YOUTH BARRIERS TO HELP-SEEKING AND REFERRAL FROM GENERAL PRACTITIONERS

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AIM

➢ Six studies were undertaken to examine youth barriers to consulting a General Practitioner, from both youth and GP perspectives. Studies one to three examined young peoples' intentions and barriers to seeking professional help for personal, emotional, and suicidal problems. Studies four to six examined GPs' understanding of young peoples' help-seeking barriers, GP attitudes towards professional psychological help-seeking and GPs' referral practices.

BARRIERS TO YOUNG PEOPLE CONSULTING A GP

Focus group themes

➢ Strong themes of:

- Adolescent autonomy.
  - Adolescents wanted health care to be independent of family.
  - Young people didn't want their family to know if they went to a GP for personal-emotional or suicidal problems.
  - Young people didn't want to consult a GP who knew their family.
- The experience of aversive emotions, particularly fear, anxiety, and shame.
- Limited knowledge about how to go about seeking appropriate help, including that of a GP.
- Seeking help from sources other than general practice (e.g., friends and family).
- Not wanting to talk about personal-emotional or suicidal problems if they felt little relationship with the GP.

Adolescent help-seeking patterns

➢ Generally low intentions to consult a GP for problems of ill-mental health.

➢ Higher intentions to seek help from friends and family than a GP for personal-emotional and suicidal problems.

➢ Similar levels of intentions to consult a GP for a personal-emotional or suicidal problem.

➢ Some groups may be more likely to consult a GP for personal-emotional and suicidal problems than other groups.

  • Public high school students were more likely to consult GPs than private high school students for personal-emotional problems.

➢ Strong positive relationship between intentions to consult a GP and actually doing so for personal-emotional and suicidal problems.

➢ Results highlighted the importance of GPs' duel role as primary health care providers and gatekeepers for all types of prevention and particularly youth suicide prevention.

➢ In some populations, GPs may be the only health care professional that is accessed for mental health problems such as suicidal thoughts.

➢ Strategies to promote general practice should target young peoples' help-seeking intentions and barriers.

Barriers predicting intentions to consulting a GP for suicidal and non-suicidal problems

➢ Lower intentions to consult a GP for a personal-emotional problem related significantly to:

  • Not wanting family to know about the help-seeking.

  • Being too embarrassed to talk about the problem.

  • Little confidence in finding relief from general practice.

  • Little consideration of help from a GP for managing the problem.

➢ Lower intentions to consult a GP for suicidal problems related significantly to:

  • Little consideration of help from a GP for managing the problem.

- Little confidence in finding relief from the help of a GP.
- Not wanting professional help.

➢ Most barriers related significantly to higher levels of hopelessness.

➢ Hopelessness was strongly associated with the belief that "nothing will change the problems I have".

➢ Several barriers significantly predicted intentions to consult a GP for personal-emotional problems:

- Not wanting family to know about the help-seeking.
- Little consideration of help from a GP for managing the problem.

➢ Several barriers significantly predicted intentions to consult a GP for suicidal problems:

- Little confidence in finding relief the help of a GP.
- Little consideration of help from a GP for managing the problem.

➢ Young people may benefit from information about ways to access a GP.

➢ Additional information should promote help from a GP as a good problem solving option.

GPs ATTITUDES, PERCEIVED BARRIERS AND REFERRAL PRACTICES FOR YOUNG PEOPLE NEEDING MENTAL HEALTH CARE

GPs help-seeking and views about youth help-seeking barriers

➢ A number of GPs have a good knowledge of youth help-seeking barriers.

➢ Some GPs may benefit from additional information about youth help-seeking barriers.

➢ GPs are often reluctant to seek professional psychological help.

➢ At least some GPs may benefit from information about the usefulness of professional psychological help for professional support.

➢ GPs' attitudes about the support provided by mental health care services may influence their referral practices.

GPs attitudes to mental health care, and youth referral and management practices

➢ Most GPs had positive attitudes to mental health care in general practice.

➢ GPs employ a range of ideal referral practices such as:

- Explaining why GPs think a referral to a mental health professional might be useful and the benefits that might be attained.

- Explaining to the young person that they have a choice about seeing a mental health professional or not.

➢ Some recommended referral practices should be used more often in general practice:

- Explaining the GP will continue to support the young person.

- Organising a referral with a mental health professional.

- Explaining to the young person that they will need to share information.

- Allowing the young person to specify information they don't want to share.

- Discussing issues of confidentiality.

- Making a referral phone call with a young person.

- Explaining what to expect in an initial mental health consultation.

- Developing a list of problems to specify mental health needs and goals with the young person.

- Explaining any costs that might be incurred and the likely duration of the consultation.

- Obtaining a record of the young person's consent for their referral.

➢ Time constraints and lack of remuneration may be significant barriers to GPs providing mental health care.

➢ GPs need to be provided additional information about ideal referral practices.

➢ More research is needed to examine the relationship between GPs' attitudes and beliefs and their referral practices.

<u>Confirming GPs perceptions of client and service barriers</u>

➢ GPs have a good knowledge of client and service related barriers to general practice.
➢ Three exceptions were found:
  • GPs were not aware that
    ▪ emotional reactions inhibit young peoples' help-seeking,
    ▪ seeking inappropriate help is an important help-seeking barrier, and
    ▪ omitting family in referral practices can be a barrier to successful referral.
➢ At least some GPs may benefit from education about youth help-seeking barriers and specific ways to overcome them.
➢ Results highlighted the need for GPs to be provided information about ideal referral practices.

<u>LIMITATIONS</u>

➢ Studies one to three used school-based samples therefore results may not be generalisable to young people outside school.
  • Results should be replicated across samples with different characteristics.
➢ Studies four and six had small sample sizes and time constraints.
  • Results may not be generalisable to all GPs.
  • Results from studies four and six need replication in larger samples.
➢ Study five had a low response rate and responses were based on self-report.
  • Results may not be generalisable to all GPs.
  • Self-report indications of referral practices did not describe quality or thoroughness or practices.
  • Results from study five need replication and may be enhanced by the inclusion of behavioural data.

RECOMMENDATIONS

The findings from studies one to six provide a basis for preliminary recommendations about ways in which GPs might reduce young peoples' help-seeking barriers, engage young people more effectively and refer them more successfully. Certainly, further research is needed in this area, particularly regarding relationships between GPs' practices for overcoming youth help-seeking barriers, GPs' attitudes towards mental health care, and GPs' referral practices. However, findings presented within the current report suggest a number of strategies for GPs to employ within the interim.

Promoting general practice

- Describe the ways GPs can help with different physical, personal, emotional, and psychological problems
- Promote general practice for solving and managing problems.
- Promote general practice as an independent problem-solving option for young people.
- Describe the relief that can be provided through general practice.
- Promotion strategies should target young peoples' help-seeking beliefs and attitudes towards consulting a GP, along with their help-seeking intentions.

Reducing professional barriers

- Increase knowledge of youth developmental stages and issues.
- Increase knowledge of youth health and mental health conditions.
- Increase knowledge of ways to manage youth health and mental health conditions, particularly suicidal ideation and behaviour.

Reducing service-related barriers

- Make sure that clinic times coincide with times that are available for young people, particularly those who are still at school. Make sure there are extended consultation times available where needed.
- Develop a 'youth friendly' environment within clinics and services. Consider youth targeted posters, magazines, flyers, background music, and décor.
- Bulk bill where possible.
- Discuss the option of individual Medicare cards if appropriate.
- Make sure charges are clearly stated before consultations.
- Develop clear policies about billing and finances. Discuss arrangements for confidential billing.

Reducing interpersonal barriers

- Be proactive in building rapport and trust with young people.
- Talk with the young person. Allow them time to build trust and rapport. Talk about the role of a GP and the help GPs can provide.
- Building rapport can be broadly divided into three areas: attending, listening, responding.
- Pay attention to non-verbal communication. Research indicates that when information communicated through non-verbal channels contradicts information communicated through verbal channels, the non-verbal communication becomes most important.
- When interacting with young people, consider eye contact, postural position (including gestural and facial expressions), verbal quality, and interpersonal space.
- When listening to a young people, direct eye contact is appropriate (unless the young person is of a culture where direct eye contact is considered inappropriate, i.e. confrontational or disrespectful).
- When talking, eye contact is often less frequent. Lean slightly forward facing the young person. Vary voice tone and show some emotionality.

Speak at a moderate rate in words the young person will be able to understand. Hold conversation at "arms length" or more for comfort.

- When listening to a young people, be attentive then paraphrase, clarify, reflect, and summarise the young person's message.
- Talk about the benefits of getting the right kind of help. Praise the young person for the visit.
- Listen to the young person's distress. Avoid minimising problems. Let young person know that no problem is insignificant if it causes distress and that coming to a GP is a good way to start reducing that distress.

Reducing emotional and cognitive barriers

- Talk about problems as a normal part of life.
- Talk about emotional reactions being cues that something is wrong rather than a true reflection of how bad a problem is.
- Point out that problems often feel worse when we try to deal with them by ourselves. Ask the young person to be courageous and trust you with their problem.
- Discuss issues of confidentiality.
- Let the young person know that everyone needs the support and help of others from time to time, no matter how independent they want to be. Getting professional help from a GP or a mental health professional might not change the problem, but it can help see the problem differently.
- Where appropriate, reassure the young person that they are not going "crazy" but that they would benefit from a professional perspective on their problems.
- Review the young person's prior help-seeking attempts. Reinforce them for using appropriate problem-solving and help-seeking strategies.
- Let the young person know that getting professional help is not about forcing them to do things they don't want to do, but about providing choices.

Reducing referral barriers

- Help young people recognise what different problems 'look like'.
- Describe the best source of help for each problem.
- When talking about referral to other professional help-providers, take a systematic approach. Start with examples about every day problems and end up with emotional and social problems.
- Consider the developmental level of the young person. Make sure your examples are relevant to the patient.
- Talk about what seeing a psychologist or a counsellor is all about. Inform the young person that they need to share information with a mental health professional.
- Use statistics to explain that a lot of young people get distressed and a lot of them get help by talking to counsellors and psychologists.
- Allow the young person to specify any information they do not want shared.
- Develop a list of problems with the young person to specify their mental health needs and goals.
- Talk about issues of confidentiality and any concerns that the young person might have about privacy in their mental health consultation.
- Talk about any costs the young person might incur and how long a consultation might take.
- Let the young person know that they have a choice about whether they see a mental health professional or not.
- Talk to the young person about the consequences not following through on referrals.
- Explain that everyone needs help at some point and sometimes trained help is the best kind.
- Explain that you don't have to be "crazy" to see a counsellor. Describe areas other than mental health where a counsellor can help. For example, for career management. Let the young person know why seeing a mental health professional might be helpful.

- If young people feel they have had unhelpful experiences with previous mental health professionals, explain that sometimes it takes a couple of tries to feel understood.
- Explain that not all mental health professionals are the same. They are normal people and just like all people, some the young person will "click" with and others they won't. Ask the young person to give a new mental health professional a chance.
- Let the young person know that even though they will be seeing a mental health professional, the GP will continue to be there for them.
- Obtain a record of consent for referral.
- If the young person feels strongly that they want their problem to remain between them and the GP, this should be adhered to.

Additional recommendations

- GPs may benefit from information about:
    - the help provided by different mental health services;
    - rates of recovery;
    - pathways to accessing different mental health services;
    - seeking professional psychological help for professional support;
    - ideal referral practices.
- GPs may benefit from networking and partnership building with selected mental health services for professional support and easier referral.

INTRODUCTION

Across the life span, young people represent the age group with the highest prevalence of mental health problems and disorders (Scanlon, 2002). They are also a group that is more likely to present symptoms related to psychological or behavioural disorders (e.g., suicide, depression, alcohol and drug dependence) rather than symptoms related to solely physical illness (*Australian Institute of Health and Welfare,* 1999). Although many young people do not seek professional help for their mental health problems, of those who do, most prefer the help of a General Practitioner (Andrews, Hall, Teesson, & Henderson, 1999; Davies, 2000; Deane, Wilson & Ciarrochi, 2001). Since GPs provide primary health care that is both known and generally accessible for many at-risk young people (Veit, Sanci, Young, & Bowes, 1995, Veit, Sanci, Coffey, Young, & Bowes, 1996), GPs have a vital role in the identification of at-risk young people, the provision of intervention, and the facilitation of access to appropriate help providers.

A number of barriers inhibit the likelihood that young people will consult a GP (e.g., Veit et al., 1996). Fortunately, GPs are in a position to reduce at least some help-seeking, engagement and referral barriers. Until recently, there has been little research that has either investigated youth perspectives about barriers to seeking help specifically from GPs or GPs' understanding of youth help-seeking barriers, particularly for help with mental health problems. Presented in this report are summaries of six studies that have been conducted to address this need. The studies examine help-seeking barriers, from both youth and GP perspectives. Study one provides a descriptive and exploratory basis for studies two to six. Studies one to three comprise section one of this report, and examine young peoples' intentions to seeking help from a GP for personal, emotional and suicidal problems. Although studies one and two have been described elsewhere (Deane, Wilson, Ciarrochi, & Rickwood, 2002), they are summarised in the current report with a focus on

youth help-seeking from general practice. Studies four to six comprise section two and examine GPs understanding of young peoples' help-seeking barriers, GPs' attitudes towards professional psychological help-seeking, and GPs referral practices. Section one relates to the general reluctance of young people to consult GPs whereas section two relates largely to the engagement and referral capacity of the GP.

SECTION ONE:
Barriers to young people seeking help from GPs

Study 1

Exploring help-negation: Is it a manifestation of help-seeking barriers?

Wilson, C. J., & Deane, F. P.

The area of positive mental health in adolescents is gaining increased research attention within Australia (Rowling, Martin, & Walker, 2002). A major area of focus has been the array of barriers that reduce the likelihood that young people will seek and obtain appropriate help for mental health issues (Miraudo & Pettigrew, 2002). Since engaging in professional health care, on one's own or one's peers behalf, is thought to offer protection against a variety of risk factors for adolescent ill-mental health (Kalafat, 1997), barriers have been examined from a number of perspectives including: the causal pathways to health care services (e.g., Zubrick, Silburn, Burton, & Blair, 2000); evaluations of actual services available to adolescents (e.g., Seiboth, 1998; Waring, Hazell, Hazell, & Adams, 2000); and the development of strategies for prevention and early intervention in the school, community, and across the country (e.g., Chamberlain, 1998; Webster, 1998; Wyn, Cahill, Holdworth, Rowling, & Carson, 2000; Zubrick et al., 2000). A growing number of help-seeking studies have also examined barriers from adolescent perspectives (e.g., Kuhl, Jarkon-Horlick, & Morrissey, 1997; Wilson, Deane, Rickwood, & Ciarrochi, 2002). Most of these studies however, use surveys that limit the information that can be obtained to structured ratings of pre-selected items. Few studies have explored adolescent perspectives and opinions about barriers to appropriate help through methods such as in-depth focus group discussions or semi-structured interviews. To meet this need,

Study 1 was conducted to provide a descriptive and exploratory starting point for the following investigation of young peoples' barriers to formal medical and mental health care.

Study 1 aimed to extend findings from several general barrier studies (e.g., Kuhl et al., 1997; Lindsey & Kalafat, 1998), to provide information about the reasons young people have for different barriers, the relative importance of different barriers, and the processes involved in the development of different barriers.

Method

Focus group discussions were used to explore help-seeking barriers in a small sample of NSW public high-school students aged 14 to 18 years ($N =$ 23, 11 male, 12 female). The high-school was situated in an outer-metropolitan industrial region. Students from across the school were recruited during Student Representative Council meetings and compulsory study classes.

Six student focus groups were conducted, however, only four focus groups were necessary for data saturation. Data saturation was determined using principles of Grounded Theory (Dey, 1999; Strauss, 1987; Strauss & Corbin, 1990, 1997). Focus groups were run in no particular order and were deliberately kept small because students in each group tended to be friends and seemed less inhibited when talking amongst themselves. Group discussions lasted approximately 90 minutes and with the permission of the participants, all discussions were recorded onto audiotape. At the conclusion of each discussion, a debriefing session was held and students were supplied with a resource that listed health services in the district.

Following group discussions, audiotapes were fully transcribed and data were organised and interpreted using a theoretically focused Immersion/Crystallization (I/C) process (Borkan, 1999; Crabtree & Miller, 1992). Interpretations are reported here as results.

Results

Consistent with prior research, strong focus group themes emphasised the important influence of fear, anxiety, shame, and adolescent autonomy. Extending prior research, transcript analysis highlighted several factors that had been previously cited as risk factors for suicide, but not to our knowledge, as specific help-seeking barriers (e.g., cognitive distortions). Cognitions (attitudes, beliefs, knowledge, cognitive distortions) and emotions (experience and expression) were shown to influence decisions to not seek help for personal-emotional and suicidal problems. Closer theme inspection revealed that aversive emotions often co-occurred with knowledge deficits about appropriate help-seeking and limited or poor professional help-seeking experience. Students indicated that cognitions and emotions acted together to influence problem perception and appraisal, problem solving strategies, and the decision to seek help as a functional step towards solving a problem. This cognition-emotion interplay seemed to be reflected across all help-seeking themes, especially in tendencies toward avoidance behaviour once problems were recognised. Themes also suggested that students experience difficulty recognising problems and have a limited knowledge about functional ways to solve problems (in this case, match problems with appropriate help sources and seek appropriate help).

As shown in other studies (e.g., Deane, Wilson, & Ciarrochi, 2001), Study 1 found that students suggested they would seek help from informal sources (friends and family) before formal health and mental health sources (GPs and counsellors). Consistent with previous research (e.g., Veit, Sanci, Young, & Bowes, 1995), during focus group discussions, students explained that they didn't want their family to know if they went to a GP for personal-emotional or suicidal problems. They also explained that they didn't want to talk to a GP who knew their family and they wouldn't talk to a professional health provider they felt didn't know them. The question was raised by students, "How can they [GPs and counsellors] help you if they don't know you?"

Summary

Although limited by sample size, Study 1 was successful in identifying a number of help-seeking barriers that relate specifically to young people consulting and engaging with a GP. The study highlighted the need to better understand the strength of young peoples' reliance on friends and family as sources of help and as a barrier to consulting a GP. Finally, the study highlighted the need to examine the extent to which young people differentiate between help sources and are able to recognize the usefulness of general practice for different health and mental health problems. Answers to these needs were explored in Study 2.

Study 2

Patterns of adolescent help-seeking intentions for suicidal and non-suicidal problems in samples with different characteristics

Wilson, C. J., Ciarrochi, J., & Deane, F. P.

A substantial research base highlights several overarching and for the most part, robust youth help-seeking patterns. In general, studies examining young peoples' help-seeking for personal-emotional problems have identified friends as young peoples' preferred help-source with parents preferred second. Preference, intention and actual rates of help-seeking for formal sources have tended to be lower than rates for informal sources, and young people have often preferred help from "no-one" above most other help-sources (see Wilson, Deane, Ciarrochi, & Rickwood, 2003, for a detailed review). In contrast, little research has examined the specific intentions that young people have to seeking help from different help sources, particularly formal help-sources such as a GP. Neither has it explored the relationship between intentions and actually seeking help from intended sources, for different problem-types in samples of young people with different characteristics.

Study 2 had two primary aims. First, to compare and contrast the general and specific help-seeking intentions of students from a public high school with those from a private Christian high school. Second, to examine the relationship between each group's help-seeking intentions and their actual help-seeking from different sources, particularly a GP, for personal-emotional problems and suicidal thoughts.

Method

Sample 1. Two hundred and sixty-four high school students were recruited from the junior to senior classes (grades 8 to 12) of an Australian public high school located in an Illawarra (NSW) industrial area. The mean age was 16.10

years (SD = 1.68 years) and ranged from 12 to 21. One hundred and forty three participants were male (54%), 121 were female (46%). Sample 2. A total of 357 high school students completed the research questionnaire. Students were recruited from the junior to senior classes (grades 9 to 12) of a private Christian high school. Eighty-eight participants (36%) were male and 157 participants (64%) were female. The mean age was 15.83 years (SD = 1.23 years) and ranged from 12 to 18. Each participant completed the anonymous research questionnaire individually under the supervision of either peer presenters or the research assistant.

Measures. The self-report research questionnaire for both samples included measures of help-seeking intentions (General Help-Seeking Questionnaire [GHSQ]; Deane et al., 2001) and actual retrospective help-seeking (Actual Help-Seeking Questionnaire [AHSQ]; Rickwood & Braithwaite, 1994).

The GHSQ was developed to assess help-seeking intentions for non-suicidal and suicidal problems, and has been related to actual help-seeking in the past month, future help-seeking behaviour, and barriers to seeking professional psychological help, in several high school samples (e.g., Deane, Ciarrochi, Wilson, Rickwood, & Anderson, 2001a; Wilson et al., 2003). The Study 2 version of the measure asked participants to rate the likelihood that they would seek help from a variety of sources for personal-emotional problems and for suicidal thoughts. Help-sources include boyfriend/girlfriend, friend, parent, relative, mental health professional (school counsellor, counsellor, psychologist, psychiatrist), phone help line, doctor/GP, teacher (year level coordinator, classroom teacher, home class teacher, dean of students, support staff), pastor/priest, and youth worker. An additional item asks participants to indicate if they "would not seek help from anyone". The two problem prompts have the following general structure, 'If you were having a personal-emotional problem, how likely is it that you would seek help from the following people?' Participants rate their intentions to seek help from each of the ten help-sources, along with "I would not seek help from anyone", on a 7-point scale (1 = extremely unlikely, 7 = extremely likely). The GHSQ also asked participants to indicate if they have ever seen a mental health

professional (e.g., school counsellor, counsellor, psychologist, psychiatrist). Participants who had sought help are asked to estimate the number of visits to health care provider and rate the usefulness of the prior help (1 = not at all useful, 5 = extremely useful).

Based on Rickwood and Braithwaite's (1994) original measure of help-seeking behaviour, the AHSQ was developed to assess actual help-seeking from sources matched to those listed in the GHSQ. Students indicated their actual help-seeking in the previous three weeks from each source on a "yes-no" checklist, along with the nature of their problem (personal-emotional or suicidal).

Results

As presented in Table 1, means and standard errors of students' help-seeking intentions indicated that students in both samples were most willing to seek the informal help of friends and family before formal help for personal-emotional and suicidal problems. Further analyses examined whether there were any differences in high school students' preferred help-source, and whether there were any help-seeking differences across problem-types. A General Linear Model repeated measures ANOVA was used to examine the impact of help-source (boyfriend/girlfriend, friend, parent, other relative, mental health professional, phone help-line, GP, teacher, Pastor/Priest, Youth Worker/Youth Group Leader, no-one) and problem-type (personal-emotional problem and suicidal thoughts) on intentions to seek help for each sample. There was a significant main effect for helping source for public high school students, $F(10, 1780) = 75.55$, $p < .001$, that was qualified by a significant interaction with problem-type, $F(20, 1780) = 19.10$, $p < .001$. Similarly, there was a significant main effect for helping source for the private high school students, $F(10, 2160) = 166.38$, $p < .001$, that was also qualified by a significant interaction with problem-type, $F(20, 2160) = 29.09$, $p < .001$, indicating that even with different school characteristics, students' preferred source of help depended upon the type of problem they were facing.

Table 1. Means (M) and standard errors of help seeking intentions (GHSQ[1]) for personal-emotional problems (Per-Emot), suicidal thoughts (Suicide-Thts), and different sources of help for two high school samples (Public and Private).

Help Source	Problem Type (Public)				Problem Type (Private)			
	Per-Emot		Suicide-Thts		Per-Emot		Suicide-Thts	
	M	SE	M	SE	M	E	M	SE
Boy/girlfriend	4.53_a	.15	3.73_a**	.16	4.41_a	.12	4.01_a*	.14
Friend	5.04_b	.10	4.24**	.13	5.84_b	.01	4.82**	.11
Parent	$4.89_{a,b}$	.12	3.68_a**	.15	4.81_a	.11	$3.90_{a,b}$**	.13
Family (non-parent)	3.92_a	.12	$3.28_{a,b,c}$**	.13	4.00	.10	$3.33_{b,c,d}$**	.12
Mental Health	2.57_c	.10	$2.90_{c,d}$	.12	2.62_c	.01	$3.20_{b,c}$*	.12
Help Line	2.11_d	.01	$2.50_{d,e}$*	.12	1.38_d	.01	2.78_c**	.12
GP	2.66_c	.10	2.50_d	.11	1.50_d	.01	1.70_e	.01
Teacher	2.62_c	.10	$2.14_{e,f}$**	.01	2.54_c	.01	$2.37_{d,e}$*	.01
Religious Leader	1.83_d	.01	1.82_f	.01	2.02_c	.01	$2.52_{d,e}$	.11
Youth Worker	2.09_d	.01	2.16_f	.10	2.56_c	.01	$2.68_{c,d}$	.12
Would not seek help	2.69	.13	2.62	.13	1.68	.11	1.83	.12

n (Public) = 264, *n* (Private) =351.

Note. Evaluations were made on a 7 point scale (1 = extremely unlikely, 7 = extremely likely). "Would not seek help" was not included in the contrasts.

[1]GHSQ refers to the General Help-Seeking Questionnaire (Deane, Wilson & Ciarrochi, 2001).

**Means differ between personal-emotional problems and suicidal ideation in the same row for each school at $p < .001$ and *$p < .05$ using Bonferroni correction.

a,b,c,d,e,fMeans within columns differ from each other at $p < .05$, with the exception of those that share a letter.

To evaluate the interaction between problem-type and help-source further, pairwise comparisons were conducted within each school sample using a Bonferroni adjustment to control for Type I error at $p < .05$. Also presented in Table 1, students in both samples indicated that when experiencing suicidal ideation rather than non-suicidal problems, they were less likely to seek help from parents and other relatives but more likely to seek help from mental health professionals and telephone help lines. When experiencing suicidal and non-suicidal problems, students indicated they would seek some form of informal help before that of no-one, mental or medical health care

professionals, or teachers and other community welfare help-sources. Both interactions indicated that students' preferred source of help depended upon the type of problem they were facing. It is noteworthy that students in both samples indicated they were most likely to seek help from friends for all types of personal problems and less likely to seek help from friends for suicidal thoughts than non-suicidal problems.

To examine the differences between public and private high school students' intentions to seek help from each source further, pairwise comparisons between help-seeking intentions across sample-types were conducted for personal-emotional problems and suicidal thoughts. As presented in Table 2, there were significant between-group differences in intentions to seek help from a number of sources. As might be expected by the religious nature of the private high school, students in this sample had significantly higher intentions to seek help from religious leaders and youth workers for personal-emotional and suicidal problems than students in the public high school sample. These students also had higher intentions than their public high school counterparts to seek help from friends. In contrast, the public high school sample had significantly higher intentions to seek help from a GP, help-line, and no-one for personal-emotional and suicidal problems than the private high school sample. This indicated that students without religious affiliation might rely on GPs and help-lines more readily than other groups for help with personal-emotional and suicidal problems. It also suggested that students without religious affiliation might be more likely than others to avoid seeking help from any source for distressing problems. However, these between-group differences are qualified by the finding that overall help-seeking patterns were consistent across both sample-types (Table 2).

Table 2. Pairwise comparisons (t) between the help seeking intentions of public and private high school students for personal-emotional problems (Per-Emot) and suicidal thoughts (Suicide-Thts).

	Problem Type			
	Per-Emot		Suicide-Thts	
Help Source	t	df	t	df
Boy/girlfriend	-.64	472	1.31	467
Friend	3.23[*]	613	3.45[*]	592
Parent	-.50	611	1.08	594
Family (non-parent)	.48	609	.27	589
Mental Health	.35	613	1.67	585
Help Line	-3.19[*]	614	1.70	594
GP	-6.60[**]	613	-2.88	595
Teacher	-.59	610	1.58	594
Religious Leader	3.99[**]	615	4.60[**]	595
Youth Worker	3.28[*]	606	3.26[*]	584
Would not seek help	-15.47[**]	593	-14.00[**]	567

n (Public) = 264, n (Private) =351. [**] $p < .001$, [*] $p < .01$.

Finally, the relationships between help-seeking intentions for personal-emotional and suicidal problems, and between help-seeking intentions for each problem-type and actual help-seeking from each source was examined within each sample. As presented in Table 3, correlational analyses between help-seeking intentions for each problem-type and source found that the relationship between intentions to seek help for personal-emotional and suicidal problems associated positively and significantly for all sources at $p < .001$, and for both sample groups (Public: $r_s = .51$ to $r_s = .72$; Private: $r_s = .48$ to $r_s = .76$). This suggests that for public and private high school students, help-seeking intentions for suicidal thoughts were related to intentions to seek help for personal-emotional problems. Correlational analyses were also conducted between students' intentions to seek help from each help-source and their actual help-seeking for a personal-emotional or suicidal problem from that source in the previous three weeks. For both groups, intentions to seek help from each informal help-source (partner, friend, parent family) associated positively and at similar levels of significance with actually seeking help from

that source in the previous three weeks. This was also true for the relationship between intentions to seek help from religious leaders, youth workers, and GPs, and actually seeking from each of these sources for both problem-types and both groups.   There were however, notable differences between the groups in their intentions to seek help from teachers, mental health professionals and help-lines, and actually seeking help from these sources, particularly for suicidal problems. The relationships between intentions to seek help from teachers and actually seeking their help for personal-emotional and suicidal problems were smaller and less significant than the same relationship for the private high school students. And, in contrast to the private high school group, the relationship between intentions to seek help from a mental health professional or help-line and actually seeking help from these sources for suicidal problems was not significant for the public high school sample. Given the significant relationship between intentions and actually seeking help from a GP for suicidal thoughts in the public high school sample, these results suggest that at least some students experienced suicidal distress for which they sought professional help and a GP was their preferred professional source of health care.

Table 3. Correlations (r_s) between students' intentions to seek help from different sources (GHSQ) and their actual help-seeking from that source in the previous three weeks (AHSQ).

Help Source	Problem Type (Public)		Problem Type (Private)	
	Per-Emot	Suicide-Thts	Per-Emot	Suicide-Thts
Boy/girlfriend	.38***	.32***	.47***	.37***
Friend	.40***	.22**	.45***	.32***
Parent	.35***	.17**	.55***	.38***
Family (non-parent)	.40***	.33***	.35***	.30**
Mental Health	.13*	.10	.27***	.17**
Help Line	.17**	.12	.17**	.16**
GP	.19**	.18**	.27***	.21***
Teacher	.15*	.13*	.43***	.36***
Religious Leader	.24***	.24***	.36***	.29***
Youth Worker	.31***	.31***	.44***	.34***

n (Public) = 264, *n* (Private) = 351. ***$p < .001$, **$p < .01$, *$p < .05$.

<u>Summary</u>

Reflecting student opinions from Study 1, high school students from both samples in study two reported higher help-seeking intentions for informal rather than formal help-sources. Intentions to seek help from friends were significantly higher than for any other help source. Students reported that they were most likely to seek help from friends then family for problems that were not suicide related, and most likely to seek from friends then no-one for problems that were suicide related (e.g., suicidal thoughts). With regard to consulting a GP, students indicated similar help-seeking intentions for personal-emotional and suicidal problems.

As might be reasonably be expected from the nature of the sample differences, there were significant differences in help-seeking intentions between groups on some items. This was particularly noticeable in relation to seeking help from religious sources and GPs. Students from the Christian high school reported significantly higher intentions to seek help from Religious Leaders and Youth Workers/Youth Group Leaders for suicidal and non-suicidal problems than public high school students. Whereas, public high school students reported significantly higher intentions to seek help from telephone help-lines and GPs for personal-emotional problems.

A particularly important finding from this study was the strong positive association found between students' intentions to consulting a GP and their actual help-seeking from a GP for personal-emotional and suicidal problems. This supports the view that for many young people, GPs provide the primary mental health care that is critical for managing their distress (e.g., Veit et al., 1995). It also highlights the important role that GPs have in the detection and prevention of youth suicide.

There is evidence that a significant proportion of distressed young people who go on to complete suicide, visit their GP close to the time of their attempt (e.g., Pirkis & Burgess, 1998; Lincoln, Harrigan & McGorry, 1998; RNZCGP, 2000).

Thus, consistent with previous reports (Deane, Wilson, & Biro, 2002; Graham, Reser, Suderi, Zubrik, Smith, & Turley, 2000), Study 2 findings highlight a need for all GPs to be competent at youth suicide assessment and referral, regardless of whether they consider themselves "youth friendly" or not. The findings also reinforce the on-going development of initiatives that strengthen partnerships between health care services and strategies for more effective referral and case management.

From a health promotion perspective, the significant association between young peoples' help-seeking intentions and their actual help-seeking suggests that efforts to bring young people to general practice may be most effective if promotion efforts target young people's help-seeking intentions. Furthermore, since barriers to seeking professional help relate to lower help-seeking intentions (Wilson et al., 2003), efforts to promote general practice should continue to target help-seeking barriers (Barnes, Ikeda and Kresnow, 2001).

Finally, the intention and actual help-seeking differences between the samples underscore the likelihood that in some populations, GPs may be the only health care professional that young people will turn to for mental health problems. Within the current study, public high school students reported intentions to seek help from GPs that were higher than other formal sources and higher than their private high school counterparts. Clearly, these findings reinforce the need for GPs to be comfortable engaging young people and competent at identifying indicators of youth mental health problems, particularly those related to suicide. The findings also highlight the need for the ongoing identification of specific barriers that reduce young people's intentions to consult a GP, particularly for personal-emotional and suicidal problems. Answers to this question were examined in Study 3.

Study 3

Adolescent barriers predicting intentions to seek general practice for suicidal and non-suicidal problems

Wilson, C. J., Deane, F. P., & Ciarrochi, J.

As noted, young people represent the age group with the highest prevalence of mental health problems and disorders within Australia (Scanlon, 2002), and the only age-based group whose psychosocial health status has not significantly improved in the past forty years (*Australian Institute of Health and Welfare,* 1998). Offering promise, there is emerging evidence that prevention and early intervention initiatives may have started to curb this trend over the last four years (*Australian Bureau of Statistics,* 2002). Nevertheless, suicide, eating disorders, mental health problems and the use of licit and illicit substances are still unacceptably high (Burns, 2001; Henderson, Andrews, & Hall, 2000; Martin, 2002). Mental health problems are the primary cause of ill-health for adolescents across Australia (AIHW, 2000).

Sawyer and colleagues (2000) surveyed the mental health care seeking of 4,500 adolescents across Australia and found that at the time of their study, 14% of the sample were experiencing symptoms of mental health problems. This is reflected in a regional Australian youth health study of 1, 939 young people which found that 75% of participants had "felt unhappy, sad, or depressed" in the previous 6 months (*Illawarra Health*, 1996). For 21% of these participants (15% of the total number of participants), this feeling had been "almost more than I can take". Seventy one percent of the participants surveyed had "felt under strain, stress, or pressure" in the previous 6 months, and 16% of these participants (11% of the total number of participants) felt that the strain had been "almost more than I can take" (*Illawarra Health*, 1996). Given these statistics, along with Study 2 results suggesting that GPs are in many cases, the only professional health care providers that young people will access for help with personal, emotional, or suicidal problems,

concern is raised by young peoples' well documented under-representation in general practice (RNZCGP, 2000; SERU, 1999).

A substantial literature base attests to the existence of barriers that reduce young peoples' willingness to seek professional help (Kuhl et al., 1997; Pescosolido & Boyer, 1999; Wilson & Deane, 2000, 2001; Wilson et al., 2003; Veit, Canci, Coffey, Young, & Bowes, 1996). While little data is available to speculate on young peoples' help-seeking for symptoms of physical distress, with respect to symptoms of mental distress and illness, results from Study 2 clearly indicate that young people from different groups within the community appear reluctant to seek professional help. The fact remains that most young people prefer to confide in peers rather than an adult or health care professional about their distress (eg. Deane et al., 2001; Kalafat & Elias, 1995; Wilson, Deane, & Ciarrochi, 2002). Sawyer et al. (2000) found that of the 4,500 children and adolescents who took part in their study, only 50% of those with a mental health problem indicated that they had attended any health care service during the previous 6 months, and only 17% had attended a mental health service. Similarly, Donald and colleagues (2000) found in their Queensland study of 3,092 young adults (aged 15 to 24 years) that 39% of the males and 22% of the females surveyed reported that they would not seek help from health care providers for personal-emotional or other distressing problems. Thirty per cent of the males and 6% of the females reported they would not seek help from anyone (Donald, Dower, Lucke, & Raphael, 2000).

In the search to identify barriers that relate specifically to young people seeking medical advice, the *Australian Access to Service and Evaluation Research Unit* (SERU, 1999) found that young people identified cost, communication, compassion, confidentiality, and convenience as the major barriers to consulting a GP. Similarly, the *Centre for Adolescent Health* (1997) found that young people were most concerned about inhibitive service fees or method of payment, communication difficulties with GPs, lack of compassion from GPs or other staff, confidentiality breach, inconvenience related to such factors as surgeries not being accessible during out-of-school hours, treatment fears, anxiety and shame, limited knowledge about the types of help that GPs can

provide, and fear of negative attitudes from staff. Sawyer et al. (2000) found that parents identified practical barriers such as "the cost of attending services, not knowing where to get help, and long waiting lists" (p. 33). Donald et al. (2000) found that young people reported "the most common barrier to formal [health] service utilisation was concern about confidentiality" (p. 44). Other barriers related to cost and fear about the help each service would provide.

Finally, in a study that examined the impact that help-seeking barriers had on adolescent intentions to seek medical and mental health care, Wilson et al. (2002) found that of those barriers examined, barriers relating to the belief that adolescents should solve their own problems were most substantial. Within the same study, higher barriers to professional help-seeking related to lower adolescent intentions to seek professional help, higher levels of student hopelessness, and negative views about the usefulness of previous professional help. Other important barriers related to time and money constraints, not wanting family to know about seeking health care, having the belief that "nothing will help", and experiencing fears about embarrassment, confidentiality breach, and coercion.

For targeted general practice promotion, as noted earlier, the findings reviewed above, along with the results of Studies 1 and 2, highlight the need for the continued examination of barriers that predict young peoples' health care seeking. Research also needs to identify variables that may influence the strength of different barriers. For the most part, belief-based and attitudinal rather than structural or contextual barriers have featured within the literature as significant to professional help-seeking (e.g., Kuhl et al., 1997; Wilson et al., 2002). They are also variables offering the most potential for targeted modification and consequent behaviour change (e.g., Ajzen, 1991).

The primary aim of Study 3 was to identify specific belief-based and attitudinal barriers to professional help-seeking that predict lower intentions to seek help from a GP for either personal-emotional or suicidal problems. Since hopelessness has been positively associated with barriers to young people seeking professional help (Wilson et al., 2002), the secondary aim of study

three was to examine relationships between specific barriers to professional help and students' levels of hopelessness.

Method

Sample. A total of 357 high school students completed the research questionnaire. Students were recruited from the junior to senior classes (grades 9 to 12) of a private Christian high school. Participants were not known to be currently receiving treatment from a mental health service. Eighty-eight participants (36%) were male and 157 participants (64%) were female. The mean age was 15.83 years (SD = 1.23 years) and ranged from 12 to 18 years. Each participant completed the anonymous research questionnaire individually and under the supervision of classroom teachers.

Measures. The self-report research questionnaire included measures of barriers to young people seeking professional help (brief version of the Barriers to Adolescents Seeking Help Questionnaire [BASH-B]; Wilson et al., 2002; Kuhl et al., 1997), attitudes towards seeking professional help (brief version of the Attitudes Towards Seeking Professional Psychological Help Scale [ATSPPHS-B]; Fischer & Farina, 1995), hopelessness (Beck Hopelessness Scale [BHS]; Beck, Weissman, Lester, & Trexler, 1974) help-seeking intentions (General Help-Seeking Questionnaire [GHSQ]; Deane et al., 2001), actual retrospective help-seeking behaviours (Actual Help-Seeking Questionnaire [AHSQ]; Rickwood & Braithwaite, 1994),

The BASH-B is an 11-item version of the BASH (Kuhl et al., 1997). The measure is a self-report questionnaire that was developed in response to a need for a shorter measure than the 37-item BASH. The BASH is supported by adequate reliability and validity. Split-half reliability r = .82, Cronbach's alpha r = .91, and test-retest reliability (assessed over a two week period) r = .91. Validity was established by correlation with treatment history, positive perception of help givers, gender, and ethnicity (Kuhl et al., 1997). The BASH-B comprises 11 BASH statements about help-seeking that are rated on a 6-point scale (1 = strongly agree to 6 = strongly disagree). Items are reverse

scored and higher scores indicate higher barriers to seeking professional psychological help. Items extracted from the BASH for inclusion in the BASH-B have been found to correlate significantly and negatively with help-seeking intentions for adolescent males and females (Wilson et al., 2002).

The BHS comprises 20 true-false items that reflect hopelessness (e.g., "My future seems dark to me") and appear to access the general hopelessness construct. Items are scored to indicate the existence of hopelessness and the extent of negative attitudes about the future. Scores range from 0 to 20. The BHS is supported by sound reliability and construct validity data across samples (e.g., Metalsky & Joiner, 1992). The measure has been found to associate positively with suicidal ideation and attempt, single-episode major depression, recurrent-episode major depression, dysthymia, drug and alcohol misuse (Beck & Steer, 1988) and other self-report measures of hopelessness (Beck et al., 1974).

The brief ATSPPHS assesses attitudes to professional help-seeking. Participants rate statements about help-seeking on a 4-point scale (0 = disagree, 3 = agree). Higher scores indicate stronger attitudes towards professional help-seeking. Positive and negative attitudes towards professional help-seeking are assessed. The GHSQ and AHSQ are described in study two.

Results

Preliminary analyses. The mean scores and standard errors of students' intentions to seek help from a GP for personal-emotional (p-e) problems and suicidal thoughts (s-t) were calculated, M (p-e) = 1.51, SE = .01; M (s-t) = 1.70, SE = .01, and found to be marginally lower than comparative means in an Australian public high school sample, M (p-e) = 2.73, SE = .14; M (s-t) = 2.63, SE = .14 (Wilson et al., 2002). The BASH-B scale mean (M = 3.40, SD = .92) and ATSPPHS scale mean (M = 1.53, SD = .54.) were also calculated, indicating that overall, barriers to professional help-seeking were moderate to high in this sample. Correlational analyses found significant negative

associations between the BASH-B scale and intentions to seek help from a GP for personal-emotional problems, $r = -.27$, $p < .001$, and suicidal thoughts, $r = -.17$, $p < .01$, and between the ATSPPHS scale and intentions to seek help from a GP for personal-emotional problems, $r = -.25$, $p < .001$, and suicidal thoughts, $r = -.28$, $p < .001$. A significant positive relationship was also found between the BASH-B and ATSPPHS scales, $r = .49$, $p < .001$. Further analyses revealed that BASH-B and ATSPPHS items could be combined as a reliable "Barriers" measure (Cronbach's alpha = .86) for use in the main regression analyses.

Main analyses

First, correlational analyses were conducted to examine the relationship between barriers to seeking professional health care and students' intentions to consult a GP. Correlational analyses also examined the relationship between barriers and levels of hopelessness. As presented in Table 4, there were small but significant relationships between a number of barriers and students' intentions to seek help from GPs for both personal-emotional and suicidal problems ($r < .30$, $p < .05$). There were also a number of moderate and positive associations between student barriers and higher levels of hopelessness (Table 4). Particularly noteworthy is the strong positive association between hopelessness and the belief that "nothing will change the problems I have" ($r = .48$, $p < .001$).

Next, two stepwise regression analyses were used to identify barriers that predicted intentions to seek help from a GP for first, personal-emotional problems and second, suicidal thoughts. To minimise the number of independent variables used in each analyses, the first regression analysis included only those barrier items that had significant relationships with intentions to seek help from a GP for personal-emotional problems (Table 4), as independent variables. Intentions to seek help from a GP for a personal-emotional problem was included as the dependent variable. As presented in Table 5, the overall model was significant, $F (3, 274) = 14.12$, $p < .001$, and thirteen percent of the variance in students' intentions to seek help from a GP

was explained by the barriers included in the analysis. The second model included barrier items that had significant relationships with intentions to seek help from a GP for suicidal thoughts (Table 4) as the independent variables. Intentions to seek help from a GP for suicidal thoughts was included as the dependent variable. The overall model was significant, $F(3, 283) = 11.68$, $p < .001$, and eleven percent of the variance in intentions to seek help from a GP was explained by the barriers included in the analysis.

Table 4. Significant correlations between adolescent barriers to formal help-seeking and high school students' intentions to seek help from a GP for personal-emotional problems (Per-Emot) and suicidal thoughts (Suicide-Thts).

		Help-seeking Intentions	
Barriers	Hopelessness	Per-Emot	Suicide-Thts
▪ I wouldn't have time to see a professional.	.20**	-.15*	-.17*
▪ A professional might make me do or say something that I don't want to.	.30**	-.15*	-
▪ I'd never want my family to know I was seeing a professional.	.31**	-.27**	-.17*
▪ Adults really can't understand the problems that kids have.	.27**	-.17*	-
▪ I'd be too embarrassed to talk about my problem.	.35**	-.27**	-.19*
▪ Nothing will change the problems I have.	.48**	-.23**	-.22**
▪ I could not afford to see a professional.	.26**	-	-.17*
▪ If I believed I was having a mental breakdown, my last thought would be to get professional attention.	.23**	-.24**	-.29**
▪ Talking about problems is a poor way to get rid of emotional conflicts.	-	-	-.16*
▪ If I were experiencing a serious emotional crisis at this point in my life, I am not confident I could find relief in professional help.	.35**	-.26**	-.28**
▪ I wouldn't want professional help if I were worried or upset for a long period of time.	.25**	-.20**	-.24**
▪ A person with an emotional problem is not likely to solve it with professional help.	.22**	-.18*	-.23**
▪ Considering the time and expense involved in psychological counselling, it would not have much value for me.	-	-.18*	-.21**
▪ A person should work out his or her own problems.	-	-	-.15*

$N = 357$. ** $p < .001$, * $p < .01$.

As presented in Table 5, significant Beta values indicated that of those barriers measured, this sample's strongest barrier to seeking help from a GP for a personal-emotional problem, was concern that family would find out that the student was seeking professional help. This was followed by lack of consideration of professional help as a suitable way to manage a personal-emotional problem. The strongest barrier to seeking help from a GP for suicidal problems was lack of confidence in receiving relief from professional help and again, this was followed by lack of consideration of professional help as a suitable way to manage suicidal thoughts.

Table 5. Significant Beta values (B) and standard errors in the Stepwise Regression analysis for barriers predicting intentions to seek help from a GP for personal-emotional and suicidal problems.

		Help-seeking Intentions		
	Per-Emot$_a$		Suicide-Thts$_b$	
Barriers	B	SE	B	SE
I'd never want my family to know I was seeing a professional.	-.25***	.03	-	-
If I believed I was having a mental breakdown, my last thought would be to get professional attention.	-.15*	.04	-.16**	.08
If I were experiencing a serious emotional crisis at this point in my life, I'm not confident I could find relief in professional help.	-	-	-.17***	.07
Considering the time and expense, professional help would not have much value for a person like me.	-.13*	.04	-.12*	.07

$_a$df = 3, 274; R^2 = .13, Adj R^2 = .12. $_b$df = 3, 283; R^2 = .11, Adj R^2 = .10.
*** $p < .000$, ** $p < .01$, * $p < .05$

Summary

A number of significant and negative associations were found between belief-based and attitudinal barriers and students' intentions to consult a GP for personal-emotional problems and suicidal thoughts. Lower intentions to consult a GP for personal-emotional problems were most strongly associated with not wanting family to know about the help-seeking, being too

embarrassed to talk about the problem, lack of confidence in finding relief from professional help, and little consideration of professional help as a suitable problem solving option. Lower intentions to consult a GP for suicidal thoughts were most strongly associated with little consideration of professional help as a problem solving option, lack of confidence in finding relief from professional help, and simply not wanting professional help. Most barriers were significantly and positively associated with higher levels of hopelessness. It is notable that high levels of hopelessness were associated with the belief that "nothing will change the problems I have", and little confidence in finding relief from professional help. This suggests that at least some student barriers to consulting a GP may be influenced by pessimism about the help that can be attained from a GP.

As expected, several barriers were found to significantly predict lower student intentions to consulting a GP. The strongest predictor of intentions for a personal-emotional problem was reluctance for family to know about the health care seeking. This was followed by little consideration of professional help as a suitable problem solving option. The strongest predictor of help-seeking intentions for suicidal thoughts was a lack of confidence in finding relief from professional help, and again, little consideration of professional help as a suitable way to manage suicidal thoughts.

Unfortunately, Study 3 was limited by the finding that the identified barriers which predicted intentions to consult a GP accounted for only 13% of the variance in intentions for personal-emotional problems and only 11% of the variance in intentions for suicidal thoughts. Nevertheless, despite this limitation, the significant associations between a number of barriers to professional help-seeking and students' intentions to consult a GP, and between a number of barriers and higher levels of student hopelessness, raise several important implications for promoting general practice, along with directions for further research.

First, given that intentions to consult a GP have been related to actually seeking help from a GP (Study 2), individual barriers that associate with help-

seeking intentions should be targeted for intervention and reduction. For example, since a substantial barrier to consulting a GP for personal-emotional problems was 'not wanting my family to know about the help-seeking', young people may be more willing to consult a GP if they are given information about ways to access their own GP. Information should describe ways for young people to find a GP who is different to the young person's family GP, along with ways that young people can meet costs and billing (e.g., within Australia, by obtaining an individual Medicare card if the young person is 15 years or older). Additional information should also convey the message that consulting a GP is a good problem solving option and that a GP can help with a variety of health care problems, including distressing personal or emotional problems.

Second, given the significant association that hopelessness had with a number of help-seeking barriers, particularly the belief that "nothing will change the problems I have", efforts to promote general practice should impart a sense of hope about the help that a GP can provide. As for the promotion of all forms of professional health care for young people, while it is important that young people have clear and realistic expectations about the health care that can be attained from a GP, it is equally important that young people develop the belief that a GP can actually be helpful. Efforts to promote general practice should include information about the ways in which GPs can assist with different problems. Through outreach and personal consultation, it is clearly important to let young people know that no problem is insignificant if it causes distress and that help from a GP is a good way to work toward reducing distress (Wilson et al., 2002).

Finally, this study highlights the need for empirical research to identify strategies that GPs should use to effectively reduce psychological distress in young people or manage their suicidal behaviours.

SECTION TWO:
GPs attitudes, perceived barriers and referral practices for young people needing mental health care

Study 4

GPs help-seeking and perceptions of youth help-seeking barriers

Wilson, C. J., & Deane, F. P.

There is evidence that GPs consult regularly with young people presenting symptoms of mental ill-health (Biro, Deane, & Wilson, 2002). In their study of mental health care in general practice, Biro et al. (2002) found that the main mental health issues which GPs discussed with young people related to substance abuse and relationship problems. Most GPs who completed the survey also estimated that they identified up to five suicidal young people within a 3-month period. The vital role that GPs have as both primary health care providers and gatekeepers for young people with mental health issues is reinforced.

Gatekeepers have been defined as "people in the community who are able to assist distressed young people to access appropriate professional support services" (Fredrico & Davis, 1996, p. 1). Models of gatekeeping consistently outline the need for gatekeepers to be pro-active (e.g. Beckman & Mays, 1985; Florio & Raschko, 1998). A pro-active role includes gatekeepers having the skills and willingness to be able to address young peoples' help-seeking barriers, identify mental health issues, engage a young person, and to refer them when necessary, to appropriate help (Deane et al., 2002). Unfortunately, there are indications that GPs' skills and knowledge may not always be adequate for addressing the barriers that young people have for seeking help

from general practice along with other professional health care services (e.g., Veit et al., 1995).

It is widely agreed that gaining knowledge and coming to understand the intricacies of the world around us underpin our ability to effect change within it (e.g., Lloyd, 1995). The implications are clear. If GPs' knowledge of young peoples' barriers to general practice and barriers that inhibit effective referral is inadequate, then GPs' ability to provide effective primary health care or successful referral is likely to be impeded.

Similar to Study 1, Study 4 was conducted to provide a descriptive and exploratory basis for an examination of variables with the potential to effect GPs' capacity to act as effective gatekeepers or provide primary health care for young people. The major aim of Study 4 was to obtain GPs' opinions about seeking professional psychological help, barriers to young people seeking general practice and barriers to engaging young people within general practice.

Method.

Thirteen GPs from an outer-metropolitan NSW region agreed to take part in a semi-structured discussion about their own help-seeking and their perceptions of youth help-seeking. The discussion was conducted as a component of a training workshop that lasted approximately 30 minutes and was recorded in shorthand, by a Project Officer. Five core questions were asked. Questions and answers (paraphrased by the Project Officer) are reported as results.

Results

Q1. "How do you feel about seeking professional psychological help?"

A. "GPs are ready to seek help but more for physical illness than mental health problems. However, as a group, GPs tend to be slow seeking help. They tend to "soldier on", seek help late, or seek help "on the run." Within the

group, male GPs tend to have a "macho" problem that makes them less likely to seek help. Male GPs tend to feel that they need to deal with their own problems rather than seeking help. This is as much a problem of being male as a product of being a GP. Male GPs tend to have a threshold that inhibits their help-seeking before the threshold is reached."

Q2. "What barriers do you think stop young people from coming to a GP or other health care services?"

A. "Young people don't come to GPs because GPs are not in a group to which young people feel they can relate. Young people don't feel they are understood by GPs as GPs are not their peers. GPs are not seen as trustworthy, they're seen as the enemy. Young people are afraid of being stigmatised by visiting a GP for help with their problems. Young people don't come to GPs because they don't think anyone can help. They think the situation is hopeless so there is no point seeking help. Young people don't come to GPs because they don't have the communication skills to explain their problem. Alternatively, young people don't come because they don't recognise they have a problem or that getting a GPs' advice will help resolve it. Young people don't perceive themselves to be different to their peers who are generally all experiencing problems. Finally, young people might not seek a GPs' help because they don't know how to access the system or they might be turned away by the receptionist."

"Young people don't access mental health providers such as counsellors because of access issues, the limited availability of services, and high costs. Other barriers include the fears of stigmatisation and the unknown. Young people don't know what they need to do during a mental health consultation. They don't know their role. They also tend to have negative attitudes towards mental health providers."

Q3. "What is it about your own practice that stops young people coming?"

A. "There is little time to build trust, engage at the young person's level, and sort out what the "real" problem is. There is also a need to ask direct questions which young people don't like. Sometimes the GPs show little empathy towards the young person. The appointment system is not suitable for young people. Some young people have developed negative perceptions about GP help because of previous helping episodes. Young people have their records stored in their family records."

Q4. "Are there instances when you have had trouble engaging young people?"

A. "Most engagement difficulties occur when a young person feels angry that they have been "dragged" or brought in by a parent."

Q5. "Are there differences between engaging young males and young females?"

A. "Not now days. Young men and women are about the same, although female GPs find it easier to engage with young females than young males."

<u>Summary</u>

Although, Study 4 was limited by sample size and time constraints applied to the discussion, the study was successful in obtaining a brief overview of some GPs' opinions about their personal help-seeking behaviours, along with their opinions about barriers to young people seeking and engaging in general practice. It is not known if the opinions of the 13 GPs in Study 4 can be generalised to all GPs. However, Study 4 provides reassurance that at least some GPs have a good knowledge of a number of important barriers that young people have reported to seeking and engaging in general practice (see Studies 2 and 3). Needing clarification is the extent to which the GPs in Study

4 are successful in addressing these barriers. This question stands for further research. In the meantime, it is possible that at least some GPs may benefit from additional information about factors that facilitate and inhibit youth health care seeking, along with strategies to reduce young people's help-seeking barriers, particularly for acute mental health problems. Biro et al. (2002) found that GPs reported that their highest training priorities were related to young people and suicidal behaviour.

With regard to GPs' own help-seeking behaviour, Study 4 provides evidence that like other gatekeepers (e.g., teachers and school counsellors; see Deane et al., 2002), a least some GPs will "soldier on" rather than seek professional help, particularly for issues associated with mental ill-health. This suggests that at least some GPs may benefit from information about the usefulness of professional psychological help for professional support. It also suggests that if at least some GPs are reluctant to seek professional psychological help for themselves, they may also be reluctant to refer young people to mental health providers. Biro et al. (2002) found that while most GPs will refer young people with mental health issues to specialist psychological services, 75% of those GPs who participated in the study believed that half the young people they treat will get better without professional psychological help. It is possible that GPs' attitudes about the support provided by mental health care services may relate to their willingness to refer young people for mental health issues. There is some indication that GPs' attitudes towards mental health care may inhibit the referral process (Barber & Williams, 1996). This question is explored in Study 5.

Study 5

GPs attitudes towards mental health care, and youth referral and management practices

Wilson, C. J., Deane, F. P., & Biro, V.

As noted, research highlights the importance of GPs' capacity to effectively engage young people during a consultation and accurately identify their mental health needs. There is also evidence that GPs have credibility with adolescents and the advice given many be important for teenage behaviour (Cusack, Deane, Wilson, & Ciarrochi, 2002; Walker & Townend, 1999). In their study of young mens' pathways to professional psychological health care, Cusack et al. (2002) found that 32% of participants who had received or were currently receiving care, reported they would not have sought specialist mental health care without the influence of others. GPs, along with intimate partners and other health care professionals, were consistently reported as providing the strongest and most frequent influence on engagement in professional psychological care. At a minimum, these results reinforce the need for GPs to pro-actively promote mental health care, exert influence towards engaging in such help when it is warranted, and collaborate with other specialist mental health care providers to facilitate effective referral when it is necessary (Deane, Wilson, & Biro, 2002).

Many systems require referral by a GP before mental health services can be accessed (Ross & Hardy, 1999). Unfortunately, only a proportion of troubled young people complete the referral process (Bailey & Garralda, 1989). A number of barriers reduce the likelihood that young people will keep referral appointments made by GPs (e.g., Pescosolido & Boyer, 1999). For young people, two major sets of barriers impact on the referral process. As examined in Studies 1 to 3, the first set relates to the general reluctance of young people to seek help for psychological problems, and particularly from

professional health care services. The second set relates to variables associated with GPs' referral practices (*Alliance of NSW Divisions Enhanced Primary Care Project*, 2000).

Making an effective referral is a complex process that has been neglected in the psychological and psychiatric literature (Graham et al., 2000). Little research describes the referral practices of GPs either for managing young people in need of mental health care (Deane et al., 2002), or the barriers that may be associated with these practices (Macdonald & Bower, 2000). It is possible that referral barriers are associated with tasks that GPs undertake within the referral process or GPs' attitudes towards the referral source.

Preliminary evidence indicates that certain referral practices can improve the success of referral (e.g., King Nurcombe, & Bickman, 2001). Thus, the reverse may also be true. Cheston (1991) views referral as a collaborative process between the helper and the client to identify the client's requirements for involving a new health care provider. According to Cheston, successful referral involves the decision to refer, contacting the referral source to obtain details for accessing the service, sharing this information with the client, and completing the appropriate paperwork, along with a range of specific tasks that should be completed within each stage. It is possible that if these "ideal" referral tasks are not completed effectively by GPs, this may impact on the success of their youth referral.

Finally, since attitudes and beliefs are thought to underpin behavioural intentions and actual behaviours (Theory of Planned Behaviour; Ajzen, 1991), GPs' attitudes towards mental health care may impact on their ability to work collaboratively with young people for effective referral. The results of Study 4 provide some support for this possibility. Similarly, in their study of GPs' referral practices when working with young people, Deane et al. (2002) found indications that GPs with low efficacy beliefs about the usefulness of professional psychological help may be less likely to follow idea referral practices.

Study 5 had two major aims. First to examine the relationship between GPs 'attitudes towards mental health care and referral, and second, to examine GPs' current referral practices.

Method

Participants & Procedure. Surveys were distributed to all members of the Illawarra and Shoalhaven Divisions of General Practice as part of their routine divisional activities. Postage paid, return addressed envelopes were provided for the return of questionnaires. All respondents remained anonymous.

Sixty-two GPs completed the attitudes items in the survey, 49 of which also completed the referral items. The average age of these GPs was 48 years (SD = 11 years) and ranged from 28 to 71 years. Most were male (70%) and 68% of the sample was in fulltime practice with the remaining 32% in part-time practice. For those in fulltime practice, 65% saw up to 150 patients per week and 77% estimated up to 20 patients per week were treated predominantly for mental health problems. For those in part-time practice, 67% saw up to 10 patients per week. There was a wide range of time in general practice (1 to 41 years) with the average duration of 18 years (SD = 11 years).

Measure. In addition to descriptive variables outlined above, respondents were asked to estimate the number of young people they saw per week presenting with five broad problem domains. Their attitudes towards mental health care in general practice, their willingness to refer, the number of young people they referred to other services and the percentage they felt were helped by seeing mental health professionals. Thirteen statements about GPs attitudes to mental health care in general practice were taken from the measure used by Phongsaven et al. (1995, p. 141). Two additional statements were also included from studies reported by the *Joint Consultative Committee in Psychiatry* (JCCP, 1997, p. 109 – 113). Referral and case management items were based on 16 items extracted from the literature on good referral practice (e.g. Cheston, 1991) and based on Enhanced Primary Care guidelines on Case Conferences that are organized and coordinated by

GPs (Commonwealth Department of Health and Aged Care, 2000). Table 6 provides an abbreviated stem for each of the items along with means and standard deviations. Under the "Referral and Management Practices" section, GPs were asked to indicate the frequency that they "currently" conduct each of the practices when "working with a young person to try and convince them to seek help from a mental health professional". Each item was rated on a Likert scale ranging from (1) Never to (5) Always. Reliability analysis was conducted on the 16-items and Cronbach alpha was = .89 indicating a high level of internal consistency and suggesting the items together relate to a single underlying construct. For some analyses the mean of these 16 items was used to reflect overall consistency of ideal referral practice.

Results

Descending means of GPs' attitudes towards mental health care are presented in Table 6, along with standard deviations. GPs' youth referral and management practices are presented in Table 7. Highlighted in Table 7 are a number of items with ratings of 4 (often) or less. These items describe important aspects of effective referral so can be considered in need of improvement in this sample of GPs.

Table 6. Descending Means (M) and standard deviations of GPs Attitudes Towards Mental Health Care.

Attitudes	M	SD
▪ Treating mental health problems is time consuming.	3.47	.62
▪ Diagnosis of mental health problems is part of my responsibility.	3.45	.76
▪ GPs should develop the skills to deal with mental health problems.	3.21	.60
▪ Remuneration would increase my readiness to provide counselling.	3.18	.74
▪ I feel comfortable discussing mental health problems with a patient.	3.07	.54
▪ I get job satisfaction from counselling.	3.00	.49
▪ I am better qualified to manage physical illness.	2.87	.76
▪ I have little time for counselling.	2.74	.77
▪ Others will feel uncomfortable if I have a mental health patient in my waiting room.	2.66	.77
▪ I am concerned about being accused of 'over-servicing'.	2.56	.94
▪ Mental health problems are difficult to treat in general practice.	2.40	.71
▪ Mental health patients are more likely to follow the advice of a counsellor than a GP.	2.00	.57
▪ I believe GPs counselling is ineffective.	1.85	.60
▪ Patients don't want the GP to ask about mental health problems.	1.63	.73

N = 62.

Note. Evaluations were made on a 4 point scale (1 = strongly disagree, 4 = strongly agree).

Table 7. Descending Means (M) and standard deviations of GPs Referral and Management Practices.

Referral Practices	M	SD
▪ Explain why I think professional mental help useful.	4.45	.65
▪ Explain there is a choice to see a mental health professional.	4.33	.88
▪ Discuss the benefits of professional mental help.	4.20	.82
▪ **Explain that I will continue to support the patient.**	**4.02**	**.90**
▪ **Organise an appointment with a mental health professional.**	**4.02**	**.88**
▪ **Explain that the young person will need to share information.**	**3.84**	**1.09**
▪ **Allow young person to specify information they don't want shared.**	**3.71**	**1.02**
▪ **Discuss issues of confidentiality.**	**3.67**	**1.07**
▪ **Make a referral phone call with a young person.**	**3.65**	**1.11**
▪ **Explain any costs that might be incurred.**	**3.43**	**1.31**
▪ **Explain the benefits and success rates of professional mental health help.**	**3.30**	**1.10**
▪ **Explain what to expect in an initial mental health consultation.**	**3.29**	**1.11**
▪ **Explain the likely duration of a mental health consultation.**	**2.80**	**1.10**
▪ **Develop a list of problems to specify mental health needs and goals.**	**2.71**	**.94**
▪ Might not refer because I think the waiting list is too long.	2.55	1.23
▪ **Obtain and record consent for referral.**	**2.52**	**1.46**
▪ Might not refer because I don't think it will help.	1.92	.98
▪ Might accompany a young person to their first appointment.	1.43	.79

N = 49.

Note. Evaluations were made on a 5 point scale (1 = never, 3 = sometimes, 5 = always)

Correlational analyses were conducted to identify any relationships that might exist between GPs' attitudes and their referral practices. There were a number of small and significant correlations. Unfortunately, many of these relationships were not clearly interpretable so are not reported further. Two associations however, seem noteworthy since helping young people to develop or clarify their problems and then specify the needs and goals associated with these problems is an important aspect of successful referral. The first association indicated that GPs were less likely to develop a list of problems with the young person to specify their mental health needs and goals if they held the attitude that treating patients with mental health problems is time consuming ($r = -.33$, $p < .05$). The second, that GPs were more likely to specify needs and goals with the patient if there was greater remuneration for counselling ($r = .30$, $p < .05$).

Summary

The results of Study 5 provided reassurance that for the most part, GPs have positive attitudes towards mental health care in general practice (only two associations may indicate exceptions). GPs also employ a range of ideal referral practices (those items with mean scores greater than 4 in Table 7). Ideal referral practices include, explaining why GPs think a referral to a mental health professional might be useful and what benefits might be attained, and explaining that young people have a choice about seeing a mental health professional or not. Additional results showed that some recommended referral practices should be used more often in general practice. Recommended referral practices include, explaining what to expect in an initial mental health consultation, developing a list of problems to specify mental health needs and goals with the young person, explaining any costs that might be incurred and obtaining the young person's consent for their referral.

Consistent with previous reports (e.g., JCCP, 1997), correlational results indicate that GPs may have two barriers to following "ideal" referral practices.

First, that GPs might be less likely to develop a list of problems with the young person to specify their mental health needs and goals if they felt time-poor. Second, that GPs might be more likely to specify needs and goals with the patient if there was greater remuneration for counselling. The JCCP (1997) reported several studies that identified time constraints to be a major barrier to GPs managing mental ill-health in general practice. Phongsaven et al. (1995) found that GPs in their study "agreed that detection and management of mental health problems were important parts of their job [however], they were less convinced that time to spend on management and counselling was sufficient" (p. 140). The JCCP (1997) also found that poor remuneration for care provided to patients with mental health problems was reported as a substantial barrier to providing mental health care.

The results of Study 5 suggest GPs might benefit by additional information about good referral practices for the mental health care of young people. Although GPs' attitudes towards mental health care in general practice were for the most part positive, the two associations between attitudes and referral practices signal that GPs' attitudes and beliefs may influence their referral practices. Further research is needed to answer this question.

Study 6

Confirmatory investigation of GPs' perceptions of client and service provider help-seeking and referral barriers for young people

Wilson, C. J., Biro, V., & Deane, F. P.

Non-attendance rates at initial intake appointments for community mental health centres have been found to range from 15% (Noonan, 1973) to 55% (Hochstadt & Trybula, 1980), and several studies suggest that rates for young people may be even higher (e.g., Deane, 1991). Along with those help-seeking barriers described in Studies 4 and 5, the literature identifies a number of service related barriers that may contribute to these statistics (e.g., Biro & Deane, 2001; Phongsavan et al., 1995). Several Australian GP studies have reported a general lack of satisfaction regarding access to mental health services (JCCP, 1997). Phongsaven et al. (1995) examined the mental health care practices of 721 GPs and found that 53% of the sample indicated that waiting lists for referral services were too long, 51% indicated that local services were insufficient, 25% reported communication difficulties between themselves and specialists that prevented referral. Twelve percent of the sample indicated that their limited knowledge about mental health services was also a significant referral barrier. These results suggest that even if GPs employ good referral practices, service related barriers may still reduce the likelihood that young people actually receive the mental health care they require.

The main aim of Study 6 was to confirm the results of Studies 4 and 5 and extend them to examine service related barriers that inhibit GPs' ability to provide young people with appropriate help or successful referral. From the findings of Studies 1 to 6 a list of recommendations for ways in which individual and service related barriers might be overcome for young people was developed (as outlined at the front of this report following the Executive Summary).

Method

During a GP and Primary Health Provider training day, 15 participants completed worksheets that asked GPs and other providers to indicate barriers they considered important for different population groups. Groups included young people aged 12 – 30 years, adults aged 31 – 65 years, low prevalence mental health disorders (schizophrenia, schizoaffective disorder, bipolar disorder, major depression), and high prevalence mental health disorders (depression, anxiety, substance abuse, suicidality). Participants were divided into different teams. As teams, participants were asked to complete two worksheets. The first asked participants to mark client help-seeking and referral barriers they considered important. Client barrier items are presented in Table 8. The second worksheet asked participants to mark service provision barriers that they considered important. Provision barriers are presented in Table 9. Items included in the client barrier worksheet were drawn primarily from the results of Studies 1 to 4 and the help-seeking referral survey used in Study 5. Items included in the provider barrier worksheet were compiled on the basis of literature review and the findings of the *Illawarra General Practitioner and Mental Health Service Partnership Project: One Year Report* (Biro & Deane, 2001). Both worksheets also asked participants to add any barriers that they considered important but omitted for their assigned population group.

Results

The participant group considering young peoples' barriers to help-seeking and referral, marked all barrier items as important except "Emotional reactions are thought by clients to reflect the severity of the problem", "Seeking inappropriate help for different mental health problems", and "Families are not included in referral processes". All barrier items on the provider worksheet were marked as important. More barriers were recognised for young people than any other population group. There were no additional barriers provided by the participant group on either the client or provider worksheets.

Table 8. Barriers reducing the likelihood that young people will seek help from a GP or follow through on referral.

Young Patient Help-Seeking Barriers

Clinic times do not coincide with times that are available for client groups.
An unfriendly environment within the clinic or service.
Limited information about the role of different providers and procedures.
No bulk-billing.
Limited access to a Medicare card.
Provider charges are not clearly stated.
Little trust for providers.
Providers are not in a group that clients feel they can relate to.
Providers who are not proficient with micro-counselling skills.
Limited client understanding of the benefits of seeking provider help.
Providers who minimise client problems or client knowledge of their problem.
Limited problem recognition.
Limited client ability to communicate their difficulties, thoughts or feelings.
Limited client knowledge of the questions to ask during a session.
Problems are not seen as a normal part of life.
Emotional reactions are thought by clients to reflect the severity of the problem.
Client concerns that confidentiality will be breached.
Client beliefs that they should be independent or that help from a mental health provider will not be useful.
Client beliefs that their problem in snot severe enough for professional help.
Client beliefs that if they ask for help from a mental health provider, they will be admitting they are "crazy".
Clients do not perceive prior help from providers to be useful.
Client beliefs that seeking help from a provider will force them to do or say things they don't want to.
Limited client knowledge of how to access the mental/health system.
Seeking inappropriate help for different mental/health problems.

Young Patient Referral Barriers

Limited client knowledge about the processes and benefits of referral.
Limited client knowledge of what to expect and what is expected when seeking help from a provider.
Negative attitudes and beliefs about seeking help from a provider.
The client does not understand that they have a choice about referral to another provider.
Limited client knowledge of the consequences of not following through on referrals.
The client feels strongly that they want their problem to remain between them and their current provider.
No consent is obtained for referral to other providers.
Families are not included in referral processes.

Table 9. Barriers reducing the likelihood that GPs will be able to offer help or provide appropriate referral for young people.
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Help-Provision Barriers
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Clinic times do not coincide with times that are available for client groups.
Lack of flexibility in specific programs and services.
Providers do not have an understanding of mental health conditions and presentations.
Limited problem recognition.
Limited information about the role of different providers and procedures.
Limited client ability to communicate their difficulties, thoughts or feelings.
Limited ability to engage clients who are closed or aloof.
Limited ability to gain the compliance of some clients.
Clients do not perceive prior help to be useful.
Client beliefs that seeking help from a provider will force them to do or say things they don't want to.
Mental health patients are time consuming.
Remuneration is needed for providers to manage mental health clients.
Providers do not feel comfortable discussing mental health problems.
Other clients are uncomfortable if mental health clients use the waiting room.
Mental health problems are difficult to treat if you are a GP.
Some providers give ineffective counsel.
Clients don't want some providers to ask about mental health problems.
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Mental Health Referral Barriers
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Not making a telephone call with the client to schedule a referral appointment.
Not identifying and discussing the benefits of seeing a mental health professional.
Not informing the client about any costs that might be incurred through referral.
No client consent is obtained for referral.
No communication is given to the client about the expectations and procedures involved in a mental health consultation.
The client is not given the opportunity to specify which information they would be willing to share during a mental health consultation.
The client's mental health needs and goals are not specified.
Issues around confidentiality are not discussed with the client.
It is not conveyed to the client that referral is voluntary.
Not discussing with the client the probable benefits and success rates of professional mental health help.
Negative provider attitudes and beliefs about the usefulness of professional mental health help.
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Summary

The results of Study 6 indicate that GPs in the current sample have knowledge of most barriers, including service related barriers that have been identified in the literature. Only three exceptions were found: "Emotional reactions are thought by clients to reflect the severity of the problem", "Seeking inappropriate help for different mental health problems", and "Families are not included in referral processes". GPs in the current study appeared to be unaware that the emotional response (e.g., anxiety, shame) that young people feel when faced with a problem often has a major influence on young peoples' willingness to seek help, particularly professional health and mental health care. Emotional responses are often interpreted by young people as indicators of the severity of their problems (Wilson & Deane, 2001). This is an important barrier of which to be aware as young men in Study 1 suggested the bigger the problem (i.e., the bigger the emotional response), the more likely they were to engage in help avoidant behaviours (i.e. "run away"), particularly from professional help providers such as GPs. It also reinforces the need for GPs to explore young peoples' emotional responses to their problems with them as part of their mental health care or referral procedure.

Although GPs in the current study did not confirm seeking inappropriate help as a barrier to general practice, GPs in Study 4 did. This discrepancy raises the possibility that the Study 6 findings may not be true for all GPs and should be interpreted with caution. Certainly, further research that involves samples of adequate size and good research design is needed. Nevertheless, since GPs in the current study did not recognise inappropriate help-seeking as an important barrier for young people, and as this is high-lighted in supporting research (e.g., Phongsavan et al., 1995; Veit et al., 1995), at least some GPs may benefit from education about youth help-seeking barriers and ways to overcome them. For example, GPs in Study 6 may benefit from information about general patterns of young peoples' help-seeking, so they may use this information to help explore young peoples' prior help-seeking experiences

and provide a basis for explaining the benefits of consulting a GP. Finally, the third barrier that GPs did not recognise as important to referral implies that GPs in Study 6, like the GPs in Study 5, may benefit from information about recommended referral practices.

DISCUSSION

Within the Australian health care system, GPs are viewed as key gatekeepers to youth health and mental health care. GPs have a key role in prevention and early intervention, particularly for high-risk young people such as young males. The findings from Studies 1 to 6 highlight several areas that should be addressed so GPs may be more effective in their health care and gatekeeping role.

Section One.

Studies 1 to 3 highlight a number barriers that young people have towards seeking professional help, including that of a GP. Barriers include attitudinal, belief, emotional, cognitive, and physical variables to which GPs need to be mindful as they attempt to engage young people within consultations. The most important finding for GPs from Studies 1 to 3 is that overall, young people have relatively low intentions to seek help from a GP for personal-emotional or suicidal problems. They would rather seek health care from friends and family or no-one for these problem-types. This is in obvious contrast with previous Australian studies which have found that general practice is the help-source of choice for many adults with mental health problems (Andrews, Hall, Teesson, & Henderson, 1999; ABS, 1997, Davies, 2000). It is possible that this contrast is related to issues of adolescent autonomy. For example, part of the adolescent developmental task of identity formation might be the identification and access of help-sources that are different to those used in childhood and under parental direction (i.e., the family GP). Certainly, the opinions reported in Study 1 and the barriers reported in Study 3 suggest that many young people do not want their family to know when they seek and engage in professional help. Many young people want to talk to a GP who even knows their family. Perhaps young people feel that they can't trust a GP because they are unaware of GPs'

bounds of confidentiality or perhaps they feel they do not have a personal relationship with a GP that is distinct from the relationship that has been formed through parents (Wilson & Deane, 2001). The opinions provided in Study 1 offer some support for this explanation and imply that young people need to be informed of ways to find and access their own GP. The results also imply that GPs should be proactive in building relationships with young people that are distinct from prior relationships with parents or other family members. GPs would do well to talk explicitly with young people about the health and mental health care provided in general practice, along with the professional bounds to which GPs adhere.

The findings from Studies 1 to 3 also suggest that young peoples' willingness to consult a GP may be increased if at least some GPs are involved in outreach that addresses young peoples' help-seeking barriers. General practice needs to be promoted to young people as a good way to deal with problems of physical and mental ill-health, including personal and emotional problems which are causing distress, and suicidal thoughts. This is reinforced by the Study 2 findings which indicate that for some youth populations, GPs may be the only professional help-source that young people will access for help managing suicidal problems.

Section Two.

In order for GPs to address barriers to engaging young people, they need an understanding of engagement barriers that young people consider important. Studies 4 to 6, indicate that at least some GPs have a good working knowledge of existing youth help-seeking barriers. However, there are also indications that GPs may be unaware of some important barriers. Consistent with previous research (e.g., Phongsavan et al., 1995; Veit et al., 1995), Studies 4 to 6 indicate that GPs may benefit by additional education about youth help-seeking barriers and ways to overcome them, particularly those barriers related to effective referral. For example, although Study 5 provided reassurance that most GPs employ some positive referral practices, the study also revealed that there are many referral practices which could be improved.

Each of the highlighted items in Table 7 describes important aspects of effective referral, yet GPs were not consistent in the implementation of these procedures.

Another important finding comes from a comparison between Studies 5 and 6. Although GPs in Study 6 indicated that they were aware of many youth help-seeking and referral barriers, this awareness may not translate to the use of strategies to address barriers. For example, while GPs were aware that not working collaboratively with young people to develop lists of mental health needs and goals is a referral barrier, in actual practise, GPs reported that only sometimes would they carry out this recommended referral practice. Examination of the relationship between GPs' understanding of young peoples' help-seeking and referral barriers and GPs youth engagement and referral practices remains for further research; as does the relationship between GPs' attitudes towards mental health care and referral. At a minimum, the findings of Studies 4 to 6 indicate that GPs may benefit from additional information about young peoples' help-seeking and referral barriers along with specific strategies to address these barriers. Limitations and recommendations are outlined at the front of this report, following the Executive Summary.

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