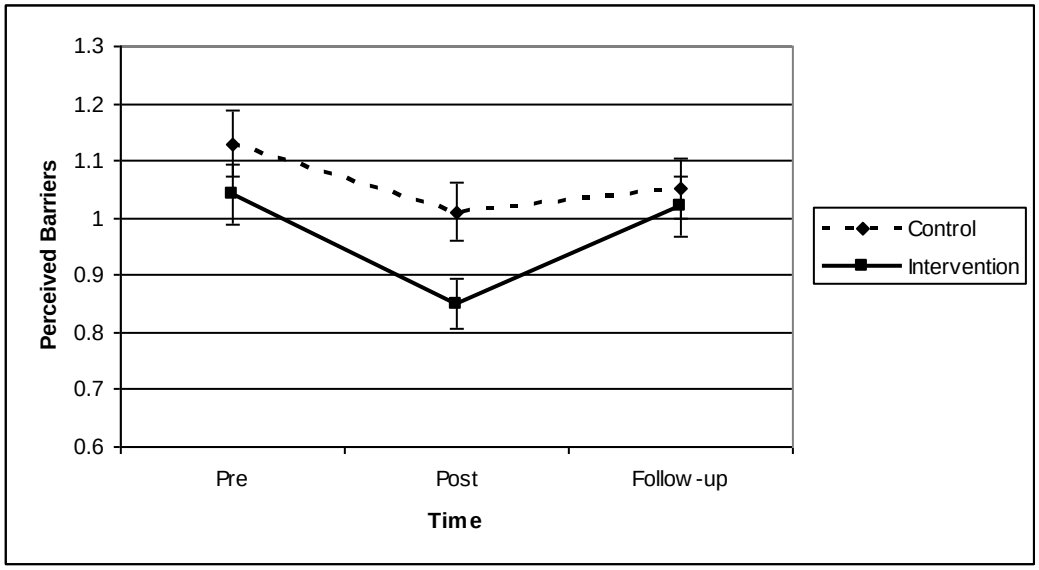

Figure 7. Perceived barriers to help-seeking: Time X Group interaction for School 2. Error bars represent 95% confidence intervals.

Table 9

Fixed Effects Estimates (Top) and Variance-Covariance Estimates (Bottom) for Model of the predictors of Help-seeking Outcomes

	Help-seeking Intentions	Perceived Benefits	Perceived Barriers
Fixed Effects			
Intercept	3.44(0.26)*	3.05(.15)*	1.04(.09)*
Level 1 (Measurement; ref group: pre)			
Time (post)	.94 (.24)*	.47(.14)*	-.19(.07)*
Time (follow-up)	.38 (.31)	.44(.19)*	-.02(.10)
Level 2 (Individual)			
Group (0: control, 1: intervention)	0.16(0.25)	.15(.18)	.09(.11)
Gender (0: female, 1: male)	-0.37(0.20)	-.14(.10)	-.01(.07)
School (1: School 1, 2: School 2)	-.19(.33)	-.21(.18)	.24(.11)*
Cross-level interactions (Time (ref group: pre) x Group)			
Time (post) x Group	-.85(.32)*	-.57(.19)*	.08(.10)
Time (follow-up) x Group	-.28(.38)	-.50(.23)*	-.07(.12)
Time(post) x Group x School	-.78(.45)	-.49(.18)*	.20(.09)*
Time(follow-up) x Group x School	-1.1(.44)*	-.61(.23)*	-.07(.12)
Random Effects			
Level 2 (Individual)			
Intercept	1.62(.20)*	.47(.06)*	.22(.03)*

Note. Standard errors are in parentheses.
*$p < .05$

Secondary Analyses

In order to try to understand the mechanisms of change in help-seeking intentions that occurred post-intervention, several models were tested. Specifically, further analyses were conducted in order to determine whether the perceived benefits of help-seeking and perceived barriers to help-seeking predicted changes in help-seeking intentions from pre-test (Time 1) to post-test (Time 2). Specifically, multiple regression analyses were conducted in order to determine whether:

1. Changes in help seeking intentions from Time 1 to Time 2 were predicted by perceived benefits and perceived barriers at Time 1
2. Changes in help seeking intentions from Time 1 to Time 2 were predicted by changes in perceived benefits from Time 1 to Time 2
3. Changes in help seeking intentions from Time 1 to Time 2 were predicted by changes in perceived barriers from Time 1 to Time 2

Analysis of residual scores is recommended as a more powerful analysis for randomised trials compared to analysis of gain scores (Fitzmaurice, Laird, & Ware, 2004). Therefore, changes in help seeking intentions were determined by standardised residual change scores.

Correlations between the standardised residual gains in help-seeking intentions from Time 1 to Time 2 and Perceived barriers and Perceived benefits at Time 1 are presented in Table 10. Regression coefficients are also presented. Positive correlations were found between residual gains in help-seeking intentions and perceived benefits at Time 1, indicating a positive relationship between perceived benefits of help-seeking and change in help-seeking intentions. The results of the regression indicate that the model was significant $F(2,168) = 4.32$, $p = .02$ and explained 5% of the variance in residual gains in intentions to seek help. Perceived benefits of help-seeking at Time 1 was a significant predictor of residual gains in help-seeking intentions. Specifically, higher perceived benefits at Time 1 were associated with higher residual gains in help-seeking intentions.

Table 10

Multiple Regression Analyses Predicting Residual Gains in Help-seeking Intentions from Time 1 to Time 2 from Perceived Barriers and Perceived Benefits at Time 1

	2	3	*B*	*t*	*p*
1. Help-seeking intentions residual gain	-.11	.22*			
2. Perceived barriers Time 1		.51*	.01	.10	.92
3. Perceived benefits Time 1			.23*	2.58	.01

*$p < .05$

Correlations between the standardised residual gains in help-seeking intentions from Time 1 to Time 2 and gains in Perceived benefits and Perceived barriers from Time 1 to Time 2 are presented in Table 11. Regression coefficients are also presented. Positive correlations were found between residual gains in help-seeking intentions and changes in perceived benefits and perceived barriers from Time 1 to Time 2. The results of the regression indicate that the model was significant $F(2,168) = 5.37$, $p = .01$ and explained 6% of the variance in residual gains in intentions to seek help. Change in perceived benefits of help-seeking from Time 1 to Time 2 was a significant predictor of residual gains in help-seeking intentions. Specifically, increases in perceived benefits at Time 1 were associated with higher residual gains in help-seeking intentions.

Table 11

Multiple Regression Analyses Predicting Residual Gains in Help-seeking Intentions from Time 1 to Time 2 from gains in Perceived Barriers and Perceived Benefits from Time 1 to Time 2

	2	3	*β*	*t*	*p*
1. Help-seeking intentions residual gain	0.14*	0.23*			
2. Perceived barriers gain		0.25*	0.09	1.22	0.23
3. Perceived benefits gain			0.20*	2.65	0.01

*$p < .05$

Discussion

Main Findings

Study 2 investigated the influence of PASS! on help-seeking outcome variables. The main aims of the study were to test the effect of the intervention on: (1) help-seeking intentions, (2) perceived benefits of help-seeking, and (3) perceived barriers to help-seeking.

Effect of the intervention on help-seeking intentions. As hypothesised, students that participated in the intervention had significantly higher help-seeking intentions post-intervention compared to baseline. Year 11 students that participated in the control presentations showed no significant changes in help-seeking intentions over time. Contrary to predictions, for the intervention group, help-seeking intentions at three months follow-up were not significantly different to baseline help-seeking intentions. These findings suggest that the intervention increased participants' help-seeking intentions in the immediate short-term; however this change was not sustained over time.

Whilst results indicate an overall improvement in help-seeking intentions for the treatment group from pre to post intervention, the mean help-seeking intentions score at post (M = 3.96, SD = 1.7) falls between *unlikely* (3) and *unsure* (4). Even after receiving the intervention, students indicated that they were still unlikely to seek professional help for emotional or mental health problems. This low help-seeking intentions score post intervention is consistent with findings from earlier help-seeking programs with high school students (i.e. BBGP; Deane, et al., 2007; Wilson et al., 2008).

Exploratory analyses were conducted in order to examine the proportion of students whose help-seeking intentions moved from unlikely to likely as a result of the intervention. The *likely* category included students who rated themselves as *unsure* and so this could best be viewed as a group who were in the contemplation stage with regard to help-seeking. Across the four help-seeking intentions items that addressed intentions to seek help from a health professional, 15% of

students receiving the intervention moved from the *unlikely* to *likely* category of help-seeking immediately after receiving the intervention. In comparison, only 4% of students in the control group moved from the *unlikely* to *likely* category of help-seeking. The *likely* category of help-seeking intentions comprised scores ranging from the *unsure* to e*xtremely likely* range on the help-seeking intentions measure, indicating that students moving from the *unlikely* to *likely* category are at a minimum, moving from a stage of pre-contemplation to contemplation. Based on the Stages of Change Model (Prochaska & DiClemente, 1986), this finding suggests that as a result of the intervention, 13-17% of students moved from having no intention to seek help when distressed, to a place of either considering seeking help, or intending to seek help when distressed. However, consistent with results from the HLM analyses, the increase in proportion of students in the intervention group moving from *unlikely* to *likely* was not sustained at 3 months follow-up.

Effect of the intervention on perceived benefits of help-seeking. Results revealed that the relationship between participation in the intervention and the perceived benefits of help-seeking was different for each school. The hypothesis was not supported in School 1, as there were no significant differences in perceived benefits over time for the intervention group. In School 2, as hypothesised, students that participated in the intervention had significantly higher perceived benefits post-intervention and at three months follow-up, compared to at baseline. School 2 students that participated in the control presentations showed no significant changes in perceived benefits over time. These findings suggest that in School 2, the designed intervention increased perceived benefits of help-seeking in the immediate short-term, and that this increase was maintained over time.

Effect of the intervention on perceived barriers to help-seeking. Results revealed that the relationship between participation in the intervention and the perceived barriers to help-seeking was also different for each school. The hypothesis was not supported in School 1, as there were no significant differences in perceived barriers over time for the intervention group. In School 2, as

hypothesised, students that participated in the intervention had significantly lower perceived barriers post-intervention compared to baseline. School 2 students that participated in the control presentations showed no significant changes in perceived barriers over time. In School 2, contrary to predictions, perceived barriers at 3 months follow up for the intervention group were not significantly lower than at baseline. Therefore, the improvements that were a result of the intervention were not maintained over time.

It is important to pay attention to the fact that improvements in perceived benefits of help-seeking and perceived barriers to help-seeking were only apparent in one of the two schools that received the intervention. The difference in findings between schools raises several potential implications around the generalisability of results, as well as any influences that the presenters may have on the effectiveness of the intervention. These will be addressed under the implications section below.

Overall effectiveness of the intervention

Findings from the current study are consistent with previous research suggesting that improvements in help-seeking variables can be made by implementing a school based intervention that is based on relevant theory and research (Wilson et al., 2008). The Intraclass coefficients (ICCs) reported earlier in the results section support the usefulness of HLM analysis to assess the relative contribution of measurement and individual-level factors to each outcome variable that was investigated. Wilson et al., (2008) also looked at brief school interventions to address help-seeking for adolescents and found effects for help-seeking intentions on the General Help-seeking Questionnaire (GHSQ) with a sample size of 291 which was similar to that used in the current study. This suggests that the sample size in the current study was likely to be sufficient to detect effects if they were present. In the current study, results show that the intervention led to some improvements in help-seeking intentions, perceived benefits of help-seeking and perceived barriers to help-seeking. An increase in actual help-seeking was also found for individuals in the

intervention group, with a significantly greater number of visits at 3-months follow-up compared to baseline.

Contrary to hypotheses, improvements in help-seeking intentions were not maintained over time. This suggests that although the designed intervention led to an immediate improvement in help-seeking intentions, the intervention did not facilitate successful long term improvement in help-seeking intentions. Whilst this finding is contrary to the hypothesis, it is consistent with findings from an earlier study in the same region using the Building Bridges to General Practice Program (Wilson et al., 2008). This finding may also be understood through consideration of the Stages of Change Model (Prochaska & DiClemente, 1986), which highlights the cyclical nature of behaviour change, involving both progress and periodic relapse. Whilst 15% of participants moved from what could be considered a stage of pre-contemplation to contemplation immediately after receiving the intervention, findings at 3-months follow-up suggest that they returned to more of a the pre-contemplative stage.

Improvements in perceived benefits and perceived barriers to help-seeking were only apparent in School 2. The intervention was designed to be conducted in a standardised manner across both schools. However, for practical reasons, there were some differences in implementation of the intervention across both schools. These differences are important to consider when attempting to understand the possible reason for differences in results between School 1 and School 2. Firstly, the facilitators of the intervention in both schools differed in several ways. In School 2, the intervention was facilitated by health professionals in regular contact with adolescents: a clinical psychologist, care coordinator and school counsellor. The involvement of health professionals that may potentially provide services to students may have led to more positive effects for several different reasons. For example, students may have felt more connected with facilitators who could potentially provide them with treatment in the future. Further, these facilitators may have been better equipped professionally to effectively challenge negative attitudes towards help-seeking.

Importantly, involvement of the school counsellor in School 2 may have communicated a greater level of school support for students in School 2 compared to School 1.

These potential reasons for differences in results between schools can be further supported through consideration of the network episode model (Pescosolido, 1992), which emphasises the importance of social networks in influencing health related behaviour. The model states that individuals do not always make health related decisions alone, and that their actions and decisions are influenced by their social network. The size and function of the individual's social network as well as his or her satisfaction with the support provided by the social network are all seen to influence the individual's health care utilisation (Pescosolido, 1992). Applied to the current study, the quality of the social environment, including the school environment is likely to influence the likelihood that students will engage in appropriate health related behaviour. Students are strongly influenced by their perceptions of how school staff members view them and interact with them (King, Wold, Tudor-Smith, & Harel, 1996), raising the possibility that the involvement of school staff in facilitation of the intervention may have facilitated a positive response from students in School 2.

Limitations

Whilst findings from the current study lend modest support for the utility of school based interventions in leading to some improvement in help-seeking amongst adolescents, a number of limitations should be considered. Firstly, it is important to consider that even after receiving the intervention students did not indicate that they were likely to seek professional help for emotional or mental health problems. This indicates that the intervention was not entirely successful at encouraging adolescents to seek professional help for emotional problems. This raises the question of whether the resources and time required to implement interventions such as this is a worthwhile investment for such a short term and seemingly temporary effect. This is particularly important to consider in the school setting, where the flexibility of teaching staff, availability of resources and

classroom space are essential. Future research must consider whether the level of time and effort invested in the design and implementation of an intervention will be justified by the effects of the intervention. Suggestions for possible strategies that may be implemented in a less intensive, but consistent manner are provided in the implications section below.

Secondly, since the current study was conducted using a relatively homogenous sample in terms of age, culture and locality, generalisations should be made with caution. There is a need to replicate the study amongst adolescents living in metropolitan areas, adolescents of different age groups and adolescents from different cultural or ethnic backgrounds.

Thirdly, it is important to take into account that all measures in the current study were self-report, and their validity may therefore be affected by responder bias. Whilst self-report measures provide a convenient means of obtaining data in the school setting, future research may benefit from obtaining quantitative data on actual help-seeking behaviour, e.g. by obtaining the rate of referrals to the school counsellor or local mental health service.

Importantly, findings revealed differences in outcome for both schools included in the current study, highlighting that findings may not be generalisable to different schools. The potential influence of aspects of a school's climate on the effectiveness of classroom interventions provides an important avenue for future research. Future research should aim to determine the specific aspects of school climate that influence the level of effectiveness of a classroom-based help-seeking intervention. The utility of future interventions can then be enhanced by tailoring interventions to meet the specific needs of different school climates.

In the current study, adolescents experiencing low levels of psychological distress were overrepresented, with mean scores across both schools largely falling between feeling distressed "none of the time" to feeling distressed "a little of the time" (M = 1.78 - 2.11). It is important to note that when responding to help-seeking intentions items, participants were required to hypothetically feel distressed, and then determine whether they would seek help when distressed. It

is possible that in the current study participants' levels of distress were so low that they were unable to "imagine" being in this state and so this may have made help seeking less conceivable. Since the current study was conducted using a non-clinical sample, it is important to note that results may not generalise to groups of adolescents that are experiencing clinical level symptoms of psychological distress. However, findings from Santor et al., (2007) revealed that a help-seeking intervention was generally more effective among students with difficulties than among those without difficulties. This would suggest the PASS! intervention may be helpful in distressed samples, but there is a need to replicate the current study amongst adolescents experiencing higher levels of symptoms of psychological distress, in order to test this hypothesis. It may be beneficial to first administer a mental health screening measure to all students and then provide the intervention for those adolescents who may be at risk for mental health problems. An example of this process is provided by the Teen Screen National Center for Mental Health Checkups at Columbia University (http://www.teenscreen.org/). Such programs may provide useful guidance for future help-seeking promotion in Australia.

Although the intervention was generally implemented as planned; a number of practical issues regarding implementation need to be considered as potential limitations. The current intervention was designed so that school staff and external health practitioners could deliver the program to students as a team. Due to various school management and curriculum commitments, the desired level of involvement from school staff was not possible in all schools involved. This may have a significant impact on the effectiveness of the intervention, especially in light of the school climate issues raised above and research suggesting that school students who perceive their teachers as supportive are more likely to engage in health promoting behaviours (McLellan, Rissel, Donnelly, & Bauman, 1999). Difficulties engaging school staff may have been related to workload pressures or other factors. Whether reasons were due to workload, confidence with the material or other factors, the unavailability of teaching or other support staff at such meetings or presentations

may send a subtle message to students that support resources are not available. If it is the case that staff are so pressured for time and could not contribute, then this too may reflect an environment that is under pressure and does not prioritise student welfare over other core curriculum issues. The role of the level of engagement by school staff may be reflected in findings from the current study, where the intervention had significant effects on all help-seeking variables in School 2 where the school counsellor was involved, but not in School 1 where the school counsellor was not involved. Future researchers may need to consider administering measures of school climate in order control for possible effects of these variables. It may also be beneficial to consider more practical and effective methods of involving school staff in the implementation of help-seeking interventions.

Another potential limitation regarding implementation of the intervention relates to the level of student engagement in the actual presentation. Whilst the intervention instructions provided ideas and direction for keeping students engaged and interested, retrospective reports from school staff indicated that students found it difficult to attend for the entire length of the presentation. Informal feedback from welfare teachers from both schools indicated that greater encouragement of student interaction was required throughout the presentation. Teachers suggested that a shorter presentation, combined with group activities may encourage better engagement from students.

Implications

Despite these limitations, the current study has several implications that provide useful guidance and direction for future research into adolescent help-seeking. A summary of recommended improvements to future interventions and research design is presented in Figure 8.

It is evident that further research and evaluation is needed to determine more fully the mechanisms that can explain the improvements in help-seeking intentions that were found post-intervention. Nevertheless, results from secondary analyses provide useful insight into the factors that may have influenced the effectiveness of PASS! on help-seeking intentions. Specifically, the perceived benefits of help-seeking at baseline predicted changes in help-seeking intentions that

occurred as a result of the intervention. This finding suggests that an individual's perception of the benefits of help-seeking may influence their level of openness to receiving further information on help-seeking. For example, in the current study, students that perceived help-seeking as beneficial prior to receiving the intervention may have been more open to receiving information on help-seeking. On the other hand, a student who did not perceived help-seeking as beneficial prior to receiving the intervention may have already decided that participating in the intervention was not going to be worthwhile. Also, results indicated that changes in perceived benefits of help-seeking predicted changes in help-seeking that occurred as a result of the intervention, suggesting that improving adolescents' perceptions about the benefits of seeking help is useful. Examination of results from the secondary analyses shows that although perceived benefits of help-seeking do significantly predict changes in help-seeking intentions, the models tested only account for 5-6% of the changes that occurred. Still, consistent with the findings from Study 1, the influence of the perceived benefits of help-seeking on adolescents' help-seeking intentions is apparent. Future research should continue to investigate the influence of this variable on help-seeking intentions, as well as aim to determine more effective methods of raising adolescents' beliefs about the usefulness of help-seeking.

An important finding is the difference in the effect of the intervention for each school involved. Schools form a central role in adolescents' social lives, making the support of school staff an important influencing factor when encouraging students to seek help. An intervention with a broader focus on school climate and school staff engagement may be more effective. Findings from a primary prevention program known as the Gatehouse Project revealed that a focus on individual skills and positive changes to the social environment of the school had a substantial impact on high school students' important health risk behaviours (Bond, et al., 2004). A similar style program that specifically targets adolescents' help-seeking from a health professional may therefore prove beneficial. Future research needs to consider the level of support provided by

school staff to students in regards to health behaviour. Accordingly, greater levels of school support and engagement around implementation of the intervention should be encouraged. It is important to consider however, that such avenues can be complex, given the need for long term commitment and support from schools (Bond, et al., 2004). Still, based on current findings, at minimum, school staff should be directly involved in promotion and facilitation of the intervention.

Findings from the current study show an increase in actual help-seeking for individuals that received the intervention. Whilst this increase is relatively small, it is important to note that the measure was administered over a relatively short period of time, during which many individuals may not have required professional help. Findings warrant further investigation into the effects of the intervention on actual help-seeking behaviour. Future research should aim to administer measures of actual help-seeking over longer periods of time.

Evaluation of the intervention also highlights the lack of strength and sustainability of improvements made as a result of the intervention. These findings indicate a need to re-consider the design, structure and timing of future interventions aiming to improve adolescent help-seeking. Several suggestions for future efforts aimed at facilitating help-seeking amongst adolescents can be made. Firstly, there is a need to consider how improvements in help-seeking can be sustained over time. This is important because, in the current study, even with immediate improvement, students demonstrated a return to baseline levels of help-seeking intentions after a 3-month period. There may be need for a maintenance phase of the intervention in order to sustain the improvements in help-seeking. The maintenance phase may involve the administration of periodic, short 'booster' sessions or activities that reemphasise themes and skills learned in the initial presentation. An example of activities that may form part of the booster sessions include question and answer sessions, group discussions, slideshow presentations, DVD clips, role plays, problem solving scenarios and quizzes or games. Alternatively, considering time and resource limitations of the school setting that may pose problems to conducting several presentations, it is possible that initial

improvements might be able to be sustained utilising less demanding methods that reemphasise the core components of the initial presentation. An example involves sending a weekly series of periodic reminder notes or posters to students that emphasise a single core component of the intervention each week. In a similar fashion, a weekly series of brief five-minute DVD clips each highlighting a core component of the intervention may be presented to students on a weekly basis, for example during Personal Development, Health and Physical Exercise (P.D.H.P.E) lessons. This could involve linking weekly core concepts to an ongoing story over several weeks that portrays an adolescent with an emerging mental health problem, or linking core concepts to different case scenarios each week.

Secondly, there is a need to consider how to strengthen the initial improvements in help-seeking made as a result of the intervention. Consideration of help-seeking intentions highlights that whilst students' help-seeking intentions had increased post-intervention, they remained in the unlikely range of help-seeking. Findings suggest that a one-time intensive presentation during high school may not be sufficient to encourage students to seek help. This is understandable considering that adolescents' attitudes towards help-seeking have developed over an entire lifetime. Effective methods of changing these attitudes may therefore need to be more long term. This may involve beginning implementation of a long-term intervention during Year 7 and periodically administering the intervention throughout high school. Such an intervention may be best presented as a part of the school health curriculum with a specific set of age appropriate objectives for each school year. A long term intervention may be more effective at targeting long standing attitudes and age specific cognitive barriers to help-seeking.

Also, in order to improve the strength and sustainability of the intervention, future research may need to consider and target the multiple contexts in which an adolescent interacts. Models of help-seeking behaviour, along with previous research indicate that there are many potential social influences on the help-seeking process. This suggests that interventions should be targeted at the

people who influence adolescents' help-seeking, specifically parents, as well as the adolescents themselves. Therefore, a combination of individual-focused and environment-focused approaches may result in more robust improvements in adolescent help-seeking. An example of such a combination may be classroom-based presentations addressing help-seeking for self and peers, combined with training for school staff and educational groups and informational flyers for parents that might also prompt discussion of help-seeking at home.

Intervention	Research Design
• Teachers and welfare support staff must co-present • Increase student participation in sessions • Assess and address school climate, e.g. presentation for school staff beforehand highlighting importance of their involvement when promoting student help-seeking • Increase practice opportunities for students, e.g. role-playing exercises	• Measurement of help-seeking intentions and actual behaviour, e.g. number of school counsellor visits and/or referrals to external agencies • Increase follow-up periods across years • Larger number of schools participating • Screening for clinical/higher levels of psychological distress

Figure 8. Summary of recommended improvements to future interventions and research design.

Conclusion

Help-seeking is defined as a request for assistance with problems that the individual does not have the personal resources to solve on their own (G. Barker, et al., 2005). Research consistently shows that adolescents are more likely to seek help from informal sources such as friends and family, rather than formal sources, such as general practitioners and psychologists. In contrast to informal help-seeking, formal help-seeking is widely recognised as a protective factor, and is vital for early treatment and prevention of mental health problems during adolescence (Wilson et al., 2010). Seeking and receiving help from mental health professionals can assist in the reduction of distressing psychological symptoms (Bergin & Garfield, 1994; Rudd, et al., 1996), as

well as successfully reduce the long term impact of many mental health problems (Rickwood et al., 2007).

While it is well established that help-seeking is a protective factor for many significant health and developmental outcomes (Barker et al., 2005; Kalafat, 1997; Rickwood et al., 2005), adolescents' use of professional health services compared to the rest of the population is disturbingly low. The disparity between the number of adolescents requiring services and the number of adolescents accessing services has therefore been a focus of recent research and is commonly referred to as the "service gap" phenomenon (Kushner & Sher, 1989; Raviv, et al., 2009; Stefl & Prosperi, 1985).

In line with models of health behaviour (e.g. Ajzen, 1985; Rosenstock, 1966), research has identified a number of factors that influence adolescents' help-seeking for psychological problems. Gender has empirically been one of the most consistent predictors of help-seeking. Research has also identified a number of perceived barriers to help-seeking, with some barriers being consistently identified amongst adolescent populations. These barriers include symptoms of psychological distress, confidentiality concerns, fear of being stigmatised, stoicism and the desire to appear independent. A review of the help-seeking literature also reveals that the perceived benefits of seeking help influence adolescents' help-seeking from a health professional.

Although a vast amount of research into factors influencing adolescent help-seeking behaviour exists, there is a need for further research aimed at increasing adolescents' help-seeking for mental health problems. Existing research indicates that improvements in help-seeking can be made by designing an intervention based on relevant theory and research (Wilson et al., 2008). Community and school based programs that aim to raise mental health awareness and promote available services can facilitate appropriate help-seeking in rural adolescents who are experiencing mental health problems (Aisbett, et al., 2007). Findings from the school-based interventions such as, Building Bridges to General Practice (BBGP) provide support for the utilisation of classroom

interventions as a way to influence variables associated with adolescents' help-seeking from professionals (Wilson et al., 2008).

The overall aims of the current research were to increase the likelihood that adolescents will implement appropriate help-seeking from professional sources. Specifically, the aims of the current research were to investigate factors that influence adolescent help-seeking from formal sources, to develop an intervention aimed at improving adolescents' help-seeking for mental health problems, to implement the intervention across schools in the Illawarra region of New South Wales, and to test the effectiveness of the intervention.

A central finding of Study one was that the perceived benefits of help-seeking were significantly associated with adolescents' help-seeking intentions. The majority of adolescents indicated that they do not believe that professional help-seeking is beneficial. The lack of perceived benefit was found to be related to lower intentions to seek professional help when experiencing emotional problems. Study one also found that although male adolescents were less likely to seek help than females, their lower help-seeking intentions did not appear to be due to higher levels of stoicism. In keeping with previous findings indicating that female adolescents are more likely than males to report feelings of distress (Schonert-Reichl & Muller, 1996; Tishby, et al., 2001), in Study one, female participants reported experiencing greater symptoms of psychological distress than males.

Findings from Study one regarding the relationship between the perceived benefits of help-seeking and help-seeking intentions clarified some of the possible reasons underlying the service gap phenomenon. The implications from Study one were that by improving adolescents' beliefs about the benefits of professional help-seeking it may possible to increase their use of professional health services to address mental health problems.

Based on theories of health behaviour, recommendations from previous research (e.g. Rickwood et al., 2004 ; Wilson et al., 2008) and findings from Study one, Study two involved

implementing an intervention that addressed adolescent barriers to seeking help, promoted hope about the benefits of seeking help and provided education about the process of seeking help. The intervention attempted to provide a unified and multidisciplinary approach to health care, by involving and promoting multiple health care professionals as sources of help.

Findings from Study two revealed improvements in help-seeking intentions, perceived benefits of help-seeking and perceived barriers to help-seeking as a result of the intervention. However, these effects were short-lived and in some cases restricted to only one of the two schools. Further, whilst students' help-seeking intentions had increased post-intervention, they remained in the unlikely range of help-seeking. Despite this, they lend some support for the utility of school-based interventions in improving adolescent help-seeking.

Importantly, the design of study two extended upon existing intervention based research into adolescent help-seeking by addressing a number of important design limitations. Specifically, study two was designed as a controlled trial with random allocation and an attention control condition. In addition, baseline, post-test and follow-up measures were administered. This design structure provided an opportunity to thoroughly explore the effectiveness of the intervention, in terms of strength and sustainability of any improvements in help-seeking variables.

Findings from the current research provide guidance for the future design and implementation of school-based help-seeking interventions. Specifically, a one-time intensive presentation during high school may not be sufficient to encourage students to seek help and there may be need for a maintenance phase as part of the intervention in order to sustain the improvements in help-seeking. Also, differences between schools in the effectiveness of the intervention highlight the need for future interventions to consider the potential role of an adolescent's social network in influencing their likelihood to seek help for mental health problems. Future research may benefit from considering and targeting the multiple contexts in which an adolescent interacts. An example of such a combination may be classroom-based presentations

addressing help-seeking for self and peers, combined with training for school staff and educational groups and informational flyers for parents.

References

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58*(1), 5-14.

Aisbett, D. L., Boyd, C. P., Francis, K. J., & Newnham, K. (2007). Understanding barriers to mental health service utilization in rural Australia. *Rural and Remote Health, 7*, 624. Retrieved from http://www.rrh.org.au

Ajzen, I. (1985). From intentions to actions: A theory of planned behaviour. In J. Kuhl & J. Beckman (Eds.), *Action-control: From cognition to behaviour* (pp. 11-39). Heidelberg, Germany: Springer.

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes, 50*, 179–211.

Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior*. Englewood Cliffs, NJ: Prentice-Hall.

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*(1), 1-10.

Andrews, G., Issakidis, C., & Carter, G. (2001). Shortfall in mental health service utilisation. *British Journal of Psychiatry, 179*(5), 417-425.

Armitage, C. J., & Conner, M. (2001). Efficacy of the theory of planned behaviour: A meta-analytic review. *British Journal of Social Psychology, 40*(4), 471-499.

Aseltine, R. H., Jr., & DeMartino, R. (2004). An Outcome Evaluation of the SOS Suicide Prevention Program. *American Journal of Public Health, 94*(3), 446-451.

Atkins, D. C. (2005). Using multilevel modeling to analyze couple and family treatment data: Basic and advanced issues. *Journal of Family Psychology, 19*, 98-110.

Ballon, B., Kirst, M., & Smith, P. (2004). Youth help-seeking expectancies and their relation to help-seeking behaviours for substance use problems. *Addiction Research & Theory, 12*(3), 241-260.

Barker, G., Olukoya, A., & Aggleton, P. (2005). Young people, social support and helpseeking. *International Journal of Adolescent Medicine and Health, 17*, 315-335.

Barker, L. A., & Adelman, H. S. (1994). Mental health and help-seeking among ethnic minority adolescents. *Journal of Adolescence, 17*(3), 251-263.

Barney, L. J., Griffiths, K. M., Jorm, A. F., & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *Australian and New Zealand Journal of Psychiatry, 40*(1), 51-54.

Bayer, J. K., & Peay, M. Y. (1997). Predicting intentions to seek help from professional mental health services. *Australian and New Zealand Journal of Psychiatry, 31*(4), 504-513.

Bergin, A. E., & Garfield, S. L. (1994). Handbook of psychotherapy and behavior change (4th ed.) *(1994) Handbook of psychotherapy and behavior change (4th ed) xvi, 864 pp Oxford, England: John Wiley & Sons; England*.

Blazina, C., & Watkins, C. (1996). Masculine gender role conflict: Effects on college men's psychological well-being, chemical substance usage, and attitudes towards help-seeking. *Journal of Counseling Psychology, 43*, 461-465.

Boldero, J., & Fallon, B. (1995). Adolescent help-seeking: What do they get help for and from whom? *Journal of Adolescence, 18*, 193-209.

Bond, L., Patton, G., Glover, S., Carlin, J. B., Butler, H., Thomas, L., et al. (2004). The Gatehouse Project: Can a multilevel school intervention affect emotional wellbeing and health risk behaviours? *Journal of Epidemiology and Community Health, 58*(12), 997-1003.

Booth, M. L., Bernard, D., Quine, S., Kang, M. S., Usherwood, T., Alperstein, G., et al. (2004). Access to Health Care Among Australian Adolescents Young People's Perspectives and Their Sociodemographic Distribution. *Journal of Adolescent Health, 34*(1), 97-103.

Boyd, C., Francis, K., Aisbett, D., Newnham, K., Sewell, J., Dawes, G., et al. (2007). Australian rural adolescents' experiences of accessing psychological help for a mental health problem. *The Australian Journal of Rural Health, 15*(3), 196-200.

Bruch, M. A. (2002). Shyness and toughness: Unique and moderated relations with men's emotional inexpression. *Journal of Counseling Psychology, 49*(1), 28-34.

Caldwell, T. M., Jorm, A. F., & Dear, K. B. (2004). Suicide and mental health in rural, remote and metropolitan areas in Australia. *Medical Journal of Australia, 181* S10-S14.

Carlton, P. A., & Deane, F. P. (2000). Impact of attitudes and suicidal ideation on adolescents' intentions to seek professional psychological help. *Journal of Adolescence, 23*(1), 35-45.

Cepeda-Benito, A., & Short, P. (1998). Self-concealment, avoidance of psychological services, and perceived likelihood of seeking professional help. *Journal of Counseling Psychology, 45*(1), 58-64.

Ciarrochi, J., Deane, F. P., Wilson, C. J., & Rickwood, D. (2002). Adolescents who need help the most are the least likely to seek it: The relationship between low emotional competence and low intention to seek help. *British Journal of Guidance & Counselling, 30*(2), 173-188.

Ciarrochi, J., Wilson, C. J., Deane, F. P., & Rickwood, D. (2003). Do difficulties with emotions inhibit help-seeking in adolescence? The role of age and emotional competence in predicting help-seeking intentions. *Counselling Psychology Quarterly, 16*(2), 103-120.

Cigularov, K., Chen, P. Y., Thurber, B. W., & Stallones, L. (2008). What prevents adolescents from seeking help after a suicide education program? *Suicide and Life Threatening Behavior, 38*(1), 74-86.

Corney, R. H. (1990). Sex differences in general practice attendance and help seeking for minor illness. *Journal of Psychosomatic Research, 34*(5), 525-534.

Corrigan, P. (2004). How Stigma Interferes With Mental Health Care. *American Psychologist, 59*(7), 614-625.

Davies, M., Stankov, L., & Roberts, R. D. (1998). Emotional intelligence: In search of an elusive construct. *Journal of Personality and Social Psychology, 75*(4), 989-1015.

de Anstiss, H., & Ziaian, T. (2010). Mental health help-seeking and refugee adolescents: Qualitative findings from a mixed-methods investigation. *Australian Psychologist, 45*(1), 29-37.

Deane, F. P., Skogstad, P., & Williams, M. W. (1999). Impact of attitudes, ethnicity and quality of prior therapy on New Zealand male prisoners' intentions to seek professional psychological help. *International Journal for the Advancement of Counselling, 21*(1), 55-67.

Deane, F. P., & Todd, D. M. (1996). Attitudes and intentions to seek professional psychological help for personal problems or suicidal thinking. *Journal of College Student Psychotherapy, 10*(4), 45-59.

Deane, F. P., Wilson, C. J., & Russell, N. (2007). Brief report: Impact of classroom presentations about health and help-seeking on rural Australian adolescents' intentions to consult health care professionals. *Journal of Adolescence, 30*(4), 695-699.

Derogatis, L. (1994). *SCL-90-R symptom checklist-90-R: Administration, scoring and procedures manual* (3rd ed.). Minneapolis: National Computer Systems.

Elliot-Schmidt, R., & Strong, J. (1997). The concept of well-being in a rural setting: Understanding health and illness. *Australian Journal of Rural Health, 5*, 59–63.

Erikson, E. H. (1968). *Identity: youth and crisis*: (1968) Identity: youth and crisis Oxford, England: Norton & Co ; England.

Evans, D. L., Foa, E. B., Gur, R. E., Hendin, H., O'Brien, C. P., Seligman, M. E. P., et al. (2005). Treating and preventing adolescent mental health disorders: What we know and what we don't know: A research agenda for improving the mental health of our youth *Treating and preventing adolescent mental health disorders: What we know and what we don't know: A research agenda for improving the mental health of our youth* (pp. xl, 818). New York, NY: Oxford University Press; US.

Farberman, R. K. (1997). Public attitudes about psychologists and mental health care: Research to guide the American Psychological Association public education campaign. *Professional Psychology: Research and Practice, 28*(2), 128-136.

Fischer, A. R., & Good, G. E. (1997). Men and psychotherapy: An investigation of alexithymia, intimacy, and masculine gender roles. *Psychotherapy: Theory, Research, Practice, Training, 34*(2), 160-170.

Fitzmaurice, G. M., Laird, N. M., & Ware, J. H. (2004). *Applied Longitudinal Analysis*. Hoboken, New Jersey: Wiley.

Fombonne, E. (1998). Increased rates of psychosocial disorders in youth. *European Archives of Psychiatry and Clinical Neuroscience, 248*(1), 14-21.

Fox, J. C., Blank, M., Berman, J., & Rovnyak, V. G. (1999). Mental disorders and help seeking in a rural impoverished population. *International Journal of Psychiatry in Medicine, 29*(2), 181-195.

Francis, K., Boyd, C., Aisbett, D., Newnham, K., & Newnham, K. (2006). Rural Adolescents' Attitudes to Seeking Help for Mental Health Problems. *Youth Studies Australia, 25*, 42-49.

Freedenthal, S., & Stiffman, A. R. (2007). "They Might Think I Was Crazy": Young American Indians' Reasons for Not Seeking Help When Suicidal. *Journal of Adolescent Research, 22*(1), 58-77.

Frydenberg, H. L., & Lewis, R. (1993). Boys play sport and girls turn to others: age, gender, and ethnicity as determinants of coping. *Journal of Adolescence, 16*, 253-266.

Fuller, J., Edwards, J., Procter, N., & Moss, J. (2000). How definition of mental health problems can influence help seeking in rural and remote communities. *Australian Journal of Rural Health* (8), 148–153.

Garland, A. F., & Zigler, E. F. (1994). Psychological correlates of help-seeking attitudes among children and adolescents. *American Journal of Orthopsychiatry, 64*(4), 586-593.

Godin, G. K., G. (1996). The Theory of Planned Behaviour: A review of its applications to health-related behaviours. *American Journal of Health Promotion, 11*, 87-98.

Golberstein, E., Eisenberg, D., & Gollust, S. E. (2009). Perceived stigma and help-seeking behavior: Longitudinal evidence from the Healthy Minds Study. *Psychiatric Services, 60*(9), 1254-1256.

Gonzalez, J. M., Alegria, M., & Prihoda, T. J. (2005). How Do Attitudes toward Mental Health Treatment Vary by Age, Gender, and Ethnicity/Race in Young Adults? *Journal of Community Psychology, 33*(5), 611-629.

Good, G. E., Dell, D. M., & Mintz, L. B. (1989). Male role and gender role conflict: Relations to help seeking in men. *Journal of Counseling Psychology, 36*(3), 295-300.

Gould, M. S., Marrocco, F. A., Hoagwood, K., Kleinman, M., Amakawa, L., & Altschuler, E. (2009). Service use by at-risk youths after school-based suicide screening. *Journal of the American Academy of Child & Adolescent Psychiatry, 48*(12), 1193-1201.

Gould, M. S., Velting, D., Kleinman, M., Lucas, C., Thomas, J. G., & Chung, M. (2004). Teenagers' attitudes about coping strategies and help-seeking behavior for suicidality. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*(9), 1124-1133.

Green, D. E., Walkey, F. H., McCormick, I. A., & Taylor, A. J. (1988). Development and evaluation of a 21-item version of the Hopkins Symptom Checklist with New Zealand and United States respondents. *Australian Journal of Psychology, 40*, 61-70.

Grinstein-Weiss, M., Fishman, G., & Eisikovits, Z. (2005). Gender and ethnic differences in formal and informal help seeking among Israeli adolescents. *Journal of Adolescence, 28*(6), 765-779.

Gunnell, D., & Martin, R. (2004). Patterns of general practitioner consultation for mental illness by young people in rural areas. A cross-sectional study. *Health Statistics Quarterly, 21*, 30 –33.

Guterman, N. B., Haj-Yahia, M. M., Vorhies, V., Ismayilova, L., & Leshem, B. (2010). Help-seeking and internal obstacles to receiving support in the wake of community violence exposure: The case of Arab and Jewish adolescents in Israel. *Journal of Child and Family Studies, 19*(6), 687-696.

Hauenstein, E. J., Petterson, S., Merwin, E., Rovnyak, V., Heise, B., & Wagner, D. (2006). Rurality, Gender, and Mental Health Treatment. *Family & Community Health: The Journal of Health Promotion & Maintenance, 29*(3), 169-185.

Heck, R. H., Thomas, S. L., & Tabata, L. N. (2010). *Multilevel and Longitudinal Modeling with IBM SPSS*. New York, London: Routledge Academic.

Henshaw, E. J., & Freedman-Doan, C. R. (2009). Conceptualizing mental health care utilization using the health belief model. *Clinical Psychology: Science and Practice, 16*(4), 420-439.

Hernan, A., Philpot, B., Edmonds, A., & Reddy, P. (2010). Healthy minds for country youth: Help-seeking for depression among rural adolescents. *The Australian Journal of Rural Health, 18*(3), 118-124.

Hillsdon, M., Cavill, N., Nanchahal, K., Diamond, A., & White, I. R. (2001). National level promotion of physical activity: Results from England's *ACTIVE* for LIFE campaign. *Journal of Epidemiology and Community Health, 55*, 755-761.

Hoyt, D. R., Conger, R. D., Valde, J., & Weihs, K. (1997). Psychological Distress and Help Seeking in Rural America. *American Journal of Community Psychology, 25*, 449-470.

Issakidis, C., & Andrews, G. (2002). Service utilisation for anxiety in an Australian community sample. *Social Psychiatry and Psychiatric Epidemiology, 37*(4), 153-163.

Jackson, H., Judd, F., Komiti, A., Fraser, C., Murray, G., Robins, G., et al. (2007). Mental health problems in rural contexts: What are the barriers to seeking help from professional providers? *Australian Psychologist, 42*(2), 147-160.

Jorm, A. F., Christensen, H., & Griffiths, K. M. (2005). The impact of beyondblue: The national depression initiative on the Australian public's recognition of depression and beliefs about treatments. *Australian and New Zealand Journal of Psychiatry, 39*(4), 248-254.

Jorm, A. F., & Wright, A. (2007). Beliefs of young people and their parents about the effectiveness of interventions for mental disorders. *Australian and New Zealand Journal of Psychiatry, 41*(8), 656-666.

Judd, F., Komiti, A., & Jackson, H. (2008). How does being female assist help-seeking for mental health problems? *Australian and New Zealand Journal of Psychiatry, 42*(1), 24-29.

Kalafat, J. (1997). Prevention of youth suicide. In R. P. W. T. P. Gullotta (Ed.), *Healthy children 2010: Enhancing children's wellness* (Vol. 8, pp. 175–213). Thousand Oaks, CA: Sage.

Kalafat, J., & Elias, M. (1994). An evaluation of a school-based suicide awareness intervention. *Suicide and Life Threatening Behavior, 24*(3), 224-233.

Kelly, A. E., & Achter, J. A. (1995). Self-concealment and attitudes toward counseling in university students. *Journal of Counseling Psychology, 42*(1), 40-46.

Kessler, R., Andrews, G., Colpe, L., Hiripi, E., Mroczek, D., Normand, S., et al. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences, 32*(6), 959-976.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). "Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication": Erratum. *Archives of General Psychiatry, 62*(7), 768.

Kessler, R. C., Foster, C. L., Saunders, W. B., & Stand, P. E. (1995). Social consequences of psychiatric disorders: I. Educational attainment. *American Journal of Psychiatry, 152*, 1026-1032.

King, A., Wold, B., Tudor-Smith, C., & Harel, Y. (1996). *The Health of Youth - a Cross-National Study: A Report of the 1993 - 4 HBSC Survey*. Canada: WHO Regional Publications

Klimes-Dougan, B., Yuan, C., Lee, S., & Houri, A. K. (2009). Suicide prevention with adolescents: Considering potential benefits and untoward effects of public service announcements. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 30*(3), 128-135.

Komiti, A., Judd, F., & Jackson, H. (2006). The influence of stigma and attitudes on seeking help from a GP for mental health problems: A rural context. *Social Psychiatry and Psychiatric Epidemiology, 41*(9), 738-745.

Kuhl, J., Jarkon-Horlick, L., & Morrissey, R. F. (1997). Measuring barriers to help-seeking behavior in adolescents. *Journal of Youth and Adolescence, 26*(6), 637-650.

Kushner, M. G., & Sher, K. J. (1989). Fear of psychological treatment and its relation to mental health service avoidance. *Professional Psychology: Research and Practice, 20*(4), 251-257.

Mackenzie, C., Gekoski, W., & Knox, V. (2006). Age, gender, and the underutilization of mental health services: The influence of help-seeking attitudes. *Aging & Mental Health, 10*(6), 574-582.

Marcus, R. F. (1996). The friendships of delinquents. *Adolescence, 31*(121), 145-158.

McKelley, R. A., & Rochlen, A. B. (2010). Conformity to masculine norms and preferences for therapy or executive coaching. *Psychology of Men & Masculinity, 11*(1), 1-14.

McLellan, L., Rissel, C., Donnelly, N., & Bauman, A. (1999). Health behaviour and the school environment in New South Wales, Australia. *Social Science & Medicine, 49*(5), 611-619.

Meltzer, H., Bebbington, P., Brugha, T., Farrell, M., Jenkins, R., & Lewis, G. (2000). The reluctance to seek treatment for neurotic disorders. *Journal of Mental Health, 9*(3), 319-327.

Mojtabai, R. (2010). Mental illness stigma and willingness to seek mental health care in the European Union. *Social Psychiatry and Psychiatric Epidemiology, 45*(7), 705-712.

Moskos, M. A., Olson, L., Halbern, S. R., & Gray, D. (2007). Utah youth suicide study: Barriers to mental health treatment for adolescents. *Suicide and Life Threatening Behavior, 37*(2), 179-186.

Nada-Raja, S., Morrison, D., & Skegg, K. (2003). A population-based study of help-seeking for self-harm in young adults. *Australian and New Zealand Journal of Psychiatry, 37*(5), 600-605.

Nadler, A. (1990). Help-seeking behavior as a coping resource *Learned resourcefulness: On coping skills, self-control, and adaptive behavior* (pp. 127-162). New York, NY: Springer Publishing Co; US.

Newman, D. L., Moffitt, T. E., Caspi, A., Magdol, L., Silva, P. A., & Stanton, W. R. (1996). Psychiatric disorder in a birth cohort of young adults: Prevalence, comorbidity, clinical significance, and new case incidence from ages 11-21. *Journal of Consulting and Clinical Psychology, 64*(3), 552-562.

Nicholas, J., Oliver, K., Lee, K., & O'Brien, M. (2004). Help-seeking behaviour and the Internet: An investigation among Australian adolescents. *Australian eJournal for the Advancement of Mental Health, 3*(1), No Pagination Specified.

O'Neil, J. M., Gable, H., & Wrightsman, D. (1986). Gender-Role Conflict Scale: college men's fear of femininity. *Sex Roles, 14*(335-350).

Offer, D., Howard, K. I., Schonert, K. A., & Ostrov, E. (1991). To whom do adolescents turn for help? Differences between disturbed and nondisturbed adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 30*(4), 623-630.

Orvaschel, H., Lewinsohn, P. M., & Seeley, J. R. (1995). Continuity of psychopathology in a community sample of adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 34*, 1525–1536.

Parslow, R. A., & Jorm, A. F. (2000). Who uses mental health services in Australia? An analysis of data from the National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry, 34*(6), 997-1008.

Pescosolido, B. A. (1992). Beyond rational choice: The social dynamics of how people seek help. *American Journal of Sociology, 97*(4), 1096-1138.

Phillips, J. A. (2005). *Defining stoicism: development of the Wollongong university stoicism scale (WUSS) and its relationship with restrictive emotionality, alexithymia and psychological distress.* University of Wollongong.

Pinheiro, J. C., & Bates, D. M. (2000). *Mixed-Effects Models in S and S-PLUS*. New York: Springer.

Prochaska, J. O., & DiClemente, C. C. (1986). Towards a comprehensive model of change. In R. Miller & N. Heather (Eds.), *Treating Addictive Behaviors*. New York: Plenum Press.

Quine, S., Bernard, D., Booth, M., Kang, M., Usherwood, T., Alperstein, G., et al. (2003). Health and Access issues among Australian adolescents: A rural-urban comparison. *Rural and Remote Health, 3*, 245.

Raphael, B. (1986). *When Disaster Strikes: How Individuals and Communities Cope with Catastrophe*. New York: Basic Books.

Raudenbush, S. W., & Bryk, A. S. (2002). *Hierarchical linear models: Applications and data analysis methods* (Second ed.). Thousand Oaks: Sage Publications.

Raviv, A., Raviv, A., Vago-Gefen, I., & Fink, A. S. (2009). The personal service gap: Factors affecting adolescents' willingness to seek help. *Journal of Adolescence, 32*(3), 483-499.

Raviv, A., Sills, R., Raviv, A., & Wilansky, P. (2000). Adolescents' help-seeking behaviour: The difference between self- and other-referral. *Journal of Adolescence, 23*(6), 721-740.

Rhodes, A. E., Goering, P. N., To, T., & Williams, J. (2002). Gender and outpatient mental health service use. *Social Science & Medicine, 54*(1), 1-10.

Rickwood, D. (1995). The effectiveness of seeking help for coping with personal problems in late adolescence. *Journal of Youth and Adolescence, 24*(6), 685-703.

Rickwood, D., & Braithwaite, V. (1994). Social-psychological factors affecting help-seeking for emotional problems. *Social Science & Medicine, 39*(4), 563-572.

Rickwood, D., Cavanagh, S., Curtis, L., & Sakrouge, R. (2004). Educating Young People about Mental Health and Mental Illness: Evaluating a School-Based Programme *The International Journal of Mental Health Promotion, 6*, 23-32.

Rickwood, D. J., Deane, F. P., & Wilson, C. J. (2007). When and how do young people seek professional help for mental health problems. *Medical Journal of Australia, 187*, S35 – S39.

Rickwood, D. J., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian eJournal for the Advancement of Mental Health, 4*(3), No Pagination Specified.

Rickwood, D. J., Wilson, C. J., & Deane, F. P. (2006). Supporting young people to seek professional help for mental health problems: Cover Feature. *InPsyc: Bulletin of the Australian Psychological Society, 28, August*.

Rosenstock, I. M. (1966). Why people use health services. *Milbank Memorial Fund Quarterly, 44*, 94-127.

Rost, K., Smith, R., & Taylor, J. L. (1993). Rural–urban differences in stigma and the use of care for depressive disorders. *Journal of Rural Health, 9*, 57–62.

Rudd, M., Rajab, M., Orman, D. T., Stulman, D. A., Joiner, T., & Dixon, W. (1996). Effectiveness of an outpatient intervention targeting suicidal young adults: Preliminary results. *Journal of Consulting and Clinical Psychology, 64*(1), 179-190.

Rule, W. R., & Gandy, G. L. (1994). A thirteen-year comparison in patterns of attitudes toward counseling. *Adolescence, 29*(115), 575-589.

Santor, D. A., Poulin, C., LeBlanc, J. C., & Kusumakar, V. (2007). Facilitating help seeking behavior and referrals for mental health difficulties in school aged boys and girls: A school-based intervention. *Journal of Youth and Adolescence, 36*(6), 741-752.

Sarbornie, E. J., & Kauffman, J. M. (1985). Regular classroom sociometric status of behaviourally disordered adolescents. *Behavioural Disorders, 12*, 268-274.

Saunders, S. M. (1993). Applicants' experience of the process of seeking therapy. *Psychotherapy: Theory, Research, Practice, Training, 30*(4), 554-564.

Saunders, S. M., Zygowicz, K. M., & D'Angelo, B. R. (2006). Person-related and treatment-related barriers to alcohol treatment. *Journal of Substance Abuse Treatment, 30*(3), 261-270.

Sawyer, M., Miller-Lewis, L., & Clark, J. (2007). The mental health of 13-17 year-olds in Australia: Findings from the National Survey of Mental Health and Well-Being. *Journal of Youth and Adolescence, 36*(2), 185-194.

Sawyer, M. G., Arney, F. M., Baghurst, P. A., Clark, J. J., Graetz, B. W., Kosky, R. J., et al. (2001). The mental health of young people in Australia: Key findings from the Child and Adolescent Component of the National Survey of Mental Health and Well-Being. *Australian and New Zealand Journal of Psychiatry, 35*(6), 806-814.

Schonert-Reichl, K. A. (2003). Adolescent Help-seeking Behaviours. *Prevention Researcher, 10*, 1-5.

Schonert-Reichl, K. A., & Muller, J. R. (1996). Correlates of help-seeking in adolescence. *Journal of Youth and Adolescence, 25*(6), 705-731.

Schulz, K. F., Altman, D. G., & Moher, D. (2010). CONSORT 2010 Statement: updated guidelines for reporting parallel group randomised trials. *British Medical Journal, 340*, 698-702.

Sheehan, M., Cahill, H., Rowling, L., Marshall, B., Wynn, J., & Holdsworth, R. (2002). Establishing a role for schools in mental health promotion: The MindMatters project. In G. M. L. Rowling, & L. Walker (Ed.), *Mental Health Promotion and Young People: Concepts and Practice* (pp. 111-127). Sydney: McGraw Hill.

Sheffield, J. K., Fiorenza, E., & Sofronoff, K. (2004). Adolescents' Willingness to Seek Psychological Help: Promoting and Preventing Factors. *Journal of Youth and Adolescence, 33*(6), 495-507.

Sherman, N. (2005). *Stoic warriors: The ancient philosophy behind the military mind*. New York, NY: Oxford University Press; US.

Silverman, M. M., & Felner, R. D. (1995). Suicide prevention programs: Issues of design, implementation, feasibility, and developmental appropriateness. *Suicide and Life Threatening Behavior, 25*(1), 92-104.

Snijders, T., & Bosker, R. (1999). *Multilevel analysis: An introduction to basic and advanced multilevel modeling*. London, UK: Sage Publications.

Stefl, M. E., & Prosperi, D. C. (1985). Barriers to mental health service utilization. *Community Mental Health Journal, 21*(3), 167-178.

Timlin-Scalera, R. M., Ponterotto, J. G., Blumberg, F. C., & Jackson, M. A. (2003). A grounded theory study of help-seeking behaviors among White male high school students. *Journal of Counseling Psychology, 50*(3), 339-350.

Tishby, O., Turel, M., Gumpel, O., Pinus, U., Lavy, S. B., Winokour, M., et al. (2001). Help-seeking attitudes among Israeli adolescents. *Adolescence, 36*(142), 249-264.

Vanheusden, K., Mulder, C. L., van der Ende, J., van Lenthe, F. J., Mackenbach, J. P., & Verhulst, F. C. (2008). Young adults face major barriers to seeking help from mental health services. *Patient Education and Counseling, 73*(1), 97-104.

Vogel, D. L., & Wade, N. G. (2009). Stigma and help-seeking. *The Psychologist, 22*(1), 20-23.

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53*(3), 325-337.

Vogel, D. L., & Wester, S. R. (2003). To seek help or not to seek help: The risks of self-disclosure. *Journal of Counseling Psychology, 50*(3), 351-361.

Vogel, D. L., Wester, S. R., Larson, L. M., & Wade, N. G. (2006). An information-processing model of the decision to seek professional help. *Professional Psychology: Research and Practice, 37*(4), 398-406.

Vogel, D. L., Wester, S. R., Wei, M., & Boysen, G. A. (2005). The Role of Outcome Expectations and Attitudes on Decisions to Seek Professional Help. *Journal of Counseling Psychology, 52*(4), 459-470.

Wagstaff, G. F., & Rowledge, A. M. (1995). Stoicism: Its relation to gender, attitudes toward poverty, and reactions to emotive material. *The Journal of Social Psychology, 135*(2), 181-184.

Webb, T. L., & Sheeran, P. (2006). Does changing behavioural intentions engender behaviour change? A meta-analysis of the experimental evidence. *Psychological Bulletin, 132*, 249–268.

Wells, J., Robins, L., Bushnell, J., Jarosz, D., & et al. (1994). Perceived barriers to care in St. Louis (USA) and Christchurch (NZ): Reasons for not seeking professional help for psychological distress. *Social Psychiatry and Psychiatric Epidemiology, 29*(4), 155-164.

Whitaker, A., Johnson, J., Shaffer, D., Rapoport, J. L., Kalikow, K., Walsh, B. T., et al. (1990). Uncommon troubles in young people: Prevalence estimates of selected psychiatric disorders in a nonreferred adolescent population. *Archives of General Psychiatry, 47*, 487-496.

Wilson, C. J., Bignell, B., & Clancy, H. (2003). Building Bridges to General Practice: A controlled trial of the IDGP ‘‘GPs in Schools’’ program, first edition. *PARC Special Issue: Youth Mental Health, 8*, 19.

Wilson, C. J., & Deane, F. P. (2001). Adolescent opinions about reducing help-seeking barriers and increasing appropriate help engagement. *Journal of Educational & Psychological Consultation, 12*(4), 345-364.

Wilson, C. J., Deane, F. P., & Ciarrochi, J. (2005). Can hopelessness and adolescents' beliefs and attitudes about seeking help account for help negation? *Journal of Clinical Psychology, 61*(12), 1525-1539.

Wilson, C. J., Deane, F. P., Ciarrochi, J., & Rickwood, D. (2005). Measuring Help-Seeking Intentions: Properties of the General Help-Seeking Questionnaire. *Canadian Journal of Counselling, 39*(1), 15-28.

Wilson, C. J., Deane, F. P., & Fogarty, K. (2004). *Building bridges to general practice: GPs in schools—participant manual*. Wollongong: Illawarra Division of General Practice.

Wilson, C. J., Deane, F. P., Marshall, K. L., & Dalley, A. (2008). Reducing adolescents' perceived barriers to treatment and increasing help-seeking intentions: Effects of classroom presentations by general practitioners. *Journal of Youth and Adolescence, 37*(10), 1257-1269.

Wilson, C. J., Deane, F. P., Marshall, K. L., & Dalley, A. (2010). Adolescents' suicidal thinking and reluctance to consult general medical practitioners. *Journal of Youth and Adolescence, 39*(4), 343-356.

Wilson, C. J., Deane, F. P., Biro, V., & Ciarrochi, J. (2003). Youth barriers to help-seeking and referral from General Practitioners. Illawarra Division of General Practice & University of Wollongong, Illawarra Institute for Mental Health.

Wilson, C. J., Fogarty, K., & Deane, F. P. (2002). *The essential youth friendly GP kit*. Illawarra Institute for Mental Health, University of Wollongong.

Wilson, C. J., Rickwood, D., & Deane, F. P. (2007). Depressive symptoms and help-seeking intentions in young people. *Clinical Psychologist, 11*(3), 98-107.

Wisdom, J. P., Clarke, G. N., & Green, C. A. (2006). What Teens Want: Barriers to Seeking Care for Depression. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(2), 133-145.

Wolfe, D. A., & Mash, E. J. (2006). Behavioral and Emotional Problems in Adolescents: Overview and Issues *Behavioral and emotional disorders in adolescents: Nature, assessment, and treatment* (pp. 3-20). New York, NY: Guilford Publications; US.

Wright, A., McGorry, P. D., Harris, M. G., Jorm, A. F., & Pennell, K. (2006). Development and evaluation of a youth mental health community awareness campaign—The compass strategy. *Bio-Med Central Public Health, 6*, 215.

Zwaanswijk, M., Verhaak, P. F., Bensing, J. M., van der Ende, J., & Verhulst, F. C. (2003). Help seeking for emotional and behavioural problems in children and adolescents: A review of recent litetature. *European Child & Adolescent Psychiatry, 12*(4), 153-161.

Appendix A

Study one questionnaire

RDGP Logo here

Building Bridges Survey (II)

This survey is about health care professionals such as a doctor, a school counsellor or a drug and alcohol worker. The survey has been developed with the Riverina Division of General Practice. Please fill out the survey as honestly as you can. There are no right or wrong answers. Do NOT put your name on this survey but please complete all the questions on this page. This survey is anonymous.

1. Write your age:_____ years.
2. What is your birth date? Day _____, Month _____, Year _____
3. What is your gender? (√) Female _____, Male _____
4. In which country were you born? _____
5. Which cultural group do you feel you belong to? (e.g., Asian, European, Australian etc.)
   _____
6. Please write your parents' first initial (e.g., if your mother's name is Jane, you would write "J").
   Mother _____, Father _____
7. Write your Year: _____

Circle the number that gives the best answer to the following questions:

1 Extremely Unlikely	2 Unlikely	3 A Little Unlikely	4 Not Sure	5 A Little Likely	6 Likely	7 Extremely Likely

8a. If you have a **physical health concern**, how likely are you to talk to a **doctor** about it?	1	2	3	4	5	6	7
8b. If you have a **physical health concern**, how likely are you to talk to a health professional **other than a doctor** about it? Write the type of professional: _____	1	2	3	4	5	6	7
9a. If you have a **personal problem like relationship difficulties** with friends, family, or at school, how likely are you to talk to a **doctor** about it?	1	2	3	4	5	6	7
9b. If you have a **personal problem**, how likely are you to talk to a health professional **other than a doctor** about it? Write the type of professional: _____	1	2	3	4	5	6	7
10a. If you have an **emotional problem like being depressed or stressed out**, how likely are you to talk to a **doctor** about it?	1	2	3	4	5	6	7
10b. If you have an **emotional problem**, how likely are you to talk to a health professional **other than a doctor** about it? Write the type of professional: _____	1	2	3	4	5	6	7

Don't forget to turn over....

1 Totally Another's Decision	2 Mostly Another's Decision	3 More Another's Decision than Mine	4 Half Mine, Half Another's Decision	5 More My Decision than Another's	6 Mostly My Decision	7 Totally My Decision

11a. If you had a **physical problem**, how much do you think your decision to get help from a health care professional would be **influenced by someone else**? Write the main person you would be influenced by: _____	1	2	3	4	5	6	7
11b. If you had a **personal problem**, how much do you think your decision to get help from a health care professional would be **influenced by someone else**? Write the main person you would be influenced by: _____	1	2	3	4	5	6	7
11c. If you had an **emotional problem**, how much do you think your decision to get help from a health care professional would be **influenced by someone else**? Write the main person you would be influenced by: _____	1	2	3	4	5	6	7

1 Not At All	2 Slightly	3 Somewhat	4 Moderately	5 Very

11d. If you were dealing with an **emotional problem**, how **beneficial** for you would it be to tell a doctor personal information about the problem?	1	2	3	4	5
11e. How **helpful** would it be to tell a doctor about a **personal problem**?	1	2	3	4	5
11f. Would you **feel better** if you told a doctor about personal feelings of sadness or anxiety?	1	2	3	4	5
11g. How **likely** would you be to get a **useful reply** if you told a doctor about an emotional problem you were struggling with?	1	2	3	4	5

4 the box that gives the best answer for each question:

12. Do you have your own Medicare card?	☐ Yes	☐ No	☐ I have applied for one
13. Do you go to your family's doctor?	☐ Yes	☐ No	
14. Do you have your own doctor who is different from your family's doctor?	☐ Yes	☐ No	☐ I am looking for one

15a. In the 6 weeks since the last *Building Bridges* survey, how many times have you been to see a **doctor** for help with a **physical health concern**?	☐ I have not seen a doctor at all ☐ Once only ☐ More than once
15b. In the last 6 weeks, how many times have you been to see a health professional **other than a doctor** for help with a **physical health concern**? Write the type of professional: _____	☐ I have not seen a professional at all ☐ Once only ☐ More than once
16a. In the last 6 weeks, how many times have you been to see a **doctor** for help with a **personal problem**?	☐ I have not seen a doctor at all ☐ Once only ☐ More than once
16b. In the last 6 weeks, how many times have you been to see a health professional **other than a doctor** for help with a **personal problem**? Write the type of professional: _____	☐ I have not seen a professional at all ☐ Once only ☐ More than once

17a. In the last 6 weeks, how many times have you been to see a **doctor** for help with an **emotional problem**?

☐ I have not seen a doctor at all
☐ Once only
☐ More than once

17b. In the last 6 weeks, how many times have you been to see a health professional **other than a doctor** for help with an **emotional problem**?
Write the type of professional: _____

☐ I have not seen a professional at all
☐ Once only
☐ More than once

18. If you have **received professional help** for a physical, personal or emotional problem, do you think you would have sought help without the influence of someone else?
Write who the person or people were: _____

☐ Yes
☐ No
☐ Not sure

Circle the number that gives the best answer to the following questions:

0 Disagree	1 Somewhat Disagree	2 Somewhat agree	3 Agree

19. I know what to expect when I go to see a doctor.	0	1	2	3
20. I feel comfortable talking to a doctor who I don't know.	0	1	2	3
21. I believe a doctor has time to listen to my problems.	0	1	2	3
22. I'm happy about my family knowing if I've visited a doctor.	0	1	2	3
23. If I tell a doctor about my personal-emotional problems, I believe they will keep it a secret.	0	1	2	3
24. I think doctors are interested in emotional problems as well as physical health problems.	0	1	2	3
25. I believe a doctor can understand my thoughts and feelings.	0	1	2	3
26. I'm not embarrassed to talk about my problems.	0	1	2	3
27. I'm not worried about telling a doctor how I truly feel.	0	1	2	3
28. Getting a doctor's help means I don't have to work out my problems alone.	0	1	2	3
29. What I think and how I feel emotionally are important enough to talk to a doctor about.	0	1	2	3
30. I have had experiences with doctors in the past that have upset me.	0	1	2	3
31. I have found a visit with a doctor extremely helpful in the past.	0	1	2	3

Below is a list of feelings that people sometimes have. Circle the number that best describes how distressing these feelings have been for you in the <u>past seven days, including today:</u>

1 Not at all	2 A Little	3 Quite a bit	4 Extremely

32. Difficulty speaking when you are excited.	1	2	3	4
33. Trouble remembering things.	1	2	3	4
34. Worried about sloppiness or carelessness.	1	2	3	4
35. Blaming yourself for things.	1	2	3	4
36. Pains in the lower part of your back.	1	2	3	4
37. Feeling lonely.	1	2	3	4

Don't forget to turn over....

1 Not at all	2 A Little	3 Quite a bit	4 Extremely

38. Feeling blue.	1	2	3	4
39. Your feelings being easily hurt.	1	2	3	4
40. Feeling others do not understand you or are unsympathetic.	1	2	3	4
41. Feeling that people are unfriendly or dislike you.	1	2	3	4
42. Having to do things very slowly in order to be sure you are doing them right.	1	2	3	4
43. Feeling inferior to others.	1	2	3	4
44. Soreness of your muscles.	1	2	3	4
45. Having to check and double check what you do.	1	2	3	4
46. Hot or cold spells.	1	2	3	4
47. Your mind going blank.	1	2	3	4
48. Numbness or tingling in parts of your body.	1	2	3	4
49. Lump in your throat.	1	2	3	4
50. Trouble concentrating.	1	2	3	4
51. Weakness in parts of your body.	1	2	3	4
52. Heavy feelings in your arms and legs.	1	2	3	4

Below is a list of ways people describe themselves. Circle the number that best describes you:

1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Slightly Agree	5 Agree	6 Strongly Agree

53. I think it is important to remain strong and silent in the face of hardship, even if you are hurting inside.	1	2	3	4	5	6
54. When the going gets tough I just grin and bear it.	1	2	3	4	5	6
55. My personal pride tends to prevent me from asking others for help.	1	2	3	4	5	6
56. I tend to keep battling with a problem on my own, even if my health is being negatively effected.	1	2	3	4	5	6
57. I believe that if I can't sort out my own problems then no-one can.	1	2	3	4	5	6
58. Talking about my feelings is difficult for me	1	2	3	4	5	6
59. I have difficulty expressing my tender feelings.	1	2	3	4	5	6
60. Telling others of my strong feelings is not part of my behaviour.	1	2	3	4	5	6
61. I often have trouble finding words that describe how I am feeling.	1	2	3	4	5	6
62. I do not like to show my emotions to other people.	1	2	3	4	5	6

Thanks for completing the survey

Appendix B

University of Wollongong Human Research Ethics Committee Ethics approval letter for Study one

School Administration Approval Form

Study one parent and student information sheets and consent forms

Debrief sheet

COPY

University of Wollongong

AMENDMENT – FINAL APPROVAL
- IAHS AUTHORISATION
In reply please quote: RN:ES HE03/371
Further Enquiries Eve Steinke (PH: 42214457)

23 November 2004

Dr.F.Deane
Department of Psychology
University of Wollongong

Dear Dr Deane

I am pleased to advise that the amendment to the following Human Research Ethics application have been **approved. A copy of this advice has been forwarded to the IAHS from whom you will need authorisation to proceed.**

Ethics Number:	HE03/371
Project Title:	Building bridges to general practice: Evaluation of Illawarra Division of General Practice (IDGP) "GPs in schools" program
Amendment:	Extension of the Building Bridges program to the Riverina Division of General Practice. Addition of Ms Nicole Onus to the Information Sheets as the local contact and co-ordinator in the Riverina region. Changes to the questionnaire as provided.
Name of Researchers:	Dr.F.Deane, C.Wilson, K.Marshall
Final Approval Date:	21November 2004
Date for Renewal:	16 February 2005

This certificate relates to the research protocol submitted in your original application and includes all approved amendments to date.

Please note that research projects of long duration must be reviewed annually by the Committee and it will be necessary for you to apply for renewal of this application if this project is to continue beyond one year.

Yours Sincerely,

'Assoc. Prof. Rod Nillsen
Chairperson
Human Research Ethics Committee

cc. Prof. Anthony Hodgson, IAHS

Research Services Office University of Wollongong NSW 2522 Australia
Telephone: +61 2 4221 3386 **Facsimile:** +61 2 4221 4338
research_services@uow.edu.au www.uow.edu.au/research
CRICOS Provider No: 00102E

Illawarra Division of General Practice GPs in Schools Project

School Administration Approval Form

I have read the University of Wollongong Human Research Ethics proposal. I have also had the details of the above project explained to me by Coralie Wilson, together with the _____High School Principal and welfare staff.

We understand that _____High School students and staff will be involved in a project to increase students' willingness to consult a GP for physical and psychological problems. We also understand that the GPs in Schools Project will involve surveys to evaluate students' help-seeking intentions and levels of mental ill-health.

We understand that _____ High School involvement is voluntary and that we can choose to withdraw our students and staff from this project at any time.

We agree to allow Ms. Wilson to conduct this project on the understanding that all information obtained during project evaluation is confidential.

We understand that if we have any questions regarding the project we can contact Ms. Wilson on (02) 4226-7052. Also, if we have any questions regarding the conduct of the research, we can contact the secretary of the University of Wollongong Human Research Ethics Committee on (02) 4221-4457.

On behalf of the _____ High School Principal, I wish to approve the commencement of this project under the conditions set out in the University of Wollongong Human research Ethics Committee Proposal.

_____ _____

Coordinator of Student Welfare and Equity Date
NSW Department of Education and Training

IDGP & iiMH logos

General Practitioners (GPs) in Schools Project

Parents and Caregiver Information Sheet
Year 11 Students

Dear Parents and Caregivers,

As part of the school welfare program, your son or daughter will hear a presentation that will be given by a doctor (a General Practitioner). During the presentation, students will be given information about different problems that a doctor can help with. They will also be encouraged to visit a doctor when they feel physically or emotionally unwell.

The purpose of this letter is to request permission for your son or daughter to be involved in a study that will evaluate the Illawarra Division of General Practice' "GP in Schools" Program.

Who is running this study?

This research study is being run by Coralie Wilson from the Illawarra Division of General Practice and Professor Frank Deane from the Illawarra Institute for Mental Health, University of Wollongong.

What is this study about?

The aim of this study is see if your son or daughter is more likely to consult a doctor for a physical, personal, emotional or suicidal problem after hearing a presentation by a GP than before the presentation.

Is my son or daughter eligible to take part?

If your son or daughter is in Year 11, they can take part in this study.

What would my son or daughter have to do?

If you agree, your son or daughter would complete a brief survey in three different sessions. Each session will take about 15 minutes:

- Session 1: One week before the doctor's presentation
- Session 2: Five weeks after the doctor's presentation
- Session 3: Ten weeks after the doctor's presentation

The survey in each session has two parts.

PART A of the survey is **anonymous** and asks students questions about visiting a doctor for different physical and emotional concerns. Examples of questions in the survey include: "If you have a physical health concern, how likely are you to talk to a GP about it?" "I know what to expect when I go to see a GP", "In the last seven days I felt soreness in my muscles", and "In the past month I thought about killing myself".

If you allow your son or daughter to participate in PART A of this study any information they provide in PART A will be kept confidential. All PART A questionnaires will be anonymous and it will not be possible for your son or daughter to be identified in any way.

PART B of the survey is **not anonymous.** The goal of Part B is to identify students who are experiencing suicidal thoughts and those who would like help from a school counsellor. If a student indicates they have suicidal thoughts or if they request confidential assistance on the survey PART B, they will be contacted confidentially by the school counsellor and given individual help.

What can I expect from the researchers?

If you allow your son or daughter to take part in the study, you and they have the right to:

- Refuse to answer any particular question, and to withdraw from the study at any time,
- Ask any further questions about the study that occur during their participation,
- Be informed of the findings from the study when it has concluded,
- Provide information in survey PART A on the understanding that it is completely confidential to the researchers. All records will be identified by a code number, and will be seen only by the researchers. It will not be possible for you to be identified in any reports that result from the study.
- Provide information in survey PART B on the understanding that it is confidential to the researchers and supporting school counsellor or psychologist. It is important to note that the survey PART B is simply a screening tool. If your son or daughter indicates they have suicidal thoughts on the survey PART B, they will be assessed by a school counsellor or psychologist who will determine the level of distress that your son or daughter may be feeling and what if any, additional health care may be required.

It is important to emphasise that the researchers will not be offering advice about your son or daughter's physical or mental health. If you have any concerns about their health, a list of healthcare services and contact information will be given to your son or daughter to assist them and you in taking appropriate action.

If you give permission for your child to take part in this evaluation, please complete the attached Consent Form and have them bring it to Year Meeting on **Thursday……., 2004**. If you have any questions about this research, please call me either Thursday or Friday on Tel. (02) 4226-7052, or Dr. Deane on Tel. (02) 4221-4523 during business hours. I can also be contacted on email at cwilson@idgp.org.au and am happy to explain any details of the study. If you have any questions regarding the conduct of this research please contact the secretary of the University of Wollongong Human Research Ethics Committee on (02) 4221-4457.

Yours faithfully,

Coralie Wilson
Program Developer & Researcher
Illawarra Division of General Practice

Detach and bring to Year Meeting, Thursday ……, 2004.

Evaluation of the IDGP GP in Schools Program

Parent/Caregiver Consent Form
Year 11 Students

Permission to complete survey PART A only

I have read the information about this study. I give permission for my son/daughter to complete the anonymous PART A of the survey to evaluate the GP in Schools Program.

Student's Name: _____ Parent/Caregiver's Name: _____

Parent/Caregiver's Signature: _____ Date: _____

Permission to complete survey PART B only

I give permission for my son/daughter to complete the non-anonymous PART B of the survey to evaluate GP in Schools Program.

Parent/Caregiver's Signature:_____ Date: _____

If you allow your son or daughter to complete BOTH survey PARTS A and B, please be sure to sign in BOTH boxes.

Thank you

IDGP & iiMH logos

General Practitioners (GPs) in Schools Project

Year 11 Student Information Sheet

Dear Student,

As part of the school welfare program, you will hear a presentation that will be given by a doctor (a General Practitioner). During the presentation, you will be given information about different problems that a doctor can help with. You will also be encouraged to visit a doctor when you feel physically or emotionally unwell.

The purpose of this letter is to ask you to be involved in a study that will evaluate the Illawarra Division of General Practice' "GP in Schools" Program.

Who is running this study?

This research study is being run by Coralie Wilson from the Illawarra Division of General Practice and Professor Frank Deane from the Illawarra Institute for Mental Health, University of Wollongong.

What is this study about?

The aim of this study is see if you more likely to see a doctor for a physical, personal, emotional or suicidal problem after hearing a presentation by a GP than before the presentation.

Are you eligible to take part?

If you are in Year 11, and you have your parents/caregivers' signed consent giving you permission to take part in this study, then you can take part in this study.

What would I have to do?

If you agree, you would complete a brief survey in three different sessions. Each session will take about 15 minutes:

- Session 1: One week before the doctor's presentation
- Session 2: Five weeks after the doctor's presentation
- Session 3: Ten weeks after the doctor's presentation

The survey in each session has two parts.

PART A of the survey is **anonymous** and will ask you questions about visiting a doctor for different physical and emotional concerns. Examples of questions in the survey include: "If you have a physical health concern, how likely are you to talk to a GP about it?" "I know what to expect when I go to see a GP", "In the last seven days I felt soreness in my muscles", and "In the past month I thought about killing myself".

If you participate in PART A of this study any information you provide in PART A will be kept confidential. All PART A questionnaires will be anonymous and it will not be possible for you to be identified in any way.

PART B of the survey is **not anonymous.** The goal of Part B is to identify students who are experiencing suicidal thoughts and those who would like help from a school counsellor. If you have suicidal thoughts or if request confidential assistance, you will be contacted confidentially by the school counsellor and given individual help.

What can I expect from the researchers?

If you take part in the study, you and they have the right to:

- Refuse to answer any particular question, and to withdraw from the study at any time,
- Ask any further questions about the study that occur during your participation,
- Be informed of the findings from the study when it has concluded,
- Provide information in survey PART A on the understanding that it is completely confidential to the researchers. All records will be identified by a code number, and will be seen only by the researcher. It will not be possible for you to be identified in any reports that result from the study.
- Provide information in survey PART B on the understanding that it is confidential to the researchers and supporting school counsellor or psychologist. It is important to note that the survey PART B is simply a screening tool. If you indicate that you have suicidal thoughts on the survey PART B, a school counsellor or psychologist will talk with you about the distress that you may be feeling and what if any, additional health care you may need.

It is important to emphasise that the researchers will not be offering advice about your physical or mental health. If you have any concerns about your health, a list of healthcare services and contact information will be given to you to assist you in taking appropriate action.

If you wish to take part in this evaluation, please make sure that you have written consent from your parents/caregivers. You will also need to give your own written consent on a form that will be given to you before you can complete a survey. If you have any questions about this research, please call me either Thursday or Friday on Tel. (02) 4226-7052, or Dr. Deane on Tel. (02) 4221-4523 during business hours. I can also be contacted on email at cwilson@idgp.org.au and am happy to explain any details of the study. If you have any questions regarding the conduct of this research please contact the secretary of the University of Wollongong Human Research Ethics Committee on (02) 4221-4457.

Yours faithfully,

Coralie Wilson
Program Developer & Researcher
Illawarra Division of General Practice

IDGP & iiMH logos

Student Consent Form

I have had the details of this research project explained to me. I understand that for PART A, I will be required to complete an anonymous survey about my help-seeking, mental health and thoughts about suicide and that PART A of this survey this will be kept confidential to the researchers.

I understand that for PART B, I will be required to complete a non-anonymous survey about help-seeking and thoughts about suicide. I also understand that the goal of PART B is to identify students who are experiencing high levels of suicidal thoughts and those who would like help from a school counsellor. I understand that if I indicate I have suicidal thoughts on PART B or if I request assistance, I will be contacted confidentially by the school counsellor and given individual help.

I understand my participation is voluntary, that I can choose not to answer any question and that I am free to withdraw from this study at any time. I also understand that the manner in which I am treated will not change if I do not give an answer or if I choose to withdraw.

I understand that if I have any questions regarding the research I can contact Coralie Wilson on (02) 4221-4207. Also, if I have any questions regarding the conduct of the research I can contact the secretary of the University of Wollongong Human Research Ethics Committee on (02) 4221-4457.

Consent to complete that anonymous survey PART A only

I have had the information about this study explained to me. I consent to complete PART A of the survey to evaluate the GP in Schools Program. My parents/caregivers have also given their permission for me to participate in PART A.

Student's Name: _____ Year: _____

Signature:_____ Date:_____

Consent to complete the non-anonymous survey PART B only

I have had the information about this study explained to me. I consent to complete PART B of the survey to evaluate the GP in Schools Program. My parents/caregivers have also given their permission for me to participate in PART B.

Student's Signature: _____Date:_____

To complete BOTH survey PARTS A and B, please be sure to sign in BOTH boxes.

IDGP & iiMH logos

Illawarra Division of General Practice GPs in Schools Project

Debrief Sheet

If you have been struggling with a health problem, either emotional or physical, it is often helpful to talk to someone about it. Often they can help just by understanding, or they might provide some ideas about how you could solve the problem.

If you have had suicidal thoughts or feelings lately, it is very important that you talk to someone about it. There are many people who you can talk to, including your doctor. If you can't get to your doctor, try talking to a trusted responsible adult. Here are some ideas: your parents, a teacher, your youth group leader, the student welfare officer or the school counsellor.

Other people and services that you can talk to are listed below.

Immediate 24 Services

Lifeline	**131-114**
Kids Help Line	**1-800-551-800**
Make a Noise	**(02) 6058-1736**
Crisis Refuge	**4228-1946**

Local Services

Counselling:	Wollongong City Mission Counselling Services	4254-0512
	Wellspring Centre	4226-2627
	UNIFAM	4229-9863
Health:	Wollongong Medical Centre	4229-7973
	Chain Health Centre for Youth	4226-5816
	Wollongong Hospital	4222-5000
	HIV Prevention Service	4228-8211
	Family Planning	4229-4638
Youth Centre:	Wollongong Youth Centre	4226-5969

Website Help

Reachout!	www.reachout.asn.au
Samaritans	www.samaritans.org.uk

Appendix C

Study two questionnaire

University of Wollongong Human Research Ethics Committee Ethics approval letter for Study two

Department of Education and Training Ethics approval letter for Study two

Control presentation checklist

Study two teacher, parent and student information sheets and consent forms

University of Wollongong  G1T1

DO NOT PUT YOUR NAME ON THIS SURVEY - it is confidential. Only the project researchers will have access to the information. Please fill out the survey as honestly as you can and complete all questions. There are no right or wrong answers.

1. Write your age _____ years

2. When is your birthday? Day_____ Month_____

3. Circle your gender: Female Male

4. In which country were you born? _____

5. Which cultural group do you feel you belong to? (e.g. Asian, Australian, etc.) _____

6. Please write your parents' first initial (e.g. if your mother's name is Jane, you would write "J")

Mother_____, Father_____

For each item, circle the number that best reflects how you feel:

1 None of the time	2 A little of the time	3 Some of the time	4 Most of the time	5 All of the time

During the last 30 days, about how often did you feel:

7. nervous?	1	2	3	4	5
8. hopeless?	1	2	3	4	5
9. restless or fidgety?	1	2	3	4	5
10. that everything was an effort?	1	2	3	4	5
11. so sad that nothing could cheer you up?	1	2	3	4	5
12. worthless?	1	2	3	4	5

The remainder of the survey refers to health professionals (e.g. doctor, psychologist, or school counsellor) and asks about emotional or mental health problems (e.g. feeling stressed or depressed).

13. Have you ever seen a health professional to get help for emotional or mental health problems? (Circle one)

Yes **No**

14. In the last 3 months how many times have you been to see a health professional for an **emotional problem** like being depressed or stressed out?

Never	Once	2-5 times	6-9 times	10 or more times

15. <u>If you circled once or more for question 14</u>, how helpful were your visits to the health professional?

1 Extremely Unhelpful	2 Unhelpful	3 Neutral	4 Helpful	5 Extremely Helpful

16. In the past 3 months how much have you talked to a family member or friend about an **emotional problem** like being depressed or stressed out?

0 Not at all	1 A little	2 Quite a bit	3 A great deal

Circle the number that best reflects your opinion.

1 Not at all	2 Slightly	3 Somewhat	4 Moderately	5 Very

17. How difficult would it be for you to share personal information with a health professional?	1	2	3	4	5
18. How vulnerable would you feel if you revealed something very personal you had never told anyone before to a health professional?	1	2	3	4	5
19. If you were dealing with an emotional problem, how beneficial for yourself would it be to share personal information about the problem to a health professional?	1	2	3	4	5
20. How risky would it feel to share your hidden feelings with a health professional?	1	2	3	4	5
21. How worried about what the other person is thinking would you be if you revealed negative emotions to a health professional?	1	2	3	4	5
22. How helpful would it be to share a personal problem with a health professional?	1	2	3	4	5
23. Would you feel better if you revealed feelings of sadness or anxiety to a health professional?	1	2	3	4	5
24. How likely would you get a useful response if you revealed an emotional problem you were struggling with to a health professional?	1	2	3	4	5

Circle the number that best reflects your opinion.

0 Disagree	1 Somewhat Disagree	2 Somewhat Agree	3 Agree

25. I know what to expect when I go to see a health professional	0	1	2	3
26. I feel comfortable talking to a health professional who I don't know	0	1	2	3
27. I believe a health professional has time to listen to my problems	0	1	2	3
28. I'm happy about my family knowing if I've visited a health professional	0	1	2	3
29. If I tell a health professional about my emotional problems, I believe they will keep it a secret	0	1	2	3
30. I think health professionals are interested in emotional problems as well as physical health concerns	0	1	2	3
31. I believe a health professional can understand my thoughts and feelings	0	1	2	3
32. I'm not embarrassed to talk about my problems	0	1	2	3
33. I'm not worried about telling a health professional how I truly feel	0	1	2	3
34. Getting help from a health professional means I don't have to work out my problems alone	0	1	2	3
35. What I think and how I feel emotionally are important enough to talk to a health professional about	0	1	2	3
36. I have had experiences with health professionals in the past that have upset me	0	1	2	3

We are interested in how likely it is that you would seek help for emotional problems. Please read each item and circle the number that best reflects your opinion.

1 Extremely Unlikely	2 Unlikely	3 A little Unlikely	4 Not sure	5 A little Likely	6 Likely	7 Extremely Likely

37. I intend to see a health professional if I were to have an emotional problem like being depressed or stressed out	1	2	3	4	5	6	7
38. I will try to see a health professional if I were to have an emotional problem like being depressed or stressed out	1	2	3	4	5	6	7
39. I plan to see a health professional if I were to have an emotional problem like being depressed or stressed out	1	2	3	4	5	6	7
40. If you were to have an emotional problem like being depressed or stressed out, how likely are you to see a health professional about it?	1	2	3	4	5	6	7
41. If you were to have an emotional problem like being depressed or stressed out, how likely are you to talk to a family member or friend about it?	1	2	3	4	5	6	7

The following questions DO have an answer that is more correct than the others. Circle the best answer to each question.

42. Which of the following health professionals can prescribe medication?

a. school counsellor **b.** psychologist

c. General Practitioner (GP) **d.** All of the above

43. Under what circumstances would a psychologist usually need to break confidentiality?

a. If your parents want to know what's going on **b.** If you, or someone else is at risk of harm

c. If your teachers want to know what's going on **d.** All of the above

44. Which of the following is a common sign of anxiety?

a. Increased heart rate **b.** Having trouble sleeping

c. Tight muscles **d.** All of the above

45. The Medicare "gap" is:

a. The part you pay when you see a health professional **b.** The part Medicare pays when you see a health professional

c. The problem with the Medicare system **d.** None of the above

46. To make the most out of your consultation with a health professional, you need to:

a. Know your background **b.** Know your problem

c. Ask questions **d.** All of the above

THANK YOU

INITIAL APPLICATION APPROVAL
In reply please quote: HE08/305
Further Enquiries Phone: 4221 4457

17 December 2008

Ms J Rughani
36 Souter St
Kogarah Bay
NSW 2217

Dear Ms Rughani

Thank you for your response dated 9 December 2008 to the HREC review of the application detailed below. I am pleased to advise that the application has been approved and forwarded to the Department of Education and Training for approval of your SERAP application.

Ethics Number:	HE08/305
Project Title:	Perceived value and barriers as predictors of adolescents' professional help-seeking for emotional problems
Researchers:	Ms Janaki Rughani, Professor Frank Deane
Approval Date:	11 December 2008
Expiry Date:	10 December 2009

The University of Wollongong/SESIAHS Humanities, Social Science and Behavioural HREC is constituted and functions in accordance with the NHMRC *National Statement on Ethical Conduct in Human Research.* The HREC has reviewed the research proposal for compliance with the *National Statement* and approval of this project is conditional upon your continuing compliance with this document. As evidence of continuing compliance, the Human Research Ethics Committee requires that researchers immediately report:

- proposed changes to the protocol including changes to investigators involved
- serious or unexpected adverse effects on participants
- unforseen events that might affect continued ethical acceptability of the project.

You are also required to complete monitoring reports annually and at the end of your project. These reports are sent out approximately 6 weeks prior to the date your ethics approval expires. The reports must be completed, signed by the appropriate Head of School, and returned to the Research Services Office prior to the expiry date.

Yours sincerely

PP A/Professor Steven Kooaenrys
Chair, Human Research Ethics Committee

cc Professor F Deane, School of Psychology

DOC09/15050

TAB A

STRATEGIC INITIATIVES DIRECTORATE

Miss Janaki Rughani
36 Souter Street
KOGARAH BAY NSW 2217
AUSTRALIA

DOC09/15050

Dear Miss Rughani **SERAP Number 2008211**

I refer to your application to conduct a research project in NSW government schools entitled *Perceived Value and Barriers as Predictors of Adolescents' Professional Help-Seeking for Emotional Problems*. I am pleased to inform you that your application has been approved. You may now contact the Principals of the nominated schools to seek their participation.

This approval will remain valid until 10-12-2009.

No researchers or research assistants have fulfilled the Working with Children screening requirements to interact with or observe children for the purposes of this research.

You should include a copy of this letter with the documents you send to schools.

I draw your attention to the following requirements for all researchers in NSW government schools:

- School Principals have the right to withdraw the school from the study at any time. The approval of the Principal for the specific method of gathering information for the school must also be sought.
- The privacy of the school and the students is to be protected.
- The participation of teachers and students must be voluntary and must be at the school's convenience.
- Any proposal to publish the outcomes of the study should be discussed with the Research Approvals Officer before publication proceeds.

When your study is completed please forward your report marked to the Director, Strategic Initiatives, Department of Education and Training, Locked Bag 53, Darlinghurst, NSW 2010. If you have any queries, please contact Dr Robert Stevens, Manager, Schooling Research on telephone 9244 5619.

Yours sincerely

Dr Max Smith
Acting Director, Strategic Initiatives
27 March 2009

Dear (name),

As part of the Cross Roads program at (school) on (date), Headspace and the Illawarra Division of General Practice will be running a presentation about help-seeking from health professionals. The purpose of this letter is to inform you that the help-seeking program is undergoing an evaluation by the University of Wollongong. From a research perspective, in order to evaluate the effectiveness of the help-seeking program, it is important that the content of the presentation you conduct does not overlap with the help-seeking presentation.

We understand that due to the nature of your topic area you may mention that professional help is available. However, we request that the content of your presentation does not address the following:

- The benefits of help-seeking. For example, mentioning that health professionals will listen to young people's problems and that seeking help means young people don't have to deal with their problems alone.
- The barriers to help-seeking. For example, young people may not seek help because they feel it's a sign of weakness or because it means that they are going crazy.
- The process of help-seeking, i.e. how to find a health professional, what happens when a young person goes to visit a health professional, confidentiality and how to pay for the service.
- Whether any of the young people have sought help in the past and whether the help was useful.
- The importance of seeking help early rather than when the problem becomes more severe.

Our program will cover the above and relate help-seeking to various mental health problems, including those related to drug and alcohol. Therefore, you can be assured that students will receive thorough information on how and why they can seek help for drug and alcohol problems.

If you have any concerns regarding this request or would like further information, please feel free to contact Janaki Rughani (4221 4207; jr925@uow.edu.au) or Monique Piper (4226 7052; mpiper@idgp.prg.au).

Yours Sincerely,

Janaki Rughani
Principal Researcher
University of Wollongong

University of Wollongong

Research Project: **Perceived Value and Barriers as Predictors of Adolescents' Professional Help-Seeking for Emotional Problems**

PARENT/CAREGIVER INFORMATION SHEET

Dear Parents and Caregivers,

As part of the school welfare program, your son or daughter will hear a presentation providing information about different problems that a health professional (such as a doctor, school counsellor or psychologist) can help with. The aim of the program is to increase students' awareness of the importance of seeking help from health professionals for both physical and emotional problems. The presentations encourage them to visit a health professional should they experience physical or emotional problems in the future. This presentation is part of the school health curriculum.

The purpose of this letter is to request permission for your son or daughter to be involved in a study that will evaluate the effectiveness of this program. The program is called "Promoting-Access-&-Support-Seeking" (PASS).

Who is running this study?

This study is being conducted by *Janaki Rughani* from the University of Wollongong. It is part of a *Doctor of Psychology (Clinical)*, being supervised by *Prof. Frank Deane and Dr. Coralie Wilson (University of Wollongong).*

What is this study about?

The aim of this study is to see if your son or daughter is more willing to seek help, thinks help will be more useful and is more likely to consult a health professional for emotional or mental health problems after hearing the PASS presentation.

Where & when will the research take place?

The research will take place at your child's school and will be conducted during the Cross Roads program which is part of the health curriculum. The Cross Roads program will run on date (Term 1) and date (Term 2).

What would my son or daughter have to do?

If you agree, your son or daughter would complete a brief questionnaire in four different sessions. Each session will take about 15 minutes:

Term 1
Session 1: Immediately before the Cross Roads presentation
Session 2: Immediately after the Cross Roads presentation

Term 2
Session 3: Immediately before the Cross Roads presentation
Session 4: Immediately after the Cross Roads presentation

The survey is **confidential.** Surveys will be identified by a code number and will only be seen by the researchers. It will not be possible for your child to be identified in any reports that result from the study. Students are asked questions about visiting a health professional for different emotional concerns. Examples of questions in the survey include: "I know what to expect when I go to see a health professional", "Would you feel better if you disclosed feelings of sadness or anxiety to a health professional?" "During the last 30 days, about how often did you feel nervous?" They will also be asked to indicate the likelihood that they would seek help and whether they have sought help in the past.

There is a small risk that some of the questions will get your child thinking more about their emotional health. For some people this may cause mild distress.

If you allow your son or daughter to participate in this study, any information they provide will be kept confidential. It will not be possible for your son or daughter to be identified in any way.

What can I expect from the researchers?

If you allow your son or daughter to take part in the study, you and they have the right to:

- Withdraw from the study at any time,
- Ask any further questions about the study that occur during their participation,
- Be informed of the findings from the study when it has concluded
- Provide information in the survey on the understanding that it is completely confidential to the researchers. All records will be identified by a code number and it will not be possible for your son or daughter to be identified in any reports that result from the study.

The data collected will be used for the principal researcher's doctoral thesis, conference presentations and publication in scholarly journals. No participants will be identifiable in any reports.

Participation is voluntary and your son or daughter will only take part if both they and you agree. If you decide that you do not wish your child to take part, it will not affect your child's results or progress at school. If you or your child changes your mind about taking part, even after the study has started, just let

the researcher know and they can withdraw their participation from the study. Any data already collected will be destroyed.

If you give permission for your child to take part in this evaluation, please complete the attached Form and have them bring it to their teacher by date. Please note that if you do not complete the form your child will still participate in the presentation but they will not be a part of the study and will not be asked to complete the questionnaires.

If you have any questions about this research, please feel free to contact:
Janaki Rughani; phone: 4221 4207; e-mail: jr925@uow.edu.au
Monique Piper; phone: 4226 7052; e-mail: mpiper@idgp.org.au

If you have any questions regarding the conduct of this research please contact the secretary of the University of Wollongong Human Research Ethics Committee on (02) 4221 4457.

This information sheet is for you to keep. Your child has also been given information about this project.

Yours Sincerely,

Janaki Rughani

Principal Researcher
University of Wollongong

University of Wollongong 

PARENT CONSENT FORM: PLEASE RETURN TO SCHOOL BY:(date)

Research Project: **Perceived Value and Barriers as Predictors of Adolescents' Professional Help-Seeking for Emotional Problems**

I (*print name*)……give consent to the participation of my child (*print name*)

…….....in the research project described below.

TITLE OF THE PROJECT: Perceived Value and Barriers as Predictors of Adolescents' Professional Help-Seeking for Emotional Problems

CHIEF RESEARCHER: *Janaki Rughani;4221 4207; jr925@uow.edu.au*

CO-RESEARCHER: *Monique Piper; 4226 7052; mpiper@idgp.prg.au*

In giving my consent I acknowledge that:

1. The procedures required for the project and the time involved have been explained to me and any questions I have about the project have been answered to my satisfaction

2. I have read the Parent Information Sheet and have been given the opportunity to discuss the information and my child's involvement in the project with the researchers

3. I have discussed participation in the project with my child and my child assents to their participation in the project

4. I understand that that my child's participation in this project is voluntary; a decision not to participate will in no way affect their academic standing or relationship with the school and they are free to withdraw their participation at any time.

5. I understand that my child's involvement is strictly confidential and that no information about my child will be used in any way that reveals my child's identity.

Signed……..

Name…….

Date…….

Any complaints about the research should be addressed to:

Janaki Rughani
Illawarra Institute for Mental Health (iiMH)
Building 22
University of Wollongong
Northfields Avenue
WOLLONGONG NSW 2522

University of Wollongong

Research Project: **Perceived Value and Barriers as Predictors of Adolescents' Professional Help-Seeking for Emotional Problems**

STUDENT INFORMATION SHEET

Dear Student,

As part of the school welfare program, you will hear a presentation providing information about different problems that a health professional (such as a doctor, school counsellor or psychologist) can help with. The aim of the program is to increase your awareness of the importance of seeking help from health professionals for both physical and emotional problems. The presentations encourage you to visit a health professional should you experience physical or emotional problems in the future. This presentation is part of the school health curriculum.

The purpose of this letter is to ask you to be involved in a study that will evaluate the effectiveness of this program. The program is called "Promoting-Access-&-Support-Seeking" (PASS).

Who is running this study?

This study is being conducted by *Janaki Rughani* from the University of Wollongong. It is part of a *Doctor of Psychology (Clinical)*, being supervised by *Prof. Frank Deane and Dr. Coralie Wilson (University of Wollongong).*

What is this study about?

The aim of this study is to see if you are more willing to seek help, think help will be more useful and are more likely to consult a health professional for emotional or mental health problems after hearing the PASS presentation.

Where & when will the research take place?

The research will take place at your school and will be conducted during the Cross Roads program which is part of the health curriculum. The Cross Roads program will run on date (Term 1) and date (Term 2).

What would I have to do?

If you agree, you would complete a brief questionnaire in four different sessions. Each session will take about 15 minutes:

Term 1
Session 1: Immediately before the Cross Roads presentation
Session 2: Immediately after the Cross Roads presentation

Term 2
Session 3: Immediately before the Cross Roads presentation
Session 4: Immediately after the Cross Roads presentation

The survey is **confidential.** Surveys will be identified by a code number and will only be seen by the researchers. It will not be possible for you to be identified in any reports that result from the study.

You are asked questions about visiting a health professional for different emotional concerns. Examples of questions in the survey include: "I know what to expect when I go to see a health professional", "Would you feel better if you disclosed feelings of sadness or anxiety to a health professional?" "During the last 30 days, about how often did you feel nervous?" You will also be asked to indicate the likelihood that you would seek help and whether you have sought help in the past.

There is a small risk that some of the questions will get you thinking more about your own emotional health. For some people this may cause mild distress.

If you participate in this study, any information you provide will be kept confidential. It will not be possible for you to be identified in any way.

What can I expect from the researchers?

If you take part in the study, you have the right to:

- Withdraw from the study at any time,
- Ask any further questions about the study that occur during your participation,
- Be informed of the findings from the study when it has concluded
- Provide information in the survey on the understanding that it is completely confidential to the researchers. All records will be identified by a code number and it will not be possible for you to be identified in any reports that result from the study.

The data collected will be used for the principal researcher's doctoral thesis, conference presentations and publication in scholarly journals. No participants will be identifiable in any reports.

Participation is voluntary and you will only take part if both you and your parent/caregiver agree. If you decide that you do not wish to take part, it will not affect your results or progress at school. If you change your mind about taking part, even after the study has started, just let the researcher know and you can withdraw your participation from the study. Any data already collected will be destroyed.

If you wish to take part in this evaluation, you will need to bring back the parent/caregiver consent form as well as give your own written consent on a form that will be given to you before you can complete a survey. Please note that if you choose not to take part, you will still participate in the presentation but you will not be a part of the study and will not be asked to complete the questionnaires.

If you have any questions about this research, please feel free to contact:
Janaki Rughani; phone: 4221 4207; e-mail: jr925@uow.edu.au
Monique Piper; phone: 4226 7052; e-mail: mpiper@idgp.org.au;

If you have any questions regarding the conduct of this research please contact the secretary of the University of Wollongong Human Research Ethics Committee on (02) 4221 4457.

This information sheet is for you to keep.

Yours Sincerely,

Janaki Rughani
Principal Researcher
University of Wollongong

University of Wollongong 

Research Project: **Perceived Value and Barriers as Predictors of Adolescents' Professional Help-Seeking for Emotional Problems**

STUDENT CONSENT FORM

In choosing to participate in the evaluation, I understand that:

1. I will be required to complete a questionnaire asking about my attitudes toward visiting a health professional for different emotional concerns.

2. The questionnaire will take approximately 15 minutes.

3. I will be required to complete the questionnaire in four different sessions: before and after the presentation in Term 1 and before and after the presentation in Term 2

In giving my consent, I acknowledge that:

1. The procedures required for the project and the time involved have been explained to me and any questions I have about the project have been answered to my satisfaction

2. I have read the Student Information Sheet and have been given the opportunity to discuss the information and my involvement in the project with the researchers

3. I understand that that my participation in this project is voluntary; a decision not to participate will in no way affect my academic standing or relationship with the school and I am free to withdraw my participation at any time.

4. I understand that my involvement is strictly confidential and that no information about me will be used in any way that reveals my identity.

If I have any enquiries about the research, I can contact Janaki Rughani (4221 4207) and Monique Piper (4226 7052). If I have any concerns or complaints regarding the way the research is or has been conducted, I can contact the Ethics Officer, Human Research Ethics Committee, Office of Research, University of Wollongong on 4221 4457.

Signed……..

Name…….

Date…….

Any complaints about the research should be addressed to:

Janaki Rughani
Illawarra Institute for Mental Health (iiMH)
Building 22
University of Wollongong
Northfields Avenue
WOLLONGONG NSW 2522
E-mail: jr925@uow.edu.au

University of Wollongong 

Research Project: **Perceived Value and Barriers as Predictors of Adolescents' Professional Help-Seeking for Emotional Problems**

TEACHER INFORMATION SHEET

The purpose of this letter is to provide you with information regarding our discussion of the evaluation of the Promoting-Access-&-Support-Seeking (PASS) program. As discussed, as part of the Cross Roads program, students will hear a presentation providing information about different problems that a health professional (such as a doctor, school counsellor or psychologist) can help with. The aim of the program is to increase students' awareness of the importance of seeking help from health professionals for both physical and emotional problems. The presentations encourage them to visit a health professional should they experience physical or emotional problems in the future. This presentation is part of the school health curriculum.

Who is running this study?

This study is being conducted by *Janaki Rughani* from the University of Wollongong. It is part of a *Doctor of Psychology (Clinical)*, being supervised by *Prof. Frank Deane and Dr. Coralie Wilson (University of Wollongong).*

What is this study about?

The aim of this study is to see if students are more willing to seek help, think help will be more useful and are more likely to consult a health professional for emotional or mental health problems after hearing the PASS presentation.

Where & when will the research take place?

The research will take place at your school and will be conducted during the Cross Roads program on date (Term 1) and date (Term 2).

What would students have to do?

Students would complete a brief questionnaire in four different sessions. Each session will take about 15 minutes:

Term 1
Session 1: Immediately before the Cross Roads presentation
Session 2: Immediately after the Cross Roads presentation

Term 2
Session 3: Immediately before the Cross Roads presentation
Session 4: Immediately after the Cross Roads presentation

The survey is **confidential.** Surveys will be identified by a code number and will only be seen by the researchers. It will not be possible for students to be identified in any reports that result from the study. Students are asked questions about visiting a health professional for different emotional concerns. Examples of questions in the survey include: "I know what to expect when I go to see a health professional", "Would you feel better if you disclosed feelings of sadness or anxiety to a health professional?" "During the last 30 days, about how often did you feel nervous?" They will also be asked to indicate the likelihood that they would seek help and whether they have sought help in the past.

If you allow your students to participate in this study, any information they provide will be kept confidential. Only the researchers will have access to this information.

What would I have to do?

Be present in a supervisory capacity while the presentation is being conducted.
Apart from your regular class supervision of students during the presentations, we can foresee no risks for you.

What can I expect from the researchers?

If you allow your students to take part in the study, you and they have the right to:

- Withdraw from the study at any time,
- Ask any further questions about the study that occur during their participation,
- Be informed of the findings from the study when it has concluded
- Provide information in the survey on the understanding that it is completely confidential to the researchers. All records will be identified by a code number and it will not be possible for your students to be identified in any reports that result from the study.

The data collected will be used for the principal researcher's doctoral thesis, conference presentations and publication in scholarly journals.
No participants will be identifiable in any reports.

Participation is voluntary and your students will only take part if they have returned the parent/caregiver consent form and provide their own consent to participate. If you decide that you do not wish your students to take part, it will not affect your relationship with the University of Wollongong. If you change

your mind about taking part, even after the study has started, you have the right to withdraw from the study. Any data already collected will be destroyed.

If you give permission for your students to take part in this evaluation, please complete the attached Form.

If you have any questions about this research, please feel free to contact:
Janaki Rughani; phone: 4221 4207; e-mail: jr925@uow.edu.au
Monique Piper; phone: 4226 7052; e-mail: mpiper@idgp.org.au

If you have any questions regarding the conduct of this research please contact the secretary of the University of Wollongong Human Research Ethics Committee on (02) 4221 4457.

This information sheet is for you to keep. Students and their parents/caregivers will also be given information about this project.

Yours Sincerely,

Janaki Rughani
Principal Researcher
University of Wollongong

University of Wollongong

Research Project: **Perceived Value and Barriers as Predictors of Adolescents' Professional Help-Seeking for Emotional Problems**

TEACHER CONSENT FORM

I have been given information about *the PASS program* and discussed the research project with Janaki Rughani who is conducting this research as part of Doctor of Psychology (Clinical) supervised by Prof. Frank Deane and Dr Coralie Wilson at the University of Wollongong.

I have been advised that I will be required to be present during the presentation in a supervisory role and that there are no foreseeable risks for me. I have had an opportunity to ask *Janaki Rughani* any questions I may have about the research and my students' participation.

I understand that participation in this research is voluntary and that I can withdraw participation at any time. Refusal to participate or withdrawal of consent will not affect *my relationship with the University of Wollongong.*

If I have any enquiries about the research, I can contact Janaki Rughani (4221 4207) and Monique Piper (4226 7052) or if I have any concerns or complaints regarding the way the research is or has been conducted, I can contact the Ethics Officer, Human Research Ethics Committee, Office of Research, University of Wollongong on 4221 4457.

By signing below I am indicating my consent for my students to participate in the research project: Perceived Value and Barriers as Predictors of Adolescents' Professional Help-Seeking for Emotional Problems.

I understand that the data collected will be used for the principal researcher's thesis and journal publication, and I consent for it to be used in that manner.

Signed ***Date***

..../...../.....
Name (please print)

.....

Appendix D

PASS! intervention PowerPoint slides

DVD scripts

Introduction to PASS! evaluation script

Structured outline of PASS! content

Website activity worksheet

Critical incident procedure and log

Part 5
Additional Resources

headspace PASS! PowerPoint slide show

headspace

headspace PASS!

(Promoting Access and Support Seeking in Young People)

Session One

S1-1
www.headspace.org.au

headspace

Who is headspace and why are we visiting your school?

- We are visiting for the first of two sessions
- We're here to meet with you and talk about different ways that
  - health care professionals help
  - headspace can help with different health problems.

S1-2
www.headspace.org.au

headspace

Who is a health care professional?

What is a headspace Community of Youth Service (CYS)?

S1-3
www.headspace.org.au

headspace

Why do we need our own CYS for help?

DVD Clip 1

S1-4
www.headspace.org.au

headspace

Introducing your local headspace CYS

- You can find us at ...

The easiest way to get to us ...

S1-5
www.headspace.org.au

headspace

What do you know about the different jobs of the CYS staff?

Form small groups at each of the spaces around the room
Your job:

- Draw a table with 3 columns that looks like this example
- Discuss the jobs that each headspace CYS staff member has, plus:
  - the types of problems that each person can help you with
- Write the answers for each staff member in the table you make.

S1-6
www.headspace.org.au

headspace PASS: PowerPoint slide show

headspace

'But getting professional help didn't help in the past!'

S1-7
www.headspace.org.au

headspace

Session one summary

We came to meet you and

- Talk with you about our local CYS
- Answer any questions you have about the CYS or the types of health problems we can help with.

S1-8
www.headspace.org.au

headspace

Preparing for Session Two

We're coming back and it would be really good if you could help us prepare

- All you have to do is spend about 30 minutes checking our website to find answers
- Fill in the sheet and you're done!


S1-9
www.headspace.org.au

headspace

headspace PASS!

Session Two

- In session one we talked about CYSs and the different ways staff can help
- This time we are going to talk about how to use a CYS and make the most of your consultation with a health care professional
- We'll also answer your questions about
  - visiting a health care professional
  - visiting a headspace CYS
  - health concerns
  - what different feelings young people may experience might mean.

S2-1
www.headspace.org.au

headspace

Review

Preparation for Session Two

S2-2
www.headspace.org.au

headspace

Feelings and thoughts that may stop young people visiting a health care professional

- A lot of people feel worried or scared when faced with a problem
- Some believe their worries or fears indicate how bad the problem is
- Some start to believe that if they feel really worried it must mean that the problem is so big that they won't be able to cope

S2-3
www.headspace.org.au

Part 5
Additional Resources

headspace PASS! PowerPoint slide show

headspace

Feelings and thoughts that may stop young people visiting a health care professional

BUT

- These unpleasant feelings are not good measures of how bad the problem really is
- They are your body's way of helping you recognise that you have a problem and to do something about it!

S2-3
www.headspace.org.au

headspace

Signs that indicate you might be feeling anxious and could use some help from a health care professional

- Heart pounding
- Butterflies in the stomach
- Feeling like you want to throw up
- 'Jumpy'
- Grumpy.

S2-4
www.headspace.org.au

headspace

Signs that indicate you might be feeling anxious and could use some help from a health care professional

- Trembling and shaking
- Having trouble sleeping
- Feeling overwhelmed and out of control
- Feeling as if you're going 'crazy'
- Feeling like you want alcohol or drugs to calm down.

S2-4
www.headspace.org.au

headspace

Signs that might indicate you are feeling depressed and could use some help from a health care professional

- Feeling really sad, worthless, hopeless or really insecure
- Losing interest in things you usually enjoy
- Not being able to sleep
- Having trouble concentrating or making decisions.

S2-5
www.headspace.org.au

headspace

Signs that might indicate you are feeling depressed and could use some help from a health care professional

- Feeling tired
- Starting to pull away from your friends and family and the people you would normally talk to or hang out with
- Feeling like you want alcohol or drugs to make the sadness go away.

S2-5
www.headspace.org.au

headspace

Signs that might indicate you are misusing drugs or alcohol and could use some help from a health care professional

- Needing more and more to feel the same way after taking the drugs or alcohol
- Repeatedly using the drugs or alcohol when it is dangerous to do so, such as when you are driving a car
- Repeatedly getting into trouble after taking the drugs or alcohol

S2-6
www.headspace.org.au

headspace

Signs that might indicate you are misusing drugs or alcohol and could use some help from a health care professional

- Not being able to keep your commitments at school, home or work
- Feeling more and more wound up, sad or confused
- Doing things when you are drinking or using drugs that you later regret.

S2-6
www.headspace.org.au

headspace

Examples of ways to overcome feelings that can stop you seeking help from a health care professional

Take a walk or listen to music to help you think clearer. Then:

- Think about feeling less upset and feeling better
- Think about dealing with the problem
- Think about finding out how to deal with similar problems in the future.

S2-7
www.headspace.org.au

headspace

Examples of thoughts that can stop you seeking help from a health care professional

- 'I don't have problems'
- 'It means I'm weak if I ask for help'
- 'If I ignore my problems, they'll go away'
- 'I feel bad so I won't get help'.

S2-8
www.headspace.org.au

headspace

Examples of thoughts that can stop you seeking help from a health care professional

- 'I'm afraid of what a health professional will think of me if I get help'
- 'Help wasn't useful in the past, so it won't be useful again'
- 'Help won't help!'

S2-8
www.headspace.org.au

headspace

What can I expect when I visit a health care professional?

What you need to know about

- The rules of confidentiality
- Costs and how you can pay.

S2-9
www.headspace.org.au

Rules about confidentiality

headspace

Health care professionals keep the conversation that you have with them to just between the two of you unless you give permission for them to talk to someone else or if the law requires it.

The law requires a health care professional to talk to someone else about your situation if

- Someone is harming you
- You are at risk of harming yourself
- You are at risk of harming someone else

This is to ensure that either you or those you might harm are safe.

If confidentiality has to be broken the health care professional will discuss it with you first.

S2-10
www.headspace.org.au

Part 5
Additional Resources

headspace PASS! PowerPoint slide show

headspace

Costs and what you pay

- Using services at a headspace CYS is either free or at low cost under a government initiative called Better Access
- Contact your local CYS for current fees charged
- Under the Better Access initiative you can have up to 12 consultations with a health care professional in any one calendar year.

S2-11
www.headspace.org.au

headspace

"How do I make the most of my consultation?"

DVD Clip 2

S2-12
www.headspace.org.au

headspace

Know your background – make sure you know about any:

- Illnesses or operations you have had
- Medications you are taking
- Allergies you may have
- Members of your family who have had any serious or inherited illness.

Know your problem – think about your problems and make sure you know the answers to the following questions:

- When did the problem start?
- If you are in pain, what is the pain like?
- Does anything make the pain better or worse?

S2-13
www.headspace.org.au

headspace

Ask questions:

- Make a list of questions you have
- Make sure you understand the health professional's explanation of your problem
- Ask about the treatment that is offered and any side effects that the treatment may have

Express your concerns about coming to see a health care professional or about your problem.

S2-13
www.headspace.org.au

headspace

Skill rehearsal –
your turn to role-play

- Pair up with someone else in the room
- Each pair acts out the role play using the brief script. One person acts as the health care professional and the other acting as the young person coming for health care. Then swap roles.

You have four minutes for the activity. I will tell you once two minutes has gone past so you can swap roles

S2-14
www.headspace.org.au

headspace

Know your responsibilities...

www.headspace S2-15

headspace PASS! PowerPoint slide show

Some useful tips

- Keep to your appointment or ring to cancel if you are unable to attend
- Be on time and let the receptionist know as soon as you arrive
- Ask about fees and the payment of your bill at the time of making your appointment
- Ask for a longer appointment if you have more than one problem to discuss. It is better to book the time in advance
- Be prepared to wait. If you cannot wait let the receptionist know and make another appointment time.

S2-16
www.headspace.org.au

Wrap-up:
Any questions we haven't answered yet?

S2-17
www.headspace.org.au

Session Summary

DVD Clip 3

In each DVD Clip the young person showed the following help-seeking steps that you can use when they need to seek help:

1. Tell another person what you are feeling or what is happening for you
2. Tell another person how long you have been feeling or acting this way and if the feeling or behaviours have gotten better or worse in this time.

S2-18
www.headspace.org.au

Session Summary cont.

3. Tell another person that you think you might need help

'It takes a lot of courage to get help but you'll be better off. Reach out. Get help.'

S2-18
www.headspace.org.au

Part 4
Appendices

Appendix F
The S3 DVD Clip 2 Summary and Script: 'Making the most of a consultation'

Overview

S3 DVD Clip 2 presents another relatively common case that has the dual purpose of teaching young people about making the most of the session and living up to their responsibilities, as well as providing an example for clinicians that demonstrates appropriate youth-friendly communication and interpersonal skills.

Content

- General symptom presentation: Young person aged 16 or 17 presents with signs and symptoms of depression: social withdrawal and dark mood, not concentrating or getting homework done, feeling agitated but lethargic, moderate use of alcohol, has experimented with drugs but not using consistently, no suicidal ideation, no clear cause or trigger for current psychological state. During the consultation the young person describes a fear of finding out they are crazy by talking to the psychologist, as well as their fear that parents and friends are going to find out they have spoken to a psychologist. The young person also explains that they are starting to pull away from their friends and parents
- Scenario: young person is in an initial consultation with a **headspace** psychologist.

NOTE: If it is not possible to play S3 DVD Clip 2 due to resource restrictions, use the following clip script to rehearse the scenario as a role-play prior to **headspace PASS!** session two then perform the role-play for the young people to watch in place of the DVD clip.

Post-clip 2 discussion (slide S2-12):

- **Summarise** key points from case and highlight the specific messages that were given in the clip which are listed in Summary S2-1 and Summary S2-2 below.

Summary S2-1: highlighting skills and content that make the most of a consultation

- The clinician:
  - demonstrates an approach that is friendly, genuine and 'natural'
  - demonstrates empathic and supportive responses to the young person
  - demonstrates open and attentive non-verbal communication with their eye contact, postural position (including gestural and facial expressions), verbal quality and the interpersonal space they maintain between the young person and themself
  - demonstrates active listening by being attentive when the young person is speaking then paraphrasing, gently clarifying, reflecting, and summarising the young person's message to show they have heard
  - initially shares small talk with the young person that allows time for trust and rapport to build (the conversation starts with general content that does not focus too quickly on emotionally 'high-risk' problems allowing the young person to 'warm up')
  - avoids using jargon
  - tells the young person that everyone needs the support and help of others from time to time, no matter how independent they want to be, and praises the young person for visiting
  - explains that getting the help from a mental health professional or another type of health care professional might not change the problem, but it can help see the problem differently

Part 4

Appendixes

Appendix H

The S3 DVD Clip 3 summary and script: Summary of Session 1 and 2

Overview

S3 DVD Clip 3 presents another relatively common case and reviews and repeats key messages that have been made throughout session one and two. It specifically shows a pathway to care which starts with a peer referring to a school counsellor who in turn refers a young person to a GP at a **headspace** CYS.

- **General symptom presentation:** Young person aged 17 or 18 presents with signs of anxiety or depression: mild agitation, markedly flat affect and lack of normal expression and flow in communication; leg shake – primary cause not clear – intensity and frequency may be linked to moderate cannabis use and heavy alcohol use, no suicidal ideation. The young person is currently in what they view as supportive partner and family relationships, family does not know about drug use or intensity of alcohol use – partner encourages the behaviour.
- **Scenario and summary points:**
  - young person talking to their best friend, friend observes young person hasn't been acting like themselves in the past few weeks and that the friend has hardly seen them, friend notes young person has been missing class, friend encourages young person to see the school counsellor, scene ends with young person walking off to make an appointment with the school counsellor
  - initial consultation is with a school counsellor who is approached by the young person who has been encouraged to talk with the counsellor
  - the school counsellor greets the young person and very briefly summarises key points from S3 DVD Clip 1 **(see Appendix A)**, and hears a brief version of the young person's story
  - the young person demonstrates:
    1. Telling the school counsellor what is happening for them
    2. Telling the school counsellor **how long** they have been feeling this way **and** that what they are feeling has **got worse in this time.**
    3. Telling the school counsellor that they think they might need help from a GP.
  - the school counsellor suggests that the young person might like to talk with a GP at **headspace,** then telephones **headspace** with the young person present to arrange an appointment
  - the young person and their friend approach the intake officer/receptionist at **headspace** with referral to a GP and demonstrating key points regarding patient responsibilities
  - intake officer summarises key points from S3 DVD Clip 1 and connects the young person with a **headspace** GP **(Appendix A)** while the young person's friend waits in the reception area
  - young person meets the GP for an initial consultation, young person and GP demonstrate key points from S3 DVD Clip 2 **(see Appendix F)**;
  - Clip 3 finishes with a final shot with the young person speaking directly into camera: 'It takes a lot of courage to get help, but you'll be better off. Reach out – get help'.

NOTE: If it is not possible to play DVD Clip 3 due to resource restrictions, use the following clip script to rehearse the scenario as a role-play prior to **headspace PASS!** session two then perform role-play for the young people to watch in place of the DVD clip.

Introduction to PASS evaluation (script)

As part of the health curriculum, you will hear a presentation called: "Promoting-Access-&-Support-Seeking" (PASS). The aim of the program is to increase your awareness of the importance of seeking help from health professionals for both physical and emotional problems. The presentation encourages you to visit a health professional should you experience physical or emotional problems in the future.

You have been asked to complete a questionnaire before and after the presentation. By completing the questionnaire, you will help evaluate whether the PASS presentation is helpful as well as help us understand which parts of it are most helpful. This will help with making any important changes to the presentation before it can be conducted across more schools in Australia.

The research is being conducted by Janaki Rughani as part of a Doctor of Clinical Psychology at the University of Wollongong. The presentation will be carried out by various health professionals such as doctors, counselors and psychologists.

If you agree to participate in the research, you would complete a 15 minute questionnaire in four different sessions: before and after the presentation today and before and after the presentation in Term 2.

Completing the questionnaires is voluntary and you will only take part if both you and your parent/caregiver agree. If you decide that you don't want to take part, it won't affect your results or progress at school. If you change your mind about taking part, even after the study has started, just let me or one of the researchers know. Any information already collected will be destroyed.

If you do participate in this study, any information you provide will be kept confidential. Questionnaires will be identified by a code number that will only be seen by the researchers. It will not be possible for you to be identified in any way.

When completing the questionnaires, please make sure that you fill out the top section of the questionnaire which asks for your birthday and parents' initials. It is very important because the researchers require this information in order to assign a code number to the questionnaires

Session 1: Relationship building, addressing attitudinal and belief-based barriers

slide #	slide title	Activity type	Purpose	Duration	Comments
S1–1	**headspace PASS!** Session 1	**Large Group** (LG = Total group: 25–30 young people), presentation	• To introduce the **headspace PASS!** program • To start building rapport between local **headspace** CYS staff and young people • To demonstrate how health care professionals, particularly, the local CYS staff, work together as a team.	6 mins	
S1–2	Who is **headspace** and why are we visiting your school?				
S1–3	Who is a health care professional? What is a **headspace** Community of Youth Services?	LG, interaction	• To find out what the young people currently know about consulting a health care professional and their local **headspace** CYS • To find out what the young people want to know about consulting a health care professional and about using their local **headspace** CYS • To uncover any incorrect information or beliefs about accessing professional health care and **headspace** CYS.	5 mins	
S1-4	Why do we need our own CYS for help?	LG, interaction	• To explain what early intervention means and provide statistics to support the need for **headspace** • To provide introductory information to address important belief-based barriers to help-seeking, particularly, professional health care seeking • To match health problem-type to the different types of professional staff found in the community and associated with the local **headspace** CYS • To explain how the local CYS staff can help as a team.	15 mins	

Session 1: Relationship building, addressing attitudinal and belief-based barriers

slide #	slide title	Activity type	Purpose	Duration	Comments
S1–5	Introducing your local **headspace** CYS	LG, presentation	To give a description of the local CYS To present the youth-friendly and multidisciplinary philosophy of the CYS.	2 mins	
S1–6	What do you know about the different jobs of the CYS centre staff?	Small Group (SG ; 5–6 young people), interactive	To describe the range and types of professional staff associated with the local **headspace** CYS To uncover any incorrect information or beliefs that the young people have about the different health care professionals, and particularly, those associated with the **headspace** CYS To rehearse matching health problem-type to the different types of professional staff found in the community and associated with the local **headspace** CYS.	10 mins	
S1–7	'But getting professional help didn't help in the past!'	LG, interactive	To address negative beliefs that young people may have about previous professional health care.	5 mins	
S1–8	Session 1 summary	LG, presentation	To review the content of the session Review the young people's questions from the start of this session and identify those that have been addressed during this session, those that should be addressed before the end of this session and those that remain for Session 2.	2 mins	
S1–9	**headspace** website activity	LG, presentation	To prepare the young people for the computer-based guided learning activity exploring the **headspace** website; To provide the young people with CYS access information to take away.	5 mins	

Session 2: Relationship building, addressing attitudinal and belief-based barriers, raising emotional and mental health literacy, skill building and information giving
(60–minute session, 50 minutes of content)

slide #	slide title	Activity type	Purpose	Duration	Comments
S2–1	**headspace PASS!** Session 2	LG, interactive	To continue building rapport between local **headspace** CYS presenters and young people.	3 mins	
S2–2	Review: **headspace** website activity	LG, presentation	To make sure young people know the correct location of their local **headspace** CYS To highlight thoughts and feelings that act as barriers to help-seeking To highlight and directly address a prominent barrier to help-seeking for psychologically distressing problems: the help-negation effect relating to suicidal thinking and other depressive symptoms in young people.	12 mins	
S2–3	Feelings and thoughts that may stop young people visiting a health care professional				
S2–4	Signs that might indicate you are feeling anxious and could use some help from a health care professional				
S2–5	Signs that might indicate you are feeling depressed and could use some help from a health care professional				
S2–6	Signs that might indicate you are misusing drugs or alcohol and could use some help from a health care professional				
S2–7	Examples of ways to overcome feelings that can stop you seeking help from a health care professional				
S2–8	Examples of thoughts that can stop you seeking help from a health care professional				
S2–9	What can I expect when I visit a health care professional?	LG, presentation	To provide information about rules of confidentiality, Medicare, costs and billing.	1 min	

Session 2: Relationship building, addressing attitudinal and belief-based barriers, raising emotional and mental health literacy, skill building and information giving
(60–minute session, 50 minutes of content)

slide #	slide title	Activity type	Purpose	Duration	Comments
S2–10	Rules of confidentiality	LG, interactive	To provide an explanation of what confidentiality is and the instances where confidentiality is breached.	4 mins	
S2–11	Costs and what you pay	LG, presentation	To provide information about the costs of using services at the **headspace** CYS, as well as Medicare, costs and billing in other community agencies.	3 mins	
S2–12	How do I make the most of my consultation?	LG and pairs, interactive	To demonstrate help-seeking skills involved in maximising the benefits of a consultation with a health care professional To have the young people rehearse and discuss the process and benefits of help-seeking skills To identify and discuss patient responsibilities To directly address help-seeking barriers related to help-negation for depression, fear of being crazy, value of help-seeking, clinician-oriented barriers.	15 mins	
S2–13	Know your background, know your problem/symptoms, ask questions, express your concerns				
S2–14	Skill rehearsal: your turn to role-play				
S2–15	Know your responsibilities	LG, presentation	To review client's responsibilities for accessing professional health care	2 mins	
S2–16	Tips to make the most of your consultation				
S2–17	Wrap-up: Any questions we haven't answered yet?	LG, interactive	To revisit the questions raised by the young people at the start of Sessions 1 and 2 and review answers; To answer any new questions the young people might have about their health or processes of taking care of their health or help-seeking To directly address help-seeking barriers that remain and are described by the young people.	3 mins	
S2–18	Session summary	LG, presentation	To review the content of Sessions 1 and 2 and summarise key points.	7 mins	

headspace Website Activity

For this activity you will need a computer with internet access and about 30 minutes for exploring the **headspace** website and answering the questions below.

1. Go to the **headspace** website... www.headspace.org.au....click on '**headspace** sites' then click on the link to **headspace** CYS sites in your State, then click on the link to your local **headspace** CYS
2. Write the address of your local **headspace** CYS:

   _____

   _____

   _____

3. Describe the easiest way for your friend to get to your local **headspace** CYS (e.g. what is the closest main road to look out for? Is there public transport close by? Could your friend walk or use a bike to get to the **headspace** centre?)

   _____

   _____

   _____

4. Go back to the **headspace** website home page. Click on 'Your Stories' then click on 'Learn from Others'. Use the next 10 minutes to read through the blogs. Share your story if you want to.

5. Go back to the **headspace** website home page. Click on 'Downloads' then click on 'Face Chase'. Check out the game and have a go. Use the next 10 minutes to get the best Face Chase time and score that you can. Come back later and have another go if you want to.

- This procedure is to be followed by **headspace** Illawarra staff during any **headspace** presentation at an educational facility and assumes that schools are aware of their responsibilities during these presentations.
- The responsibility of student's welfare is the schools. Supervising teachers should be present at all times to help monitor student's behaviour and should take care of students who may become distressed as a result of content of the **headspace** presentation. Supervising teachers will follow critical incident procedures specific to their school.
- In the event of a student becoming visibly distressed during the course of a **headspace** presentation:

  a) the **headspace** staff member present (or GP, if there is no IDGP staff member present) is to ensure that the supervising teacher is aware of the situation and that the student is being cared for.

  b) at the end of the presentation, the **headspace** staff member present and GP talk to the supervising teacher about the student's condition – particularly, if the student/s has/have recovered, what was the possible trigger for the student/s to become upset and if the student/s is/are being referred to the school counsellor.

  c) the Head/organising teacher is to be contacted by the **headspace** in Schools Program Officer, either at the school, or when the **headspace** in Schools Program Officer returns to the IDGP office, to discuss the incident, to clarify what follow-up is being undertaken and/or the outcome for the student/s.

  d) an entry is to be made in the **headspace** in Schools Incident Log (T/headspace/headspace in Schools/School Critical Incident Log) by the **headspace** in Schools Program Officer.

  e) the headspace in Schools Program Officer is to make a report to the IDGP CEO and the headspace in Schools Steering Committee about the incident.

  f) the Head/organising teacher is to follow the school's own Critical Incident Procedures.

- In the event of one or more students becoming distressed as a result of any headspace Illawarra presentation:

  a) the Head/Organising teacher is to inform the headspace in Schools Program Officer – particularly, what was the possible trigger for the student to become upset and any follow-up action being taken by the school.
  b) an entry is to be made in the headspace in Schools Incident Log by the headspace in Schools Program Officer.

  c) the headspace in Schools Program Officer is to make a report to the IDGP CEO and the headspace in Schools Steering Committee about the incident.

  d) the Head/organising teacher is to follow the school's own Critical Incident Procedures.

headspace in Schools Program Officer – Monique Piper

This Procedure is to be reviewed in June 2009.

Critical Incident Log:

1 Date	School	1.1 Detail	Action	By

Appendix E

Exploratory analyses results tables

Exploratory Analyses on Help-seeking Intentions

Percentage of Students in the Unlikely, Unsure and Likely Ranges of Help-seeking at Pre, Post and Follow-up

Control Group			
Help-seeking Intentions	Pre %	Post %	Follow-up %
Unlikely	53	44	60
Unsure	16	26	14
Likely	31	30	27

Treatment Group			
Help-seeking Intentions	Pre %	Post %	Follow-up %
Unlikely	53	40	55
Unsure	25	18	25
Likely	22	42	19