MENTAL HEALTH HELP SEEKING IN YOUNG PEOPLE

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EXECUTIVE SUMMARY

<u>Aims</u>

The research program aimed to address the following broad questions:

➢ Why do young people and particularly young males not seek help when they are in psychological distress or suicidal?

➢ How do we better engage young people in services?

➢ What might account for findings that healthy young people say they would avoid or refuse help when suicidal?

➢ How ready are community gatekeepers to support young people to access appropriate help for personal-emotional problems?

<u>Research Strategy</u>

➢ A series of focus groups were conducted with young people with differing risk characteristics.

➢ A series of focus and "discussion" groups were conducted with a range of community gatekeepers.

➢ A core set of variables were identified to be administered to a wide range of young people particularly in the 14 through 24 age range (e.g. help seeking intentions, recent help seeking behaviour, barriers to help seeking).

➢ Around the core set of variables specific sets of variables were administered to some of the subsamples to test specific hypotheses (e.g. suicidal ideation, hopelessness, emotional competencies).

➢ Opportunities allowed preliminary testing of brief interventions aimed at improving help seeking (pre-post intervention).

➢ Data was available for up to 2721 young people for some of the core variables

Focus groups

➤ High School Student Groups

- o Positive relationships and trust were approach factors related to help seeking.
- o Memories of successful prior helping episodes appeared to be an approach factor.
- o Some difficulties identifying whether problems of sufficient magnitude or importance to warrant seeking help.
- o Social networks have important influences on help seeking.
- o Strong belief that seeking help should be last resort and that one should take care of ones' own problems.
- o Indications of help seeking avoidance for suicidal thoughts.
- o Worries about emotional reactions of others if suicidality revealed.
- o Beliefs that people are not helped by formal therapy.

➤ Rural Focus Group

- o Trust mentioned as important factor in seeking help
- o Parents preferred help source but
  - Reluctance to seek help from parents due to not wanting to worry them and fear of loss of respect
- o Gossip, lack of confidentiality and stigma concerns in a small town a major barrier to help seeking

➤ Aboriginal Adolescent Group

- o Trust again mentioned as approach factor.
- o Preference for family and particularly "Mums" as help source.
- o Good awareness of Aboriginal Counselling Services through teachers and school.
- o Embarrassment and shame strong barriers, particularly for some specific problems.

➤ Treatment Seeking Drug Users Group

- o Reluctance to seek help from family because they were embarrassed and/or had already exhausted family helping resources
- o Good awareness of D&A treatment services
- o Denial of addiction viewed as key barrier to early help seeking

o Fears regarding treatment another barrier

o Strategies for advertising services described

Help seeking intentions: Preferences for help source by problem type

➢ Help seeking intentions vary significantly across different samples (high school, university, TAFE, Church and Youth Centre samples).

  o Global help seeking intentions also vary between High School samples.

  o Suggestions that demographic, contextual and/or environmental factors may influence help seeking intentions (e.g., supportive school climate).

➢ Young people have preferences for help sources dependent on the problem type.

➢ On average high school students are most likely to seek help from friends for all problem types.

  o On average, they prefer seeking help from informal (friends/family) sources prior to more formal sources (mental health professionals/GPs)

  o They are significantly less likely to seek help from friends for suicidal thoughts than other personal-emotional problems

  o They are more likely to seek help from mental health professionals and telephone help lines than from parents for suicidal thoughts

  o However, overall help seeking intentions for suicidal thoughts were rated low and in most samples adolescents were more likely to seek help for a "personal-emotional" problem than for "suicidal thoughts"

➢ There were gender effects for help seeking intentions for "personal-emotional" problems but no gender effects for intentions related to "suicidal thoughts"

Barriers to seeking help

➢ For high school students a desire to resolve problems on ones own was the highest rated barrier to seeking help from a therapist

➢ Embarrassment was the second highest barrier.

➢ Contrary to prior research and our own focus group findings concerns about confidentiality were ranked relatively low as a barrier.

➢ The desire to work out their own problems had the strongest inverse relationships with intentions to seek help.

➢ Barriers were related to hopelessness

Developmental and gender differences in adolescent help seeking for personal-emotional problems

➢ In a large sample (n = 1184) of Year 7 through Year 10 high school students from the ACT.

➢ Females were more likely to seek help from friends than were males from Year 7 to Year 9.

➢ From Years 7 through 10 both males and females had consistently decreasing intentions to seek help from family.

➢ Intentions to seek help from formal sources decreased over Years 7 and 8 and remained steady through Y9 and Y10.

➢ Males were more likely to seek help from family than other sources.

➢ Retrospective reports of actual help seeking over the previous month revealed that on average females had sought help more across all year levels with one exception.

   o In Year 7 males reported more formal help seeking than females.

➢ Males are more likely to seek help from family than friends, but intentions to seek help from friends, declines steadily through Y7 to Y10.

➢ Females help seeking from family also declines from Y7 to Y10 but there is a parallel increase in help seeking intentions from friends.

➢ Intentions to seek help were related to retrospective ratings of actual help seeking from formal sources.

Do intentions predict actual help seeking behaviour?

➢ Other studies and our research indicates that intentions to seek help are related to retrospective reports of actual help seeking.

➢ Using a brief questionnaire we asked 173 high school males whether they would "…like to be confidentially approached by your school counsellor to talk about how you are feeling?"

- 22.5% responded "yes" and asked to see the school counsellor.

- Intentions to seek help were related to a subsequent request to see the school counsellor.

- Intentions to seek help from a friend and from a teacher/school advisor were the two reliable predictors.

- Lower intentions to seek help from friends and greater intentions to seek help from teachers predicted actual requests to see the school counsellor

<u>Help negation for suicidal thoughts</u>

- Thus far, across all non-clinical samples of young people surveyed (12-24 years) we have found a negative relationship between suicidal ideation and help seeking intentions for suicidal thoughts.

  o Higher levels of suicidal ideation were associated with lower levels of help seeking intentions.
  o This relationship has been referred to as help negation.

- It has been suggested that this finding may be due to hopelessness that often accompanies suicidal ideation

  o Hopelessness was unable to fully account for the help negation effect

- It has been suggested that help negation may occur due to impairments in problem solving capacity associated with the suicidal state.

- Participants in focus groups indicated difficulty with knowing whether their problems were of sufficient magnitude to warrant seeking help

  o Problem solving ability was unable to fully account for the help negation effect in a university student sample
  o In one high school sample there was an inconsistent and relatively weak help negation effect compared to other samples.
    ▪ When problem solving ability was controlled this weak help negation effect became insignificant

- Potential sampling biases suggest caution in interpreting this result and the need for replication

➢ It is possible that the help negation effect may in part be explained by difficulties with problem recognition and problem solving appraisal

Emotional competence and help seeking

➢ Emotional competence (EC) refers to the ability to accurately perceive and appropriately manage emotions in one's self and in others.

➢ Difficulties with problem recognition could be related to the inability to accurately perceive the emotional difficulties one is experiencing.

➢ In a university sample, managing ones own emotions and managing others emotions were significantly related to help seeking intentions from a range of sources for suicidal thoughts.
  o Being male, poor at managing the emotions of others and feeling more hopeless was associated with low levels of help seeking intentions.
  o Emotion management and intentions to seek help were mediated by the usefulness of peoples past help seeking experiences with a mental health professional.

➢ In a high school sample of older adolescents (16-18 years), for those who has seen a mental health professional previously, the perceived usefulness of this contact correlated significantly with future help seeking intentions (r = .55).
  o Higher emotional competence was associated with greater intention to seek help, but mostly from informal sources versus more formal sources
  o Those who were good at identifying and describing their emotions had higher intentions to seek help for suicidal thoughts, but again only for informal sources of help.
  o Quality of social support was able to partially explain the relationship between emotional competence and help seeking.
  o Adolescents low in emotional competence are less likely to seek help from informal sources but not formal sources
  o This may still be problematic for seeking professional help because prior research indicates that adolescents continue to rely on informal sources (e.g. parents) to help link them with formal sources of help.

- In a high school sample of younger adolescents (13-16 years), managing own emotions, managing others emotions and emotion perception were all related to help seeking intentions from informal sources.

  - These relationships were present for general personal-emotional problems and suicidal thoughts.
  - The nature of these relationships varied dependent on the age of respondents.
    - Younger adolescents (13 years) who felt they could not identify and describe their emotions were more willing to seek help from doctors (GPs).
    - As age increased, by age 16, those adolescents who could not identify and describe their emotions were the least willing to seek help from doctors (GPs).

  - As these adolescents got older they appeared to shift their help seeking away from parents and towards boyfriends and girlfriends.
  - They did not "replace" their parents as sources of help and instead reported increased intentions to <u>not</u> seek help from anyone.

Brief interventions to improve help seeking

- A trial was conducted of a brief informational booklet aimed at reducing barriers to help seeking such as negative attitudes and beliefs, aversive emotions and limited knowledge about available help sources.

- The attempted trials in a high school sample revealed the difficulties associated with even very brief implementation of such resources in a cooperative school environment.

- A brief presentation of 15 minutes along with copies of the booklet was associated with improvements in knowledge, but no reductions in perceived barriers to help and no improvements in help seeking intentions or behaviour three weeks later.

- A similar second trial lead to no pre-post differences on knowledge, barriers, help seeking intentions or behaviour.

- There were potential sampling biases due to the stringent consent procedures.

- More comprehensive interventions are likely needed to positively influence help seeking

Who influence men to go to therapy?

- Fifty males currently or recently attending a range of psychological services for treatment rated the extent to which they were influenced by others to seek treatment.

- 66% of men indicated the decision to seek help was influenced by others and the remaining 34% indicated the decision was totally their own, however…

- 94% indicated a least some level of influence from specific individuals

  o Most (68%) endorsed multiple sources of influence
  o Intimate partners and GPs were the most frequent and strongest sources of influence

- 36% said they would not have sought help without the influence of others

How ready are gatekeepers to support help seeking?

- Teachers
  o 18 teachers participated in focus groups that revealed they held similar personal barriers to help seeking as do samples of young people.
  o Teachers indicated they were more likely to <u>not</u> seek help from anyone than from a range of other help sources (e.g. friends, GPs etc) for personal-emotional problems.
  o If they were to seek help teachers would go to informal sources (friends, family) prior to more formal sources (GP, mental health professionals).
  o Teachers appeared to have similar attitudinal barriers toward seeking help from formal mental health sources as do their students.

- Youth workers
  o 24 youth workers completed a workshop(s) aimed at providing strategies to facilitate help seeking in young people, they were compared to a control group of 26 youth workers who did not attend the workshop.

o Workshop attenders had increases in their personal intentions to seek help for suicidal thoughts, in actual help seeking behaviour and problem solving at 4 month follow-up, however
- The results may be in part due to workshop attenders starting out with relatively low help seeking rates compared to controls
o The workshop group had significantly higher levels of knowledge regarding help seeking compared to the control group at 4 month follow-up.

➢ General Practitioners
    o 49 GPs completed a questionnaire which assessed the frequency with which they engaged in good referral practice with young people when referring to a mental health professional.
    o The GPs followed a range of recommended referral practices with young people "most of the time" including.
       - Explaining what would be useful about the referral, what benefits might accrue, voluntary nature of referral and organizing an appointment.
    o 41% of GPs used the following referral practices only "some of the time"
       - discussing issues of confidentiality, clarify costs, explaining what to expect in initial consultation, explaining likely benefits and success of treatment, recording consent for referral.
    o 39% of GPs "rarely" or "never" explained the likely duration of the mental health consultation.
    o Several resources were developed and trialled to help GPs more effectively engage young people (see resource manual).

➢ School Counsellors
    o 21 school counsellors rated the barriers they anticipated students experienced to accessing psychological treatment.
    o The three highest rated barriers were "Thoughts about therapy are scary", "Adults can't understand", and "I wouldn't want my friends to know I was using therapy".
    o Data from our high school samples indicated that students prioritized different barriers, such as not believing therapy would be helpful or wanting to resolve problems on their own.

- School counsellors personal willingness to seek help for personal-emotional problems was relatively high compared to other samples
- Counsellors identified mental health professionals as their most likely source of help for suicidal thoughts.
- Overall, school counsellors appeared to be good models for promoting professional help seeking in schools.

Incidental observations

➤ There are school "policies" which are likely barriers to facilitating more formal help seeking for suicidal thoughts amongst high school students.
  - The questionnaire suicide screen in high schools, which indicated the need for further assessment lead to a strong tendency by school counsellors to automatically inform parents. This was despite the need for further assessment.
  - Focus group and questionnaire data from students indicated strong concerns regarding confidentiality and worries about distressing parents were barriers to seeking help for suicidal thoughts.

➤ Pathways to appropriate mental health care are not always clear within high schools

Limitations

➤ We were unable to conduct the number of focus groups that had been planned
  - particular difficulties in obtaining Aboriginal focus group participants despite several attempts.

➤ Sampling
  - The emphasis on school based samples means that results may not be generalisable to young people not in school, however
    - The project was successful at recruiting large numbers of participants in the 12 through 24 year age range who were either in high school or other tertiary educational systems.
    - High school respondents were recruited from at least four different high schools and from the ACT, NSW and Queensland.

- o We believe the stringent consent procedures in NSW schools that required both student and parental consent AND consent for anonymous and nonanonymous protocols led to low participation rates in some samples
  - ▪ We suspect this may have lead to individuals with fewer mental health difficulties participating.

- ➢ Most of the studies relied heavily on students self reported intentions to seek help as the key dependent variable, however
  - o in some studies we were able to measure actual help seeking behaviour

- ➢ We have limited data on young males from more marginalized groups
  - o We have data for 45 males from Neighbourhood Youth Centers
    - ▪ Further data analysis for this sample is pending.

  - o The overall, levels of help seeking intentions for the male youth center sample and the male TAFE trades students sample were equivalent and the lowest of the general sample sources.
    - ▪ Combined, they will provide a male sample of 177 who have low help seeking intentions.

  - o There is considerable overlap between samples with regard to help seeking intentions (ACT High School had the lowest help seeking intentions of all samples).
    - ▪ It is likely that subsamples of young males with particularly negative attitudes and help seeking intentions can be extracted for analysis.

- ➢ There are a number of hypotheses and analyses yet to be tested
  - o These will be completed as time and resources allow but there are likely to be delays due to exhausted project funds for research assistance.

RECOMMENDATIONS

Overall, we believe that our research program reveals the need for a multifaceted approach to address relatively poor help seeking in young people and particularly young males. Broadly speaking this would involve interventions aimed at changing the attitudes, beliefs and perceived barriers to seeking help held by young people and, secondly, improving the readiness of gatekeepers to facilitate help seeking.

Our data provides information to help develop these approaches that includes targeting the following elements:

1. Young people need increased opportunities for informal contact particularly with professional help sources. The school environment provides an obvious opportunity. Experience should include activities for students to informally meet school counsellors on either an individual basis or within small group contexts. This might include introductions that describe the kinds of work that school counsellors do and how to make contact with the school counsellor. In addition, key community gatekeepers such as GPs need to be involved in high school outreach that provides opportunities for students to meet different health care professionals, understand what different health care providers do, and develop foundations for trust and approach (see GPs in Schools program).

2. There is a need to target young people early in their schooling, particularly the early years of their high school experience. This appears to be especially important for young males who have a notable reduction in help seeking intentions between Year 7 and Year 8. We are unclear of the processes that lead to such changes, but suspect a combination of influences. In males these might include, increased independence (especially individuation and separation from parents) and beliefs that they should be able to manage their own problems, strong male peer influence regarding what is considered "masculine", a coping approach that tends toward distraction or ignoring problems etc.

3. Whilst there were differences between males and females on most of the help seeking variables, e.g. attitudes, intentions, barriers. Overall, the problematic relationships (e.g. help negation) appeared to be present for both males and females. Many of the reasons that males do not seek help are shared by females,

but it appears males are affected by these factors to a greater degree (i.e. they have more negative attitudes, but negative attitudes are still related to help seeking in both males and females). There do appear to be gender differences on some variables that would suggest specific targets for males. For example, the timing of interventions around Year 7 in high school.

4. Intervention programs need to be more than just informational. Our brief information presentation was not effective at modifying help seeking variables. The positive influence that memories of prior help seeking experiences had and the positive influence of prior help seeking on future help seeking, suggest any intervention program should include experiential activities. This might include, visiting and reporting back on available formal help sources in the community.

5. Content of interventions should address, attitudes and beliefs, and other known help seeking barriers including:

   a) Clarification that despite wanting to handle problems on ones own, there are times when every one needs support and help from others.

   b) Clarification of how to assess the seriousness of problems and when to seek other peoples help (e.g. acuity, length of time unresolved etc).

   c) Providing a language for the emotions that young people are likely to experience when faced with problems but have difficulty describing and expressing.

   d) Identification of available help-sources within the community and the school contexts. Clarification of ways to access help sources.

   e) Clarification of who the best sources of help are for particular types of problems.

   f) Recognition that friends are often the first source of help, but that they may not always be the best source of help for all problems (provide examples).

   g) Given a strong desire by young people to "handle problems on their own", there needs to be consistent messages indicating that part of the responsibility for managing one's own problems involves knowing when to

seek others help. Examples that support appropriate development of independence in the help seeking domain could include, instruction in how to go about obtaining their own Medicare card (instead of the family card). The independence and responsibility components would also extend to a willingness to make an appointment and go to a GP for problems not just related to physical illness (i.e. personal-emotional problems). Content of these exercises needs to be focused on young peoples development, particularly building on strengths and well being.

h) Help seeking programs should examine examples of prior help seeking experiences, and search for and reinforce positive aspects and outcomes of the prior help. Prior help seeking should not necessarily be limited to professional help sources.

i) Challenging beliefs that therapy cannot help and reinforcing that professional counseling or therapy is generally effective. It is particularly important to instill positive outcome expectations regarding professional counseling or therapy.

j) Our experience in conducting research in schools suggested there was a reluctance to directly address suicide as an issue, but to instead focus on positive coping strategies (such as help seeking). We accept that this is a good general strategy. However, it may be necessary to discuss problems related to suicide in order to address the help negation process. Whilst we have not unraveled what maintains this relationship, our data strongly suggests that it is present in healthy young people. Thus, there needs to be consideration given to the special case of help seeking in relation to suicidality. Specifically, it may be important when discussing help seeking to address the issue of suicide explicitly and to challenge beliefs associated with being suicidal e.g. "If I am suicidal I would not/should not seek help", "Nothing will help". There is a need to highlight that individuals who are suicidal usually have distortions in their thinking and logic. That whilst they may believe these things at the time they are acutely suicidal, in the vast majority of cases, this is complicated by the presence of mental illness (e.g. depression). Young people need to be given concrete examples of "untrue" or distorted thoughts they might experience when they are distressed. In

addition, it needs to be reiterated that there are very effective treatments for problems such as depression and as a result those who attempt suicide without accessing these treatments, are making a serious mistake. Finally, it needs to be made explicit that individuals may be carrying these illogical and unhelpful beliefs regarding their willingness to seek help when suicidal, even when they are not acutely suicidal. A process that encourages young people to challenge such beliefs should be developed.

k) Information should be provided to help young people accurately appraise the risk to their well-being of having different problems and not doing anything about it or relying only on ones self.

l) Our data suggest that those who are low in a range of emotional competencies are also the least willing to seek help. At this point our results do not clarify why this relationship is present (e.g. not able to recognize emotional problems, not able to appropriately engage helping resources?). However, broad-spectrum training in emotional competencies may be useful to promote help seeking. A major target of such training might include problem-solving abilities related to recognition and appraisal of problems, but particularly emotional difficulties associated with recognising, describing and expressing emotion. There are suggestions that the problem recognition and appraisal components of problem solving may partially account for the help negation process.

m) Interventions might also provide information to peers regarding what to do if they have a friend in need. How to go about encouraging and facilitating help seeking and clarification of the circumstances to seek the support of trusted adults?

n) There are a range of existing pretherapy preparation materials that provide guidance for addressing specific expectations regarding mental health services (e.g. Deane et al., 1992) or professionals (e.g. Australian Psychological Society website).

o) Our data highlight many more specific issues that could be developed to promote appropriate help seeking and additional suggestions are embedded in the full report and attached articles.

p) Young people need to be included in the process of program development. Their views need to inform the ways in which young people and gatekeepers are trained.

6. As noted, there is a need to develop and refine help seeking interventions for young people. The research team is currently providing a consultative role with Lifeline Southcoast, who received funding from Rotary Club of Illawarra Sunrise to develop a video that can be used in high schools to promote appropriate help seeking. This may provide a supplement to such interventions.

7. Various mental health or drug and alcohol services and pathways to care could be better described for young people and gatekeepers. We found that entry criteria and types of services provided were not well understood by either young people or key gatekeepers (including GPs). Projects such as the NSW Health funded School Link programs will help bridge gaps between schools and service providers.

8. Assertive outreach appears to prompt help seeking in some groups. Simply asking students at one boys high school lead to over 22% indicating a desire to meet with the school counsellor. Similar prompts might be used, particularly at known stressful periods in high school life (e.g., HSC or other examination periods). To manage the potential high response, this might be done on a class-by-class basis and tied to appropriate classroom activities such as health or mental health curriculum (e.g., Mind Matters). There should be the potential to provide additional counseling support if there are large numbers of requests. Similarly, there should be criteria to prioritise such requests if necessary.

9. Assertive outreach activities could also be attempted at locations where there are high-risk young people, particularly males. It may be possible to have informal visits by mental health workers from the public sector or NGOs visit locations like Neighbourhood Centers.

10. Given concerns about confidentiality and trust in some samples, help sources such as anonymous telephone help lines and the use of internet helping resources,

should also continue to be supported. Whilst, on average, young people do not use telephone help lines as a frequent source of help, it is possible that the confidentiality that these services offer, means that a subgroup of young people are inclined to use them. In addition, in at least one sample the help negation effect was not present for intentions to seek help from a telephone helpline.

11. Gatekeepers. Our data suggest that most males who receive professional psychological services have been considerably influenced by a number of gatekeepers.

a) There is a need to prepare and develop gatekeepers' skills at relating and engaging with young people, particularly young males.

b) GPs are potentially in the best position to work effectively with intimate partners and family of reluctant males to influence their help seeking behaviour.

c) Training programs for gatekeepers should address some gatekeeper groups own attitudes toward help seeking and beliefs particularly regarding the effectiveness of professional counseling or mental health treatment.

d) Training programs also need to clarify the most important help seeking barriers endorsed by young people in addition to providing skills and strategies to better address these barriers (see the Essential Youth Friendly GP Kit; GiS Presenters Manual).

e) Gatekeepers and mental health professionals may need training in presentation skills for engaging adolescent samples if they are conducting outreach (such as talking in schools to classes).

f) Since young people are focus on the quality of the relationship with the potential helper, gatekeepers may need to be trained in building therapeutic relationships with young people.

g) Gatekeepers and mental health professionals need to understand the ways in which they may inadvertently violate young peoples trust.

h) School counsellors seem in a particularly good position to promote appropriate formal help seeking in school settings, and promoting formal help seeking in out of school community settings as needed.

i) GPs and other gatekeeper groups need to know good referral practice with young people in order to increase the probabilities that the young person will attend and engage in formal counseling or mental health services. This should also be a component of gatekeeper training.

j) Some of the findings from our research have already been integrated into practical resources and training programs. This is evidenced by the Essential Youth Friendly GP Kit (Wilson, Fogarty & Deane, 2002) and GPs in Schools training and high school outreach program (Wilson & Fogarty, 2002). These were developed in conjunction with the Illawarra Division of General Practice. Examples of these resources are accompany this report and have been used for training over 20 GPs from the Illawarra, receiving favourable preliminary evaluation. There is a need to more formally evaluate the impact of such training and resources on actual practice and engagement strategies.

k) There were mixed but generally promising findings from the youth worker training program. With further refinement we believe the outcomes for this program will be strengthened and more consistent. Youth workers come from a very diverse background and with relatively variable training. Consideration should be given for integrating aspects of identification of mental health problems and particularly suicide risk and also good referral practice in youth worker training programs (e.g. TAFE). This gatekeeper group appears to hold a unique position in terms of coming into contact with more young males who may not be engaged in formal education.

l) There are several other potential gatekeeper groups that could be targeted. Coaches may be another important group, particularly those who are coaching young males in the 12 through 14-year age range. Coaches are often in the unique position of having a trusting relationship with young people (which was expressed as an important prerequisite to help seeking). They are thus, in a position to provide support should they identify distressed youth. Whilst some coaches undoubtedly are already aware of this privileged position, some

may benefit from awareness raising in this regard and specific skills in engaging young males who may be experiencing psychological problems. There are many components of such training, including, how to encourage and support the young person to share their concerns with other helpful adults (e.g. parents), issues of confidentiality in the relationship, identification of more serious mental health problems etc. It may be possible to integrate some of these skills into existing coaching programs.

m) Parents are another gatekeeper group who are likely to need information regarding how best to encourage their children (and sons in particular) to talk about personal-emotional problems. They are also likely to facilitate access to more formal sources of help in adolescents. Parents and other family are likely to be particularly important in certain contexts (e.g. rural and Aboriginal).

Future Research Directions

1. Pooled data and data from some specific samples from the present research have yet to be fully analysed.

2. We are continuing to collect data from men who are currently or who have recently received psychological services. The aim is to clarify whether emotional restrictiveness (a male oriented gender role characteristic) is related to therapeutic alliance. Thus, we will extend aspects of our emotional competency findings into the therapeutic relationship in an attempt to better understand engagement in mental health services.

3. There is a need to test the relationship between parental help seeking variables (e.g. attitudes, barriers) and how these relate to the help seeking attitudes and intentions of their adolescent children. This should clarify whether aspects of family influence are related to young people's willingness to seek professional help.

4. It has been argued that schools are thought to have the strongest influence on young people after family. There is a need to test the relationship between teacher help seeking variables and how these relate to similar help seeking variables in

their students. This should clarify the extent to which teachers impact on students willingness to seek formal help.

5. There is a need to continue to pursue what contributes to and maintains the help negation effect. In particular a retest of social problem solving to explain or account for the help negation effect, in high school age adolescents is needed. Further tests of potential moderating or mediating effects.

6. Further research is needed to better understand the strategies that gatekeepers and other significant others use to influence men into therapy. Whilst we know that most men are influenced to attend mental health services, we do not know what strategies are most effective.

7. A longitudinal study that assesses help seeking variables at Time 1 and then monitors subsequent help seeking behaviour over at least a 6-month period. This would permit a more complete test of the relationship between help seeking predictors (attitudes, barriers, intentions, distress) on actual help seeking behaviour.

8. There is a need to develop and test a range of interventions aimed at improving help seeking knowledge, attitudes, perceived barriers, intentions and ultimately help seeking behaviour. We have already outlined potential content and timing components for these interventions. After pilot testing a comprehensive package, we would recommend a randomized controlled trial of the package. This should be a longitudinal study that monitors actual help seeking variables over at least a 6-month period. It is recommended that any interventions have the potential to be integrated into existing school curriculum or programs (e.g. Mind Matters).

9. There is a need to develop and evaluate gatekeeper training programs. These should be developed with a view to integrating such training into existing educational systems for the various gatekeeper groups (e.g. medical schools, teacher training etc), but should also have the capacity to stand alone for those who are already working in the community.

INTRODUCTION

This study aimed to address the questions: Why do young people and particularly young males not seek help when they are in psychological distress or suicidal? How do we better engage them in services? In trying to research these questions there were a range of other questions that needed to be addressed. Broadly, these included providing a description of patterns of help seeking, barriers, intentions and behaviours, and their relationships to age and gender across multiple samples. Second, to systematically examine hypotheses that might explain identified associations within and between groups with different sample characteristics.

Given the dynamic processes and complexity of help seeking particularly in relation to different problem types (e.g. personal-emotional, suicide), it is difficult to test one all encompassing model of help seeking. Whilst there are many models and theories which might be used to understand help seeking, for the present grant we focused on those variables we thought had the most promise for integration into prevention or treatment programs. In addition, we focused on two areas (1) characteristics of the individual and (2) those people who have contact youth who might be able to influence and facilitate help seeking (i.e., gatekeepers).

REPORT FRAMEWORK & PROJECT STRATEGY

This report summarises the findings from the series of studies conducted under the auspice of the NHMRC grant. Detailed introductions and analysis are provided in published articles and manuscripts in preparation that are appended to this report. We have attempted to provide a relatively non technical report that guides the reader through the various studies conducted. Parts of this report are segments that have been taken directly from some of the published journal articles, those submitted or in preparation. We do not provide a separate list of references at the end since most of the citations are in appended manuscripts.

Given the sensitivity associated with youth suicide research and the difficulty associated with collecting data from known hard-to-reach high-risk groups, to meet the requirements of the project aims, data was collected across a number groups through targeted sampling (e.g., Carlson et al., 1994; Ziek et al., 1996; Watters &

Biernacki, 1989). Other issues also influenced our data collection strategy, these included requirements in some settings (especially high schools) that individuals at risk of suicide be identified and referred to appropriate help. This lead us to survey more accessible youth groups first (e.g. university students) in order to refine our protocols and at the same time begin testing substantive research questions. The general order of recruitment (excluding focus group work) was university students, high school students, TAFE students, church groups, youth centers, males receiving mental health services. Although the overall aim was to conduct a large scale cross-sectional survey, the nature of the research demanded that we conduct our data collection over time and with samples small enough for us to offer comprehensive debriefing and pathways to care should they be necessary. Where possible we analysed data from samples sequentially in order to test specific hypotheses and then integrate promising new variables into subsequent surveys to test new hypotheses.

The focus on young males is a result of previous findings that males are less likely to seek help than females. While males are relatively poor help seekers compared to females, we thought it unwise to exclude females from our sampling for several reasons. Firstly, not all studies have found males have more negative help seeking characteristics than females (e.g. Atkinson & Gim, 1989; Lorion, 1974; Nickerson, Helms & Terrell, 1994). Second, inclusion of females provides a reference and comparison point. This allows us to more clearly see how males and females differ which in turn has implications for the targeting of any recommended prevention strategy. Finally, some of the same processes that prevent males from seeking help when they need it are also highly likely to be present in females. Thus, most studies include both males and females, but analyses are usually conducted to determine whether there are gender related differences.

Project surveys included core measures of mental health, suicidal ideation, help seeking intentions, behaviours and barriers, in addition to sociodemographic information. Additional measures were included for some samples when testing newly identified hypotheses. Details of all core project measures are reported in appended manuscripts with the exception of the General Help seeking Questionnaire (GHSQ; Deane et al., 2001; Wilson et al., 2002). The GHSQ was developed to assess help seeking intentions and was one of the key dependent variables. The intentions

variable is measured across all project studies. A summary of a study describing the measure and its psychometric properties is provided later in this report.

BUILDING PARTNERSHIPS

The studies summarized here are the product of a tremendous effort by a wide range of individuals, organizations and in some cases communities (see Acknowledgements). In the original application the NHMRC stated that, "preference will be given to projects what have potential to build linkages and collaborations".

Underlying each aspect of this project was the theme of partnership and collaboration. As a research team, we have been successful in establishing strong working relationships with a number of Government and Non-Government Organisations. The strength of these relationships and peoples' willingness to be involved in data collection and the overall project direction has been central to the success of the project. As a result of our community partnerships we have accessed a wide range of populations that have provided a wide range of data. The data have allowed us to systematically examine a range of different but linked hypotheses and to make a number of connected recommendations for increasing individual help seeking and developing resources for prevention and early intervention. In some cases, our partners are already applying our disseminated recommendations and resources for the purposes of building community capacity and individual resilience for suicide prevention. The strengths in building partnerships in facilitating help seeking will also become apparent through this report.

The first published article related to a conceptual model to facilitate understanding the development of partnerships in the context of the NHMRC Help seeking grant itself. This was first presented at: Wilson, C.J., Rickwood, D., Deane, F.P., & Ciarrochi, J. (2001, March) *Intersectoral and interagency partnerships to investigate youth help seeking and the responses of at-risk young men to intervention services*. 4th National Conference of Infant, Child and Adolescent Mental Health. Brisbane. Australia.

http://www.aicafmha.net.au/conferences/brisbane2001/papers/rickwood_d.htm

(Attachment 1). The following article based on this presentation has now been submitted for publication

Wilson, C. J., Rickwood, D., Crow, T., Deane, F. P. & Ciarrochi, J. **Developing Partnerships through a Working Alliance Framework.** Manuscript submitted for publication. (See Attachment 2)

This article reviews the authors' experiences in partnership building during the conduct of the NHMRC Help seeking project. It conceptualizes partnership building as similar to the development of therapeutic alliance as first outlined by Bordin (1979). Using examples from their work the model is elaborated. It concludes that successful partnerships need to (1) Allow time for partnerships to develop. Time needs to be both formal and informal in context. (2) Start partnership building by agreeing on shared global goals. (3) Negotiate specific short-term goals that will enable global goals to be met. (4) Specify the tasks and responsibilities necessary for achieving specific goals. (5) Ensure regular contact and meetings between partners. There should be meetings to coordinate initiatives and provide feedback where possible. (6) Ensure explicit recognition and reinforcement for effort as well as goals achieved. (7) Review and reassess goals explicitly.

These formed the broad principles upon which we tried to work with other organisations but we believe these also have implications for working with gatekeeper organisations.

FOCUS GROUPS

Adolescent Opinions About Help seeking

A series of focus groups with young people were conducted to explore opinions about help seeking. These included groups of high school students from metropolitan community, students from a rural community, young people accessing drug and alcohol services and a group of Aboriginal young people.

The first of these focus groups was conducted with high school students from a metropolitan community who were not identified as experiencing any specific psychological problems.

This was published as Wilson, C. J., & Deane, F. P. (2002). **Adolescent opinions about reducing help seeking barriers and increasing appropriate help engagement.** *Journal of Educational and Psychological Consultation, 12,* 345-364. (See Attachment 3)

Summary

Four focus groups were conducted and involved 11 male (ages 15-17 years) and 12 female high school students (ages 14-17 years). Positive relationships and trust were key approach factors for current help seeking. Memories of successful prior helping episodes were also important. Help providers need to reinforce to young people that they are not "alone" with their problem and that no problem is too small to talk about. Most of the suggestions provided by students about how gatekeepers (e.g. teachers) should make these approaches, were consistent with commonly used counseling strategies (e.g., reflective listening). This reinforces Lindsey and Kalafat's (1998) suggestion that school personnel should "be trained to provide supportive initial response to any student" (p. 190). Education about appropriate help seeking, presented in ways consistent with those currently used by adolescents (e.g., through peer networks), might reduce help seeking barriers. Education should include key adults who act as gatekeepers within adolescent networks (e.g., parents and teachers). Consistent with previous research, students suggested that people in adolescents' social networks have important influences on current help seeking processes. Assertive outreach and follow-up might be important factors for continued help-source engagement. The themes identified through group discussion provided a basis for a range of suggestions about ways to facilitate adolescent help seeking and

maintain appropriate help-source engagement. These focus groups also helped reinforce the need to include a range of help sources and gatekeepers on our research agenda.

Adolescents' Opinions About the Role of Barriers in Help Negation

A second article based on the same series of focus groups provided integration of questionnaire data and focus group themes related to the help negation process and barriers to help seeking. Put simply, help-negation refers to the refusal to accept or access available help. Help-negation was first identified in hospitalized samples that were acutely suicidal but did not engage in available help. There are a range of hypotheses to explain why this process occurs. For example, it has been suggested that help negation is a function of associated pathology, particularly depression and hopelessness that often co-occurs with suicidality. Of particular importance for suicide prevention, are findings that a similar help-negation process appears to occur in high school samples who are not acutely suicidal or identified as experiencing any clinically significant problems (Carlton & Deane, 2000). Several researchers have described the reluctance of adolescents to seek help when psychologically distressed or suicidal. However, the specific and troubling relationship found by Carlton and Deane involved a negative correlation between suicidal ideation (SIQ) and help seeking intentions such that higher levels of suicidal ideation are associated with lower help seeking intentions. As a result of findings such as this, it has been theorized that suicidal ideation may act as some form of help seeking "barrier" (Saunders et al., 1994). The mechanism by which this works is at this point unknown and the exploration of potential processes is the subject of studies outlined later in this report. However, there are several important points to be noted from these earlier findings. Firstly, if help negation occurs in "normal" high school age students, the findings is clearly a risk-factor for youth suicide, in that it reduces the potential for students to access appropriate forms of help when they are suicidal. Secondly, if we are able to identify the mechanisms by which help negation occurs, we may be able to prevent this process from developing. Whilst the current research program pursued these questions, we first took a relatively direct approach to trying to understand help negation by simply asking students why they were reluctant to seek help for a number of different problems including suicidal problems. These questions formed the substance of the following article by Wilson and Deane (submitted).

Wilson, C. J., & Deane, F. P. (2002). **Exploring adolescent help-negation: Is it a manifestation of help seeking barriers?** Manuscript submitted for publication. (See Attachment 4).

Summary

Four focus groups were conducted and involved 11 male (ages 15-17 years) and 12 female high school students (ages 14-17 years). Barriers to help seeking identified from thematic analysis included: a strong belief by participants that they should only seek help as a last resort and they should take care of their own problems without external help, difficulty trusting potential sources of help, stigma related barriers (e.g., weakness, perception of friends and family), limited knowledge of the help that mental health professionals can provide and concerns about cost, anxiety and embarrassment associated with attending services. There was evidence of a tendency to avoid help particularly if experiencing suicidal thoughts. Again issues of trust were raised as barriers, as were: the perceived emotional reactions of others (e.g. suicidal feelings may cause upset to family members), fear and shame associated with revealing suicidality, and inertia by being overwhelmed by emotions associated with being suicidal. There also appeared to be a "rationalised" argument that if one was suicidal you would be past the point of wanting help or thinking anyone could help. Within each focus group the Barriers to Adolescents Seeking Help questionnaire (BASH) (Kuhl et al., 1997) was also administered. This measure focuses on barriers associated with seeking therapy. The most strongly endorsed barriers were beliefs that people are not helped by therapy, followed by not knowing where to find a therapist, a belief that friends and family could help more than therapy and the tendency to want to solve the problem on their own. Potential explanations for help negation were found in correlations between help seeking intentions and barrier items. For example, intentions to seek from a mental health professional was negatively correlated with the item "Nothing will change the problems I have" at $r = -.47$. Suggesting that hopelessness may be related to low help seeking intentions. Surprisingly, anxiety about going to therapy and specifically concerns "I might find out I am crazy" was strongly correlated with intentions ($r = -.67$).

In short, the high school focus groups allowed us to reduce the number of items in the BASH and confirmed the need to explore the role of hopelessness in the help negation process. It highlighted the need to better understand the strength of the

reliance on friends and family as sources of help and potential barriers to seeking professional help. In addition we needed to understand the extent to which young people differentiate between help sources and are able to recognize the more appropriate help sources for different kinds of problems. Before exploring these questions through quantitative methods in the project's larger samples the findings from additional focus groups are summarized below. Maree Vukovic (Illawarra Health, Mental Health Service) conducted the rural, Aboriginal adolescent and treatment seeking drug user focus groups.

Rural Youth Focus Group

Dudley et al. (1998) indicated that since1993 rural towns in Australia have had higher suicide rates than in metropolitan centres, and that these increases have been mostly accounted for by young males [15-25 years]. It has also been argued that rural youth have a higher risk and seem to be more susceptible to the effects of stigma, physical isolation and the prevailing masculine culture than in other geographical areas (Esthers at al., 1998). A rural male focus group was conducted to explore factors related to help seeking for psychological problems and suicidal behaviours, with an emphasis on identifying specific issues that might be unique to the rural context.

Five males (ages 16-23 years) took part in the rural focus group. All participants were students and attended TAFE at a rural town of 22,000 located in NSW. All of these students lived outside of the town on farms or in small communities with the average drive being 30 minutes to the town. Two students were enrolled in HSC studies, two were enrolled in Mechanical trades and one was enrolled in a hospitality related course. All described themselves as Australians of European descent. There were a number of common themes consistent with the High School focus groups. Trust in help sources was raised. The help source most preferred were parents who the group believed would keep things confidential. However, there was reluctance to go to parents for all problems (e.g. drugs) and barriers to this help source included not wanting to worry parents and fear of loss of respect from them. The notion of seeking help from friends had a predominantly negative response. Participants' main concerns were related to the lack of confidentiality and gossip particularly in a small community.

R2 Yeah, mainly cause its smaller, everythings such a small crappy town, ya know one person says one thing and the next day most of [Town name] knows, its ridiculous, so you think that if your gonna confide in someone, ya know if one person hears or they happen to mention something that gonna get out, then what do ya do?

R4 See thing is lately, massive gossip, this town is one big gossip cesspool…

Moderator Do you think that's part of living in a small town?

R4 Yeah, I'd say it would be cause it just gets around so quick.

There was reluctance to seek help from formal sources such as a mental health center for a range of reasons including: lack of belief that mental health services are helpful (example of poor response to a family member was provided), reluctance to talk to someone they did not know and stigma related concerns. The most mentioned barrier to seeking help in the rural context related to the lack of confidentiality. Another concern was difficulty getting around particularly if they did not have a driver's license and had to rely on parents for transport to access help. With regard to formal help seeking the participants had concerns that services at times exacerbate the problems of privacy regarding the provision of mental health care in a small community. One participant described a visit by local services to a relative at home: "Thing is that on their cars… they got big mental health signs". "Yeah, so they park out the front …and the neighbours all see that and they are going around." With regard to visiting mental health services in the community one participants stated: "Make their places more discrete" "Just a house on the street or something."

When describing reluctance to visit health staff, the role of the clinician in facilitating communication and the individual expression skills of clients were raised:

R3 They (health clinician) need like have more communication skills.

Moderator: Why's that?

R3 Because they sit down and wait for you to talk and like, no one wants to say stuff first, they want them to start talking first.

R2 The stuff they do, I'm not sure if it's the same as a psychiatrist or not but the stuff they do out of a stupid book, stupid

> questions and get like these cards you know. What do you see in this picture or what do you see in this picture? The whole time ya just feeling trapped in. Here ya go 80 bucks or whatever.

This theme continued when describing why some individuals benefit more from therapy than others.

> **R4** Some people are better at opening up than others, some people can just talk and get things of their chest and that, sometimes you just can't find a word to say, even if you do want talk about it.

> **R3** You don't know how to start it off. You don't what your gonna say…

In sum, the rural focus group raised several issues requiring attention. Perhaps most important for prevention is the reluctance in this small group to seek help from friends because of concerns that personal material would not remain confidential. In most non-rural adolescent samples friends are an important first point of help.

Aboriginal Adolescent Focus Group

Several unsuccessful attempts were made to establish Aboriginal focus groups and on one occasion a group was cancelled due to a recent suicide in the community from which participants had come. However, one focus group was achieved and involved four Aboriginal adolescents aged 13 through 16 years. There were three females and one male participant. All were students attending high school with one each in Year 8, and Year 10 and two in Year 11. All lived in or around a NSW rural town of approximately 22,000. As with other focus groups similar themes of trust were raised and considered important in help seeking. Participants indicated that family were often the first source of help with "Mums", and cousins mentioned by the female participants and a brother by the male participant. There was a strong theme related to embarrassment and shame that appeared to act as a barrier to help seeking.

> **F1** It embarrassed us – like you don't want to be (noticed) – you just want to work it out for yourself

> **Moderator** Is there a reason that you feel embarrassed?

F1 Ahem , no not really. It's just, you know – you don't want everyone else knowing or a typical, typical person knowing what your going on whatever, you just want to keep it to yourself

F2 Well some things my mother would be ashamed of or I think I'd get in trouble

When asked about professional help services participants mentioned: Aboriginal Counselling Services and indicated they heard about his through a teacher and classes in school. They believed this service could assist with problems related to "alcohol addiction" and "abusive relationships". For people attending school, the school counsellor was mentioned. The "Medical Service" was also suggested but when participants were asked "…is there something that would stop you going to those services?" they replied:

F2 Probably child abuse.

Moderator Child abuse

F2 Yeah, probably you feel embarrassed.

Moderator Why would you be embarrassed going to a professional service even though it was an Aboriginal profession, what would be….

F2 Probably be ashamed or scared they will (give it out) to everyone […...] tell anyone or you know….

When asked about seeking help when having suicidal thoughts, the primary sources of help identified were again family, but with some ambivalence.

Moderator Ok, if *you* were having thoughts of harming yourself or killing yourself, would you go and get help from anyone?

F1 Yeah

F1 You wouldn't want to be in that way by yourself, but - then you wouldn't really want to involve other people in that situation.

F2 I would go to me mum, Oh but I don't know if I'd go to my mum, but go to my cousin or something and she would say "well talk to your mum about it" and then I will go and talk to mum and she'll say […................] I'll take you to […...] sort it out or talk about it.

F2 [……….] I'd go there for my mum

P Yeah I'd probably I wouldn't go to my mothers family
to sort it out

When asked about what formal services could do to better facilitate help seeking, participants suggested better advertising, attending schools and providing talks about services, dropping off pamphlets at homes and the use of websites. For improving engagement in counseling services the following responses were provided:

S Trust [……….]

F And like you feel comfortable talking to them about it, and tell them that that they can come to you for whatever, other reasons that they need and [……………..]

F Another family member or friend or something to be next to you [……………..]

Overall, for this group of Aboriginal adolescents, family were strongly identified as a source of help. Mothers in particular were mentioned, but this may have been a function of the mostly female composition of the group because the male participant indicated a preference for his brother. For problems that were embarrassing or may have lead to mothers feeling ashamed, there appeared to be a movement toward other non-parental relatives (e.g. cousins). A range of formal helping services were mentioned and several of these were Koori specific. Whilst names of services were mentioned there was not a lot of specific information about how to access these services. Initial responses indicated that these adolescents would seek help for problems related to suicidal thoughts. Again, family was the first source of help, but there was more hesitation on further reflection.

Treatment Seeking Drug User Focus Group

One focus group was conducted with three male drug users from a youth D&A service and three male drug users from adult D&A services. Services accessed included outpatient and residential drug and alcohol services. Ages ranged from 16 to 29 years.

Participants indicated that they were reluctant to approach family members for help and currently preferred more formal sources of help. This appeared to be because they were embarrassed or had exhausted family as potential help sources.

Moderator   How do you feel about asking people for help?

M   Yeah I find it pretty hard, pretty - you know - demoralizing. Yeah I'd say feeling worried about how people are going to judge you

M   …. Um - but with me, like um, I sort of more, more sort of get embarrassed with having a problem with say - someone who knows me - like me family or friends - you know - like this - I sort of always try to keep the front up that everything's going alright with those sort of people, but if it's a service - you know - such as the rehab or whatever I know that there's sort of people ringing up and asking help, I know what that help is so I don't sort of get embarrassed for ringing the services such as them but it's - like but when its family and that you know - I just get really embarrassed

M2   I've took them (family) through enough shit already,… I just gotta - you know - sort of stand on my own two feet and front up whether it's a good situation or a bad situation

R   …like the only reason why I don't go to them (family) is because I'm too embarrassed - you know - I've got a problem I'm normally too busy trying covering it up on my own…

All participants appeared to have a good awareness of drug and alcohol treatment services. The first and most frequently used services appeared to be for detoxification and participants believe these services were relatively accessible. Other services mentioned included Salvation Army and a private counsellor. Access to rehabilitation units was considered more difficult. One participant noted the following:

M   Yeah well I found that you get, we get a lot more help in the drug and alcohol field if you have got private health insurance.

Moderator   Oh ok?

M   Um - you can get straight into rehabs

All participants agreed that not recognizing that they had a problem or their own denial regarding the significance of their drug abuse was a barrier to seeking help.

> **M**   I was addicted about a year before I done anything about it you know.

> **M**   …I sort of bullshit myself, I thought no I sort of - I accepted it heaven knows why I accepted it at the moment but - and I just tried to hide it from other people - yeah I was sort of happy to know within myself as long as no one else knew.

> **M2**   I'm still recognising that I had a problem with drink and with drugs. I guess I'm still coming to terms with it.

With regard to seeking help for suicidal thoughts there were belief based barriers consistent with other groups but also some sample specific barriers related to drug taking.

> **R**   …- I think if you go, if you're the type of person that would go to them, you're looking to be rescued you know

> **R**   …you know - if I was thinking about harming myself because I was depressed you know - I would take, take my drugs it's a medication for me to - you know - you don't think, you don't have to think about the shits that's going on you just concentrate on having a good time…

> **Moderator**   So it's - can I just clarify that - so that you feel - ahem - using the drug and alcohol stopped you from getting help?

> **R**   Yeah more or less - yes. Like I said I use that instead of help.

When asked how barriers to help seeking might be reduced, as in previous focus groups, recognition that there is a problem was suggested along with providing more information about help sources and processes in accessing help. It was suggested that information might best be delivered by individuals with high credibility because they have begun addressing their drug abuse and have started on the path to recovery. It was also suggested that services should be advertised in public places such as bus depots or on vehicles.

M There's not much - not much you can do for someone unless they are going to listen, but I think the younger person who's been there, who may have done a little bit of jail time and something like that,

M They have to acknowledge the problem themselves, if they want help [……………….] I suppose someone close to them or someone they have to help themselves,

R For starters they have got to realise that they need help, and if they really want to go with it and then start offering and they just need more people, people like us - you know - that's been through recovery and still clean, ya know what I mean, recovered for a few years or even longer.. We need more people like that, and information, you know.

I What sort of information?

R Information - let them know there is places that are, that do help, you know like places like this, detoxes.

Specific content of the information was also suggested, and related to the reduction of fears about who attends drug and alcohol services.

M Yeah I reckon - ahem – to, you should have - you know - a bit more like information on rehabs and detoxes, and you know - maybe - you know - because people think that detox and rehab is really bad, you know or you - like my picture of detox or rehab before I went to one - you know - down and out junkies, always sick and it's not like that at all it's just [good] people wanting to get well - you know.

R …because that's what I was most worried of before I went to a rehab - you know - like I didn't want to be hanging out with all people that were sick and you know what I mean, and it's not like that all, ahem - you are really - you are looked after in places like this and you become really - like [……..] my room mate - you know - and become pretty good mates and everyone in here's - you know - really good recovery buddies and all they all do is talking and that and that's really good, it's a safe place that - unless you've been here and you knew that - you know.

<u>Focus groups summary</u>

Although caution has to be used in making generalizations from focus group data, it does provide us with hypotheses regarding specific and potentially unique factors from each of the groups that impact on help seeking. Most groups had similar concerns to the general high school samples with regard to help seeking, although emphasis varied and some unique issues were also identified. The rural group appeared particularly concerned about confidentiality and rumors in a small community. The Aboriginal group emphasized embarrassment and shame regarding some problems that would make them more reluctant to seek help. Both the rural and Aboriginal groups also appeared to place greater emphasis on family and in the Aboriginal group also extended family as the first source of help. Conversely, those in the treatment seeking drug user groups indicated that family were currently not a source of help that they accessed and greater emphasis was placed on more formal or professional services. Lack of recognition and denial of drug problems were considered major barriers to seeking help by this group.

Wilson, C. J., Deane, F. P., Ciarrochi, J., & Rickwood, D. **Properties of the General Help seeking Questionnaire: Help seeking Intentions in a High School Sample.** Manuscript in preparation.

One of the key help seeking constructs used in the present study was help seeking intentions. Whilst there have been various attempts to measure intentions and related constructs (e.g. willingness), we felt there was a need to improve the measurement of this construct and developed the General Help seeking Questionnaire as a consequence. A more detailed rationale for the development of the GHSQ appears in the introduction of the manuscript in preparation.

A clear understanding of help seeking intentions and behaviour is fundamental to the identification of factors that can be modified to facilitate young peoples help seeking when they are psychologically distressed or suicidal. Despite a number of articles on help seeking intentions and behaviour for personal-emotional or distressing problems, integrating prior research has been impeded by inconsistent and in some cases poor help seeking measures. The General Help seeking Questionnaire (GHSQ) has been developed to formally assess two aspects of help seeking: (1) current intentions to seek help from different sources for different problems; and (2) quantity

and quality of previous professional psychological helping episodes. The GHSQ assesses intentions to seek help from different help seeking sources for different problems. Whilst most of the help sources will remain the same across different samples, the GHSQ was designed to allow for additional help sources to be added where appropriate. For example the Doctors Health Advisory Committee is a specific help source for GPs (e.g. Smith & Coombs, 2000). Similarly, whilst we use the generic "personal-emotional" as one of the identified problems, the problem types can also be modified for particular samples (e.g. suicide related behaviours, drug and alcohol, anger etc).

Method. One-hundred and fifty-nine students (85 males, 74 females), aged 16 to 21 (M = 17.11, SD = .74), completed the anonymous but individually coded study questionnaire. The questionnaire was administered twice over a period of three weeks. Codes were matched to allow comparison between Time 1 and Time 2 results. The survey comprised measures of actual help seeking (AHSQ; Rickwood & Braithwaite, 1994) and 11 help seeking barriers (BASH; Kuhl et al., 1997), in addition to the General Help seeking Questionnaire (GHSQ; Deane et al., 2001). The GHSQ includes items that assess intentions to seek help from different sample-targeted sources (e.g., partner, friends, parents, non-parent family, mental health professionals, telephone helpline, General Practitioners, teacher, religious leader, youth worker, and no-one) on a 7-point scale (1 = extremely unlikely, 7 = extremely likely), for two broad problem domains (personal-emotional problems and suicidal thoughts). Higher scores indicate stronger help seeking intentions. The GHSQ also includes items that ask participants to indicate whether they have ever seen a mental health professional (e.g., counsellor, psychologist, psychiatrist), and to rate how helpful this was.

Results. Means and standard deviations of students' help seeking intentions indicated that students 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 MANOVA 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. There was a significant main effect for helping source, $\underline{F}$ (10, 710) = 65.08, $\underline{p}$ < .001. However, this effect was qualified by a significant interaction with problem-type, $\underline{F}$ (10, 710) = 10.69, $\underline{p}$ < .001, indicating that high-school students' preferred source of help depended upon the type of problem they were facing.

To evaluate the interaction between problem-type and help-source further, pairwise comparisons were conducted using a Bonferroni adjustment to control for Type I error at $\underline{p}$ < .05. Students indicated they were most likely to seek help from friends for all types of personal problems but less likely to seek help from friends for suicidal thoughts than non-suicidal problems. Students also 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 health care professionals, or teachers and other community welfare help-sources.

To examine the factor structure of the GHSQ for each problem-type, the 10 help-sources were submitted to two exploratory principal-component analyses (PCA) ("Would not seek help" was excluded). The first PCA was conducted for personal-emotional problems, the second for suicidal problems. Four factors with eigenvalues greater than 1, that explained 63% of the variance for personal-emotional problems, and three factors with eigenvalues greater than 1, that explained 66% of the variance for suicidal problems, were extracted. Varimax rotation found that all help-sources loaded on a single factor with loadings greater than .3. Additional analyses revealed that once "would not seek help" was reverse scored, GHSQ items could be reliably reduced in several ways. First, as a single help seeking intentions scale that included all help-source options (i.e. both suicidal and "personal-emotional" problems (Cronbach's alpha $\underline{r}$ = .85, Split-half reliability $\underline{r}$ = .81, test-retest reliability assessed over a three week period $\underline{r}$ = .87). Second, as two separate subscales comprising help seeking from all help-source options for suicidal (α = .83) and personal-emotional problems (α = .70). Third, as subscales comprising "formal" help seeking for suicidal thoughts (mental health professional, physical health professional, phone help-line) (α = .85), "informal" help seeking for suicidal thoughts (friends, parents, non-parent family, teachers, religious leaders, and youth workers) (α = .78). "Formal" help

seeking for personal-emotional problems (α = .57), informal help seeking for personal-emotional problems (α = .58), and not seeking help for both problem-types. Finally, the test-retest reliability of the GHSQ item asking students to rate the efficacy of prior professional psychological help assessed over a three week period was r = .95.

Next, the relationship between intentions to seek help from different sources and actually seeking help from that source in the previous three weeks was examined. A number of positive significant associations were found between intentions to seek help from informal sources and seeking help from that source in the previous three weeks, for both personal-emotional and suicidal problems, r_s = .24 to .38, p < .01. As might reasonably be expected with restricted sampling domain of three weeks, no formal help seeking intentions were significantly associated with help seeking behaviours.

The next analyses investigated the possibility that intentions to seek help from a mental health professional might be associated with prior professional psychological help seeking experience (GHSQ). The perceived quality of previous mental health help was positively related to professional psychological help seeking intentions for personal-emotional, r_s = .52, p < .001, and suicidal problems, r_s = .59, p < .001, and negatively related to seeking help from no-one for personal-emotional problems, r_s = -.39, p < .01.

Finally, the possibility that professional psychological help seeking intentions (GHSQ) might relate to adolescent barriers to professional psychological help seeking (BASH) was examined. There were significant negative associations between professional psychological help seeking barriers and intentions to seek help from mental health professionals for personal-emotional, r_s = -.17, p < .05, and suicidal problems, r_s = -.30, p < .00, indicating that higher help seeking barriers related to lower help seeking intentions. There were also significant positive associations between professional psychological help seeking barriers and intentions to seek help from no-one for personal-emotional, r_s = .40, p < .001, and suicidal problems, r_s = .26, p < .01, indicating that higher help seeking barriers related to higher intentions to seek no help.

<u>Conclusion</u>. Consistent with the overall GHSQ factor structure found by Deane et al. (2001), the results of the current study found that the GHSQ could be reliably collapsed into subscales that measure help seeking from different formal and informal sources and from "no-one". However, the moderate alpha coefficients for formal and informal scales for "personal-emotional" problems indicate modest internal reliability suggesting the need for caution for this general problem type in this sample. Overall, the results indicate that the GHSQ has satisfactory reliability and validity, and is a sufficiently flexible tool for measuring help seeking intentions and prior help. In sum, the matrix structure of the GHSQ appears to provide a suitable method for measuring help seeking intentions for different problem-types, different help-sources, and prior help.

HELP SEEKING INTENTIONS: PREFERENCES FOR HELP SOURCE BY PROBLEM TYPE

There was a need to confirm aspects of qualitative findings (i.e. focus groups) with quantitative data from larger, more representative samples. Several articles produced as part of this grant provide data regarding highest rated intentions to seek help from different sources for a personal-emotional problem and separately for "suicidal thoughts" (e.g., Deane, Wilson, & Ciarrochi, 2001; Wilson & Deane, 2002; Thompson & Rickwood, 2002). The patterns of help seeking outlined in these subsamples are generally consistent. The following analyses involve pooled data from across several samples.

Help seeking intentions for a "Personal-emotional" problem

To describe the overall intentions of young people to seek help, data was pooled from a range of samples. The analyses are restricted to those aged between 12 and 24 years (we excluded the small amounts of data for ages outside of this range). More details regarding specific samples are included in journal articles.

Sample descriptions

Targeted samples were obtained from a variety of youth oriented sources that catered for young people aged between 12 and 24 years of age. We sampled schools and other groups we thought may differ due to their specific settings and contexts. These variations can be seen particularly in the different high school samples. High Schools included a Sydney Private Boys High School, Queensland mixed Lutheran High School, Illawarra mixed Public High School and ACT mixed public high school. Sample sizes are provided in tables below. Further details regarding samples are provided in journal articles studying specific project questions within each sample.

The University sample was recruited through Department of Psychology undergraduate student research pools, TAFE students were recruited from a wide range of classes and courses with an emphasis on trades. The relatively small Youth Church and Youth Centre groups were recruited from a wide range of these services across the Illawarra region.

Table 1.   **High school sample gender frequencies**

High School	Gender		Total
	Male	**Female**	
Lutheran	131	224	355
Illawarra	142	119	261
Boys Private	285	0	285
ACT	582	581	1163
Total	1140	924	2064

Table 2.   **Mean age for each high school sample**

	N	Mean	SD
Lutheran High School	356	15.329	1.561
Illawarra High School	261	16.103	1.680
Boys Private High School	285	15.568	.653
ACT High School	1163	13.610	1.172
Total	2065	14.491	1.629

For these exploratory analyses a mean GHSQ score was used. Factor analysis of the 10 GHSQ items for "personal-emotional" problems suggests several factors, but also a strong single factor involving all help sources. Cronbach alpha for 10 help sources across a range of samples is generally between .75 and .80 suggesting acceptable internal reliability. Help seeking intentions were significantly correlated with age in high school students $r = .12$, (and the total sample $r = .23$, $p < .001$). Surprisingly, there was no significant difference between males and females on the GHSQ in the high school samples ($p < .05$). (When the Boys High School sample was excluded from the analysis, there was a significant sex effect for remaining high school students). For the total sample there was a significant difference between males ($M = 2.94$, $SD = 1.12$, $n = 1147$) and females ($M = 3.18$, $SD = .97$, $n = 1361$) on the GHSQ $t(2288.6) = 5.56$, $p < .001$, but the mean difference was relatively small. Thus,

age and gender were controlled in the following analyses of differences in high school samples.

There were significant differences between the High School samples on the GHSQ when measuring intentions to seek help for a "personal-emotional" problem from a variety of help sources.

ANCOVA with the GHSQ scale mean score as the dependent variable and age and sex as covariates indicated significant differences between schools on the mean GHSQ. Post-hoc tests using a conservative Bonferroni correction to control for multiple comparisons found that students from the Boys Private School had significantly higher general intentions than all other high school samples whereas the ACT sample had significantly lower intentions than all other samples. ANOVAs also revealed that only the ACT school was significantly different from the other schools in that it had lower help seeking intentions for both formal and informal help sources on the GHSQ. Table 3 provides the means between schools.

Table 3: <u>**High School samples Means and SDs for intentions to seek help for personal-emotional problems (GHSQ)**</u>

	N	Mean	SD
Lutheran High School	354	3.2254	.9793
Illawarra High School	261	3.1767	.9705
Boys Private High School	170	3.4816	1.2006
ACT High School	1161	2.7134	.9755
Total	1946	2.9358	1.0351

Similarly, there were significant differences in GHSQ scales when comparing high school samples with University, TAFE, Youth Church group and Youth Centre samples. Post-hoc tests following ANCOVAs (again using Bonferroni correction) found that for the mean GHSQ, University and Church samples were significantly higher than High school, TAFE and Youth Centre samples.

Table 4: **All samples Means and SDs on intentions to seek help for personal-emotional problems (GHSQ)**

	N	Mean	SD
High School	1946	2.9358	1.0351
University	563	3.5395	.9604
TAFE	132	2.9474	1.0071
Church	35	3.5997	1.1685
Youth Centres	45	2.8316	.9503
Total	2721	3.0681	1.0493

In sum, there appear to be a range of differences between high school samples and between other youth samples even when controlling for age and sex. The reasons for such differences are unclear, but we would suggest that institutional culture, attitudinal and socioeconomic factors may all interact to create such differences. These findings also suggest the need to assess help seeking patterns separately for some of the samples. We believe that the large ACT sample and the Boys High School sample should be considered separately.

Wilson, C. J., Ciarrochi, J., Rickwood, D., & Deane, F. P. (2002, July). **Help seeking patterns for suicidal and non-suicidal problems in two high school samples.** Paper presented at the 9th Annual Conference of Suicide Prevention Australia, Sydney. (to appear in conference proceedings). (See Attachment 5)

The Illawarra High School and Lutheran High School samples were combined for this paper because they had similar levels of overall help seeking intentions. Prior research generally indicates that when young people are asked who they prefer to seek help from for their problems, friends are usually ranked first followed by parents (e.g. Boldero & Fallon, 1995; Offer et al., 1991). Few young people prefer formal sources of help such as mental health or medical professionals. In many instances young people have a strong preference to seek help from "no-one" if this option is provided and/or indicate a preference for managing their problems on their own (e.g. Offer et al., 1991).

Summary

A GLM repeated measures MANOVA was used to examine the impact of help-source (e.g. friend, parent, mental health professional, GP etc) and problem type (personal-emotional problem and suicidal thoughts) on intentions to seek help. For both the Illawarra and Lutheran samples there was a significant main effect for help source that was qualified by a significant interaction with problem-type. Thus, separate analyses for both high schools indicated that student's preferred source of help was dependent on the type of problem. Pair-wise comparisons with Bonferroni adjustment were used to clarify where these differences occurred. Students in both samples indicated they were most likely to seek help from friends for all types of personal problems. In general, students had greater intentions to seek help from informal help sources before more formal sources such as mental health professionals, other health care professionals, teachers or other community welfare sources. Whilst they were most likely to seek help from friends they were still significantly less likely to seek help from friends for suicidal thoughts than non-suicidal problems. For suicidal thoughts students from both samples were less likely to seek help from parents and other relatives and more likely to seek help from mental health professionals and telephone help lines. The overall pattern of preferred help seeking sources was similar between the two schools, but there were several differences in the strength of intentions for different help sources between the schools. For example, in the Lutheran school "Religious leader" was rated significantly higher than in the public school. In addition, the students in the Lutheran school rated intentions to seek help from a GP as extremely unlikely (approx. M = 1.60) whereas those from the public school had significantly higher likelihood ratings (approx. M = 2.55).

For the combined samples (n = 608) correlations were conducted between the intentions measures and actual help seeking over the previous 3 weeks. All coefficients were significant (p < .001) and ranged from r = .17 (Telephone help line) to r = .47 (Parent) for a "personal-emotional problem". Similarly, for "suicidal thoughts" correlations between actual help seeking and intentions ranged from r = .14 (mental health professional and helpline) to r = .34 (boyfriend/girlfriend). Overall, the coefficients for "suicidal thoughts" were lower than for "personal-emotional" problems, probably as a function of the lower prevalence of the former. Whilst findings such as this provide some support for the focus on help seeking intentions we

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could locate no studies that assessed young peoples intentions and then monitored their *future* help seeking from professional sources. Later in this report we describe what we believe to be one of the first studies to address this issue (see Deane et al., submitted).

University students

The ability of high school students to make distinctions between preferred help sources for different problems was also found in university students (Deane, Wilson & Ciarrochi, 2001). This study focused on the help negation effect and is discussed in more detail below. However, the article also provides data on the 302 undergraduates (mean age 20.58 years) help seeking intentions from different help sources for different problems. As expected females had higher intentions to seek help for nonsuicidal problems than males from a variety of sources. However, there were no gender effects on intentions to seek help from any sources for suicidal thoughts. As with the high school samples there was a significant interaction for intentions between help source and problem type, indicating peoples preferred source of help was dependent on the problem. Overall participants were most likely to seek help from friends for personal problems. However, they were significantly less likely to seek help from friends, parents and other relatives for suicidal thoughts compared to other personal-emotional problems, and more likely to seek help from mental health professionals and telephone help lines.

Both high school and university aged students appeared to make distinctions between help sources dependent on whether the problem was of a general "personal-emotional" nature or related to "suicidal thoughts". Whilst there was a lower likelihood they would seek help from informal sources for suicidal thoughts compared to personal emotional problems, students appeared to be more inclined to seek help from mental health professionals and telephone help lines for suicidal thoughts.

BARRIERS TO SEEKING HELP

Wilson, C. J., Rickwood, D., Ciarrochi, J., & Deane, F. P. (2002, June). **Adolescent barriers to seeking professional psychological help for personal-emotional and suicidal problems.** Paper presented at the 9th Annual Conference of Suicide Prevention Australia, Sydney. (To appear in conference proceedings). (See Attachment 6).

The mental health survey of 4500 young people in Australia (Sawyer et al., 2000) assessed the reasons parents gave to explain why children and adolescents (4-17 years) who met criteria for needing mental health help, did not attend a professional service. They reported these as "Barriers to service use" (p. 32). The most frequently cited barrier was that help was too expensive (51%), followed by: didn't know where to get help (48%), could handle the problems on their own (46%), asked for help but didn't get it (42%), had to wait too long to be seen (37%), child didn't want to attend (25%), service too far away (24%), thought treatment wouldn't help (21%) and, "other" reasons (17%). Only 6% of parents reported they did not seek help because they were afraid of what their family and friends might think. The survey also asked adolescents with mental health problems why they did not attend services and they gave different reasons. Most indicated they preferred to manage their problems themselves (38%), followed by thinking nothing could help (18%), not knowing where to get help (17%) and being afraid of what people think (14%). Other reasons were given by approximately 12% of their adolescent sample.

Our focus group data also revealed perceived barriers to seeking help in adolescents (presented earlier, see Wilson, C. J., & Deane, F. P. 2002. Exploring adolescent help-negation: Is it a manifestation of help seeking barriers?). One such barrier was concerns regarding confidentiality and fears about what might happen in therapy, similar findings have been found in other studies. Donald et al. (2000) found that in a sample of Queensland young people reported "the most common barrier to formal service utilisation was concern about confidentiality" (p. 44), followed by cost barriers and fear about what the service would do. We combined data from the two mixed gender high schools to explore perceived barriers to help seeking and their relationship with help seeking intentions.

Six hundred and eight students recruited from high schools in New South Wales and Queensland took part in the study. Students ranged in age from 12 to 21 years

($\underline{M}$ = 15.64, $\underline{SD}$ = 1.69) and represented high school grades 8 to 12. Students completed self-report questionnaires that measured barriers to professional help seeking, intentions to seek professional help for personal-emotional problems and suicidal thoughts, the quality of prior professional help, and hopelessness. Barriers were measured by 11-items from the Barriers to Adolescents Seeking Help survey (BASH; Kuhl et al., 1997). Help seeking intentions and prior help were measured by a high school focused version of the General Help seeking Questionnaire (GHSQ; Deane et al., 2001a). Hopelessness was measured by the Beck Hopelessness Scale (BHS; Beck et al., 1974).

Consistent with the National survey (Sawyer et al., 2000) the high school sample's desire to resolve the problem themselves was the highest barrier (two items M = 4.30 and 4.03). This was followed by embarrassment (M = 3.58). Of the 11 barriers listed, the item "If I went for help, the counsellor would not keep my secret" received the lowest mean score (M = 2.54) on a 6-point Likert type scale ranging from "strongly agree"(1) to "strongly disagree" (6) (reverse scored in original scale). This contrasts with Donald et al. (2000) who found concerns about confidentiality to be the most common barrier. Correlations between individual barrier items and help seeking intentions revealed that thinking that "I should work out my own problems" had the strongest inverse relationship with intentions to seek help from a mental health professional for both suicidal thoughts (r = -.21) and non-suicidal problems (r = -.19). Similar relationships were found for help seeking intentions from a medical practitioner but with barriers such as embarrassment and not wanting family to know also related to intentions. The barrier item "nothing will change the problems I have" was significantly correlated (r = -.11 to r = -.17) with all intentions to seek help from a mental health professional and GP. This suggests the potential of hopelessness to account for the negative relationship between barriers and help seeking intentions. However, even when hopelessness (BHS) was controlled, total barriers still significantly predicted help seeking intentions for suicidal thinking. For those students who had received prior psychological help, once the quality of prior help seeking was controlled, barriers no longer predicted help seeking intentions, again reinforcing the role of prior help and particularly positive prior help seeking experiences for increasing future help seeking from professional sources.

DEVELOPMENTAL AND GENDER DIFFERENCES IN ADOLESCENT HELP SEEKING.

Thompson, C. S., & Rickwood, D. **Gender differences in adolescent help seeking: Sex-typed barriers to seeking professional help.** Manuscript in preparatio**n.**

The Theory of Planned Behaviour (Ajzen, 1991) is a social cognitive model that has been used extensively to explain a wide range of health related behaviours (Godin & Kok, 1996). The TPB indicates that the single greatest determinant of behaviour is an individual's intentions. In turn, intentions are determined by an individual's attitudes, subjective norms (expectations and influence of significant others) and perceived behavioural control (PBC). Perceived behavioural control refers to the extent an individual believes they control the decision to perform the behaviour. It is theorized that for certain behaviours PBC may not only be mediated by intentions, but also have a direct influence on behaviour.

The present study sought to identify gender differences in barriers to help seeking. The following barriers were included: trust in adults, social support, prior help seeking experience, interpersonal openness, confidence in the support process, access to services and stigma.

Participants were 1232 volunteers from Years 7 through 10 at four different public high schools in the Australian Capital Territory. A total of 1184 useable questionnaires were completed. Mean age of participants was 13.58 years (SD = 1.20) and ranged from 12 to 17 years. Half were male (n = 595) and the remainder female (n = 589). Both student and parental consent was obtained and only 11 students were excluded at their parents request. Response were anonymous. Questionnaires were completed in regular classes and took between 40 and 50 minutes to complete.

In addition to "barrier" measures noted above the following measures were also included: the GHSQ for a "personal-emotional" problem, actual help seeking from a variety of sources over the previous month (AHSQ), attitudes toward seeking help, subjective norms, and perceived behavioural control.

Help sources on the GHSQ were combined to form intentions to seek help from "Friends", "Family" and "Formal sources" (e.g. mental health professionals, GPs etc). Analysis of year level and gender trends in help seeking intentions revealed that

across all year levels, females were more likely than males to report intentions to seek help from friends. In general this gap became progressively greater to year 9. Females indicated progressively higher intentions to seek help from a friend though years 7 to 10. Males' intentions declined from years 7 through 9 and then increased at year 10.

There was no significant gender effect for help seeking intentions from family, but there was a main effect for year, suggesting a consistent decrease in intentions to seek help from family from year 7 to year 10.

There was a significant main effect for year level and gender for Help seeking intentions from more formal sources. Females again expressed higher intentions to seek help for formal sources more than males. Across years there tended to be a decrease from Year 7 to Year 8, flattening between Years 8 through 10.

Analysis of gender differences in help source preference revealed a significant interaction between help source and gender. Males were more likely seek help from family than from friends or more formal sources. For females there was no significant difference between intentions to seek help from friends and family, but they were more likely to seek help from family than more formal sources. As noted previously males and females only differed in their intentions to seek help from friends. Females also more frequently reported seeking help over the previous month than males across all year levels and help sources with one exception. Significantly higher proportions of Year 7 males reported formal help seeking (9.7%) than Year 7 females (7.3%).

There were significant gender differences on measures of attitudes, subjective norms, social support, Openness, Confidence in the support process, with females having more positive aspects of all of these variables. Multivariate linear regression was used to predict help seeking from formal sources for a personal-emotional problem. Gender and year level were entered in the first step. In the second step the TPB constructs (attitudes, SN, PBC) were entered and in the third step the remaining predictors that has significant correlations with intentions. A log transformation for intentions was used to reduce the positive skew. Gender and year level accounted for only 2% of the variance in log of intentions. The TPB constructs added a further 7% of the variance with the remaining variables only adding 2%. Together all variables accounted for only 11% of the variance in the log of help seeking intentions. In the

final model, subjective norms, PBC previous formal help seeking and Year in school (lower associated with higher intentions).

Conclusions

There were several notable new findings from these analyses. Males were more likely to seek help from family than friends, but intentions to seek help from family declined steadily through Years 7 to Year 10. A similar decline also occurs for females, but there appears to be a parallel increase in help seeking intentions from friends. In contrast, no increase in help seeking from friends occurred for males. There were no gender differences for intentions to seek help from formal sources with both males and females expressing relatively low intentions. One surprising finding was that Year 7 males more frequently reported having received actual formal help than females or males in more advanced year levels. This is noteworthy because there was a relatively dramatic decline in both intentions and actual formal help seeking following Year 7. In the ACT Year 7 is the first year of high school, it is possible that these students arrive with a greater willingness to seek help, but are influenced by each other to change these views by Year 8. It has been stated that adolescent males have a tendency to become the "police of masculinity" in that they pressure each other to conform to particular socialized views of masculinity (Connell et al., 1982, p. 95). This might include changes in the importance of peers' opinions (e.g. subjective norms), attitudes, openness, willingness to express emotions and other variables that might lead to reductions in help seeking intentions. This is an area requiring additional research.

As with data from emerging research (Skogstad, P. 2002. Help seeking among prison inmates: A test of the Theory of Planned Behaviour), prior formal help seeking may be one of the strongest predictors of future formal help seeking amongst males. This has implications for help seeking research future directions. In short, if prior help seeking predicts future help seeking, preliminary research efforts should be directed in getting males into treatment rather than on determining what keeps them in treatment.

DO INTENTIONS PREDICT ACTUAL HELP SEEKING BEHAVIOUR?

As part of the recruitment process it became apparent early on that high schools and the Department of Education and Training were not happy with researchers coming into schools and asking students about suicide and then leaving. There were expectations that there would be something positive left with the school community as a result of their participation. The research team had not fully anticipated the level of expectation in this regard but believe this has helped our partnerships with these community organizations. However, it has also taken a fairly substantial toll on our research resources (especially time). The school system asked that we also do a presentation to students regarding help seeking (with the goal to promote appropriate help seeking) at the completion of data collection activities (see trial of Do It Together kit below, Richardson et al., in preparation). It should be added that we had an extremely lengthy and rigorous process to be able to get into the public school system in NSW. A requirement was that we first clarify pathways to care for each school and screen and identify students "at risk" for suicide. This required we divide our data collection into two parts, the first an anonymous questionnaire and the second a non-anonymous questionnaire to allow us to identify students who may be "at risk" of suicide and require additional assessment. This required separate informed consent procedures for each part from each parent and student (total of four consent forms). Whilst this highlights the additional demands on researchers who are investigating suicide related variables and in this case the expectation of DET for increased return for participation, these requirements also allowed us the opportunity to assess actual help seeking behaviour. The results from this study were presented at the 8th Annual Conference of Suicide Prevention Australia (Deane et al., 2001) and the following summary is based on an article in preparation (see Attachment 7).

Deane, F. P., Ciarrochi, J., Wilson, C. J., Rickwood, D., & Anderson, S. **Do high school students intentions predict actual help seeking from school counsellors?** Manuscript in preparation. (See Attachment 7).

The child and adolescent version of the Australian National Survey of Health and Wellbeing involved 4,500, four through 17 year olds (Sawyer et al., 2000). Of the 14% experiencing mental health problems only one in four had attended any services. In children and adolescents identified by parents as needing help, 23% received counselling in schools over the previous 6 months, the most frequently used service.

For those adolescents (13 to 17 years) identified with a mental health problem 16% had received counselling in school. Of the adolescents with very high levels of problems, 42% reported they had seriously considered suicide over the previous 12 months (Sawyer et al., 2000).

Most of the research on help seeking, particularly in males relies on predictors of actual help seeking such as attitudes and intentions to seek help, rather than on actual help seeking behaviour. To a large extent this is understandable because it is difficult to conduct prospective studies that measure these variables and then track individuals to see whether they go on to seek professional help. Most studies assessing actual help seeking behaviour have relied on retrospective self-reports of prior help seeking (e.g. Rickwood & Braithwaite, 1994).

A highly relevant theory for help seeking behaviour is the Theory of Planned Behaviour (TPB) and its precursor the Theory of Reasoned Action (TRA, Ajzen & Fishbein, 1980). In short, the TPB proposes intentions as the immediate precursor and best predictor of behaviour. "According to TRA, all behaviours are based on behavioral intentions. In the case of the TRA the only immediate cause for any behavior is an individual's intentions to engage or refrain from that behavior", (Hedeker, Flay & Petraitis, 1996, p. 109). Prior research provides some support for intentions as a predictor of a range of health related behaviours, but we could locate no prospective study assessing the extent to which intentions predict helpseeking from a counsellor.

Participants were 173 adolescent males from a private nonreligious high school in Australia. Seventy-eight were in year 9 and 95 were in year 10. The mean age of participants was approximately 15 years. Participants completed a brief questionnaire which assessed suicidal ideation (SIQ, Reynolds, 1988), help seeking intentions (GHSQ) and actual help seeking (request to meet with school counsellor). Participants were informed: "The names of participants who reach a certain score by endorsing key items on this measure, or those who request confidential assistance, will be given to the school Principal" and that "Each student will then be confidentially and sensitively approached individually by the school counsellor who can help, and offer assistance". The help seeking behaviour measure stated: "Regardless of your responses to any of the previous questions would you like to be confidentially

approached by your school counsellor to talk about how you are feeling?" Respondents circled either Yes (1) or No (2).

Intentions to seek help for "personal-emotional" problems and "suicidal thoughts" were highly correlated in this sample (all r's > . 59) so intentions ratings were averaged across problems. Correlations between intentions to seek help from the six help sources were significant for all but one pair (friends - phone help line r = .11). The significant relationships ranged from r = .15 (friends - school counsellor) to r = .74 (teacher – school counsellor). Thirty-nine of the 173 students (22.5%) asked to see the school counsellor. Those who sought help had significantly higher intentions for both teacher/school advisor and school counsellor compared to those who did not seek help. A direct logistic regression analysis was performed on help seeking behaviour as the outcome and help seeking intentions from different sources as predictors. Intentions were able to significantly predict actual help seeking group membership and accounted for 13% of the variance. Only intentions to seek help from a friend and from a teacher/advisor were reliable predictors, such that higher intentions to seek help from a teacher/school advisor and lower intention to seek help from a friend were associated with more requests to seek help from a school counsellor.

The findings show that (1) intentions are related to actual help seeking from a school counsellor, (2) it is not simply higher overall intentions that predict behaviour. Less reliance on friends and greater willingness to seek help from teachers appears related to greater likelihood of professional help seeking. Whilst the predictive power of intentions is modest (13% variance) it is consistent with 'clinical screening' behaviours such as cancer checks and seeking medical care promptly (approximately 16% of explained variance) (Godin & Kok, 1996). However, our findings also confirm what Bayer and Peay, (1997) refer to as "a significant discrepancy between people's intentions and actual helpseeking behaviour", (p. 511).

Two additional issues were raised by this study. The ability of a simple screen to encourage 22% of the participants to request contact with a school counsellor highlights the potential for assertive outreach to encourage young males to seek help. Finally, the help negation effect was found where-by suicidal ideation was negatively correlated with, all but one help seeking intention source (help line). Significant

correlations ranged from r = -.17 (school counsellor) to r = -.37 (parent). This suggests that as suicidal ideation increases, help seeking intentions decrease.

HELP NEGATION

As noted, help negation refers to the refusal to accept available help. The process was first identified in samples of patients who were hospitalized due to acute suicidal crises (Rudd et al., 1995) and, was subsequently identified within non-clinical samples of New Zealand high school students (Carlton & Deane, 2000). Help negation was represented as a negative correlation between suicidal ideation and help seeking intentions. Given the implications of help negation for suicide prevention a series of project studies aimed to: (1) establish whether the help negation relationship was present in Australian samples, specifically adolescents and university students and, (2) begin to systematically test hypotheses about which variables might explain or account for the help negation process.

Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2001). **Suicidal ideation and help negation: Not just hopelessness or prior help.** *Journal of Clinical Psychology, 57,* 901-914. (See Attachment 8).

Three hundred and two undergraduate university students competed a questionnaire measuring suicidal ideation (SIQ), hopelessness (BHS), prior help seeking experience and help seeking intentions (GHSQ). Participants indicated that they would seek help from different sources of help for different problem types, but friends consistently were rated as the most likely source of help. Help-negation was suggested by higher levels of suicidal ideation being associated with lower help seeking intentions. Prior research has found that one of the best predictors of help seeking intentions is prior mental health help, particularly if it was perceived as "helpful" (Deane & Todd, 1999). In addition, it has been theorized that help negation in acutely suicidal samples may be a function of associated cognitive factors associated with depression and the suicidal state (e.g. hopelessness and cognitive narrowing). However, the negative suicidal ideation/help seeking-intentions relationship was not explained by hopelessness or prior help seeking. Thus, help-negation appears to involve more than just negative expectations regarding the future. Cognitive narrowing associated with suicidal states may influence problem-solving

capacity and the discussion proposed problem-solving orientation as another variable that may influence the help negation process.

The help-negation relationship was also assessed in high school students in two further studies. The first of these used data from the Queensland, Lutheran High School.

Wilson, C. J., Deane, F. P., Ciarrochi, J., & Rickwood, D. (2002, June). **Help-negation for suicidal thoughts in university and high school samples.** Paper presented at the 9th Annual Conference of Suicide Prevention Australia, Sydney. (To appear in conference proceedings). (See Attachment 9).

Three hundred and forty-five high school students completed the self-report research questionnaire. Students were recruited from the junior to senior classes (grades 9 to 12) of a private Christian high-school. The mean age was 15.83 years ($\underline{SD}$ = 1.23 years). The research questionnaire in both studies comprised measures of suicidal ideation (SIQ, Reynolds, 1988a), hopelessness (BHS, Beck et al., 1974), prior help seeking experience, and help seeking intentions (GHSQ, Deane, et al., 2001). As with the university sample, help negation was found as reflected by negative correlations between help seeking intentions for suicidal thoughts and suicidal ideation. The correlations ranged from -.19 (GPs) to -.49 (Family), all significant at p < .001. In addition, suicidal ideation was a significant predictor of help seeking intentions even when hopelessness and prior help were included as covariates. This suggested neither hopelessness nor prior help were able to fully explain the help negation effect.

Wilson, C. J., Deane, F. P., Ciarrochi, J., & Rickwood, D. **Help negation for suicidal thoughts: The role of social problem-solving.** Manuscript in preparation.

It has been suggested that poor social problem-solving may in part explain help negation in nonclinical samples (Deane et al., 2001). Help seeking can be viewed as an adaptive coping response to problems. However, some individuals may not seek help for suicidal thoughts because they do not necessarily view this as a problem to be solved. Our focus group work (Wilson & Deane, submitted) suggested that adolescents may sometimes not seek help because they had trouble determining whether their difficulties were sufficiently problematic. This may suggest specific difficulties with problem recognition and appraisal. At subclinical levels, suicidal

ideation would not normally be considered "problematic". There is data that most adolescents have some thoughts of suicide but these may be fleeting or transient and dismissed as inappropriate solutions to their difficulties(e.g. Dobert & Nunner-Winkler, 1994). Thus, it is possible that at nonclinical levels suicidal ideation is not viewed as a problem requiring help. However, this would suggest that lower levels of suicidal ideation would be related to lower help seeking intentions. Yet, the help negation effect involves lower help seeking intentions being associated with higher levels of suicidal ideation. It is likely that some more complex process associated with higher suicidal ideation, even at subclinical levels is operating. There is increasing research assessing cognitive risk factors in suicide ideators and attemptors. This research has focused on the poor problem-solving skills of suicidal individuals (Weishaar, 1996). A lack of active problem solving has been found in adult and adolescent suicide ideators or attempters (Linehan et al., 1987, Rotheram-Borus et al., 1990). Wishaar (1996) reported the findings of Spirito et al, (1989) that found suicidal adolescents used social withdrawal as a coping strategy more frequently than other psychiatric and normal controls. Weishaar concluded that suicidal patients may also "have trouble engaging in problem solving and have difficulty accepting problems as a normal part of life", (p. 235). If similar processes occur in nonclinical samples, it is possible that those with higher levels of suicidal ideation may also have trouble engaging in problem solving and may actively avoid seeking solutions such as help seeking. In addition, social withdrawal may further reduce the probability that informal help sources might be utilized. The following two studies, the first with a university sample and the second with a public high school sample, assessed the impact of problem recognition and problem solving appraisal on the help negation relationship.

Study 1

Three hundred and fifty-one university undergraduates completed and anonymous questionnaire that comprised measures of suicidal ideation (SIQ, Reynolds, 1988), help seeking intentions (GHSQ), and a measure of social problem-solving: the Social Problem-Solving Inventory for Adolescents, Short Form (SPSI-A; Frauenknecht & Black, 1995). Mean age of participants was 20.58 years (SD = 4.98). Most of the sample were female (77%). As with our previous help negation study (Deane et al., 2001) there was no gender effect for intentions to seek help from any source for

suicidal problems. However, a gender effect was found for help seeking intentions for a "personal-emotional problem". The help negation effect was evident by significant negative correlations between suicidal ideation and help seeking intentions for suicidal thoughts for all help sources (range, Lecturer $r = -.11$ to Family $r = -.31$). Further analyses revealed that, problem-solving appraisal was generally not significantly related to help seeking intentions (only 1 of 12 help sources was significant). However, problem-solving recognition was significantly correlated with help seeking intentions for suicidal thoughts from Friends ($r = .11$, $p < .05$) and a physical health professional ($r = .18$, $p < .001$). Similarly, problem-solving recognition was significantly correlated with help seeking intentions for a personal emotional problem with Friends ($r = . 19$), physical health professional ($r = .23$) and a mental health professional ($r = .15$).

Two GLM MANCOVAs were conducted with suicidal ideation predicting help seeking intentions while controlling for social problem-solving appraisal and recognition. Suicidal ideation continued to be a significant predictor of intentions even when problem-solving was controlled. Analyses were also conducted to test whether problem solving moderated the relationship between suicidal ideation and help seeking intentions, but there were no significant interaction effects. These results suggest that in a university sample social problem solving could not fully account for the help negation effect.

Study 2

One hundred and five high school students completed the anonymous questionnaire. The mean age was 14.54 years (SD = 1.53) and age ranged from 12-17 years. Fifty-five percent were female. For comparison, the same constructs were measured and the same analyses were conducted as on the university sample in Study 1 above. Levels of suicidal ideation in this sample on the SIQ were found to be notably lower than in other New Zealand (Carlton & Deane, 2000) and Australian samples where we have used the measure (Wilson et al., 2002). This may suggest sampling bias and we suspect this was related to the demanding consent procedures involving separate consent for both this anonymous and a second non-anonymous survey. There was no gender effect for intentions to seek help from any source for either suicidal problems or non-suicidal problems. Suicidal ideation was significantly negatively correlated with only help seeking intentions from family members for both suicidal ($r = -.27$)

and non-suicidal problems ($r = -.28$, both p <.001). Athough evident, the help negation effect was not as strong in this sample as in the previous university and high school studied described above. We suspect this was a function of the overall lower levels of ideation compared to other samples and due to a smaller sample size (some correlations were -.18 but not significant). To test whether suicidal ideation continued to predict help seeking intentions from family, two GLM MANCOVAs were conducted. When wither problem recognition and appraisal or problem solving was controlled, suicidal ideation no longer significantly predicted help seeking intentions for suicidal thoughts or non-suicidal problems. These results should be interpreted with some caution given that the sample may be a better functioning group than other high school samples. However, they provide preliminary evidence that aspects of problem solving, particularly problem recognition and problem solving appraisal may play a role in the help negation process. Further studies are clearly needed to confirm and expand these findings.

As we suggest above, some individuals may not seek help for suicidal thoughts because they do not necessarily view this as a problem to be solved. We also found significant correlations between problem recognition and help seeking intentions. It is possible that one component of young peoples' reluctance to seek help is the lack of recognition of emotional difficulties. We included measures of emotional competence with some of our samples to explore the potential role of this variable in relation to help seeking. In addition, emotional competence was considered important because as with problem solving it has the potential to be modified if found to be important in help seeking.

EMOTIONAL COMPETENCE AND HELP SEEKING

Emotional competence (EC) is defined as the ability to perceive emotions, and the ability to manage self-relevant emotions and to manage others' emotions in a socially acceptable way (e.g. make other feel better when they are down) (Ciarrochi, Chan & Caputi, 2000). There are several potential hypotheses regarding the relationship between emotional competence and help seeking. It could be argued that people with high levels of emotional competence will be less likely to seek help because they believe themselves to be capable of handling their emotional problems on their own. However, even the most emotionally competent person will encounter crises that they can not handle on their own and there is no reason to expect they would be less likely to seek help. In the first of our studies that examined emotional competence, we argued that emotional competence would be associated with greater intentions to seek help because people high in EC tend to have more sources of social support and thus more opportunities for seeking help. In addition, those high in emotional competence would be more likely to have the ability to recognize when they are distressed which should cue help seeking (i.e. problem recognition). Finally, those high in EC would be likely to have better skills at managing the emotions of others that, in principle, increases the probability that their help seeking approach behaviour will be more successful in eliciting appropriate helping response.

Ciarrochi, J. V., & Deane, F. P. (2001). **Emotional competence and willingness to seek help from professional and nonprofessional sources.** *British Journal of Guidance and Counselling, 29*, 233-246. (See Attachment 10).

An anonymous questionnaire was completed by 300 university undergraduates. The average age was 20.58 years (SD = 4.98), 80% were 21 years or younger and 77% were female. A self-report measure of emotional competence (Shutte et al., 1988) with three scales was included. The scales measured perceiving emotions, managing ones own emotions, and managing the emotions of others. The Beck Hopelessness Scale (BHS, Beck et al., 1974) and the GHSQ were also administered.

Preliminary analyses indicated that people who had previously sought professional help had higher intentions to seek help from a mental health professional, GP and help line for personal emotional problems and from a mental health professional for "suicidal thoughts". In contrast, those who had previously sought

professional help tended to be less willing to seek help from family for both personal-emotional problems and suicidal thoughts.

Managing one's own emotions and managing others' emotions were both significantly correlated with intentions to seek help from family (r = .27 and .24) and friends (r = .18 and .35) for a personal-emotional problem. Managing own emotions was significantly correlated with help seeking intentions from Family (.23), friends (.22), mental health professional (.18) and GP (.15) for suicidal thoughts. Similar relationships were also found between managing others' emotions with the exception that it did not correlate significantly with intentions to seek help from family. There were no significant correlations between perceiving emotions and help seeking intentions. In general, self reported skills at managing own emotions and the emotions of others were associated with higher help seeking intentions.

GLM repeated measures ANCOVAs were conducted to investigate the impact of EC, help seeking source (professional versus nonprofessional) and help seeking problem-type (suicidal thoughts vs. personal-emotional problem). Gender, hopelessness and prior help seeking were entered as covariates. The analysis revealed that females, people high in managing own emotions and people low in hopelessness were most willing to seek help. In addition, managing others' emotions was more strongly associated with help seeking from nonprofessionals than from professionals for personal emotional problems. A similar relationship, but of less strength was found for help seeking intentions for suicidal thoughts.

Finally, we investigated whether the relationship between emotion management and willingness to seek help was mediated by the usefulness of people's past help seeking experience with a mental health professional. This was tested on the 92 (31%) participants who indicated that they had seen a mental health professional in the past. Managing others emotions predicted the usefulness of prior mental health help experience (UPH) and UPH in turn predicted intentions to seek help from professionals for both personal-emotional problems and suicidal thoughts. Finally, the direct link between managing others' emotions and intentions to seek help was no longer significant with UPH in the model.

In sum, the study found clear evidence for a relationship between emotional management skills and help seeking intentions. Further, it appears that the usefulness

of prior professional help seeking experience may be sufficient to explain the relationship between managing others' emotions and help seeking intentions. The concerning aspect of these findings are that those people who have poor emotional management skills are the least likely to seek help.

The next study used a high school sample, further explored this finding and extended them by testing the hypothesis that the quality of social support mediates the relationship between emotional competence and intentions to seek help.

Ciarrochi, J., Deane, F. P., Wilson, C. J., & Rickwood, D. (2002). **Adolescents who need help the most are the least likely to seek it: The relationship between low emotional competence and low intention to seek help.** *British Journal of Guidance and Counselling, 30,* 173-188. (See Attachment 11).

In this study we expected to confirm that people low in emotional competence would have lower intentions to seek help from a variety of nonprofessional sources. There were several reasons for proposing this relationship. First, people low in emotional competence tend to have fewer sources of social support (Ciarrochi, Chan & Bajgar, 2001) and thus ought to have fewer opportunities for seeking help. In addition, those low in emotional competence may have had less successful help seeking experiences in the past (Ciarrochi & Deane, 2001) and these past help experiences may make them less willing to seek help in the future.

Participants were 137 senior high school students from a private Christian school. The average age was 16.9 years, ranged from 16 to 18 years and 56% were female. All completed an anonymous questionnaire that included the Beck Hopelessness Scale, the measure of help seeking intentions (GHSQ) and the self-report of emotional competence (Shutte et al., 1998). Emotional competency measures were supplemented with the Levels of Emotional Awareness Scale (LEAS, Lane et al., 1996), which is a measure of emotional awareness and requires participants to describe their anticipated feelings and those of another person in each of 20 vignettes. High scores reflect higher emotional differentiation and awareness of emotional complexity in self and in others. The Toronto Alexithymia Scale (TAS-20, Bagby et al., 1994) was also included and measures difficulty in identifying feelings, difficulty describing feelings and externally-oriented thinking. Finally, a 6-item version of the Social Support Questionnaire (SSQ, Sarason et al., 1983) was administered.

Preliminary analyses revealed that adolescents had greater intentions to seek help from friends, parents and other family members for emotional problems than for suicidal thoughts. They were more likely to seek help from a phone help line for suicidal thoughts than for a personal-emotional problem. Twenty-nine percent percent (38/133) of participants stated they had seen a mental health professional in the past and also provided ratings of the usefulness of the visit. Higher perceived usefulness was related to higher intentions to seek help from a mental health professional (r = .55).

In the main analyses GLM MANCOVAs were conducted to assess the effects of emotional competence on intentions to seek help from 10 help sources for a personal-emotional problem. Hopelessness and emotional competence were entered as covariates (there were no gender differences on intentions for this sample). There were significant multivariate relationships between help seeking for personal-emotional problems and the LEAS, managing own emotions, managing others' emotions, TAS identification and TAS externally-oriented thinking. Follow up GLM ANCOVAs found that higher emotional competence was associated with greater intention to seek help. The significant relationships tended to involve help sources that the help seeker probably know on a personal level (e.g. parents, friends, teachers). In contrast, almost none of the significant relationships involved help from less personal sources (mental health professional, help line, GP).

The same analyses were conducted to assess the effects of emotional competence on intentions to seek help for suicidal thoughts. Only the TAS identification and TAS describing were significantly related to suicide-related help seeking. People who were good at identifying and describing their feelings had higher intentions to seek help from a parent and other relative. In general, the emotional competency-help seeking intentions relationships were present for informal but not more formal sources of help.

Mediational analyses were conducted to determine whether the quality of social support mediated the relationship between emotional competence and help seeking. The analyses suggested that social support could explain some, but not all of the variance between emotional competence and help seeking intentions.

This study provided further support that low emotional competence is associated with lower intentions to seek help. Six of the seven emotional competence measures

showed a significant multivariate relationship with help seeking. Adolescents low in emotional competence were less likely to seek help from informal sources (e.g. parents, friends, teacher, pastor), but not less likely to seek help from formal sources (mental health professional, phone help line, GPs). This pattern replicates the findings in the university sample (Ciarrochi & Deane, 2001). We also found evidence that skill at managing and describing emotions leads to better social support, and better social support, in turn, leads to greater intentions to seek help. Whilst these relationships were not found for formal help sources (e.g. mental health professional), this may not necessarily minimize the impact of emotional competencies on accessing formal help sources. This is because most adolescents continue to rely on informal sources of help, particularly parents to help them access more formal forms of help (Logan & King, 2001). If they have poorer emotional competencies, poorer quality social support, and poorer help seeking intentions, it is possible that together, this will also reduce the capacity for informal help sources to facilitate access to mental health services.

In sum, variables in addition to social support are needed to fully explain the emotional competence-help seeking intentions relationship. One possibility is that skill at identifying emotions may be an essential prerequisite for knowing when to seek help. For example, adolescents low in emotional identification skill may not realize the extent that they are depressed and may therefore be unclear about whether or not they need to seek help. This hypothesis is consistent with findings suggesting poor problem recognition is also related to help seeking intentions. There is a need to test these hypotheses in future research.

Ciarrochi, J., Wilson, C. J., Deane, F. P., & Rickwood, D. (in press). **Do difficulties with emotions inhibit help seeking in adolescence? The role of age and emotional competence in predicting help seeking intentions**. *Counselling Psychology Quarterly*. (See Attachment 12).

Given previous age-related findings associated with help seeking intentions identified by Thompson and Rickwood (2002), we wanted to test whether there were any developmental changes in help seeking intentions during the adolescent years. Specifically, we were interested in knowing whether there was any relationship between emotional competence and help seeking as a function of age. Our prior findings indicated that amongst older adolescents (16-18 years) and adult university students, those who had the most difficulty managing their emotions were the least

willing to seek help. In the next study we wanted to determine whether this would also hold for younger adolescents? (13-16 years).

The sample came from the same Christian high school as in Ciarrochi et al., (2002), but this time students who were aged between 13 and 16 years of age were included. This meant that there was some overlap of students aged 16 years between the two studies. There were 217 student participants from grades 8 through 11 with a mean age of 14.38 years (SD = 1.18). However, sample sizes varied for some analyses because the emotional competency measures were administered last in the questionnaire and this resulted in some students not being able to complete the measures. The same measures as in Ciarrochi et al., (2002) above were included in analyses with the exception of the performance based Levels of Emotional Awareness Scale (LEAS) which many of the younger students had difficulty finishing in time in part because it required written narrative responses.

As with the older adolescents there were multivariate relationships between help seeking intentions for personal-emotional problems from informal sources and the TAS managing own emotions, TAS managing others emotions and emotion perception. Higher emotional competence was associated with higher intentions to seek help from family and friends for emotional problems. The same results were found for help seeking intentions for suicidal thoughts. There was a significant interaction between age and the TAS measures in predicting intentions for both problem-types. The interaction was significant when predicting intentions to seek help from parents and other relatives for both problem types. The analyses indicated that as age increased, the size of the relationship between emotional competence and help seeking intentions becomes increasingly positive.

At age 13, there is a negative relationship between emotional competence and help seeking. The more that young adolescents feel they cannot identify and describe their emotions, the more willing they are to seek help from family members. However, as age increases, this relationship becomes increasingly positive. By age 16, all relationships are significantly positive, indicating that adolescents who are least emotionally competent are also less likely to seek help from family members.

Greater skill at identifying and describing emotions was associated with higher intentions to seek help from mental health professionals, doctors, teachers and priests

for suicidal thoughts. Age again moderated the relationship between emotional competency and intentions. At age 13, the more these young adolescents feel they can not identify and describe their emotions, the more willing they were to seek help from doctors. However, as aged increased the relationship became increasingly positive. By age 16, all relationships were significantly positive, indicating older adolescents who had the most difficulty with identifying and describing their emotions were the least likely to seek help from doctors. As in Ciarrochi et al. (2002), social support partially explained the relationship between emotional competence and help seeking intentions, but in this case in younger adolescents.

As they get older, adolescents appeared to shift their help seeking away from parents and towards boyfriend and girlfriends. However, they did not "replace" their parents entirely with other sources of help, because they reported an increased likelihood of not seeking help at all. This is consistent with the findings in the ACT high school sample that found a decrease in help seeking from family with friends as they progressed through school, but no increase in other sources of help to compensate for this (Thompson & Rickwood, 2002).

We are still not able to fully explain the why emotional competence is associated with help seeking intentions. In this study, gender, hopelessness and prior help were unable to account for the relationship and social support accounted for only some of the variance. As noted earlier, it is possible that the inability to identify and describe emotions prevents adolescents recognizing the presence of a problem requiring help.

BRIEF INTERVENTIONS TO IMPROVE HELP SEEKING

As noted, high schools often required that as part of research participation some kind of presentation be provided to students. As a result of this expectation the research team in collaboration with a high school Student Representative Council and teachers, developed the Do It Together Kit (DIT Kit). The DIT Kit is a bound booklet aimed at providing information to young people to promote appropriate help seeking. Given the focus of the NHMRC grant was not to evaluate such a tool, a minimalist approach to evaluating the DIT Kit was taken. In short, we first had students complete our research measures (e.g. attitudes, knowledge, intentions, barriers to help seeking) then provided copies of the DIT Kit to participants with varying presentation lengths explaining the contents. We then asked them to complete follow-up measures several weeks later. Two separate trials of the DIT Kit were completed.

A number of school-based interventions have attempted to increase appropriate help seeking behaviour in students through improving knowledge of suicide and warning signs (Kalafat & Elias, 1994), mental health (Esters, Cooker & Ittenbach, 1998) and help sources such as psychiatrists (Battaglia, Coverdale & Bushong, 1990). Most of these programs are relatively long in duration, ranging from a low of 45 minutes (Battaglia et al., 1990) to four and a half hours (Esters et al., 1998). Several studies (e.g., Esters et al., 1998; Kalafat & Elias, 1994) have demonstrated that mental health "educational" programs alter attitudes toward help seeking, however, others (e.g., Shaffer et al., 1991; Vieland et al., 1991) have failed to find evidence of any program effect. There are a number of possible explanations for these contradictory results.

The content and quality of the programs may have varied. Only general information about each of the programs was available and, although this information suggested the programs were quite similar, the focus of the programs may have been different. Because the objectives of the programs differed somewhat, the criteria by which they were evaluated differed as well. While Kalafat and Elias (1994) and Battaglia et al. (1990) examined attitudes toward help seeking, Vieland et al. (1991) focussed on the incidence of actual help seeking behaviours. Although attitudes are related to behaviours (e.g., Azjen, 1991; Bandura, 1977), it remains to be seen whether "knowledge and attitude changes translate into performance in actual

situations" (Kalafat, 1997, p. 189). One can speculate that if Kalafat and Elias (1994) had investigated actual help seeking behaviours, they may have failed to find a program effect. Conversely, it is possible that Vieland et al. (1991) would have found a program effect if they had restricted their study to students' attitudes toward help seeking. In addition, follow-up periods (i.e., the time that elapsed between delivery of the program and testing) varied from five minutes to six weeks. Battaglia et al. (1990) had students complete questionnaires immediately after the respective programs concluded and obtained a significant treatment effect, whereas Shaffer et al. (1991) allowed four to six weeks to elapse before re-administering the questionnaires and found no effect. A recency effect or other artefacts may have contributed to Battaglia et al.'s (1990) findings. Overall, there is some evidence that the American programs changed students' knowledge and attitudes towards help seeking in the short-term, but no evidence suggesting the programs had longer term, or sustained, effects on knowledge or attitudes.

Australian programs, such as *MindMatters* (Wyn, Cahill, Holdsworth, Rowling, & Carson, 2000) and *Roller Coaster – Dealing with the Ups and Downs* (Odgers, 2000) include small components on help seeking.The *Yellow Ribbon Program* specifically encourages and empowers young people to ask for help in times of need (Here For Life, 2001). However, we are not aware of any data that indicate these programs change young peoples attitudes, knowledge, intentions or actual help seeking behaviour.

As noted, the *Do It Together Kit (DIT Kit)* was designed to complement whole of school programs such as Mind Matters and supplement the help seeking component of this program. The *DIT Kit* was developed to promote appropriate help seeking for a variety of adolescent problems, including personal-emotional problems and suicidal ideation. It is the product of a partnership between the Illawarra Institute for Mental Health (iiMH) and Illawarra high school students and teachers. Based on data from our focus groups (Wilson & Deane, submitted), the *DIT Kit* targets the reduction of help seeking barriers, such as negative help seeking attitudes and beliefs, aversive emotions, and limited knowledge about available help sources, offers strategies for overcoming these barriers and provides information about available help sources and the usefulness of help seeking.

Deane, F. P., Wilson, C., Richardson, A. Greenfield, V., Knight, T., & Malak, P. **The "Do It Together Kit" (*DIT Kit*): Evaluation of a brief informational intervention to promote help seeking for adolescent problems.** Manuscript in preparation.

Study 1

Participants were 158 students from years 11 and 12 from a suburban Australian high school. Fifty-three percent were female (n = 84) and 47% (n = 74) were male. Students had a mean age of 17.06 years and ranged from 15 to 18 years. Participation was voluntary. There was missing data on some variables that reduced the sample size for some analyses (potential sampling bias as a result of missing data was assessed, see results). Year 11 students participated in the study as part of the "school welfare program" facilitated by teachers. All surveys were anonymous and a unique identifier was used to match pre-post intervention questionnaires. Students were provided the pre-intervention questionnaire then each student was provided with a copy of the DIT Kit and this was reviewed using over head projector slides with an overview of the the contents of the booklet and how it might be used. Students were urged to read the DIT Kit in their own time. The whole procedure lasted no longer than 15 minutes. For Year 12 students the same procedure was followed, except it was presented by a trained year 12 student during a regular year meeting at the school. Three weeks later the follow-up questionnaire was administered in classes.

Measures included a 13-item knowledge questionnaire, a 13 items from the Barriers to Adolescents Seeking Help scale (BASH, Kuhl et al., 1997), the General Help seeking Intentions Questionnaire (GHSQ) and the Actual Help seeking Questionnaire (AHSQ, Rickwood & Braithwaite, 1994).

Complete pre-post data was available for only 52 participants.Comparisons of those who completed only pre-test questionnaires and not the post-test questionnaires revealed a potential sampling bias. Those with both pre and post-test data had significantly higher intentions to seek help for a personal emotional problem and significantly lower intentions to seek help for suicidal thoughts on the pre-test measures than those who did not complete the post-test measures. This suggests the need for some caution in interpretation of results.

Paired sample t-tests indicated there was a significant increase in knowledge 3 weeks following the presentation, but there were no significant improvements in help seeking intentions, actual help seeking or perceived barriers.

Study 2

A total of 790 students comprised the potential participant pool. The parents/caregivers of 105 students (13%) consented to their child participating in the study. After excluding students with missing data (e.g., students completed pre-test or post-test only), only 60 participants remained. Of the 60 students who completed the study questionnaire both before and 3 weeks after exposure to the *DIT Kit*, 53% were female. The participants ranged in age from 12 to 17 years (*M* = 14.50 years, *SD* = 1.48).

Approximately three days after the pretest questionnaire administration, all students were presented with the *DIT Kit*. Teachers at the high school distributed *DIT Kit*s to students during normal class time. It was anticipated that students would be given approximately 40 minutes of class time to review and discuss the *DIT Kit,* however, the constraints of the school environment did not allow the presentation to occur as planned. As such, the intervention (i.e., the *DIT Kit*) was not uniformly administered. Some students were exposed to the *DIT Kit* for approximately 10 minutes, while others were given an opportunity to discuss the *DIT Kit* for more than an hour. The questionnaire was re-administered approximately three weeks after the *DIT Kit*s were distributed.

The questionnaire comprised six self-report scales: the Social Problem-Solving Inventory for Adolescents (SPSI-A: Frauenknecht & Black, 1995); the Hopkins Symptom Checklist-21 (HSCL-21: Green, Walkey, McCormick, & Taylor, 1988); the Suicidal Ideation Questionnaire (SIQ: Reynolds, 1988); the General Help seeking Questionnaire (GHSQ); the Actual Help seeking Questionnaire (AHSQ: Rickwood & Braithwaite, 1994); and the 13 items from the Barriers to Adolescents Seeking Help (BASH-B: Kuhl et al., 1997). In addition, 10 questions that measured students' knowledge of available health care services were included.

The scores on the Suicide Ideation Questionnaire were highly skewed indicating the majority of respondents had very low levels of suicidal ideation. Transformations could not improve the distribution and thus the SIQ was excluded from parametric

analyses. There were no pre-posttest differences in knowledge, perceived barriers, intentions, or the frequency of actual help seeking behaviours from a variety of sources. There was a small but significant decrease in global social problem solving.

Summary

These studies demonstrated the difficulty in implementing even a simple intervention in school settings when there are high levels of cooperation from school personnel. In the second study the intervention itself was inconsistently administered (with only 10 minute presentations in some classes). We believe the demanding requirement of both anonymous and non-anonymous consent procedures for both parents and adolescents in the second study led to a reduction in the participation rate, with only 13% of those approached volunteering. In addition, we believe that the attrition from the follow-up phase of the study lead to a highly select sample. Still, it was clear that the brief intervention was not effective in changing students' help seeking variables over a 3 week follow-up. At best, such brief interventions may improve students' knowledge of help resources. More troublesome was the potential for brief interventions to have negative outcomes (e.g., global problem solving). Other studies have also found their program did not affect attitudes toward suicide or increase students' tendency to offer help to distressed peers. One study found that male students exposed to the program reported increased hopelessness and maladaptive coping (Spirito et al., 1988). Our experience suggests that a "minimalist approach" to promoting help seeking which includes only the provision of information with little time for discussion or processing of the material, offers no medium term gains.

WHO INFLUENCE MEN TO GO TO THERAPY?

Cusack, J., Deane, F. P., Wilson, C., Ciarrochi, J., et al. **Who influence men to go to therapy? Reports from men attending psychological services.** Manuscript in preparation. (See Attachment 13)

Much of the literature into health service utilisation identifies two pathways to care. Individuals are assumed to have made the "choice" to access services or to have been "coerced" into accepting help. More recent research however has suggested that "choice" or "coercion" may not adequately represent the only pathways to care.

Studying the pathways to in-patient psychiatric care, Pescosolido, Gardner and Lubell (1998) identified a sample of individuals whom they term as "muddling through", neither fitting neatly into the "choice" or "coerced" pathway. In a second study using an in-patient psychiatric population, it was reported that 46% of individuals entering care report no pressures from others to access services whilst 10% report the use of force. The remaining 38% however reported efforts to persuade them to seek help from others (Monahan, Hoge, Lidz, Eisenberg, Bennett et al., 1996).

The reported reluctance of males to seek help for psychological distress suggests that those who do finally make it into care, may have been strongly "influenced" by others. However, to our knowledge, no research has explored the extent to which males attending outpatient psychological services have been influenced by others. A better understanding of these influences may provide insights into how to get men in psychological distress to seek help. The first aim of the current study is to ask males who are currently, or have recently received professional psychological services, to what degree their access to a professional helping service was influenced by others.

Summary

Participants were 50 males (aged 18-56) who were currently accessing, or had in the last 12 months accessed a professional mental health service. Participants completed a questionnaire that included the GHSQ to measure help seeking intentions and the Help seeking Influences Questionnaire. The HSIQ was developed specifically for this study as a measure of who influenced the client's decision to seek help. There were three core questions. Participants were asked to indicate, on a 7-point Likert scale, (1

= Totally others decision, 7 = Totally my decision) "How much you think the decision to seek professional help was your own or influenced by others". Participants were also asked to indicate, on a 5-point Likert scale (1 = not at all, 5 = a great deal) "How much each of the specific people listed influenced your decision to seek professional help". Potential influences listed were consistent with five of the sources of help identified in the GHSQ. All participants were asked, "If your decision to seek help was influenced by others, do you think you would have sought help without their influence?" Participants who replied "yes" to this question were classified as belonging to the "Independent" help seeking group. Participants who replied "no" were allocated to the " Influenced group.

Whilst 34% of individuals suggested the decision to seek professional psychological help was totally their own decision, 64% suggested the decision was influenced by others and 2% suggested the decision was totally someone else's decision. These results are not entirely consistent with those provided by participants when asked to rate separately the degree to which five different sources influenced their decision to seek help. In this case, only three subjects (6%) suggested they were not influenced to any degree by the sources listed.

For the 47 participants (94%) who indicated at least some influence by others, for each source: 27 participants (51%) indicated that G.P's or other health professionals influenced them, 26 (55%) indicated intimate partners, 22 (47%) indicated parents or other relatives influenced them, 19 (40%) reported friends influenced them and 3 (6%) suggested a legal professional influenced their decision to seek professional help. Thirty-four participants (68%) endorsed multiple sources of influence. Most of those influences identified in the "other" category could have been subsumed under the groups noted above, however, the single largest new source of influence was work related (n = 5) with two specifically mentioning their work manager. Paired t-tests indicated that intimate partners and G.P's / other health professionals provided a significantly greater degree of influence on the decision to seek help than did friends or legal professionals.

Most (64%) suggested they would have sought help regardless of the influence of others (Independent group) and 36% suggested they would not have sought help without the influence of others (Influenced group). There were no significant differences between the Independent and Influenced group with regard to their

intentions to seek help in the future (GHSQ). The results strongly suggested that most males who end up in treatment have been influenced, and in many cases strongly influenced by others to seek help. They suggest the need to target these groups to increase the effectiveness of their influence and to potentially join forces to facilitate men into treatment.

GATEKEEPERS

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 to be able to identify mental health issues, to engage a young person and to refer them to appropriate help. Research has demonstrated that pro-active gatekeeping can enhance community networks (Capp et. al., 2000), and can facilitate a higher number of correctly identified mental health issues and contacts with appropriate help sources (Pfaff et. al., 2001).

A series of studies were conducted with a variety of gatekeepers groups. Gatekeeping models seem to have an underlying assumption that gatekeepers will value, and be positively predisposed toward mental health services. However, gatekeepers and professional helpers alike are not immune to attitudinal and stigma related barriers related to accessing professional mental health services. For example, trainee psychologists in a recent study were averse to seeking psychological help due to beliefs that "I would worry about perceived weakness by colleagues" and "I might feel a huge stigma attached to it" (Farber, 2000). Our focus group work also confirmed similar concerns (Wilson & Deane, submitted).

As a result, the broad aims of the gatekeeper related studies were to assess the level of readiness of existing gatekeeper groups. More specifically we aimed to identify gatekeepers' perceived barriers and attitudes toward seeking help from both formal and informal sources. In addition, we provide preliminary exploration of the potential effects such attitudes might have on their referral skills. For some samples

we examine the effects of gatekeeper workshop participation on attitudes and personal help seeking intentions.

Teachers

Commentators agree that teachers and the school context are second only to parents and families, in the strength of their influence on student behaviour (e.g., Cowen, Hightower, Pedro-Carroll, Work, Wyman & Haffey, 1996; Evans, 1999; Kalafat, 1997; Lindsey & Kalafat, 1998). Greenberger, Chen, and Beam (1998) found that up to two thirds of the 201 students who took part in their study identified a teacher as a significant other. More importantly, Tatar (1998) found that significant others' attitudes and behaviours had enduring influence in young peoples' lives.

Certainly, teachers either as instructors or mentors have a major role in the development of young peoples' willingness to seek help (e.g., Hamilton & Darling, 1989; Hendry et al., 1992; Newman, 2000; Tatar, 1998). Teachers help students realise that appropriate help seeking is an effective means for achieving a suitable solution for their problem (Newman, 2000). Moreover, through classroom discourse, students internalise and gradually adopt teachers' other- and self-regulating beliefs and behaviours (Rogoff, 1990; Wertsch, 1985; Vygotsky, 1978).

In terms of professional psychological help seeking, it seems likely that teacher's own beliefs and behaviours will influence young peoples' help seeking for distressing personal-emotional or suicidal problems. If teachers are not help-seekers, they may, intentionally or not, exhibit behaviours or attitudes that deter appropriate help seeking in their students. Although students come to the classroom with underlying attitudes and beliefs about appropriate help seeking, teachers play an important role in the development of these beliefs in addition to the continuation of adaptive help seeking processes. As stated by Newman (2000), teachers "have direct bearing on [students'] cognitive and social competencies as well as [the] motivational resources needed for adaptive help seeking" (p. 378).

Wilson, C. J., & Deane, F. P. **If we can't seek help, how can the kids?** Manuscript submitted for publication. (See Attachment 14).

Eighteen teachers took part in the study. All but one of the teachers described themselves as Australians of European descent. The teachers worked at an Australian public high-school situated in an urban industrial area. Three teacher focus groups were formed. Teachers also completed the General Help seeking Questionnaire (GHSQ; Deane, Wilson & Ciarrochi, 2001) prior to the start of all discussions. Although GHSQ responses were kept anonymous, each group's responses were reviewed briefly by the moderator before each discussion. In addition to focus group prompts GHSQ responses served to guide participants to explain the reasons for their help seeking intentions for suicidal and non-suicidal problems. On the GHSQ teachers indicated they were more likely not to seek help from anyone rather than seek help from any of the other sources listed (e.g. friends, GPs etc). This pattern held for a variety of different problems including "suicidal thoughts". Themes from the discussions suggested a number of negative influences on professional help seeking including:

The competency of clinicians and effectiveness of treatment:

"I know a few people who haven't had any success."

"I wouldn't feel comfortable with what I know about those people…a lot of people have done it (mental health training) because they've got their own problems."

Stigma and anxiety about the experience.

"They're very type-cast, counsellors"….

"It's a bit threatening…you think, "Can I say anything that's not going to get analysed?""….

"They're a bit scary, some of those people"….

"It's stigma associated"…. "You get loopy psychiatrists in films and television…they're certainly not helping things."

Positive prior help seeking experiences either by themselves or by others that seemed to enhance help seeking opinions.

> "I have had to use a counsellor in my adult life and I found it very useful at the time…I think that I would access that again"….

> "I started to see the worth in (getting professional help) because we've had someone in the family go to someone."

> "I think that you've got to have…a personal contact…someone who has been (to a mental health professional)."

As with other samples, teachers were more likely to go to informal sources of help such as family and friends before formal sources such as mental health professionals or GPs. For "suicidal thoughts" they were less likely to seek help from these informal sources and more likely to seek help from formal sources compared to other problem types (e.g. "anxiety-depression").

As with other samples teachers showed some reluctance to seek help. Their overall intention ratings were similar or marginally higher than students from the same school for a "personal-emotional" problem (e.g. for mental health professional: teacher M = 3.00, students M = 2.57; GP: teacher M = 3.01, students M = 2.67). However, teachers had scores that indicated they were more likely to not seek help at all (M = 5.62) compared to their students (M = 5.31). For "suicidal thoughts" there were greater differences between teachers and students intentions to seek help from formal sources (mental health professional: teacher M = 4.31, students M = 2.90; GP: teachers = 3.54, students = 2.50).

While teachers appear to have similar attitudinal barriers to seeking help as student samples, for problems related to suicide, they had higher intentions to seek help from more formal sources such as mental health professionals and GPs. It is unclear whether these differences reflect greater knowledge of such services, more positive attitudes or merely that they have better control over accessing such services compared to adolescent student samples. The study suggested the need to provide education to teachers regarding the potential benefits of help seeking from

professional sources. They are also consistent with a "whole of school" approach to promoting help seeking.

Youth Workers

Cartmill, T., Deane, F. P., & Wilson, C. J. **Youth workers' attitudes to help seeking for mental health issues and their referral practice with young people.** Manuscript in preparation. (See Attachment 15).

Youth workers have been identified as 'key community gatekeepers' (NSWHD, 2000, p. 2). It has been argued that youth workers, particularly those who are involved with neighbourhood youth centers come into contact with a group of young people who are more likely to be on the "margins" of the mainstream community. For example, the Keys Young (1997) Commonwealth commissioned research on young people and mental health found "Young homeless people frequently indicated that they relied on *workers at youth drop-in centers* for referral, basic needs, general counseling and support. These were distinguished from social workers, case workers and even youth refuge workers. Numbers of these young people indicated that they would rely exclusively on the youth centre worker (often one particular worker) to deal with any problems; they would generally 'trust' a referral to some other source of support if it were made by that worker." (p. 50).

While youth workers clearly provide an essential link with mental health services, it is unknown to what extent referral is undertaken. The Australian Psychological Society discussion paper on suicide highlighted the urgent need for research and training in referral processes (Graham, Resser, Zubrik, Smith & Turley, 2000). There is some evidence that particular referral practices can improve the success of the referral (e.g. King, Nurcombe & Bickman, 2001), and successful referral to mental health help can halt the progression toward suicidal behaviours (Kalafat, 1997).

Summary

A brochure was sent to all Illawarra Community Centres inviting youth workers to attend the "Youth Empowerment Series" (YES!). This series comprised three workshops (1) strategies to facilitate appropriate help seeking (2) strategies to facilitate effective youth problem solving (3) strategies to identify mental health needs of youth, and facilitate appropriate help-service engagement (referral). The overall aim of the workshops was to educate youth workers about help seeking for mental

health issues. Forty-seven youth workers attended at least one of the workshops. The personal attitudes and help seeking intentions of participants were examined as part of the workshops. Participants also consented to be contacted for a follow up 4 months after the workshop. Twenty-four participants completed measures during the workshops and also at 4-month follow-up and 26 youth workers who did not attend the workshops comprised a control comparison group. Measures assessed intentions to seek help (GHSQ), actual help seeking over the previous month (AHSQ), perceived barriers to professional help seeking (BASH), a measure of

There were significant pre-post workshop increases in measures of help seeking intentions for "suicidal thoughts", actual help seeking behaviours and social problem solving. No significant changes were found for intentions to seek help for a personal emotional problem, help seeking barriers or referral skill. However, improvements in actual help seeking and social problem solving may have been a function of sampling bias. Those who completed the workshop started out with significantly lower levels of actual help seeking behaviour and problem solving skills than the control group. Thus, any changes on these variables should be considered within the context of their relatively low scores compared to other youth workers. Comparison of the control group and workshop groups at post-test indicated the workshop group had significantly higher levels of knowledge regarding help seeking in young people and problem solving strategies. In addition, the workshop group had significantly lower perceived barriers to help seeking. Whilst workshop participants had higher personal intentions to seek help for both suicidal and non-suicidal problems these did not reach statistical significance. There were no significant relationships between global measures of personal help seeking intentions and referral skills.

In summary, these results suggest that for youth workers who start out with relatively low levels of problem solving skill and actual help seeking behaviour, the workshops lead to improvements in both of these variables and, intentions to seek help for "suicidal thoughts". Whilst barriers did not show significant pre-post workshop reductions, at post-test the workshop group had significantly lower barriers than the control group.

General Practitioners

Pirkis and Burgess (1998) found 73% to 83% of individuals who committed suicide had contact with their G.P within one year of death. Thirty-four to 38% had contact with their G.P within one month of death (Pirkis & Burgess, 1998). Such figures reinforce the potential role of G.P's as an influence on men to seek professional psychological help.

Deane, F. P., Wilson, C. J., & Biro, V. **General Practitioners' mental health referral practices when working with young people.** Manuscript in preparation. (See Attachment 16)

Given the vital role in managing the needs of many patients with mental health issues, there is a significant need for GPs to work collaboratively with other mental health providers and in some cases, they choose to transfer care completely. For young people there are two significant factors which impact on the success of this referral process. The first relates to the general reluctance of young people to seek help for psychological problems and even greater reluctance to seek help from mental health professionals (Deane, Wilson & Ciarrochi, 2001). The second factor is the referral skill of the GP.

The Australian Psychological Society discussion paper on suicide highlighted the urgent need for research and training in referral processes (Graham, Reser, Suderi, Zubrik, Smith & Turley, 2000). They noted that "…making an effective referral is a complex process, and this is a neglected topic in the psychological and psychiatric literature" (p. 19). There is preliminary evidence that certain referral practices can improve the success of the referral (Victorian Suicide Prevention Task Force cited in Graham et al., 2000; King, Nurcombe & Bickman, 2001). Nonattendance rates at initial intake appointments for community mental health centers range from 15% (Noonan, 1973) to 55% (Hochstadt & Trybula, 1980), with most falling in the 20% to 40% range (Larsen et al., 1983; Carpenter et al., 1981). Several studies have found that nonattendance rates are even higher for younger adults (e.g. Deane, 1991). A study investigating factors that lead to patient nonattendance at their first psychiatric outpatient appointments following referral by a GP, found that an absence of a clear psychiatric diagnosis were associated with nonattendance (Neeleman & Mikhail, 1997). Similarly, Grunebaum et al., (1996) found patients with mild distress and those with significant resistance to seeing a psychiatrist were more likely to miss

appointments. These studies point to potential interventions in the referral process (i.e., clearly specifying identified problems and reasons for referral) that have potential to improve appointment keeping by patients.

Summary

Forty-nine GPs completed a questionnaire regarding their referral practices with young people. The 16 questionnaire items were 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). Under the "Referral and Management Practices" section, GPs were asked to indicate the frequency with which 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-type scale ranging from (1) Never to (5) Always.

The results suggest that on average, GPs in this sample follow a range of recommended referral practices with young people most of the time. These include, explaining why they think a referral to a mental health professional might be useful and what benefits might accrue, explaining that they have a choice about whether they see the mental professional or not, then organizing the appointment for the young person. Referral practices that might ideally be conducted all of the time but were followed only some of the time by 41% of GPs included discussing issues of confidentiality, clarifying any costs associated with seeing a mental health professional and explaining what to expect in the initial consultation. Referral practices that should ideally be conducted "often", were followed only some of the time by GPs and included, explaining the likely benefits and success of seeing a mental health professional and recording consent for referral. Only 29% of GPs "often" explained the likely duration of a mental health consultation and 39% indicated that they "rarely" or "never" explained this. The present study also found some evidence that those GPs with low efficacy beliefs regarding the helpfulness of seeing a mental health professional may be less likely to follow ideal referral practices. This effect was small, but does signal the potential effect that beliefs or attitudes may have on referral practices. The study provides data to help target improved referral practices and makes suggestions about strategies such as education of GPs and the provision of pretherapy information for patients.

School Counsellors

Twenty-one primary and secondary school counsellors were asked to rate barriers that they anticipated students would have using the Barriers to Adolescents Seeking Help (BASH, Kuhl et al., 1997). School counsellors were also asked to rate their own personal help seeking intentions using the GHSQ. School counsellors rated several barriers higher in priority than did students from previous high school samples. Specifically, school counsellors anticipated that "Thoughts about therapy are scary", "Adults can't understand" and "I wouldn't want my friend to know I was using therapy" were the three highest barriers whereas students themselves have indicated that believing therapy may not be helpful, not knowing where to find a therapist and concerns regarding confidentiality were their main barriers (e.g. Wilson & Deane, submitted). This suggested that school counsellors might benefit from better understanding student perspectives of barriers to seeking professional help in order to better address these barriers in their schools. Overall the GHSQ indicated that school counsellors personal willingness to seek help was relatively high compared to other samples. School counsellors indicated they were most likely to seek help from an intimate partner for "personal-emotional problems" and "Anxiety-depression". The next most likely source of help was a mental health professional for these problems, followed by friends. For "suicidal thoughts" a mental health professional was the most likely source of help followed by "Intimate partner", "GPs" and then "Friends". The pattern of help sources for different problems was encouraging given less than ideal findings with other samples. Counsellors showed a relatively high willingness to seek help and desirable preferences for mental health professionals in the face of suicide related difficulties. These findings suggested that school counsellors are likely to be good models for promoting appropriate help seeking particularly in school environments.

Limitations, recommendations and future research directions are outlined at the beginning of the report immediately following the Executive Summary.

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