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Tania Cartmill
University of Wollongong

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**Gatekeeper training for mental health issues:
An evaluation of youth workers' personal help-seeking
and referral practice.**

A thesis submitted in partial fulfillment of the requirements for the award of the degree

Doctor of Psychology (Clinical)

from

University of Wollongong

Tania Cartmill

Bachelor of Psychology, University of Wollongong

Department of Psychology

2004

Thesis certification

I, Tania Kristen Cartmill, declare that this thesis, submitted in partial fulfillment of the requirements for the award of Doctor of Psychology (Clinical), in the Department of Psychology, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institute.

Tania Kristen Cartmill

13 February, 2004

**Relevant manuscript and conference presentation
in the course of the candidature**

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Abstract

Gatekeeper training programs that promote help-seeking have been recommended as key mental health and suicide intervention strategies for adults who work with young people. Extensive research suggests that young people do not seek the help they need for mental health issues, and may be reliant on adult gatekeepers to facilitate help-seeking. Further, some research suggests that gatekeepers may not be positively predisposed to seek professional help themselves, and may even have the same barriers as young people to seeking help for mental health issues. This study investigated the personal help-seeking practice of 73 youth workers who attended gatekeeper workshops that incorporated training in awareness of personal help-seeking as well as help-seeking among young people. Personal help-seeking, including perceived barriers, intentions, actual help-seeking behaviours and social problem solving skills were examined prior to, and after a workshop intervention. The relationships between help-seeking variables and referral skill were also explored to investigate the impact that personal help-seeking may have on youth workers' professional practice. Pre-post workshop measures revealed that actual help-seeking behaviour, intentions to seek help for a personal-emotional problem, and social problem solving skill significantly increased, while there were no changes in perceived barriers, or intentions to seek help for suicidal thoughts. Compared to a control group, the workshop group reported significantly higher intentions to seek help for a personal-emotional problem knowledge of help-seeking and social problem solving skill, and lower perceived barriers. There were no differences in referral skill pre-to-post workshop, or in intervention and control group comparisons. Results suggest that the workshop intervention influenced awareness and skills of personal help-seeking, although the relationship with referral skill was unclear. The study is discussed in the context of research that suggests that personal-

emotional functioning and attitudinal barriers toward mental health services are factors that may influence professional service provision.

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Chapter 1

Introduction

Chapter 1 provides an overview of the major components that comprise the rationale for gatekeeper training, and the evaluation of personal help-seeking and referral practice among youth workers, and outlines the contents of the other chapters in the thesis.

Gatekeeper training programs have been identified as key intervention strategies in the prevention of suicide and mental illness among young people (Frederico & Davis, 1996; Gould & Kramer, 2001; Grossman & Kruesi, 2000; NSWHD, 2000). Gatekeeper programs involve the education and training of adults and peers who come into contact with young people in schools and in the community. Adults who are potential gatekeepers have been described as “natural community helpers...because they are often in a position to be among the first to detect signs of suicidality and offer assistance” (Gould & Kramer, 2001, p. 14). Typically the purpose of gatekeeper training is to develop knowledge and skills to identify young people at risk of suicide, and to examine personal attitudes toward suicide given the effect that attitudes may have on gatekeepers’ reaction to managing a suicidal young person (Frederico & Davis, 1996; Gould & Kramer, 2001). While findings of gatekeeper programs are encouraging, there is little research examining the effectiveness of the training, or utilising a repeated measures design. Furthermore, there is a paucity of data exploring the effects of training for particular groups of community gatekeepers, such

as youth workers, who may have a critical role in connecting young people with mental health services.

Young people have the highest prevalence of mental health problems including suicide, in Australia (Andrews, Hall, Teeson & Henderson, 1999). Similar rates of mental health problems have been found in the United States, Canada, and Norway (Cantor, Neulinger & De-Leo, 1999) and some estimates suggest that only one in twenty psychologically distressed young people will actually reach professional mental health help (Costello, Burns, Angold & Leaf, 1993). Research on young people's help-seeking barriers and intentions indicates that distressed young people often do not seek help from adults (Kalafat, 1997), and are less likely to seek help when they are experiencing suicidal thoughts (Carlton & Deane, 2000; Saunders, Resnick, Hoberman & Blum, 1994). These concerning findings suggest that gatekeepers or adults who work with young people will need to be positively predisposed toward facilitating help-seeking, in order to support young people to seek professional help for mental health issues.

Youth workers have been able to engage distressed young people by being highly accessible, and acting as advocates. They often see a range of young people, particularly those who may be disconnected from social supports such as family or school (Bourke & Evans, 2000). Yet youth workers may come across substantial barriers in their endeavour to act as a gatekeeper, and assist young people to seek help. These barriers include an often confusing role as both 'soft' law enforcement and as an advocate (Flowers, 1998). In the broader public context the youth work sector has been described as marginalised, and at the same time having to engage a marginal population of young people (Sercombe, 1997a; 1997b). These difficulties may be exacerbated by the potential for burnout due to dealing with young people's psychological problems (Bourke & Evans, 2000), a lack of

opportunity for training in the identification of mental health problems and skills in effectively referring to other services (Wright & Martin, 2000), and the possibility that youth workers may have their own personal barriers to help-seeking (Wilson & Deane, 2000).

Of particular concern is research that suggests adults in a gatekeeping role may have the same barriers as young people in seeking professional help for a mental health issue (Wilson & Deane, 2000). Research examining help-seeking among adults found that higher attitudinal barriers have been associated with lower intentions to seek help from a mental health professional (e.g., Bayer & Peay, 1997; Deane & Todd, 1996). Similarly, higher help-seeking barriers have been associated with lower intentions to seek help in young people (e.g., Carlton & Deane, 2000). While attitudes and barriers to seeking help for mental health issues have been examined in gatekeeper samples (Capp, Deane & Lambert, 2001), there is little research that has explored the impact of personal mental health help-seeking tendencies and professional practice. Personal factors, such as the attitudes gained from a personal history of suicidality, have been suggested to be deleterious to effective professional practice (Neimeyer, Fortner & Melby, 1999; 2001). Very little is known about the personal barriers and help-seeking intentions of youth worker samples, and the potential impact of personal barriers on a gatekeeping role, such as referral. Thus, one of the central aims of this study was to investigate youth workers' personal help-seeking tendency, with a particular focus on attitudinal barriers and intentions toward seeking help from a mental health professional.

Training in effective referral has been recommended as a core skill in gatekeeper training programs (Frederico & Davis, 1996), and a recent discussion paper on suicide prevention argued that research on referral skill is urgently needed (Graham, Reser,

Scuderi, Zubrick, Smith & Turley, 2000). While youth workers are likely to provide an essential link with mental health services, it is unknown to what extent, and how effectively referral is undertaken. Thus, youth workers' referral practice was investigated, with a focus on frequency of specific referral skills, and the relationship between referral and personal help-seeking.

Social problem solving has not traditionally been studied as a help-seeking variable, yet the steps in social problem solving (D'Zurilla, 1986) appear to be consistent with the steps in a help-seeking process. Some gatekeeper training programs have utilised components of social problem solving skill to model the process of help-seeking for mental health issues (e.g., Shochet, Dadds, Holland, Whitefield, Harnett & Osgarby, 2001). Further there is evidence that social problem solving skill is related to positive mental health outcomes (e.g., Kant, D'Zurilla & Maydeu-Olivares, 1997), and adaptive coping with life problems (D'Zurilla & Chang, 1995). This study utilised the social problem solving process as a model of help-seeking in the gatekeeper training intervention. Thus, a preliminary investigation of youth workers' social problem solving, and the relationship between problem solving, barriers, intentions and referral skill was conducted.

Gatekeeper training workshops in this study were conducted in the context of NSW health initiatives that suggest gatekeeper training programs are a successful suicide prevention strategy (Frederico & Davis, 1996, NSWHD, 2000). In addition, youth workers have been cited as having a fundamental gatekeeping role in the community (Frederico & Davis, 1996, NSWHD, 2000). While the thesis provides a focus on the context of Australian trends in mental health, help-seeking and gatekeeper training intervention, the issues appear relevant internationally. The content and experiential elements of the

gatekeeper training program in this study were informed by research and guidelines outlined in Chapter 2.

Chapter 2 reviews a) gatekeeping as a preventative suicide intervention strategy, and gatekeeper training, b) research on help-seeking among young people that underscores the need for gatekeeper training to include help-seeking concepts, c) the potential difficulties of a youth worker role that may impact on the ability to carry out gatekeeping functions, d) the effect that personal barriers may have on professional and gatekeeping activities such as effective referral to mental health services, e) social problem solving skills that may be crucial to gatekeeper training and practice f) a brief outline of the core skills of engagement and referral that were outlined and practiced in the workshop intervention. **Chapter 3** describes the methodology, sample and measures in the present study. **Chapter 4** presents an outline of the statistical analyses, and the results of the evaluation. **Chapter 5** examines youth workers' personal help seeking, including effects of the gatekeeper training intervention on personal help-seeking and referral practice. This is discussed within the context of literature that suggests that there may be risks associated with reliance on personal experience to guide professional practice. The implications for future training and evaluation are suggested.

Chapter 2

Gatekeeper training for youth workers

This chapter describes gatekeepers and gatekeeper training programs within the context of suicide prevention strategies that are suggested to be effective at targeting suicide and mental health issues in young people. An overview of the literature on suicide and help-seeking among young people highlights the need for gatekeeper training programs, and introduces the specific skills that gatekeepers may need in their endeavour to engage with and facilitate help-seeking with young people. Youth work and the particular barriers that may impact on youth workers' capacity to perform a gatekeeper role are described. An examination of the literature regarding the potential impact of personal help-seeking on professional practice is provided as a rationale for the investigation of the relationship between personal help-seeking tendency and referral practice in the present study. An overview of the literature on a social problem solving model suggests how problem solving can facilitate understanding of the help-seeking process that is demonstrated in gatekeeper training, and that may be an essential part of a gatekeeper role. Finally, a brief outline of the content and delivery of the gatekeeper training workshop is provided.

2.1 The context: gatekeeping as suicide prevention

The prevention of youth suicide has become a significant focus since The National Youth Suicide Prevention Strategy was launched in Australia in 1997, and it has been

recognised that multidisciplinary efforts are needed to comprehensively understand and respond to youth suicide (Graham et al., 2000). Accordingly, debate about effective suicide and mental health prevention has proliferated

The Institute of Medicine (IOM) model identifies three different levels of mental health prevention according to the level of risk in the population targeted (Mrazek & Haggerty, 1994). These levels are; universal interventions for populations at general risk, selected interventions for groups at increased risk, and indicated interventions for those at highest risk. Young people have been identified as those at highest risk of suicide, with the highest rates of youth suicide among individuals under 25 years of age (Graham et al., 2000).

Interventions that address only one level in prevention do not appear to be adequate in targeting young people who are at highest risk of experiencing mental health problems. For example, school based mental health programs have been found to be successful in raising awareness of youth suicide and mental health issues through classroom education (e.g., Battaglia, Coverdale & Bushong, 1990), but have been criticised for their apparent inability to reduce suicide rates (Beautrais, 2000; Coggan, Patterson & Fill, 1997; Kalafat & Elias, 1994; Vieland, Whittle, Garland, Hicks & Schaffer, 1991). Estimates indicate that school programs are only able to reduce suicide rates by 12% (Coggan et al., 1997). School based programs seem to provide an educational and 'selected' level of intervention rather than a more specific intervention and may not reach young people who have dropped out, or may never have attended school. Thus, it has been recommended that other community based programs are needed in addition to school based interventions as a way of reaching young people in distress (Frederico & Davis, 1996; Grossman & Kruesi, 2000).

Community gatekeeper training has been classified according to the IOM model as an early intervention that is at the 'indicated' level (Silverman & Felner, 1995). In this model gatekeepers are trained in recognising signs and symptoms of mental health problems on an individual level. Snyder (1988) identified the gatekeeper philosophy as a management approach to youth mental health that "seeks to identify the well trodden paths in the community which troubled people use in seeking help" (in Frederico & Davis, 1996, p. 39).

Community gatekeepers are defined as "people in the community who have daily contact with youth, and who are able to assist young people to access professional support services" (Fredrico & Davis, 1996, p. 2). For example, youth workers often work in services in the community that are accessed by troubled young people, and have been targeted in youth suicide intervention programs as key gatekeepers for young people to access mental health services (Fredrico & Davis, 1996; NSWHD, 2000). The present study included youth workers from a wide range of different work services such as health, welfare, counselling, employment, education and training, and disability.

Even though gatekeeper training programs have been used as an early intervention strategy for the past 20 years in Australia and internationally, Fredrico and Davis's (1996) review of programs in Australia found that of the few that were evaluated, most utilised participant satisfaction surveys. Subsequent to Frederico and Davis's review, research evaluating potential gatekeepers and gatekeeper programs has increasingly introduced measures of knowledge regarding rates and indicators of suicide (e.g., Leane & Shute, 1998), attitudes toward suicide that may impact on the ability to respond to a suicidal young person (e.g., Stuart, Waalen & Haelstromm, 2003) and intervention skill (e.g., Neimeyer et al., 2001).

Research investigating community gatekeeper groups is now widespread, and has targeted; doctors (Pfaff, Acres & McKelvey, 2001) teachers (Patton, Glover, Bond, Butler, Godfrey, et al., 2000) and clergy (Leane & Shute, 1998), school counsellors (King, Price, Telijohann & Wahl, 1999), parents (Maine, Shute & Martin, 2001; Shochet et al., 2003), school peers (Shochet et al., 2003; Stuart et al., 2003), people who work with the elderly (Schmall & Pratt, 1993) and gatekeepers in cultural settings, such as indigenous Australian communities (Capp et al., 2001). The proliferation of this research has assisted in confirming the location of potential gatekeepers in the community, and map the profile of gatekeepers' knowledge of and personal response toward suicide (e.g., attitude). However, the majority of these studies provide preliminary data in respective gatekeeper groups, and as such, findings have limited generalisability.

For example, Leane and Shute (1998) explored the attitudes, knowledge and prior contact with suicidal young people in a sample comprising 219 teachers and clergy. Interestingly, teachers' religiosity was strongly correlated with nonacceptance of suicide ($r = .70$), although the authors conceded that there may have been conceptual difficulties with the factor representing 'acceptability' (e.g. "suicide is normal behaviour"). Sixty eight percent of the sample had known someone who had completed suicide, and about 50% had been approached by a suicidal person. However, there were no differences in knowledge of suicide lethality between those who reported prior exposure to suicide, or prior training in suicide, than those who did not. While the study recommended that research needs to continue into examining knowledge and attitudes, and the relationship to intervention skill, there were no specific implications drawn from the data for future training for this group of gatekeepers. Given that there were differences in knowledge and attitudes among clergy of different denominations, future research may need to identify specific suicide intervention

needs within gatekeeper samples (e.g., negative attitudes). To this extent, the generalisability of results could be facilitated through repeated examination of gatekeepers' response to suicide.

Single-sample cross-sectional survey designs that rely only on self-report may have limited utility in the formation of preventative training programs, and results may be affected by response bias. King et al., (1999) suggested that those school counsellors who did not respond to their survey regarding confidence with recognising students at risk of suicide, may have been those who perceived low self-efficacy regarding youth suicide. A number of studies employing a single-group designs show potential to extend their research to a repeated measures design; they have had substantial sample sizes (e.g., King et al., 1999, $n = 340$; Leane & Shute, 1998, $n = 219$). Interestingly, none of the studies mentioned here have yet conducted known follow-up for the respective gatekeeper groups, even though findings seem to highlight a need for further evaluation and potential training.

One of the difficulties with comparing studies describing gatekeepers response to suicide has been that different measures are utilised. Some standardized measures are used more frequently, such as the Suicide Opinion Questionnaire, (SOQ; Domino, Moore, Westlake & Gibson, 1982), and Death Attitude Profile-Revised (DAP-R; Wong, Reker & Gesser, 1994). These measures ask about participants' perception of the meaning of suicide (e.g., mental illness, a cry for help, normal behaviour etc.) and whether suicide is thought of as a situation that should be approached or avoided. However, the combination of measures appears to be different across studies. Further, similar constructs are measured in different ways. For example, knowledge of the indicators of suicide has been measured with unstandardized instruments, such as the Recognition of Suicide Lethality (RSL; Holmes & Howard, 1980, in Leane & Shute), and a number of knowledge measures are

created for the purpose of a particular study. The Knowledge of Suicidal Signs (KSS) was devised by Maine et al., (2001) for parents, and Capp and colleagues (2001) modified a set of knowledge questions about misconceptions of suicide from government health department guidelines. Nevertheless, results provide useful information about the gatekeeper groups, and it is promising that researchers are consistently utilising similar measures of knowledge and attitude.

Gatekeeper training programs have been evaluated using a repeated measures design, in indigenous Australian (Capp et al., 2001), parent (Maine, Shute & Martin, 2001) and school peer samples (Stuart et al., 2003). These studies report notable improvement in gatekeepers' knowledge and attitude toward suicide. Key ingredients in these programs seem to reflect Fredrico and Davis's (1996) recommendation that gatekeepers' acquire specialist knowledge of and attitudes toward mental health and suicide, and generic skills of engagement and referral (pp. 32-42).

For example, Stuart and colleagues (2003) conducted one-day training workshops for 65 school peers aged 12-14, which included information about signals of suicide and role-plays of suicidal young people. A significant increase in knowledge about indicators of suicide, and skills in helping a suicidal peer was found after the training, and was maintained 3 months later. While attitudes significantly improved post-training, there was a significant loss of favourable attitudes at the 3 month follow-up. The pre-post design of this study provides useful direction for continued evaluation of gatekeeper programs in general. However the study had a small sample size (e.g., only 37 completed all three questionnaires), and inferences about the effect of training were limited as there was no control group. Findings may be specific to peer gatekeeper training, thus particular consideration of evaluative studies targeting adult community gatekeeper groups is needed.

Capp and colleagues conducted a study evaluating one day training workshops that were attended by 44 adult gatekeepers from Aboriginal communities. A significant increase was found in knowledge of the indicators of suicide, and confidence in being able to identify a person-at-risk of suicide over the course of the workshops. However an unexpected finding was a reduction in intention to refer to a mental health centre at the end of the workshops. Explanations for this finding included the possibility that increased confidence in being able to help a suicidal person decreased the likelihood of referral to a mental health service. Furthermore there was a strong culture of “self-determination” described by the sample, and there was “a perception that non-Aboriginal mental health workers may not understand the experiences of an Aboriginal person” (Capp et al., 2001, p. 320). While the training seemed to improve these gatekeepers’ ability to intervene with a suicidal young person, the reduction in intention to refer raises concern that barriers (e.g., perceptions of a mental health service) may impede access to mental health services even after attendance at a training program.

There is current debate in the literature about the measurement of predisposition toward suicide in gatekeeper groups. For instance, Maine et al., (2001) argue that a distinction may need to be made between attitude toward *people who are suicidal*, and attitude *toward* suicide. That is, it is thought that a gatekeeper may *intend* to help someone who is suicidal, despite their personal attitude toward suicide. In Maine and colleagues study which evaluated an educational video about the indicators of suicide, 112 parents answered questionnaires on knowledge of suicidal signs, responses to the suicidal person, intention to help and attitude toward suicide. The measure of intentionality was included to investigate the potential difference between intention (e.g., “I would feel uneasy about befriending a suicide attempter”) and attitudes as measured by the SOQ. Intentionality and

knowledge were found to have a significant positive association with response to statements made by suicidal youth, whereas attitudes were not related to the statements. Maine and colleagues contend that this finding provides some evidence for the difference between attitude and intention to help. However, the intention items were devised for the study and were of unknown validity. Furthermore the intention items did not appear to be direct statements about how likely help would be offered, thus interpretation of these findings may have been limited. Further 'intention to help', may not necessarily denote intention to contact appropriate care. Nevertheless, Maine et al.'s study included a control group, and results highlight that intention to help may be an important factor that has been neglected to date in the investigation of gatekeepers' response to suicide.

Despite the debate about the relative role of attitude and intention, research suggests that personal responses to suicide may often underlie a professional approach. For example, Leane and Shute (1998) reported that some teachers and clergy in their study objected to the wording of some questions about suicide on the Suicide Opinion Questionnaire (e.g., "some people are better off dead"). Neimeyer et al., (1999) argue that gatekeepers who are have a more accepting stance toward suicide, may be less effective at intervening (see section 2.4).

Capp and colleagues (2001) unexpected finding that intentions to refer to a mental health service reduced after training, suggests the need to also examine predisposition toward mental health professionals / services in general. It is possible that personal beliefs about mental health services act as barriers, and are related to intention to refer (see section 2.2 and 2.4). Even though gatekeepers' may acquire the skills to accurately identify, and successfully engage with a young person at risk of suicide, these skills may not necessarily act as a precursor to facilitating contact with professional mental health assistance. As such,

this study sought to specifically investigate youth workers' personal help-seeking tendency, including attitudinal barriers *and* intentions regarding seeking help from a mental health professional.

Within in the context of the literature on mental health service utilization, help-seeking has been defined as the “study of how individuals make contact with formal care” (Pescosolido & Boyer, 1999, p. 393). Pescosolido and Boyer assert that an individual's connection with formal care is dependent on three informal systems of care, including 1) a lay system (e.g., friends, family, self-help) 2) a folk system (e.g., religious groups), and 3) a human-social service system; (e.g., police, clergy, teachers, and social security clerks). Youth workers can be occupationally located in the human-social service system, and are arguably one of the few gatekeeper groups that can most successfully connect with troubled youth in the community. However, there are many social and cultural factors that may influence an individual's connection with a mental health service (Rogler & Cortes, 1993), and a help-seeker's efforts to reach help may be significantly affected by a help-giver's beliefs about seeking help, and their position in a system of care. In the context of help-seeking and mental health service utilization, gatekeepers such as youth workers, can be viewed as key help-seeking agents, and connections to mental health services.

Theoretical models of gate-keeping consistently outline the need for gatekeepers to be pro-active (e.g., Beckman & Mays, 1985; Florio & Raschko, 1998; Fredrico & Davis, 1996; Raschko, 1990). A pro-active role requires gatekeepers to have the skills to identify mental health issues, engage a young person and refer them to appropriate help. Research has demonstrated that pro-active gate-keeping can enhance community networks (Capp et al., 2001), and can facilitate a higher number of correctly identified mental health issues and contacts with appropriate help sources (Pfaff et al., 2001). However, gatekeeping

models seem to have an underlying assumption that potential gatekeepers will themselves value, and be positively predisposed toward mental health services. Extensive research suggests that young people have poor help-seeking skills regarding mental health issues, and as a result, may be heavily reliant on gatekeepers to model appropriate help-seeking behaviour. Yet, if gatekeepers are not positively predisposed toward help-seeking and mental health services, substantial difficulty may arise in implementing preventative and indicated interventions. The following discussion outlines some of the data on youth suicide and help-seeking that supports the need for gatekeeper training and the core skills that gatekeepers may need to instigate effective help-seeking strategies for mental health and suicide prevention.

2.2 Youth mental health and help-seeking: implications for training gatekeepers

Research on youth mental health and help-seeking indicates that there is a significant need for a collaborative approach between gatekeepers such as youth workers, and mental health providers. Youth suicide consistently ranks as the second or third leading cause of death among young people around the world (Cantor, Neulinger, Roth & Spinks, 1998; Cantor & Neulinger, 2000; Popenhagen & Qualley, 1998). In Australia the suicide rate amongst young people aged 15-24 is second only to motor vehicle accidents (ABS, 1997). The rate of increase in the last 30 years is especially noticeable for males. Although suicide rates for males aged 20-24 are almost double that of the 15-19 age group, the rate of increase over the past years for the 15-19 aged group has been greater (Cantor et al., 1998). Suicide affects as many as 25 in 100,000 males and 4 in 100,000 females – a ratio of 6.25:1. (Cantor et al., 1998).

Studies have found that up to 62.6% of young people report suicidal ideation sometime in the previous year, and up to 23.4% report current or recurrent suicidal ideation (Madge & Harvey, 1999). Of community studies that have examined psychiatric disorders, all found that psychiatric problems constitute major risk factors for suicidal ideation and behaviours (e.g., Andrews & Lewinsohn, 1992; Lewinsohn, Rohde & Seeley, 1996). One recent study found around 70% of children and adolescents who had either had suicidal thoughts or had attempted suicide, met the criteria for a psychiatric disorder, and about half of the attempters and a third of the ideators had more than one psychiatric diagnosis (Gould, King, Greenwald, Fischer, Schwab-Stone et al., 1998).

The prevalence rates of diagnosed mental disorders in Australia have been found to be highest for youth (Andrews et al., 1999). A recent study of over 10,000 Australians, reported that 27% of those aged between 18 and 24 had had a mental disorder in the previous six months (ABS, 1998). One study surveying 2,300 school aged children aged 11 to 18, found that 40% of teenagers reported feelings of depression, while one in three reported self confidence problems (Ferrari, 1998). Despite increased awareness of youth suicide, and prevention strategies that provide early intervention, these statistics suggest that research needs to continue with investigation of effective early detection of youth mental health problems. These data also suggest that gatekeepers, as early intervention agents, would need to be trained in awareness of the indicators of youth mental illness and suicide (see Clarke & Fawcett, 1992, for a review of risk factors in youth suicide).

Yet there may be considerable uncertainty with recognising indicators of youth suicide (Graham et al., 2000). Accurate identification of youth mental health problems involves an understanding the sorts of barriers that may impede a young person's ability to recognise a problem, and a young person's view of their difficulties.

In an effort to understand the reason for the high incidence of undetected suicidality among young people, extensive research has investigated the help-seeking tendencies of teen and young adult samples. There is a general reluctance among young people to seek help for psychological problems, and an even greater reluctance to seek help directly from mental health providers (Deane, Wilson & Ciarrochi, 2001). Young people who are depressed (Garland & Zigler, 1994), suicidal (Carlton & Deane, 2000; Schepp & Biocca, 1991), substance abusing (Naginey & Swisher, 1990) and homeless (Chamberlain & Mackenzie, 1996) are often reluctant to seek help. Less than one third of youth who experienced suicidal ideation were found to seek help (Carlson & Butcher, 1992).

Many of the youth who have been found to seek help for suicidal ideation or emotional distress, do not seek 'appropriate' help (e.g., Dubow, Lovko & Kausch, 1990; Offer, Howard, Schonert & Ostrov, 1991). Appropriate help-seeking is thought to occur when an individual is able to seek help from a source that can provide useful ways to reduce distress (Kalafat, 1997). For example, it has been found that 90% of distressed young people will seek help from a less appropriate source such as a peer, rather than from a professional (Kalafat, 1997; Kalafat & Elias, 1994). Peers may be poorly equipped to provide helpful responses to their distressed friends (Coggan, Patterson & Fill, 1997). Furthermore, disturbed adolescents show an affiliation with fellow disturbed peers and are said to form "poor quality relationships" (Cole, Protinsky & Cross, 1992, p. 817). Having an awareness that young people do not seek the appropriate help they need, allows gatekeepers be more proactive and assertive in their attempts to engage with young people. Gatekeepers need to be trained to actively inquire about a young person's experience as soon as early indications of mental health difficulties are detected (e.g., social withdrawal).

In the investigation of help-seeking behaviour, research has typically examined barriers, including negative attitudes, and the association with intentions to seek help. In part, the study of help-seeking barriers and intentions has been guided by the constructs in the Theory of Planned Behaviour (TPB) (Ajzen, 1991). In brief, the TPB postulates that intentions are immediately proximal to behaviour, and that an individual's attitudes, feelings of social pressure and perceived behavioural control will influence their intentions to seek help. Intentions have been defined as "a person's sense of their conscious plan or decision to exert effort to perform a behaviour" (Connor & Norman, 1996, p. 12). The TPB suggests that help-seeking intentions may be more closely related to actual behaviour than other constructs. For example, a meta-analysis of relationships between attitudes, intentions and behaviour reported generally higher correlations between intention and behaviour, than between attitude and behaviour (Kim & Hunter, 1993b). However, research into help-seeking barriers and intention in the context of seeking help from a mental health professional is relatively recent. A number of the findings from studies with young people are reported below, and findings from studies with adults are reported in section 2.3.

There is increasing evidence that adolescents who are most distressed hold the most negative attitudes towards service seeking (Garland & Zigler, 1994), and adolescents with the highest level of suicidal ideation have the lowest intentions to seek professional help (Carlton & Deane, 2000; Saunders et al., 1994). In a sample of 221 non-clinical high school students aged 14-to-18, Carlton and Deane (2000) found that suicidal ideation was negatively associated with help-seeking intentions ($r = -.24$) and was a unique negative predictor of help-seeking intentions for suicidal ideation (Beta = $-.33$). That is, as suicidal ideation increased help-seeking intentions decreased. This finding was contrary to the authors' initial prediction. They speculated that the negative association between suicidal

ideation and intention may be influenced by cognitive factors, such as an inadequate use of problem solving skills when exposed to stressful life circumstances. These findings highlight the need for gatekeepers to understand the potential relationship between barriers and intentions for mental health help-seeking. If attitudinal barriers prevent the likelihood of seeking professional help, then gatekeepers' knowledge of the various potential barriers and techniques to reduce them, may have a positive impact on help-seeking intention and subsequent behaviour.

There are numerous attitudinal barriers that have been found to influence a young person's intention to seek appropriate professional help for their problems. These include; the fear that confidentiality will be breached or that privacy will be invaded (Dubow et al., 1990), increased psychological and/or emotional distress (Offer et al., 1991; Rickwood & Braithwaite, 1994), negative perceptions of potential professional help providers (Cepeda-Benito & Short, 1998), negative attitudes to help-seeking (Lindsey & Kalafat, 1998), the perception that no person or service can help (Kushner & Sher, 1991) and / or that the therapy will not be useful (Pipes, Schwartz & Crouch, 1985), seeking help from peers (Offer et al., 1991) and the phenomenon of help-negation (Rudd, Joiner & Rajab, 1995). Help negation has been broadly used to describe the circumstance when available help is refused despite some level of need such as the presence of suicidal ideation (e.g., Deane, Wilson & Ciarocchi, 2001; Rudd et al., 1995).

Whilst these findings reveal a relationship between attitude and intention there are various other factors that have also been found to predict help-seeking intention. Some of these include being female (Rickwood & Braithwaite, 1994), having emotional competence (Ciarrochi, Wilson, Deane & Rickwood, 2003) an internal locus of control (Schonert-Reichl & Muller, 1996), and experience with prior help-seeking (Carlton & Deane, 2000;

Saunders et al., 1994). Saunders and colleagues found that adolescents who experienced a family history of suicidal behaviour in the past, were more likely to recognise a need for help with their problems. These authors suggested that prior exposure to mental health issues may act as a “priming effect” (p. 726). There is also some evidence that older adolescents (e.g., 16-19 years) may have lower help-seeking intentions than younger adolescents (Ciarrochi et al., 2003; Rickwood, 1995).

Gatekeepers may need to be especially aware that young males tend to seek help less than females, and that finding out about prior help-seeking experiences may assist in understanding current help-seeking barriers and intentions. Gatekeepers may also need to consider the impact of age on the particular type of barriers (e.g., conflict between autonomy and dependence later in adolescence) that may impact on help-seeking intentions. On a practical level, some evidence suggests that young people and their families may not know where to search for help from professional services (e.g., McArt & Shulman, 1999). This research provides an important structure for the content of a community gatekeeper training program promoting help-seeking among gatekeepers, and in turn, among young people.

Studies that have examined adolescent opinions about reducing barriers found that potential gatekeepers may not appear accessible (Cepeda-Benito & Short, 1998; Lindsey & Kalafat, 1998). If people in gatekeeper roles, such as school teachers or counsellors, were able to convey that they were “non-judgemental, related to teenagers, and could make themselves available”, then young people may be more likely to approach the adult gatekeeper for help (Lindsey & Kalafat, 1997, p.180). Wilson and Deane’s (2001) study asked 23 adolescents about the approaches a mental health professional could take in talking with them about an emotional problem. Participants reported that mental health

professionals should raise issues gently, listen for ambiguous comments and inquire about them. Feeling comfortable with a mental health professional and “like they actually care” were important influences on adolescents’ decision to seek help from a potential help-giver (p. 356). Adolescent opinions about an accessible adult point to the particular skills of engagement that gatekeepers need in their relationship with a troubled young person.

Youth workers need to be skilled in identifying and addressing potential barriers, and be prepared to guide young people to appropriate help. However, Wright and Martin (2000) argue that youth workers “are key members of our community... and are in an excellent position to identify suicide risk, manage crises, and refer to the health system where appropriate, but often they have had very little training in issues related to depression, self harm and suicidal behaviours” (p. 39). Indeed some youth worker samples have asked for the opportunity for further training in how to assist young people (e.g., Coyle & Loveless, 1995; Howard & Ziebert, 1994; Snow, 1994). Relatively little is known about youth workers’ knowledge and skill in identifying barriers to seeking help for a mental health issue, either for themselves as gatekeepers or for young people.

2.3 Youth workers as gatekeepers

There are several factors that may influence youth workers’ ability to be positively predisposed toward mental health services in a gatekeeping role. The social context of the youth work role seems likely to impact on youth workers’ vision to provide a service for young people. Sercombe (1997a) argues that “the youth sector, assigned to engage a marginal population is itself marginalised....youth workers’ status as professionals is

provisional, contested and tentative, and the sector is kept on a short leash by short-term government funding” (pp. 44-45).

Literature regarding the different functions of youth work highlights the contradictions that seem to be inherent in the role (Flowers, 1998; Sercombe, 1997a). Youth workers often acknowledge that they are acting in young people’s interests and are advocates for a rights based perspective. Conversely “they also acknowledge that their work serves the interests of parents, police, business and government authorities” (Flowers, 1998, p. 34). The tension between these two roles has meant that youth workers have had to carefully consider how the different functions in their role may affect their relationship with young people (Bourke & Evans, 2000). Advocating a rights based approach, even though a ‘soft-cop’ option is appropriate, may be the difference between a young person engaging with a youth worker, or leaving a service indefinitely. It would appear that a rights based approach may obtain initial engagement. However it is unclear which role youth workers may undertake when acting as a gatekeeper where facilitation of further engagement with mental health services could be an extremely difficult task.

There are differing opinions within the youth work literature of what youth work entails. The main models that have been identified suggest general goals such as “the ability to help young people to identify how they can change themselves in order to become more successful in society” (Cooper & White, 1994, p. 33). There is confusion among youth workers about their role, including their professional and ethical responsibilities toward distressed youth (Bourke & Evans, 2000). In Bourke and Evans’s (2000) qualitative study that asked 16 youth workers about their difficulties with working with young people, participants agreed that their professional boundaries were often violated in their work. For example, they often continued to provide services to clients who no longer fitted the age

category, or were being verbally and physically abusive toward workers. Youth workers reported that they felt they needed to continue to provide a service as clients often had nowhere else to go. If youth workers were to have a clearly outlined gatekeeping role, it may combat some of the conflict that seems inherent in youth work, and assist to empower youth work as a critical link in the youth and mental health sectors.

As well as dealing with role conflict and a marginal social position, youth workers have reported emotional difficulties that have been the result of dealing with troublesome youth issues and psychological problems such as homelessness, neglect and abuse, depression and suicide, violence and addiction (e.g., Bourke & Evans, 2000; Snow, 1994). It has been argued that emotional burnout, including feelings of depression may occur as a consequence of being in a role where little support may be available for helping youth with severe psychosocial problems (Bourke & Evans, 2000). In a study of the symptoms of Post Traumatic Stress Disorder among 20 youth workers who had all been recipients of verbal or physical assault, 75% of the sample reported recurrent and distressing recollections of incidents and 50% reported that they did not receive adequate supports, such as supervision and the opportunity to discuss the incident after the assault (Snow, 1994). A limitation of the study was that the data were collected retrospectively and asked participants to think back over their whole career in youth work. Nevertheless results point to the notion that youth workers' own personal-emotional functioning may be substantially affected by working with troubled youth, and if youth workers do not receive the help they may need, it is possible that this may affect their capacity to assist others. In short, some evidence suggests that youth workers work in environments that do not adequately facilitate appropriate help-giving for problems associated with mental health.

Young people may learn protective or help-seeking behaviours by modelling the behaviours of the important adults in their lives (e.g., Bandura, 1977). Yet it seems that help-seeking behaviours may be less likely to be facilitated by youth workers if there is a lack of opportunity in youth workers' own workplaces to access appropriate help. As Rickwood and Braithwaite (1994) comment, "one has to know how to seek help, not by being told what to do, but by being shown how to do it, by being involved in a network where discussing personal problems is accepted and encouraged" (p. 569). One of the main aims of the gatekeeper training was to encourage a help-seeking stance among youth workers so that they gained insight into the help-seeking process from their own attitudes and experiences, and felt able to use this approach with young people. Thus, one of the initial aims was to identify youth workers' own barriers to help-seeking for mental health issues (i.e. to use an experiential approach to training).

Although there are studies that have specifically investigated youth worker knowledge and skills relevant to specific youth mental health problems such as drug use (Howard & Zibert, 2000) and emotionally disturbed youth (Pazaratz, 2000), there is little data on youth workers' personal beliefs about professional help for mental health problems, and the ability to provide a gatekeeping service such as referral for young people.

Limitations of prior studies of youth workers include the small sample sizes, a lack of evaluative designs and suggestions for future research to assist with opportunity to improve intervention skills. Despite this, they provide valuable insight into potential barriers that youth workers may encounter in carrying out a gatekeeping role. It seems intuitive to assume that youth workers' attitudes and barriers to seeking help from professional services would be influenced by the challenge of working at the crossroads

between the demands of youth in their care and fitting a ‘marginalised’ position in the mental health services network.

2.4 Personal help-seeking and professional practice

Some evidence suggests that adults, including community gatekeepers, have the same barriers to help-seeking for personal problems as young people (Wilson & Deane, 2000). In Wilson and Deane’s qualitative study involving focus groups with 18 high school teachers, barriers to help-seeking were explored. Respondents’ barriers included a lack of trust towards mental health professionals, limited knowledge about where to obtain help, and feeling anxious or uncomfortable with accepting help from mental health professionals. The latter may have been due to beliefs about negative media stereotypes of mental health professionals that were described by the sample. The study was devised to generally examine potential barriers to help seeking, yet the process of uncovering barriers also raised awareness of how personal barriers may impact on help-seeking practice with young people. One respondent’s statement reflected the emerging awareness of the group “[i]f I can’t seek help, then what good am I to them?” (p. 8). Wilson and Deane concluded it is “possible that teachers general attitudes to appropriate help-seeking may influence their students..if teachers do not seek help, or at least, understand the importance of appropriate help-seeking as a positive coping strategy, they might inhibit their students’ help seeking” (p. 14). While the study was a preliminary investigation of one potential gatekeeper group, it raises an important question regarding the potential impact of adult personal help-seeking tendency on professional practice.

Studies investigating adults' help-seeking tendencies have found a similar association between help-seeking barriers and intentions as has been found in the research examining barriers and intentions of young people. Significant association has been found between positive attitudes toward seeking help and intentions to seek professional help, with correlations ranging from $r = .38$ to $r = .68$ (Bayer & Peay, 1997; Deane & Todd, 1996). Negative attitudes toward, and fears about professional psychological help are suggested to represent substantial barriers to help seeking among adults. Fears have been identified as one of the main motives for delaying or avoiding psychological services (e.g., Amato & Bradshaw, 1985; Kushner & Sher, 1989; 1991). Fears include embarrassment, judgement from others, concerns that a therapist may not listen, and negative past experience (Kushner & Sher, 1991). Similar to findings with young people some adults have reported wanting the same characteristics of 'trust' and 'openness' in a person they would see for a mental health problem (Wilson & Deane, 2000). The present study sought to investigate whether personal attitudinal barriers, may have an impact on youth workers' intentions to seek help for a mental health issue.

Research that has explored the impact of personal factors on professional functioning reinforces the need to explore the effect that gatekeepers' attitudes may have on their ability to perform a gatekeeping role. For example, Neimeyer and colleagues (1999; 2001) investigated attitudes toward suicide and counseling competency in a sample of 131 undergraduate and post graduate psychology students, and suicide hotline volunteers. They found that attitudes toward the legitimacy of suicide, such as viewing suicide as a personal right, and increased probability of choosing to attempt suicide in the future, were significantly negatively related with suicide counseling competency, ($r = -.24$ and $r = -.40$ respectively). They suggested that "counsellors who have experienced or who

are currently experiencing their own suicidal tendencies might not respond optimally to their potentially suicidal clients” (p. 46). While these findings may have practical implications specific to the sample of counsellors, the complexity of some attitudinal variables made interpretation of the relationships between attitudinal and competency variables difficult. For example, the variable ‘Death Acceptance’ was positively correlated with the Suicide Intervention Response Inventory (SIRI; Neimeyer & McInnes, 1981). Yet it was unclear what aspect of death acceptance (e.g., neutral acceptance or avoidance) was measured, and how it may have related to suicide intervention competency. While the study provides a focus on response to suicide, the relationship between personal and professional factors urges further development of investigation of the personal beliefs of gatekeepers to mental health issues in general.

Bourke and Evans (2000) found that youth workers’ draw on what they believe helps young people, this usually consists of a combination of “personal experience, on the job experience, training and general values” (p. 43). Yet it has been found that youth workers have reported negative prior experience with regard to help-seeking in their workplaces (e.g. Bourke & Evans, 2000; Snow, 1994). It has been found that negative prior experience is likely to lead to more negative attitudes and lower intentions to seek help for personal problems. (e.g., Carlton & Deane, 2000; Deane & Todd, 1996). Little is known about the prior help-seeking behaviours of youth workers. Neimeyer and colleagues argue that there is a need for closer evaluation of the personal histories and experiences of people who work with vulnerable and demanding populations. They suggest that a “focus during training on increasing awareness of personal attitudes” may increase appropriate responding to suicidal crises (1999, p. 46). Raising awareness of personal attitudes and values towards youth and suicide has been identified in Fredrico and Davis’ (1996) report

of best practise guidelines for gatekeeper training, as “specialist knowledge and skills required for working effectively with vulnerable youth” (p. 37). Thus, one of the goals of the present study is to explore some of the attitudinal barriers and help-seeking intentions that might impact on youth workers’ role as gatekeepers for distressed youth.

Research with youth samples suggests that gender and age may also influence personal help-seeking tendencies among adults. Much research has suggested that males have higher barriers and lower intentions to seek professional help than females (e.g., Addis & Mahalik, 2003; Mahalik, Good & Englar-Carlson, 2003), yet the effects of gender, and other potential influences such as those associated with age, have not been studied in gatekeeper samples, or with youth workers. Thus, the present study explored the relationships between age and gender, and help-seeking tendency including barriers and intentions, and referral skill.

After a youth worker or gatekeeper has determined a young person has a mental health problem, they may need to make a referral to appropriate help sources. Anecdotal data has suggested that inappropriate referrals to mental health professionals may occur when gatekeepers are emotionally troubled themselves (Persi, 1997). There is no empirical research about the effect of personal help-seeking and referral skill amongst gatekeepers. The Australian Psychological Society has emphasised that “making an effective referral is a complex process...and a neglected topic in psychological literature...more research and training in referral processes is urgently needed” (Graham et al., 2000, p. 19).

There is evidence that community gatekeepers may be able to reach and refer high risk populations more than medical or family sources (Florio & Raschko, 1998), and that particular referral practices can improve the success of the referral (e.g., Cheston, 1991; King, Nurcombe & Bickman, 2001). Successful referral practices have included informing

a client of the process of a referral, and the benefits of seeing a mental health professional, information about a suggested referral service (e.g. session time, cost), and facilitating a connection between the referrer, referee and referral service (e.g. direct phone call, or face to face meeting). Furthermore, Cheston (1991) suggests that successful referral involves considerations such as the compatibility between the referee and referral service, the timing and delivery of the referral suggestion to the client, and the ability to address the client's feelings regarding the referral suggestion. These ingredients are part of Cheston's recommendations about how to "therapeutically connect the client with another helper" (p. 1).

The majority of studies in referral to mental health services have focussed on medical practitioners' referral practice. Collaborative service interventions such as the Consultation-Liaison in Primary Care and Psychiatry have successfully implemented an integrated referral system between primary caregivers; in this case general practitioners and mental health services (Meadows, 1998). In this intervention the client, the psychiatrist and the GP attended the first one or two sessions together and established a plan of management (Meadows, 1998). The interconnectedness of this referral system facilitated improvement in clients physical and mental health and provided some evidence for the cost-effectiveness of this referral system. Similar systems of referral in crisis services have been shown to treble successful referral rates (e.g., King et al., 2001; Victorian Suicide Prevention Task Force, 1997).

Youth workers have the potential to provide a vital referral link between youth and mental health services. Rogler and Cortes (1993) suggest that social and cultural norms may shape different links in the 'pathways' to help-seeking behaviour. Viewed within the broader social context, gatekeepers' own help-seeking behaviour can serve as the beginning

of the pathway for young people, and as a culture of help-seeking. Those gatekeepers are more positively predisposed toward seeking professional help for mental health problems, may be more likely to refer to mental health services, and employ referral skills effectively. Thus referral can be seen as a representation of gatekeepers' help-seeking behaviour in the effort to link young people with professional help.

Referral practices, such as talking to a young person about a mental health service and making contact with the referral service, were included in the present study's intervention outline and evaluation of referral skill. We aimed to assess how often referral skill was utilised, and whether training in help-seeking and referral skill improved youth workers' referral practice.

2.5 Help-seeking and social problem solving

Social problem solving (SPS) has not traditionally been studied as a mental health help-seeking variable. However, it appears that SPS may provide a conceptual framework for understanding the steps in a help-seeking process, and there is empirical evidence that SPS can be a protective factor to the development of mental health problems.

The steps involved in models of SPS appear to be closely aligned with the steps in the help-seeking process, consideration of it in help-seeking research seems warranted. Models of social problem solving skill outline several steps that are involved in the process; (1) an ability to view life stresses as problems to be solved (2) problem identification (3) generation of alternative solutions to the problem (4) identification of positive and negative consequences associated with alternatives (5) selection and implementation of an identified alternative as a means to solve the problem (D'Zurilla, 1986). Models of mental health

help-seeking include stages of problem recognition, the decision that professional help is necessary, the decision to obtain professional help, and the selection of a professional (e.g., Saunders et al., 1994).

The utility of SPS as a model of the help-seeking process is apparent when considering help-seeking difficulties among young people. The first step of problem recognition is often the most difficult for young people, and they have reported difficulty determining whether their problem is severe enough to tell an adult, or whether it is a normal part of their experience of growing up (Wilson & Deane, 2001). However, if youth workers are skilled in identifying mental health problems and utilising problem solving steps, they may be more likely to be able to facilitate or model the skills when working with young people.

Some authors such as Kant and colleagues (1997) have suggested that social problem solving may best be conceptualised as a mediating variable between help-seeking intentions and behaviour. Social problem solving skill can be viewed as an intervening variable in a causal chain linking some antecedent variable, (e.g., intention to seek help) and outcome or criterion variable (e.g., help-seeking behaviour). The need for mediation might be understood by the potentially negative effect of avoiding problems; a greater number of unresolved problems results in a more negative problem orientation, which then leads to less constructive problem solving, which in turn results in higher levels of psychological distress (Kant, D’Zurilla & Maydeu-Olivares, 1997). Conceptualising the social problem solving steps may provide gatekeepers with a useful framework to reverse a negative outlook on help-seeking for a mental health problem, and assist young people to move from their help-seeking intention to their behaviour. While the present study does not provide an examination of the potential mediation effect of SPS, SPS is included to

enable a preliminary investigation of its relationship with other help-seeking variables, and the potential impact of training youth workers in an SPS model.

SPS skill appears to be related to mental health outcomes. Various studies have suggested that there is a relationship between social problem solving and psychological adjustment (e.g., D’Zurilla & Chang, 1995; Kant et al., 1997; Preister & Clum, 1993; Rudd, Rajab, Orman, Stulman, Joiner & Dixon, 1996). It has been proposed that increases in social problem solving competence might be associated with decreases in psychopathology (D’Zurilla, 1986). For example, if an ‘at risk’ adolescent were able to recognise that they had a problem, and use specific ways of thinking about their problem to attain help, then it is reasonable to assume that they are more likely to receive the help that they need, thereby decreasing the chance that their problem would become worse (e.g., halting suicidal thought). D’Zurilla (1986) argues that the ‘problem’ should be viewed as the inability to employ social problem solving skills, rather than the individual’s response to stressors (e.g., anxiety or depression in response to family conflict). Research has shown that young people are particularly susceptible to believing that their personal problems are embarrassing, unreasonable or unable to be resolved (Kalafat, 1997). In suicidal individuals, the decision to obtain help may be impeded by deficits in social problem solving ability (Schotte & Clum, 1987), and ‘avoidance’ has been found to characterise their coping style (Orbach, Bar-Joseph & Nitrit Dror, 1990). Levenson and Neuringer (1971) observed that whether or not problem solving is considered a diathesis, problem solving incapacity should be viewed as a “lethal consequence” in the case of suicidal young people (p. 435). For the varied and complex problems of young people, it seems that if helpers or gatekeepers have sound problem solving skills themselves, they would have higher potential to model similar problem solving for young people.

There are three main parts of SPS that have been measured. D’Zurilla and Nezu (1990) identified SPS as a complex cognitive-affective-behavioural process that consists of problem orientation and problem solving skills. Problem orientation includes general cognitive, emotional and behavioural schemas, that are the way a person thinks and feels about their problems, and their problem solving ability (Chang, 1998; Chang & D’Zurilla, 1996). For example, a person with a negative orientation will be more likely to perceive a problem as a threat to their well being, respond to the problem with negative emotions (e.g., depression) and avoid or expect that the problem is too big. Problem orientation seems to directly influence the initiation of problem solving behaviour, and there is some research that has suggested that problem orientation may play a more important role in the instigation of help-seeking than problem solving skills (Chang, 1998; Kant et al., 1997). Problem solving skills are activities that allow for evaluation of a problem (e.g., develop a list of options, consider the strengths and weaknesses of each option. As a result of this background theory and research, the investigation of problem orientation and skill was included in the design of the gatekeeper training program in the present study.

Another aspect of problem solving that was of particular relevance to the present study are informal processes outlined in Black and Frauenknecht’s (1990) SPS model. The informal or “automatic process” includes “personal knowledge and information about a conflict and problem solving” (Frauenknecht and Black 2003, p.2). Theoretically, it is thought that when solving a problem an individual will continue to use the automatic or informal process that has previously been used (e.g., calling a friend). The automatic process is probably considered a relatively habitual response to a problem, and therefore a learned response. A formal or evaluative problem solving process is thought to be more

effortful, and only utilised if the personal facts, rules and techniques in an automatic response are not successful (e.g. the friend does not want to talk).

Problem solving ability was of particular interest in the present study as it is thought that youth workers need to have good problem solving capacity if they are to successfully help young people negotiate the many barriers to seeking and accessing help. There is no known research investigating youth workers' own problem solving skill and how this may impact on help-seeking and referral skill.

2.6 Gatekeeper training workshop outline

An interactive learning approach was central to facilitation of the social problem solving model in this study's workshop training program. That is, participants were asked to brainstorm their own potential barriers to help seeking, and these were then incorporated into the next step of problem solving in order to locate the most influential barriers. The training facilitator was familiar with the research regarding youth suicide and gatekeeper training, and was experienced in modelling problem solving processes. Each workshop provided the opportunity to observe the facilitator's demonstration of the skills of engagement and referral, and then to practice the skills. Thus, as well as providing education regarding key help-seeking steps, the gatekeeper workshops in this study aimed to facilitate experiential components to learning about personal barriers and problem solving skills, to enhance understanding of what a young person may feel when encountering their own barriers, to model the gatekeeping role, and to empower youth workers in their role as gatekeepers.

It has been suggested that an empowerment-based approach to training is desirable if a sustainable help-seeking stance is to be fostered among gatekeepers (e.g., Toumbourou & Gregg, 2002). That is, empowerment through training could include adequate recognition and support of a demanding role, and encouragement to persist in that role. The literature regarding clinical supervision for mental health professionals allows for one way of understanding the technique and importance in using an empowerment-based approach for training (see Bernard & Goodyear, 1998). A supervisor's ability to use a balance between support and challenge has been found to facilitate competence and self-confidence among mental health trainees (e.g., Worthington & Roehlke, 1979). Further, structured supervision (e.g., outlining crisis management steps) may be beneficial for training in intervention with severe problems such as suicide (e.g., Tracey, Ellickson & Sherry, 1989). As a gatekeeper's role includes potential confrontation with difficult mental health issues on a daily basis, empowerment-based training seems essential to the conception and maintenance of this role. Thus, this approach was used by the facilitator in the experiential elements of training.

Youth workers practiced core skills for potential 'on-the-spot' engagement with young people. Skills of engaging young people are seen as of paramount importance (Fitzgerald, 1996; Geldard & Geldard, 1999; Wright & Martin, 1998) and provide a platform from which to facilitate social problem solving, and referral to appropriate professionals. Skills of engagement include learning the techniques of building a therapeutic alliance (e.g., Egan, 1998; Rogers, 1957); being able to show warmth and understanding, talking about problems as things that people experience everyday while conveying that their fears and barriers are understandable, and that their problem is important (Wright & Martin, 1999). While youth workers have reported utilising these

skills (Bourke & Evans, 2000), it is unclear how much they are utilised in the context of the facilitation of referral to mental health services.

Identifying which of a young person's problems is most severe will impact on the type of assistance that they will need and whether the gatekeeper is likely to refer to professional help. For example, if a young person is homeless, a gatekeeper may need to organise immediate shelter. But if a young person is homeless and has suicidal thoughts, the gatekeeper may need to refer directly to professional mental health helpers. Youth workers see many distressed youth on a regular basis and therefore need to know how to prioritise young people's problems.

The gatekeeper intervention used in the present study aimed to provide gatekeepers with the skills to engage and refer young people who are experiencing psychosocial distress. Gatekeeper training for youth workers in this study used an educational workshop format to a) convey research on youth mental health and suicide, b) develop competence in help-seeking intervention skills including social problem solving skills and referral, c) raise awareness of personal barriers and intentions that may affect referral skill. The main purpose of this study was to evaluate the effectiveness of the gatekeeper training intervention.

2.7 Aims and hypotheses

The main aims of this study are;

1. To explore youth workers' personal help seeking, including barriers, intentions, social problem solving skill, actual help-seeking behaviour, and the influence of gender and age on help-seeking tendencies.
2. To explore youth workers' referral skill.

3. To evaluate the effects of educational and interactive workshops on youth workers' ability to improve their personal help-seeking; including barriers, intentions, social problem solving skill and behaviour, and referral practices with young people.

Hypotheses:

A. Relationships between variables prior to the gatekeeper training workshop

1. There will be gender differences in help-seeking intention
2. Barriers will be negatively related to intention
3. Social Problem Solving will be positively related to intention
4. Barriers and social problem solving will predict intentions to seek help
5. Help-seeking intentions will be related to referral skill

B. Effects related to participation in the gatekeeper training workshop

1. There will be increases in youth workers help-seeking behaviours, intentions, social problem solving skill from pre to post workshop.
2. There will be increases in youth workers' ability to refer young people from pre to post workshop.
3. There will be a decrease in youth workers barriers to seeking professional help from pre-to-post-workshop.
4. Youth workers who attended the workshops will have lower barriers, and higher intentions, actual help-seeking behaviour, social problem solving skill, and knowledge of mental health and help-seeking issues, than those who did not attend the workshops.
5. Youth workers who attended the workshops will have a higher frequency of good referral skill than youth workers who did not attend the workshops.

Chapter 3

Method

3.1 Design

This was a quasi-experimental design with pre-post assessment for the intervention group and post-test only for the control group. The design is a combination of one-group pre-test post-test design, and post-test only design with non-equivalent groups (Cook & Campbell, 1979). The post-test only control group was utilised because the gatekeeper workshops were conducted before a pre-test control group was obtained (see Procedure). Thus, tests for potential selection bias between the intervention and control groups post-test were conducted, and are reported in the results. Figure 1 displays the design.

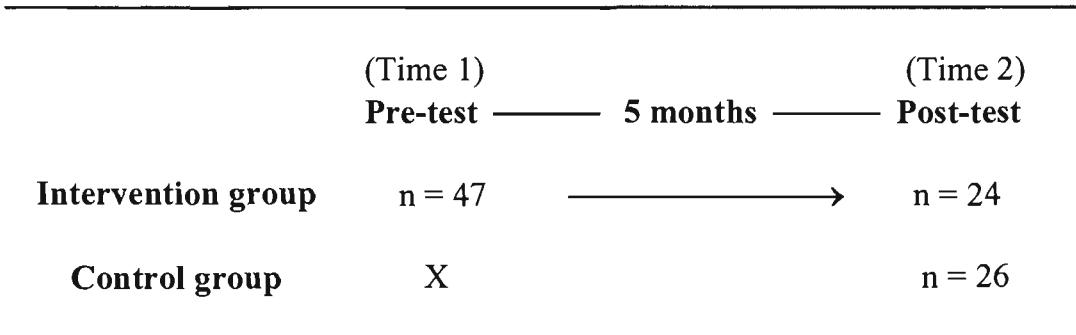


Figure 1. Pre-post test design with post-test control

Post-tests occurred 5 months after the pre-test administration and participation in the workshop interventions. Participants who attended at least one of three help-seeking workshops comprised the intervention group and completed the research questionnaire immediately prior to the workshop (Time 1) and again five months after the workshop

(Time 2). A control group of youth workers who did not attend the workshops, was mailed the research questionnaire at Time 2 (post-test only). Delay in the post-test was planned due to previous findings that immediate gains from gatekeeper training are often attained (e.g., Capp et al., 2001), but may not necessarily be maintained over longer periods (e.g., Stuart, et al., 2003).

3.2 Participants

Approximately 147 people in youth working positions were contacted regarding this research (see Procedure for detail). Of these 73 (50%) participated in the research. Fifty seven (39%) attended at least one of the workshops on help seeking for mental health issues. However, ten workshop participants did not consent to fill out the research questionnaire, leaving 47 (32%) workshop participants who filled out the research questionnaire at pre-test. Twenty-six (18%) comprised the control group who did not attend any of the workshops and completed the research questionnaire at post-test only. Demographic, help seeking and referral information was collected from all participants who consented to participate in the research.

Demographic data were collected regarding age, gender, level of education, and workplace for the entire sample. As there were no significant differences in age found between the pre-post intervention and control groups, the mean age of the entire sample was calculated; 35.8 years (SD = 9.78), range 18 to 56 years. Each person in this sample had attended tertiary education, with 65% obtaining tertiary education directly related to the youth working occupation (e.g., welfare, social work, psychology). Participants were employed in a wide range of work settings including health, welfare and job agencies, education and outreach, and a majority were from local community centres. Community

centres provided a range of services, including counselling, placement in accommodation, and youth projects. Workplace was divided into three categories that seemed to represent participants’ main work areas. Demographic differences between pre-post intervention and control groups are reported in the results of the pre-post analyses. Table 1 displays sample characteristics for the entire sample, and the intervention and control groups at post-test.

Table 1. Sample percentages for gender, tertiary education and workplace.

	Pre-test	Post-test	
% Demographic	Total** N = 73	Intervention n = 24	Control n = 26
Gender			
Male	33	85	39
Female	67	15	61
Tertiary Education			
Certificate/Diploma	45	65	38
Degree	55	35	61
Workplace			
	52	51	53
Community centre	34	34	36
Outreach*	14	15	11
Health and welfare agency			

Note: * Participants in ‘Outreach’ in the total sample included three teachers from local high schools. Those participants did not respond at post-test, and there were no teachers in the control group.

 ** Total constitutes n = 47 completed pre-test prior to the workshops, and n = 26 from the control group.

3.3 Procedure

The project received review from the University of Wollongong Research Ethics Committee. Participants were recruited by a convenience sampling method. All potential participants in youth working positions were located via local community youth services

directories that were compiled by the Wollongong and Nowra City Council Youth Services branch in 1999 and 2000 respectively. The directories were designed to assist young people and youth workers with information about a range of services within the Illawarra and Nowra regions. Service contact details that can be found in the directories include accommodation, counselling, disability, employment and training, health and welfare agencies, legal services, youth projects and minority groups (e.g., gay, Aboriginal). A brochure was sent to a variety of services from the directories, including local community centres, inviting youth workers to attend a series of three help-seeking workshops. Workshop participants answered a help-seeking and referral questionnaire prior to the workshop training (see Appendix A). At time 2 a letter (see Appendix B) and the research questionnaire (Appendix A) were sent to the 47 workshop intervention participants and 90 potential control group participants. The control group was recruited by a similar method as the intervention group. That is, the community youth services directories were used to locate other services and participants who had not attended the workshops. Potential control group participants were not sent a brochure, but were mailed a letter (see Appendix B) and the research questionnaire. Knowledge questions were sent to the intervention and control groups at time 2 only (see Appendix B). It is likely that some of the control group participants received the brochure regarding the workshops in the first mail-out. However, effort was made to mail the questionnaire at time 2 to control group participants who worked at different services to those who participated in the workshops, to decrease the chance of control group members' exposure to the workshop material (e.g., handouts, worksheets).

The workshops were delivered in the Wollongong and Nowra areas given the relatively low attendance rate at the initial workshop program in the Wollongong area. The

opportunity was taken to recruit a control group as overall attendance at the workshops was lower than expected. Informal inquiries indicated that low attendance was, in part, a result of potential participants' work commitments.

The workshops were conducted in local community or "neighbourhood" centres. No participants attended workshops in both areas. There were three workshops in the series on strategies to facilitate; (1) appropriate help seeking (2) effective youth problem solving and (3) identifying mental health needs of youth, and appropriate help-service engagement (referral) (see Appendix A for an outline of workshop content). There was an average of 8 participants in each workshop which allowed for a variety of teaching methods including role-play and small group work. Each workshop was of three hours duration. In total, four help-seeking workshops, three social problem solving and three adolescent mental health workshops were conducted, and participants could choose to attend all three workshops in the series. As shown in Table 2, all participants attended the help-seeking workshop, and 18 attended a social problem solving and /or adolescent mental health workshop as well. The overall aim of the workshops was to educate youth workers about help seeking for mental health issues. The three different content areas were devised to reflect the need for training that has been identified in the help-seeking literature. However, in the first hour of each workshop information and research on help- seeking facts and barriers to seeking professional psychological help was covered. In addition, each workshop followed Frederico and Davis's (1996) recommendation to facilitate insight into gate-keeping barriers, and began with an exploration of participants' own help-seeking barriers that might affect their approach to mental health services and their work with young people. The barriers that were identified were incorporated into the workshop material to validate

participants’ experience, and to provide an example of how this technique of identifying barriers could be utilised with young people.

Table 2. Attendance at help seeking workshops

Group*	HS	SPS	AMH
Help Seeking (HS)	29	--	---
Social Problem Solving (SPS)	14	7	---
Adolescent Mental Health Issues (AMH)	4	2	0

Note: $n = 47$ * Eleven people attended all three workshops.

3.4 Measures

Help seeking intention. Intentions to seek help was measured by the General Help Seeking Questionnaire (GHSQ; Deane, Wilson & Ciarrochi, 2001). The GHSQ asks participants to rate on a 7-point scale (“1= extremely unlikely; 7=extremely likely”) how likely it would be that they would seek help from a selection of ten help sources for two problem types; a personal emotional problem and suicidal thoughts. The help sources include informal sources such as “intimate partner”, “parent” or “friend”, and formal sources such as “GP”, “teacher” or “mental health professional”. Higher scores indicate stronger intentions to seek help. Wilson, Deane, Ciarrochi and Rickwood, (2003b) reported internal reliability (Cronbach alpha) of the GHSQ that included all help source options of $r = .70$ for a personal-emotional problem, and $r = .83$ for suicidal thoughts and reported test-retest reliability over three weeks as $r = .86$. In the present study Cronbach alpha for all help source options was $r = .71$ for a personal-emotional problem and $r = .80$ for suicidal thoughts. Wilson et al., (2003b) also found positive correlations between help seeking

intentions and evaluations of helpfulness of prior professional help, and a negative relationship between intentions and barriers, which supported convergent and discriminant validity of the GHSQ. To provide an indication of general help seeking tendency, the mean of all 10 items for the two problem types; personal-emotional problem and suicidal thoughts, was reported in descriptive analyses. However, the single item of “mental health professional (e.g., counsellor, psychologist, psychiatrist)” was the focus of investigation in the main analyses. Intention not to seek help is measured by the item “I would not seek help from anyone”, where higher scores indicate greater likelihood of not seeking help. The GHSQ also includes items that ask participants to indicate whether they have ever seen a mental health professional (“Yes / No”), to indicate which type of mental health professional was seen (e.g., “counsellor, psychologist, psychiatrist”), and to rate the helpfulness of prior mental health assistance on a 5-point scale (“1 = extremely unhelpful; 5 = extremely helpful”).

Help seeking behaviour. The Actual Help Seeking Questionnaire (AHSQ) was derived from an earlier measure used by Rickwood and Braithwaite, (1994) and was developed to measure recent actual help seeking behaviour. The AHSQ asked respondents to indicate (i.e., “Yes / No”) if they had actually sought help from a variety of ten sources of help in the previous 5 months. The list of people included formal and informal sources of help (e.g. “partner, friends, relative, Doctor/GP, mental health professional, teacher, help line”), and gave the option of indicating a person or service not included in the list. AHSQ help source items matched the items of the GHSQ. The AHSQ has been utilised in research that aimed to identify the formal and informal sources of help that may exist in personal networks (Rickwood & Braithwaite, 1994).

Barriers to mental health help. Barriers to Adolescents Seeking Help-Brief (BASH-B) version was derived from the 37-item longer scale developed by Kuhl, Jarkon-Horlick and Morrissey, (1997) to measure barrier categories found in research investigating adolescent barriers. Kuhl et al., (1997) reported a Cronbach alpha of $r = .82$, and test-retest over two weeks was $r = .90$. BASH scores have been found to correlate negatively with positive perception of help givers, and people who indicated a prior or current history of mental health treatment indicated significantly lower BASH scores, as did females compared with males (Wilson, Deane, Ciarrochi & Rickwood, 2003a). In the present study a variation of the adolescent scale was utilised for youth workers in view of Wilson and Deane's (2000) suggestion that gatekeepers have many of the same barriers to adolescents. Wilson and Deane sought to reduce the 37-item scale since the BASH was utilised in combination with a variety of other help-seeking measures. In addition, the 37-item scale was found to have satisfactory reliability and validity, but a high Cronbach alpha ($r = .91$) suggested that there might be item redundancy. Thus, a 13-item BASH-B short version was derived from pilot data from a high school sample, and items were selected based on those most strongly endorsed barriers (Wilson et al., 2003a). A reliability analysis of the 13-item scale utilised in Wilson and Deane's (2000) study, revealed a Cronbach alpha of $r = .60$ with inclusion of two items. The scoring of these two items was difficult to interpret (e.g., "I have had problems in the past which really upset me") and were not appropriate for adults' view of their personal help seeking (e.g., "Adults can't understand the problems that kids have"). Thus, these items were removed, leaving eleven items that comprised the BASH-B scale in the present study (see Appendix A). Each item is rated on a 6-point scale ("1= strongly agree; 6 = strongly disagree"). Content includes stigma related barriers (e.g., "I'd be too embarrassed to talk to a therapist"), perception of the therapist (e.g., "A

therapist might make me do or say something that I don't want to"), and confidentiality (e.g., "I'd never want my family to know"). Higher scores indicate lower barriers to seeking professional help. However, to ease interpretation of results items were reversed so that lower scores represent lower barriers (i.e. "1 = strongly disagree; 6 = strongly agree"). In the present study Cronbach alpha for 11-item BASH-B for the full sample was $r = .85$.

Social problem solving. The Social Problem Solving Inventory for Adolescents (SPSI-A; Frauenknecht & Black, 2003) is a 30-item self-report scale that assesses social problem solving skills. Ratings for each item are made on a 5-point scale ("0 = not at all true of me; 4 = extremely true of me"). As the title suggests, the SPSI-A was developed for adolescents (e.g., Frauenknecht & Black, 1995), however it was derived from the 70-item adult version; the SPSI, (D'Zurilla & Nezu, 1990) and the content is appropriate to use with adult samples. For example, items in the SPSI-A match items in the SPSI, only some words in the SPSI-A were changed so that it may be understood by younger people. The short version was utilised in this study to increase the chances that participants would respond to all items. The SPSI-A consists of three subscales. Automatic Process (3 items) consists of statements such as "To solve a problem I do what has worked for me in the past". Problem Orientation (9 items) includes statements such as "I avoid dealing with problems in my life". Problem Solving Skills (18 items) assesses the extent that people are effective at identifying a problem, generating, evaluating and implementing alternative solutions, with items such as "When I solve a problem I think of a number of options". A total social problem solving score is obtained by summing all 30 items and dividing by the number of items. Each subscale score is obtained by summing the subscale items and dividing by the number of items. Frauenknecht and Black (2003) investigated the reliability and validity of

the SPSI-A 30-item version. Cronbach alpha estimates for the total scale were between $r = .91$ and $.94$, and subscales; automatic process $r = .73$ to $.81$, problem orientation $r = .77$ to $.80$ and problem solving skill $r = .92$ to $.95$. Test-retest reliability over two weeks was $r = .83$ for the total scale, and $r = .67$, $.78$ and $.77$ for the subscales. In the present study Cronbach alpha for the full sample total inventory was $r = .80$ and the three subscales were $r = .72$, $.80$ and $.93$ respectively. Considerable revision of the SPSI instrument provided content validation, and concurrent validity was supported by correlations with the Problem-Solving Inventory (PSI: Heppner & Peterson, 1982) $r = .82$ (Frauenknecht & Black, 2003).

Referral skill. The Youth Referral Survey (YRS: Deane, Wilson & Biro, in Deane, Wilson, Ciarrochi, & Rickwood, 2002) is a 16-item self-report questionnaire designed for this study that asks about the frequency of specific referral activities when working with young people. Questions ask participants the frequency with which they engage in referral activities thought to encourage young people to access help from a mental health professional. Each item is rated on a 5-point scale (“1 = never; 5 = always”). Examples of items are “I would be willing to accompany a young person to their first appointment with a mental health professional”, “[I would] obtain and record the young person’s consent to be referred” and “ [I would] let the young person know why I think that seeing a mental health professional might be useful”. The specific referral items were based on literature on referral technique, such as Cheston’s (1991) comprehensive description of optimal referral practices. The items were also based on Enhanced Primary Care Guidelines for Case Conferences that were developed for General Practitioners (Commonwealth Department of Health and Aged Care, 2000) and on research that has demonstrated that successful referral has been facilitated by triangulated contact between the referrer, the

young person and the referral source (King, Nurcombe & Bickman, 2001). Cronbach alpha for the scale in the present study was $r = .92$ indicating a high level of internal consistency. As the study was interested in youth workers willingness to refer, two additional items were included in descriptive analyses; e.g., “I might not be willing to refer a young person to a mental health professional because a) I don’t think it will help, and b) I think it will take too long to get an appointment”. Participants were also asked to provide estimates of the number of young people that came to their service in a week, the percentage of different problems that were discussed (e.g., suicide, drug use, problem behaviours), and the percentage of clients that were referred to mental health services.

Knowledge. The knowledge measure was devised for this study and was administered to the intervention and control groups at Time 2 only. Knowledge questions comprise 30-items that ask about the help seeking, social problem solving and adolescent mental health content of the workshops. There were 10 items per workshop content area and each item had a response format of “Yes, No or Don’t know”. Help seeking items included “When a young person is in distress, should you wait for them to come to you?” (Correct Rating – No). Social problem solving items included – “Should you talk to young people about problems being a normal part of life” (Correct – Yes), and Adolescent mental health items included- “Are poor social supports and alcohol misuse considered to increase risk of suicidal behaviour?” (Correct – Yes). Four items asked how often the workshop skills had been applied to working with young people (e.g., “How often do you help a young person identify their negative thoughts that may be acting as barriers to help seeking?”) on a 5-point scale (0 = Never; 4 = Very often).

Chapter 4

Results

4.1. Statistical analyses

Statistical analyses were completed using the Statistical Program for Social Sciences (SPSS, v.11). The analyses performed included reliability analyses (Cronbach's alpha) that are reported in the method, and descriptive, univariate and bivariate statistics that are reported in these results.

Independent samples t-tests were conducted to ascertain if the intervention ($n = 47$) and control groups ($n = 26$) could be combined for the purpose of analysing relationships between help-seeking variables and referral skill prior to any intervention. Data met assumptions of normality for the analysis. No significant differences were found for both intentions to seek help for a personal-emotional problem (GHSQ_MHP_PE) and suicidal thoughts (GHSQ_MHP_ST's). Similarly there were no differences between the intervention and control groups for barriers (BASH-B), social problem solving (SPSI-A) and referral skill (YRS). However, a significant difference was found for the frequency of actual help seeking between intervention ($M = 1.86$, $SD = 1.39$) and control groups ($M = 3.30$, $SD = 2.07$), $t(70) = -3.16$, $p = .003$. Therefore percentages of actual help-seeking are reported separately for the intervention and control groups (see Appendix C). Given there were no significant differences on the other variables, the intervention and control groups

were combined for cross-sectional analysis and constituted a sample of youth workers who had not yet received any gatekeeper training.

Prior to analysis, data for the total sample were first tested for accuracy of data entry, missing values, normality, linearity and the presence of outliers. Two variables were found to have more than 5% of cases with missing data. These were for referral skill (YRS), which had 14% missing ($n = 63$ out of 73), and intentions to seek help from a mental health professional for suicidal thoughts (GHSQ_MHP_ST), which had 8% missing ($n = 67$ out of 73). Mean substitution was considered as an option in order to compensate for data loss. However, after this procedure was conducted substantial changes to the relationships between variables occurred. Thus, for ease of interpretation, no data replacement procedures were used with the variables with more than 5% of missing data. The BASH-B, GHSQ_MHP_PE, SPSI-A and subscales, all contained less than 5% of missing cases, all $n = 70$ to 73 (see Table 3).

Two scores were identified as outliers on the Social Problem Solving variable (Total scale) and the Social Problem Solving scale did not meet the assumptions of normality for bivariate analyses. On examination of the outlying cases, the data entry was correct, however it was found that participants responded with the same rating to all items on the scale (e.g., “1 = slightly true of me”). Tabachnick and Fidell’s (2001) recommendation for reducing the influence of outliers was followed. These two outlying cases were removed as they did not appear to represent the variation in responses from other respondents in the sample. Afterward, the assumption of normality was then met for the social problem solving variable. No total scale variables showed notable skewness or kurtosis, and the Kolmogorov-Smirnov statistic for each variable was non-significant and indicated normality ($p > .05$). Histograms of each variable demonstrated relatively well-

formed normal distribution, and scatter plots revealed a relatively linear distribution for each variable.

The subscales of the Social Problem Solving Inventory (SPSI-A) and intention to seek help from a mental health professional, for two problem types (GHSQ_MHP_PE and ST) were used in bivariate analyses. These variables were also tested for normality. The Problem Solving Skill subscale met assumptions, however Automatic Process and Problem Orientation did not fit assumptions of normality.

Given that a majority of variables met assumptions of normality, parametric analyses were performed. Transformation of Automatic process and Problem Orientation was considered, however violation of normality did not seem substantial on visual inspection, or by statistics that represent skewness and kurtosis. As a precaution, in analyses that utilised the social problem solving subscales, non-parametric analyses were also run. Non-parametric tests yielded almost identical patterns of findings in correlation, and one way ANOVA, thus parametric findings are reported for ease of interpretation. This method of preliminary analysis was also used for all variables in the t-tests between intervention and control groups.

4.2 Pre-intervention analysis (N = 73)

4.2.1 Descriptive data regarding personal help seeking and referral practice

As there were differences between AHSQ for the intervention $n = 47$ and control groups $n = 26$, descriptive data is reported for each group, and frequency of actual help-seeking was excluded from further total sample analysis. As mentioned, the frequency of actual help-seeking for the intervention group was $\underline{M} = 1.86$, $\underline{SD} = 1.39$, and for the control

group $M = 3.30$, $SD = 2.07$. As was expected from the difference in overall mean frequency, control group members reported higher overall help-seeking from each help source. For example, approximately 50% percent of the intervention group had sought help from a partner or friend, compared with 60% of those in the control group. Seventeen percent of the intervention group had sought help from a mental health professional, compared with 25% in the control group (see Appendix C for percentages in each help source).

On average, this sample of youth workers did not tend to agree in general with the BASH-B barriers to seeking help from a therapist. Means indicate that participants somewhat disagreed with the individual barrier items (see Appendix C). Highest mean scores suggested that there may be a preference for seeking help from family or themselves (e.g. items 1 and 2) , and that practical barriers, such as time and money (e.g. items 3 and 12) may influence a decision to seek help from a therapist.

Except brief investigation in exploratory and correlational analyses, the GHSQ total scales were omitted from further examination, because intentions to seek help specifically from a “mental health professional” was of interest in examining personal intentions to seek mental health help. As seen in Table 3 means indicated that for a personal-emotional problem intentions seeking help from a mental health professional (Intent_MHP_PE) was rated as “a little unlikely”, whereas intentions to seek help for suicidal thoughts was rated as “somewhat likely” (Intent_MHP_ST’s). Section 4.3 reports the mean of intentions to seek help from 10 individual help source items and statistical differences.

Social Problem Solving Scale means and standard deviations were derived from the total scale and three main subscales (see Appendix C). The mean of Automatic Process suggests that participants generally solve a problem with the method that has worked for

them in the past. As all items (except 6) within Problem Orientation are reversed, the mean indicates that negative cognitive, emotional and behavioural styles of approach to problem solving were rated as only “slightly true” for this group. The mean of problem solving skill indicates that constructive skill use is generally “moderately” to “very true” for these participants.

Table 3. Means, standard deviations of help seeking and referral variables

Help seeking variable	<u>M</u>	<u>SD</u>	<u>n</u>	Scale Ranges	
GHSQ_Intent_PE. (Total)	3.45	.87	72	Extremely Unlikely	Extremely Likely
Intent_MHP_PE	3.65	2.22	71	1 -----	7
GHSQ_Intent_ST's. (Total)	3.41	1.05	71		
Intent_MHP_ST's	4.87	1.89	68		
Barriers	2.65	.67	73	Strongly Disagree	Strongly Agree
				1 -----	6
Social Problem Solving (Total)	3.03	.51	72	Not at all True of me	Extremely True of me
Automatic Process	2.68	.57	72	0 -----	4
Problem Orientation	3.05	.62	72		
Problem Solving Skill	2.48	.61	72		
Referral Skill	4.15	.56	63	Never	Always
				1 -----	5

Note: sample sizes varied due to missing data where participants had not responded to any items. Two outlying cases in the Social Problem Solving total scale were removed in bivariate analyses (e.g. t-tests, one-way ANOVA).

This group indicated that in general, good referral skills were used often. Means indicated that youth workers were at least “sometimes” using referral skills. They rated “developing a list of problems” as the least frequently used referral skill, and rated “letting

the young person know I will continue to be there for them” and “why seeing a mental health professional might be useful” as the most frequently used referral skills. Of note was that the occurrence of referral skills occurred substantially more than being unwilling to refer to a mental health professional (see Appendix C).

On average, four young people were seen by each youth worker each day. Approximately 4% of young people were identified as suicidal in the past three months (i.e. about 1 out of 20 young people seen per week). Fifty four percent of all young people seen were thought to have problem behaviours (e.g., drug use, difficulty managing emotions). This sample of youth workers thought that about 51% of young people are helped by seeing a mental health professional. However, only 21% of young people were thought to actually get better from seeing a mental health professional for a serious emotional problem. An average of 21% of all young people seen at youth services were reported to be referred to mental health services for assistance with psychological difficulties.

4.2.2 Exploratory analyses of gender, age and prior help-seeking

Gender: Help-seeking research suggests that females may be more likely to engage in general help-seeking, thus gender differences were explored in this sample. Independent samples t-tests were conducted to ascertain any differences between females' ($n = 47$) and males' ($n = 24$) general help-seeking intentions, barriers, social problem solving and referral skill. The difference in GHSQ total scales was investigated. There was no difference between females ($M = 3.68$, $SD = .77$, $n = 45$) and males ($M = 3.12$, $SD = .96$, $n = 24$) general intentions to seek help for suicidal thoughts $t(67) = -1.66$, $p = .10$. However there was a significant difference between females' ($M = 3.80$, $SD = .84$) and males' ($M =$

2.95, $\underline{SD} = .87$) intentions to seek help for a personal-emotional problem $t(69) = -3.87, p = .000$.

There was no difference between females' ($\underline{M} = 5.04, \underline{SD} = 1.83, \underline{n} = 47$) and males' ($\underline{M} = 4.5, \underline{SD} = 2.22, \underline{n} = 24$) intentions to seek professional help from a mental health professional for suicidal thoughts $t(71) = -1.06, p > .05$. However, there was a statistically significant difference at the $p < .05$ level between females' ($\underline{M} = 4.31, \underline{SD} = 2.07$) and males' ($\underline{M} = 2.26, \underline{SD} = 1.86$) intentions to seek professional help for a personal-emotional problem $t(69) = -.403, p < .001$. Females reported significantly lower barriers on the BASH-B ($\underline{M} = 2.53, \underline{SD} = .61, \underline{n} = 49$) than males ($\underline{M} = 2.91, \underline{SD} = .69, \underline{n} = 24$), $t(71) = 2.32, p > .05$, and significantly higher use of referral skill on the YRS ($\underline{M} = 4.28, \underline{SD} = .55, \underline{n} = 49$) than males ($\underline{M} = 3.89, \underline{SD} = .46, \underline{n} = 24$), $t(71) = -2.98, p < .01$. There were no other significant differences, all $p > .05$.

Age: There appears to be little data on help-seeking patterns and age among gatekeeper and youth worker groups. As such this factor was investigated. The sample was divided into three groups (e.g. Group1: 18-30, Group 2: 31-45, Group 3: 45+) with relatively equal frequencies for the purpose of this analysis (ie. $\underline{n} = 20, 28, 25$). A one-way between groups analysis of variance was conducted to explore the impact of age on help-seeking and referral. There was a statistically significant difference at the $p < .05$ level between the groups for automatic process [$F(2, 67) = 3.22, p = .04$], and for referral skill [$F(2, 70) = 4.12, p = .02$]. There were no other statistically significant differences between age groups for the other help seeking variables. Post-hoc comparisons using Bonferroni adjustment indicated that for automatic process the mean score for Group 3 ($\underline{M} = 2.87, \underline{SD} = .50$) was not significantly different from Group 2 ($\underline{M} = 2.67, \underline{SD} = .53$) but was

significantly greater than Group 1 ($\underline{M} = 2.44$, $\underline{SD} = .63$). For referral skill, the mean score for Group 3 ($\underline{M} = 3.92$, $\underline{SD} = .58$) was not significantly different to Group 2 ($\underline{M} = 4.21$, $\underline{SD} = .41$), but was significantly lower than Group 1 ($\underline{M} = 4.37$, $\underline{SD} = .61$).

Prior help seeking from a mental health professional: Forty one youth workers (56%) reported that they had sought help from a mental health professional in the past. Of these three (4%) had sought help from a school counsellor, 12 (16%) from a counsellor, 21 (27%) from a psychologist, and 7 (10%) from a psychiatrist. These youth workers' reported that they found their visit to the mental health professional was generally "helpful" ($\underline{M} = 3.88$, $\underline{SD} = 1.06$).

An independent samples t-test was conducted to ascertain if there were any differences between those who had been to a mental health professional in the past, and those who had not. Those who had been to a mental health professional in the past reported higher intentions to seek help for suicidal thoughts from a mental health professional ($\underline{M} = 5.55$, $\underline{SD} = 1.48$, $\underline{n} = 41$) than those who had not ($\underline{M} = 3.74$, $\underline{SD} = 2.18$, $\underline{n} = 27$), $t(66) = 4.05$, $p < .001$. Those who had been to a mental health professional reported significantly lower barriers ($\underline{M} = 2.40$, $\underline{SD} = .54$, $\underline{n} = 41$), than those who had not ($\underline{M} = 3.01$, $\underline{SD} = .65$, $\underline{n} = 28$), $t(67) = -4.25$, $p < .001$. There were no significant differences between those who had been to a mental health professional and those who had not, for intentions to seek professional help for a personal-emotional problem, social problem solving or referral skill, all $p > .05$.

4.2.3 *Help-seeking intentions for two problem types*

Related samples t-tests were conducted to examine the difference between intentions to seek help for a personal-emotional problem and suicidal thoughts, for ten different help sources on the GHSQ. Each help-source was compared with all other help-sources to investigate differences within means of the help sources for the two problem types. A multivariate analysis of variance (MANOVA) was not conducted due to small sample sizes. Instead, as recommended by Tabacknick and Fidell, (2001) a conservative level, $p < .001$ was set for pairwise and within mean comparisons, due to the high number of comparisons and concomitant risk of Type 1 error. These analyses were conducted predominantly to check the pattern of differences that may be similar to other groups (e.g., Deane et al., 2001). Specifically, to examine the finding that most individuals prefer to seek help from informal sources followed by professional sources for personal-emotional problems. For suicidal thoughts professional sources tend to be more strongly endorsed, than for personal-emotional problems.

As seen in Table 4 youth workers indicated that they were significantly more likely to seek help from a parent or a relative for a personal emotional problem, than for suicidal thoughts, ($t(67) = 5.03, p < .001$, and $t(65) = 4.89, p < .001$ respectively). Intention to seek help from a mental health professional for suicidal thoughts was significantly more likely than for a personal-emotional problem, $t(67) = -3.74, p < .001$. Mean differences indicated that intention to seek help for a personal-emotional problem was more likely from a friend, parent or partner than from a teacher or youth worker. Intention to seek help for suicidal thoughts were rated as more likely from mental health professional, intimate partner or friend, rather than from a parent, other relative or GP.

Table 4. Means (M) and Standard Deviations (SD) of youth workers’ help seeking intentions (GHSQ¹) for personal emotional problems (Per-Emot) and suicidal thoughts (Suicide-Thts), for different sources of help.

Help source	Problem Type			
	Per-Emot		Suicide-Thts	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Intimate Partner	4.19 _a	2.42	4.68 _a	2.15
Friend	4.29 _a	2.18	4.65 _a	2.06
Parent	4.29 _a	2.37	2.78 _b ***	2.02
Other relative/family member	4.19 _a	2.20	3.12 _{b,c} ***	2.04
Mental Health Professional	3.65 _b	2.22	4.87 _a ***	1.96
Phone Help Line	3.06 _c	1.91	3.56 _{b,c}	2.12
Doctor / GP	3.90 _{a,b}	1.91	3.68 _{c,d}	2.10
Teacher	2.31 _d	1.72	1.95 _e	1.44
Pastor / Priest	2.06 _e	1.64	1.60 _e	1.25
Youth worker	2.82 _{c,d}	2.11	2.75 _b	2.16
Not seek help	1.91	1.59	2.24	1.87

Note. Sample size ranged from $n = 68$ (intimate partner) to $n = 62$ (teacher)
 Evaluations were made on a 7 point scale (“1 = extremely unlikely, 7 = extremely likely”). Higher scores on “Not seek help” reflect higher intentions to not seek help from anyone. “Not seek help” was not included in the within group contrasts.
 Means differ between the two problem types; personal-emotional problem and suicidal thoughts in the same row at * $p < .001$ (two-tailed).
_{a,b,c,d,e} Means within columns differ from each other at $p < .001$ with the exception of those that share a letter.

4.2.4 Relationship between personal help-seeking and referral

Table 5 provides the correlation matrix (Pearson) for the variables in the study. As mentioned, non-parametric correlations were run as Automatic Process, Problem Orientation, and intentions to seek help from a mental health professional for suicidal thoughts (e.g., Intent_MHP_ST's) appeared to be somewhat skewed. Consistent with the general analytic strategy non-parametric results are only reported where there are differences between parametric and non-parametric tests. However, the pattern of correlations between variables in parametric and non-parametric tests remained similar, and only one relationship did not remain significant; Intent_MHP_PE and Intent_MHP_ST's. This relationship was not a focus of investigation, thus the results of the parametric correlations were reported.

As expected there was a negative relationship between barriers and intentions to seek help from a mental health professional for a personal-emotional problem $r = -.18$, $p = .068$ however this did not reach significance. There was a moderate negative and significant relationship between barriers and intentions to seek professional help for suicidal thoughts, $r = -.44$, $p < .001$. While GHSQ general intentions (all sources) to seek help for the two problem types was not the main focus of this study the relationship with barriers is worth noting. There was a significant negative relationship between barriers and general intentions to seek help for a personal-emotional problem (GHSQ_PE), $r = -.45$, $p < .001$, and general intentions to seek help for suicidal thoughts (GHSQ_ST) $r = -.35$, $p < .01$.

Of particular interest was the relationship between help-seeking intentions and social problem solving, and between help-seeking intentions and referral skill. A significant positive relationship was found between intentions to seek help for suicidal thoughts

(Intent_MHP_ST's) and social problem solving scales; automatic process, problem orientation, and social problem solving skill. A significant positive relationship was found between Intent_MHP_PE and referral skill, and a significant negative relationship was found between automatic process and referral skill.

Table 5. Intercorrelations between help seeking variables, problem solving and referral skill.

Measure	1	2	3	4	5	6	7
1. Intent MHP _ PE	--						
2. Intent MHP _ ST	.21*	--					
3. Barriers	- .18	-.44**	--				
4. Automatic Process	.06	.31**	-.14	--			
5. Problem Orientation	- .11	.20*	-.23*	.31**	--		
6. Social Prob. skill	.03	.29**	-.08	.46**	.54**	--	
7. Referral skill	.34**	-.03	.02	- .25*	-.09	.01	--

Note. Sample sizes range from n = 63 (Referral skill) to N = 73 (Barriers). Intent MHP_PE = Intentions to seek help from a mental health professional for a personal- emotional problem item from GHSQ. Intent MHP_ST's = Intentions to seek help from a mental health professional for suicidal thoughts item from GHSQ. Barriers = Mean of items from BASH-B. Automatic Process, Problem Orientation and Social Prob. skill = means of the three subscales of Social Problem Solving Inventory; SPSI-A. Referral skill = mean of items on YRS. *p < .05, **p < .01 (one-tailed).

4.2.5 *Predicting intentions and referral skill*

Having established the bivariate relationships between the help seeking and referral variables, standard linear regression analyses were conducted. Some data loss occurred for the regression analyses using listwise deletion ($n = 59$ to 68). Thus, a maximum of four variables were entered into each standard regression model following Stevens (1996) recommendation that “15 subjects per predictor are need for a reliable equation” (p. 72). Assumptions of linearity and homoscedasticity were met for the purpose of this analyses.

Predicting intentions to seek help from a mental health professional

Two standard linear regression analyses were conducted to investigate the hypothesis that barriers and social problem solving could predict intentions to seek help from a mental health professional for the two problem types. In the first model barriers, and social problem solving (automatic process, problem orientation and problem solving skill) did not significantly predict intention to seek help for a personal-emotional problem. [$F(4,65) = 1.44, p > .05$].

In the second model barriers, automatic process, problem orientation and problem solving skill were able to predict help-seeking intentions for suicidal thoughts (Intent_MHP_ST). The variables predicted 21% of the variance in Intent_MHP_ST and [$F(4, 63) = 5.35, p < .001$]. As shown in Table 6 Barriers was a significant contributor to this outcome ($p = .001$).

Table 6. Regression Analysis Summary for barriers and social problem solving predicting intentions to seek help for suicidal thoughts.

Help seeking variable	<u>B</u>	SEB	<u>Beta</u>
Barriers	-1.20	.34	-.39**
Automatic Process	.51	.38	.16
Problem Orientation	-.13	.37	-.05
Social Problem Solving	.58	.41	1.96

Note: Adjusted R Square = .206 (n = 67, **p < . 01)

Predicting referral skill

Intent_MHP_PE was selected as a predictor of referral skill following the hypothesis that intentions may be related to referral. The problem solving scales were also entered as independent variables in the regression. A standard linear regression analysis revealed that together these predictors accounted for 10% of the variance in referral skill, and were significant predictors [F (4, 56) = 2.64, p < .05]. Table 7 includes the relative contributions of each variable in predicting referral skill. Intent_MHP_PE and Automatic Process were significant contributors (p = .04, p = .01 respectively).

Table 7. Regression analysis summary for personal intentions and social problem solving predicting referral skill

Help seeking variable	<u>B</u>	SEB	<u>Beta</u>
Intent_MHP_PE	.07	.03	.26*
Automatic Process	-.27	.13	-.35**
Problem Orientation	.01	.14	.01
Problem Solving Skill	.16	.14	.18

Note: Adjusted R Square = .099 (n = 60; *p < .05, **p < .01)

4.3 Effects of gatekeeper training: pre and post intervention analyses

4.3.1 Assessing attrition bias

Chi-square analyses were performed to test for any differences in demographic characteristics as a result of the loss of participants in the follow-up group. There was a significantly higher proportion of females than males who participated in the post-workshop follow-up, $\chi^2 (2, n = 24) = 8.37, p < .01$. There were no differences found for age, education or workplace.

Independent samples t-tests were conducted to ascertain if there were differences in help-seeking and referral variables created by the loss to follow-up of participants who attended the workshops. This was necessary to rule out any attrition bias as an explanation for any differences found as a result of workshop participation. At pre-test (Time 1) the follow-up group had significantly lower mean barrier (BASH) ratings ($M = 2.41, SD = .64$), compared with the group who did not complete the follow-up ($M = 2.89, SD = .71$), $t (45) = -2.40, p < .05$. The follow-up sample had significantly higher intentions to seek help for suicidal thoughts ($M = 5.28, SD = 1.58$) than those who did not complete the follow up ($M = 3.23, SD = .53$), $t (45) = -2.78, p < .01$. There were no significant differences between groups for either intentions to seek help for a personal-emotional problem, social problem solving skill (SPSI-A) or referral skill (YRS) variables. There was a significant difference in the frequency of actual help-seeking between follow-up ($M = 1.56, SD = 1.20$) and non-follow-up groups ($M = 2.06, SD = .97$), $t (42) = 2.40, p < .05$.

Sixty seven percent ($n = 16$ of 24) of the follow-up group had sought help from a mental health professional in the past, compared with 40% ($n = 9$ of 22) of those in the

non-follow-up group. To explore the possibility that prior professional help-seeking may have contributed to participants decision to follow-up, independent samples t-tests were conducted between follow-up and non-follow-up groups for 1) those who had sought help in the past and 2) those who had not sought help in the past. There were no significant differences in help-seeking or referral variables between those who had sought help, and those who had not (all $p > .05$).

4.3.2 *Assessing selection bias*

If there was no selection bias between the intervention and control groups, then the pre-workshop measures of those in the intervention group (Time 1) should be, in theory, the same as those in the control group (Time 2). There were no demographic differences found between the workshop follow-up ($n = 24$) and control groups ($n = 26$) (both Time 2). The intervention group mean for intentions to seek help from a mental health professional for a personal-emotional problem was significantly higher ($M = 4.33$, $SD = 1.81$) than the control group ($M = 3.12$, $SD = 2.40$) $t(48) = 2.03$, $p < .05$. Social problem solving was significantly lower ($M = 2.01$, $SD = .37$) than the control group mean ($M = 3.19$, $SD = .45$), $t(48) = -10.30$, $p < .001$. There was a significant difference in the frequency of actual help seeking (AHSQ) between follow-up ($n = 24$) at time 1 ($M = 1.56$, $SD = 1.37$) and control group participants ($n = 26$) ($M = 3.30$, $SD = 2.07$) $t(38) = -3.98$, $p < .01$. There were no significant differences for barriers, intentions to seek professional help for suicidal thoughts, social problem solving or referral (all $p > .05$).

Together, these findings suggest that participant attrition and recruitment procedures may have lead to some self-selection bias in group formation. Those in the

intervention group who completed follow-up appeared to start out with lower perceived barriers to help seeking and were more likely to seek help for personal-emotional problems. It appears that there may be systematic bias, as it is expected that with lower barriers, there would be a greater intention to seek help. Participants in the follow-up group were predominantly female and had lower barriers, and this combination of factors reflects research suggesting an increased likelihood of general help seeking amongst females (Rickwood & Braithwaite, 1994). Comparisons of the intervention group (Time 1) and control group (Time 2) indicate that the control group had significantly lower ratings of intention to seek help from a mental health professional for a personal-emotional problem, and higher ratings of problem solving capacity. This bias is most likely a function of participant's self-selection to attend the workshops. It was speculated that those who chose to attend the workshops may on average have had higher intentions to seek help, and perhaps their attendance at the workshops reflected this tendency. They also had poorer self-rated problem solving ability. As such, the following results should be interpreted with these caveats in mind.

4.3.3 Pre and post-test comparisons

Paired samples t-tests were conducted to investigate the changes in variables from pre and post workshop. Table 8 provides the means, standard deviations and t-test results for these comparisons. The number of help sources accessed (AHSQ) increased significantly by an average of 1.8 help sources from pre-to-post workshop ($p < .001$). Similarly, there was a significant increase in mean intentions to seek help for a personal-emotional problem ($p < .05$) and social problem solving ($p < .01$). No significant

differences were found for intentions to seek help for suicidal thoughts, barriers or referral skill (all $p > .05$).

At time 2 independent samples t-tests were conducted to investigate the possibility that differences in the pre-post means might have been due to attendance at more than one workshop, for the follow-up group at time 2. No differences between help-seeking and referral skill variables were found (all $p > .05$) between those who attended more than one help-seeking workshop ($n = 10$) and those who attended only one workshop ($n = 12$).

Table 8. Pre-post workshop intervention comparisons.

Pre-post test Help Seeking	Pre Workshop		Post Workshop		<u>t</u>
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	
Actual Help seek	1.56	1.37	3.34	2.42	-4.01***
Intent. MHP_PE	4.08	1.59	4.96	1.52	- 2.27*
Intent. MHP_ST	5.29	1.59	5.54	1.86	- .69
Barriers	2.44	.64	2.40	.46	0.36
Prob. Solving	2.01	.37	2.97	.55	-7.81***
Referral	4.19	.51	4.36	.44	-1.19

Note. Sample size ranged from $n = 19$ (Referral) to $n = 24$ (Barriers) * $p < .05$; *** $p < .001$ (two-tailed).

4.3.4 Post workshop (T2) and control group (T2) comparisons

Conclusions about the effects of the workshop based on pre-post workshop comparisons would be further strengthened if there were also significant differences between the post-workshop measures, and control group measures (Time 2). Table 9 provides means, standard deviations and independent samples t-test coefficients for these comparisons. Intentions to seek help from a mental health professional for a personal emotional problem was significantly higher for the intervention group ($p < .01$). Barriers to seeking help from a mental health professional was significantly lower for those in the intervention group compared to the control group ($p < .05$). Knowledge was significantly higher for the workshop group in the help seeking ($p < .05$) and problem solving domains ($p < .05$). There were no significant differences found between the two groups for knowledge of mental health issues ($p > .05$).

There were no significant differences between intervention and control groups regarding how often the skills of help-seeking, problem solving and mental health needs were facilitated, all $p > .05$. Means in each group suggested that in general each of these areas of skill were used “often”.

Table 9. Post-test differences between Intervention and Control groups

Post-test Help seeking	Intervention Group		Control Group		t
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	
Actual Help Seek	3.34	2.42	3.30	2.07	.35
Intent. MHP_PE	4.96	1.52	3.12	2.41	3.26**
Intent. MHP_ST	5.54	1.86	4.73	2.20	1.49
Barriers	2.40	.46	2.71	.59	- 2.03*
Prob. Solving	2.97	.55	3.19	.59	-1.57
Referral	4.36	.44	4.17	.62	.25
Knowledge					
Help seeking	7.57	1.50	6.57	1.47	2.28*
Prob. Solving	7.34	1.36	6.46	1.61	2.06*
Mental Health	7.57	1.50	7.23	1.45	.78

Note. Sample sizes ranged from n = 20 (Referral) to n = 26 (Barriers), * $p < .05$, ** $p < .01$ (two-tailed).

Chapter 5

Discussion

5.1 Findings prior to the workshop intervention

5.1.1 Exploratory investigations

The first main aim of this study was to conduct a preliminary investigation of youth workers' personal help-seeking tendency, and referral skill. With the exception of actual help-seeking, there were no differences in the study variables, between those in the intervention and control groups. Thus, participants were combined to create a group of youth workers who had not yet been exposed to the study intervention.

This sample reported relatively low barriers to seeking help from a mental health professional. This was somewhat contradictory to findings suggesting that community gatekeepers may have the same barriers as young people to seeking help for a mental health issue (Wilson & Deane, 2000). It appears that this sample reported more practical barriers (e.g., too expensive, not enough time), than youth (e.g. Wilson & Deane, 2001) or adult samples (e.g., Amato & Bradshaw, 1985), that have tended to report fears regarding confidentiality or stigma. Mean scores suggested that personal solutions to a problem (e.g., solving a problem by myself, or my family would help more..) may be somewhat preferred to visiting a mental health professional. Low perceived barriers may not be surprising given that 56% of the sample reported that they had sought help from a mental health

professional in the past, and almost a third had sought help from a psychologist. The rate of mental health help-seeking is comparable with Deane and Todd's (1996) sample of 107 adult university students, in which 40% had sought prior help from a mental health professional. However, it is unknown whether the rate in this sample is representative of youth workers' in general. Nonetheless, this samples' report of low barriers seems to indicate a positive predisposition to the idea of visiting a mental health professional. A positive personal stance, and experience of prior help may make youth workers more inclined to refer young people in need of help.

Highest intentions to seek help for personal-emotional problems were for more informal sources of help such as partner, friend, parent or other family member. While intentions to seek help from a partner or a friend remained relatively high for suicidal thoughts, intention to seek help from parents and other family members was significantly lower for suicidal thoughts than for a personal-emotional problem. The pattern of high intentions to seek help from friends or partners relative to other help-sources is consistent with studies of intention among young people (e.g., Ciarrochi, Deane & Wilson, 2002; Deane, Wilson & Ciarrochi, 2001b; Wilson, Deane, Ciarrochi & Rickwood, 2003). This seems to provide further evidence for the notion that adults may have similar help-seeking patterns to young people. In general, the differences in help-seeking intention found between personal-emotional problems and suicidal thoughts supports past research suggesting that people respond differently to these two problems (Deane, Ciarrochi, Wilson & Rickwood, 2001a).

One apparent difference between youth workers and samples of young people was the relatively high intentions to seek help from a mental health professional for suicidal thoughts. For instance, Wilson and colleagues (2003b) found intentions to seek help for

suicidal thoughts on the GHSQ was $\underline{M} = 3.05$ among a high school sample. Youth workers' relatively high intentions ($\underline{M} = 4.87$) seems a reassuring finding in that it suggests that these youth workers may value help-seeking from mental health services for such problems. Perhaps this finding reflects a predisposition toward mental health help, and may be particularly important as much past research has demonstrated that as suicidal ideation increases, intention to seek help decreases among young people (Carlton & Deane, 2000; Saunders et al., 1994; Wilson et al., 2003).

Youth workers who had previously sought help from a mental health professional had lower barriers and higher intentions to seek help. This relationship between prior help seeking, barriers and intentions has been found in other studies with youth (e.g., Boldero & Fallon, 1995; Carlton & Deane, 2001; Saunders et al., 1994) and adult samples (e.g., Deane & Todd, 1996). It is encouraging that those youth workers who had been to a mental health professional in the past rated their prior experience as "helpful". Thus, it seems likely that this positive perception of prior experience influenced prospective help-seeking intention for suicidal thoughts. A prospective study would be needed to confirm this hypothesis. Prior experience did not appear to impact on referral skill, although it is possible that positive prior experience may enhance youth workers' ability to utilise referral skills. For example, identifying and discussing the benefits of seeing a mental health professional, or explaining what is involved in a first visit, may be introduced to a young person in a convincing fashion if a youth worker has had a positive prior experience themselves.

This sample reported a relatively high frequency of referral skill use. While there is no other data on youth workers' referral skill, mean referral ratings for this sample were higher than a GP sample using the YRS ($\underline{n} = 49$) (Deane, Wilson, Ciarrochi & Rickwood, 2002) (e.g., youth workers $\underline{M} = 4.15$, $\underline{SD} = .56$, GP group $\underline{M} = 3.18$, $\underline{SD} = 1.11$). Highest

ratings in both samples reflected gatekeepers' report that they would let a young person know the useful aspects of seeing a mental health professional, and that the visit would be their choice. Among the lowest mean ratings for both groups was the item "develop a list of problems with the young person to specify their mental health needs". One possible explanation for this pattern may be that it is a reflection of gatekeepers' relative inexperience with uncovering mental health needs using problem solving skills. Among youth workers' lowest ratings was "organise an appointment for a young person". There may be a number of contributors to this result. Some of the young people who seek help from youth services (e.g., welfare) may be difficult to engage and refer (e.g., those who are using drugs, or aggressive). Perhaps youth workers perceive that organising an appointment may impede the development of a relationship with a young person, that making contact with the mental health service is the young person's responsibility, or that it is not an imperative aspect of their role.

While the overall ratings of referral skill frequency seem promising, actual referral to mental health professionals was estimated to be only 21% of young people with emotional or behavioural difficulties. It is unclear whether this discrepancy is a function of reluctance by the young person, capacity of youth worker to manage the difficulties with existing resources, a relatively low level of problem severity, or inconsistent referral behaviour. Encouragingly, there were low ratings on the two items that asked about unwillingness to refer, based on youth workers' perception of a mental health service (i.e. they may not be able to help, or too much time before an appointment). However, it would be useful for future research to clarify why only 21% of young people with emotional or behavioural difficulties are referred to mental health professionals, and if this percentage is typical of referral rates from youth work services.

The exploratory investigation of age effects revealed that older youth workers (i.e. those 45+) tended to use an automatic problem solving process more than the youngest group (i.e. those 18-30), and tended to refer less than the youngest group. While there are previous studies that may help contextualise the finding that personal help-seeking tendency may be associated with professional practice (e.g., Neimeyer et al., 1999), the difference in automatic process, referral and age raises additional questions about the effect that past experience may have on professional practice. Automatic process relates to habitual responses to problems. Furthermore, it is thought to consist of personal knowledge, rules and techniques that have worked in the past; a default mechanism prior to engaging in a formal and more effortful process of evaluating problem options (Frauenknecht & Black, 2003). Older youth workers appear to rely on what they have used in the past, perhaps from life and / or work experience. This finding may be of concern when considering that this group also reported lower use of referral skill. It is possible that relying on past personal strategies may be a barrier to facilitating help-seeking for mental health issues. It would be of use for future studies to investigate which automatic process strategies have been used in the past (e.g., avoiding problems, versus using problem solving skills), and the skill level of youth workers who are less likely to refer (e.g., have they a particular skill in mental health intervention).

5.1.2 Barriers, intentions, and social problem solving

While the total sample mean reflected relatively low barriers, females reported significantly lower barriers to seeking mental health help than males. As was expected, females also reported significantly higher general intentions to seek help for a personal-emotional problem, and intentions to seek help for a personal-emotional problem from a mental health professional. These findings are consistent with gender effects found in males' and females' help-seeking for mental health problems (Addis & Mahalik, 2003; Bayer & Peay, 1997; Deane & Todd, 1996; Mahalik, et al., 2003; Rickwood & Braithwaite, 1994). The gender difference found in intentions provides evidence for the notion that similar patterns of help-seeking seem to exist in adult gatekeeper and youth samples. It was notable there was no gender difference in intentions to seek help for suicidal thoughts. This may be a reassuring finding given that youth workers' predisposition to use mental health services is likely to be important in a gatekeeping role.

As expected, a negative relationship was found between barriers and intentions to seek help from a mental health professional, for suicidal thoughts only. This finding is consistent with other studies that have found that negative attitudes impact on intentions to seek professional help (e.g., Bayer & Peay, 1997; Carlton & Deane, 2000; Deane & Todd, 1996). However, the non-significant relationship between barriers and intentions to seek professional help for a personal-emotional problem was somewhat unexpected. This result may be, in part, due to a small sample size and reduced power, but it does suggest a weak relationship nonetheless. It may be that there was potential difficulty with interpreting the definition of "personal-emotional" on the GHSQ. Personal-emotional could encompass a broad range of problems, and respondents may have had different ideas of what sort of

personal-emotional problem would warrant seeking professional help. Future research may need to include specific definitions of mental health problems, such as ‘anxiety’ and ‘depression’, that have been used in other studies investigating help-seeking intention (e.g., Cepeda-Benito & Short, 1998; Deane et al., 2001b, Hinson & Swanson, 1993). “Suicidal thoughts” is quite a clearly defined mental health problem, thus the intention to go to a mental health professional may be easier to estimate. The moderate negative relationship between barriers and intentions to seek professional help for suicidal thoughts is encouraging. The finding seems to support the notion in the Theory of Planned Behaviour (TPB) (Ajzen, 1991) that barriers are associated with intentions to seek professional help. Yet, this finding also has important practical implications for future gatekeeper training. In training, it may be useful to identify the highest barriers, and those that are most strongly related to intentions, so that the chance of facilitating intentions to seek-help, and subsequent behaviour, are increased. As suggested in Leane and Shute’s (1998) findings, different attitudinal barriers may be specific to different groups of gatekeepers, or even within groups of gatekeepers.

Since social problem solving can involve help-seeking as a way of resolving mental health problems, it was thought that social problem solving ability would be related to help-seeking intentions. A positive relationship was found between all three social problem solving subscales and intentions to seek professional help for suicidal thoughts. Given that the social problem solving skill subscale contains items that most closely resemble steps in the help-seeking process (e.g. “I determine the effect that a solution may have on my well-being”), it was promising to find that it was positively related to intention to seek professional help. If the likelihood of seeking professional help is associated with problem

solving ability, then it would be of use for future programs to further test the hypothesis that problem solving is related to intention, and subsequent behaviour such as referral.

The positive relationship with Automatic Process may be a satisfactory finding for those who are predisposed to help-seeking (i.e. help-seeking is automatically employed as a way to solve a problem). Although as mentioned, it raises concerns for gatekeepers who may not have this positive automatic inclination. There is a need for future research to test the hypothesis that those gatekeepers who have more positive attitudes towards help-seeking, and who have an automatic process that involves using problem solving, would be more likely to seek help.

There was a negative correlation between poor problem orientation (i.e. items were reversed so that lower scores indicated poorer problem orientation), and barriers (i.e. the BASH-B scale was reversed for ease of interpretation so that low scores represent low barriers). This suggests that individuals who are poorer at orienting themselves toward problem solving are more likely to hold barriers to seeking help from a mental health professional. Problem orientation on the SPSI-A comprises statements of negative cognitive (e.g., I often doubt there is a good way to solve problems I have), emotional (e.g., I feel afraid when I have a problem to solve) and behavioural responses (e.g., I avoid dealing with problems in my life) to dealing with problems. If problems are viewed as issues to be avoided, then it is less likely that a help-seeking activity, such as going to a mental health professional, would be considered. While these findings seem intuitive, they also build preliminary evidence for the relationship between problem solving and help-seeking tendency among this group. Identifying cognitive, emotional and behavioural aspects of personal problem orientation in gatekeeper training may be one way of facilitating an awareness of barriers to help-seeking in general. In addition, gatekeepers'

ability to identify problem orientation seems an important skill since research has suggested that poor problem orientation is associated with suicide (Orbach et al., 1990; Schotte & Clum, 1987).

As expected barriers and social problem solving predicted intentions to seek professional help, although this effect was only found for intentions to seek help for suicidal thoughts. Further, barriers were found to negatively predict intentions to seek professional help for suicidal thoughts. As mentioned, further identification of specific barriers and development of interventions to target these, may assist to reinforce pro-active help-seeking for suicidal thoughts.

5.1.3 Personal help-seeking and referral skill

There are no known studies that have examined the potential impact of personal help-seeking on referral skill, thus the results provide a starting point from which to determine whether further investigation might be warranted. The moderate positive relationship found between referral skill and intentions to seek professional help for a personal-emotional problem suggests that personal intentions may be related to referral practice. This finding can be considered within the TPB, which postulates that intentions are immediately proximal to behaviour. If the same relationship had been found between intentions to seek professional help for suicidal thoughts and referral, interpretation would have been strengthened. Nevertheless, this finding provides preliminary evidence for the idea that personal factors may influence professional practice related to gatekeeper functions. The relationship of referral skill with automatic process again raises the need to clarify the types of skills that youth workers may have used in the past, and the specific

relationship with the different referral skills. Given that some potential gatekeeper groups have been found to have “more laissez-faire accepting stances” toward suicide when they have had a personal experience with a suicidal crisis in the past (Neimeyer et al., 1999, p. 45), further investigation of the impact of help-seeking barriers and attitudes on gatekeeping functions seems warranted.

In summary, it has been recommended that personal response to mental health issues is included as a separate area of investigation in gatekeeper training including suicide and mental health issues (Frederico & Davis, 1996; Gould & Kramer, 2001). To this extent this study provided additional data on personal help-seeking tendencies of a youth worker gatekeeper group, and provided the first known data on personal help-seeking and its potential impact on referral skill within gatekeeper and youth worker groups.

5.2 Findings from evaluation of the workshop intervention

5.2.1 Youth workers' personal help-seeking

The second main aim of this study was to evaluate the effect of a workshop intervention on personal help-seeking and referral practice. The strongest evidence for change would be inferred from a combination of differences from pre-to-post intervention, and differences between the intervention and control group. An examination of the pattern of results will be outlined, and a focus on findings that suggest the most robust effects will be provided within the context of the limitations of a quasi-experimental design.

Barriers were significantly lower for the intervention group compared with the control group. This finding is particularly of note, given that there were no differences between the intervention group and the control group at Time 1, suggesting initial

equivalency on the barriers variable. It was hypothesized that the training in awareness of personal and general help-seeking barriers would decrease barriers, and increase intentions to seek professional help from pre-to-post-workshop. Intervention group means remained between “somewhat disagree” to “disagree” pre-to-post test on the BASH-B. Low barriers at pre-intervention may have, in part, been influenced by a potential attrition bias in the follow-up group. Those completing the follow-up measures tended to have lower perceived barriers and higher intentions to seek professional help for suicidal thoughts at time 1. The follow-up group comprised a majority of females, and some research has demonstrated that females are more likely than males to have positive help-seeking attitudes (Rickwood & Braithwaite, 1994). Nonetheless, it is encouraging low barriers to seeking professional help were maintained over a 5 month period, particularly as other related research found that favourable attitudes toward help-seeking for suicide were not maintained over a 3 month post-test period (Stuart et al., 2003). Low barriers for the intervention group, compared with the control group, seems an important finding given that one of the central aims of the training was to identify and reduce potential personal barriers to seeking professional help.

Intentions to seek professional help for a personal-emotional problem increased pre-to-post-test, and remained significantly higher for the intervention group when compared to the control group. Selection bias may have in part accounted for the difference between intervention and control groups; where the intervention group started out with higher intentions for a personal-emotional problem. It appears that this group of youth workers reported an increase in their intentions to seek professional help for more general problems, rather than for more severe problems such as suicidal thought. This result may be explained in part, by the fact that intentions to seek help for suicidal thoughts was relatively high at Time 1. Perhaps there was a cumulative change in youth workers’ intentions to seek

professional help, and a more accepting stance of the appropriateness of seeking professional help for more general psychological issues.

In the gatekeeper workshops, youth workers were asked to explore their notions of when it might be appropriate to seek professional help. A number of participants commented that coming into regular contact with depressed and / or suicidal young people influenced personal-emotional feelings associated with burnout, and that exploring the impact of their work has tended to strengthen their belief that dealing with distressed young people can impact on their own mental health. It could be speculated that the intervention group may have become more positively predisposed to seeking professional help in general.

Social problem solving (SPS) ability increased significantly for the intervention group at 5 month follow-up. Again a self-selection bias may have been evident as the intervention group started out (Time 1) with significantly lower social problem solving than the control group. Thus, this finding may be restricted to individuals who started out with relatively low problem solving skills (follow-up), given that there were no differences between the full sample of intervention participants ($n = 47$) and the control. It is possible that those youth workers who perceived that they required training in social problem solving to allow them to resolve some of the difficulties they faced with young people, were more motivated to join the intervention group, and provide follow-up feedback about their skills. While self-selection is a consideration, it is of note that the intervention group still reported a significant increase in their problem solving ability. During the workshop, participants commented that even though they thought SPS should be “commonsense”, they also thought that recognising a personal problem was often “the most difficult step” in a process of seeking help for themselves. Interestingly, these comments mirror those found

with samples of young people (Wilson & Deane, 2001), and suggest that increased awareness of using problem solving steps may have assisted with improving personal help-seeking. Since actual help-seeking behaviour and intentions increased post-intervention, it was thought that improvements in SPS were related to these changes. At this point it is difficult to determine the nature of this relationship, however it could be speculated that as problem solving orientation improves (e.g., I recognise that I have a problem that needs to be solved), there are concomitant increases in intentions and behaviour. A comprehensive answer to this suggestion is beyond the scope of this thesis, however it would be beneficial to test this hypothesis in future research to map the relation between SPS and help-seeking.

There were increases in actual help seeking behaviour from pre-to-post intervention. The intervention group also had higher help-seeking behaviour compared with a control group at post-test. A manual count of intervention group help-sources indicated a higher frequency of formal help sources post-intervention, including mental health professionals and General Practitioners (GP). It is possible that overall increases were due to participants going to their GP for a routine visit (e.g., cold) in the 5 months between questionnaires. Although, the slight increase in the number of participants who sought help from a mental health professional ($n = 2$ at time 1; $n = 5$ at time 2) suggested that there may have also been an increase in mental health help-seeking behaviour. It is acknowledged that actually seeking mental health help may not have been necessary for many youth workers during the course of the study. In addition, actual experience with professional help may not necessarily be an indicator of future help facilitation (i.e. an individual may have a negative experience). What was of interest was the general trend in increased predisposition towards mental health help-seeking.

Saunders et al., (1994) comment that studies using the measurement of actual help-seeking behaviour as a one-step process (i.e. whether help was sought or not) may have limited generalisability. Saunders and colleagues assert that to “break down the process of help-seeking into multiple steps...result[s] in the capacity to differentiate among persons at various stages of the process” (p. 724). Indeed, creating an actual help-seeking measure that breaks down the steps of help-seeking behaviour, may provide an indication of prospective social problem solving ability after a training intervention. Future studies must examine the help-seeking process for youth workers and other community gatekeepers in more detail, in order to understand the kinds of help-seeking sources that gatekeepers themselves value, and to gauge the effectiveness of training in the help-seeking process.

Intervention group knowledge regarding general help-seeking skill and social problem solving was higher than the control group. Increased knowledge of the indicators of suicide has been suggested to be a precursor for increased confidence in being able to identify people at risk of suicide (e.g., King et al., 1999). As there was no pre-test of knowledge for either intervention or control groups, it is not possible to determine the effect of training on knowledge. Although, as the knowledge questions were derived directly from the workshop content, it is likely that the finding was a direct result of exposure to the workshop material. It seems possible that the intervention group referred to their workshop workbooks and handouts when they were answering the questions. Therefore recall of information may have been aided by a review of the workshop material. Nonetheless, if a review were a substantial contributing factor to recall, then regular reviews of it in staff training may be warranted. Given that some evidence suggests that past personal experience or training in the indicators of suicide may not be sufficient to facilitate knowledge of indicators or intervention skills (e.g., Leane & Schute, 1998),

regular compulsory retraining may be an advantageous strategy to improve and maintain knowledge levels.

5.2.2 Youth workers' referral skill

There were no changes in referral skill either pre-to-post-test or between intervention and control groups. In addition, there were no differences between intervention and control groups at pre-test. These findings were somewhat unexpected for two main reasons. As far as is known, youth workers in this sample had not had the opportunity to attend formal training in specific skills of referral for mental health issues. Thus it was thought that their perceived use of referral skill would be lower than the relatively high mean ratings reported at Time 1. In addition, it was thought that training in specific skills of referral would increase the use of the skills. Despite these results, the trend in use of referral skill suggested a change in the expected direction. That is, there was a small increase for the intervention group pre-post-test, and post-test ratings remained slightly higher than for the control group.

One possible explanation for relatively high referral ratings for pre and post-test groups may be due to measurement effects. Since the YRS was the last measure in the questionnaire, more positive ratings of referral to mental health services may have been estimated after increased sensitisation to personal help-seeking practice. Further, the measure of referral did not ask how many referrals were actually successful (e.g., the young person attended the referral service for one or more sessions). Future research may need to make a distinction between referral practice or skill, and referral outcome or success. Other aspects of the referral process, such as the delivery of a referral suggestion, and ongoing

contact with the referee and referrer (e.g., Cheston, 1991) may also enhance our understanding of youth workers and their function as gatekeepers.

The YRS is a new measure with unknown validity. Psychometric validation assessing whether high scores reflect actual “good referral practice”, and whether the report of referral skill can actually lead to successful referral is needed. It may be that various other contextual factors, such as setting, region, or workplace determine the success of the referral process. Since the high Cronbach alpha found on the YRS is suggestive of item redundancy, it may be appropriate for future research to reduce the number of items pertaining to referral skill, and develop items that address contextual and outcome factors in the referral process.

In summary, there are self-selection and attrition biases that may be confounds that impact on the differences in actual help-seeking, intentions to seek help for a personal emotional problem and social problem solving ability. However, it is of note that personal help-seeking improved (e.g., barriers, intentions), and seemed to have been sustained over a relatively long time. To this extent this study provides some evidence that gatekeeper training addressing personal help-seeking practice, and can facilitate change that may extend beyond immediate post-training gains. No changes in referral skill were found. However the relationship with intentions and problem solving raise important questions about the potential impact of personal inclination on professional help-seeking facilitation.

5.3 Methodological limitations

5.3.1 Study design

At the beginning of recruitment, this study sought to encourage all youth workers in the region to attend the gatekeeper workshops. Given that attendance at the workshops was relatively low, in part due to work demands, the opportunity was taken to recruit a control group. While including a control group at post-test provided some additional internal validity to the study, assessment of intervention and control group differences (at Time 1) indicated that non-random assignment may have led to some selection bias. To reduce threats to internal validity, such as selection differences between groups, Cook and Campbell (1979) recommend a design which is generally interpretable, and that includes an intervention and control group pre-test and post-test. One of the uncontrolled threats that may have existed in this study was that of selection-maturation. That is, there may have been differences between the intervention and control groups that occurred over time as a function of self-selection bias (e.g., those interested in help-seeking workshops) rather than as a result of the training. The intervention group was exposed to the same measures twice and they may have grown somewhat more sensitised to their own personal-help seeking compared with the control group. In addition, expected improvement in help-seeking after training may have added to response bias. These issues point to the need to employ rigorous pre-post test designs using randomisation. For example, future studies could recruit youth workers to the general research topic; 'help-seeking for mental health issues', and then randomly allocate participants to workshop and to wait-list groups. Nevertheless, the pre-post-test intervention design is a commonly used design in social science research

(Cook & Campbell, 1979) and pre-post-test differences did suggest satisfactory change on some variables.

Having three workshops with variation in the content in the last half of each workshop made have impacted on the change in help-seeking variables. To enhance robustness of findings, future programs could devise one workshop so that each participant is exposed to identical information. Nevertheless, an emphasis on the link between personal help-seeking and the potential impact on professional practice was consistently maintained across workshops, and it is therefore possible that the changes noted in personal help-seeking tendency were a result of this training.

Recruiting the sample in this study was a particularly challenging task. As mentioned, unforeseen events, such as other work demands meant that attendance at the workshops was lower than expected. Finding volunteers willing to complete a questionnaire purely to contribute to research made recruitment of control participants difficult. Anecdotal observations suggested those attending the workshops seemed more motivated to fill out the questionnaires, as they received training and completed measures that were relevant to the workshop content.

Due to recruiting limitations, the sample sizes in the intervention group that completed pre and post-test measures remained small. Statistical analyses were limited by the design of the study and by small sample sizes. For example, with a pre-post intervention and control group design, two-way ANOVA could be performed. Further, although combining the sample provided a more suitable size for analyses such as standard regression, statistical power may still have been limited. In addition, Pedhazur and Schmelkin (1991) highlight that no statistical procedures may allow for the uncontrolled differences between groups in a quasi-experimental design.

5.3.2 Measures

The selection of measures was based on two assumptions; 1) that gatekeepers may have the same barriers and / or help-seeking tendency as young people and 2) that awareness of personal barriers to seeking professional help would facilitate referral skill used with young people. The first assumption was investigated with the BASH-B, GHSQ and SPSI-A to obtain an insight into youth workers' barriers, intentions and social problem solving ability. Yet other psychometrically sound measures such as the Attitudes to Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970) may have provided extra data particular to mental health help-seeking, such as the recognition for the need for professional help, stigma tolerance and confidence with a mental health practitioner. The ATSPPHS was considered as a potential measure for the current study, however the existing questionnaire was already of considerable length. Future research could incorporate this measure in assisting to explain the mechanism of change in mental health help-seeking behaviour.

Examining the impact of personal help-seeking on professional practice seems an important area of inquiry. Yet measurement of the link between personal and professional factors presents considerable methodological hurdles. Studies have had difficulty arguing for a relationship between personal history and professional response (e.g., Neimeyer et al., 1999), because there may be a myriad of potential combinations of personal and professional factors that could influence professional conduct. Future gatekeeper training programs may also need to ask more about professional factors within youth services (e.g., work milieu, burnout) and professional experience with mental health services (e.g.,

reactions to mental health services), that may influence a decision to refer. Nevertheless, increased personal intention to seek professional help was found to be associated with increased referral skill in this group. Prior experience may contribute to this relationship although this suggestion is speculative at this stage. To confirm such a hypothesis research may need to examine prior personal *and* professional experience at pre and post-intervention.

Research that has conducted specific examination of intervention responses to suicide seems to provide a useful direction for future evaluation of the relationship between training and skill acquisition. For example, Tierney (1994) utilised a Suicide Intervention Protocol (SIP: Tierney, 1988) in a preliminary study that assessed gatekeepers' intervention skills after attending a suicide intervention workshop. The SIP is an observational measure whereby trained judges assess the performance of participants on their intervention skill in a simulated situation. Specific behaviours, such as responding to clues of suicide, using skills of engagement, and of risk identification, assessment and contracting are scored (Tierney, 1994, p. 70). These practical evaluations can assist to enhance gatekeepers' skills, and are likely to confirm the effectiveness of gatekeeper training on professional skill. In addition, it has been suggested that self-report of behaviour may be more unreliable than objective measures, due to self-presentational biases (Armitage & Connor, 2001). Inclusion of objective measures of behaviour change may also assist to strengthen evaluation of proposed theoretical links (i.e. TPB) between help-seeking attitude and / or barriers, intention and behaviour.

Neimeyer and Pfeiffer (1994) assert "there is a clear role for written tests of suicide knowledge and intervention skills" (p. 153). While promising results were found in knowledge of help-seeking in this study, there were no differences in help-seeking or

referral *skills* used. Social problem solving steps may provide a way to operationalise the measurement of help-seeking behaviour in gatekeeper training models. Future programs could use the SPS steps in evaluating gatekeepers' practical skills after training. For example, similar to the evaluation in the simulated scenarios of the SIP, gatekeepers' could be asked to respond to clinical vignettes involving a distressed young person; to indicate which social problem solving steps would be most appropriate in order to facilitate referral to a mental health service, and to rate their intention to refer after using the skills.

Another potential limitation was the relatively large number of measures that were adapted for this study, and that have only preliminary psychometric data (e.g., AHSQ, BASH-B, SPSI-A, YRS). For example, psychometric data on the SPSI-A pertains to "young adults" aged 17-26 years. Whilst items appear highly consistent with adult versions (SPSI) it is unclear to what extent the measure is valid for use with older adult samples. As has been noted, the GHSQ has been used more extensively in help-seeking research, and appears to have satisfactory validity. While the focus on the item "mental health professional" in this study provided some specific data on youth workers' mental health help-seeking intention, utilising the single item may have increased risks to reliability.

5.4 Implications for further training and future directions

Gatekeeper training has been recommended as a key intervention strategy for the prevention of suicide and mental illness among young people (Frederico & Davis, 1996). In addition, examination of personal barriers and intentions toward mental health services is thought to increase the likelihood that in professional practice gatekeepers will engage in supporting help-seeking in others using good referral skill. The present study provided

some preliminary evidence to support the notion that a workshop that addresses personal help-seeking issues was related to reduced barriers and increased intention to seek professional help. As such, the continued development and evaluation of personal help-seeking variables in gatekeeper training programs seems warranted.

Currently it is unclear where or whether routine training in gatekeeper activities including skills in facilitation of help-seeking occurs. Inquiry at New South Wales Department of Education and Training ('TAFE') institutions in the Wollongong area revealed that there are no courses within qualifications for youth work that specifically outline gatekeeper functions. Incorporating gatekeeper training as part of educational qualifications may assist to further define part of the youth work role. Given that there are different courses in which an individual can train to become a youth worker (e.g., Welfare and Youth Work certificates, and/ or Diplomas), consistency across qualifications would be optimal.

Gatekeeper training could also continue from the work setting. Some youth gatekeeper groups have expressed a need for improved collaboration between youth services and mental health services (Ford & Nikapota, 2000; Moore, 1997). One form of connection could be a regular meeting between youth workers and mental health professionals, to address potential barriers to the referral process, and to clarify what benefits various services might offer to potential youth clients.

If the youth worker role is as challenging as depicted in the literature, and by some of the workshop participants, then gatekeeper training may also provide the opportunity for peer support, shared learning and to empower youth workers within the youth and mental health service sectors. Aspects of the youth worker role could be formalised, by including

gatekeeper functions (i.e. help-seeking and referral for mental health issues) in written contracts that youth workers make with young people when they access youth services.

The findings of the present study also have implications for future training programs. As male youth workers reported higher barriers, lower intentions, and less use of good referral skill than female youth workers, future training may need to uncover specific barriers that male youth workers' may have toward mental health help-seeking. Training that involves identifying and addressing barriers may continue to provide a forum for youth workers to discuss potential hurdles to mental health help-seeking practice, including the impact that personal barriers may have on facilitation of help-seeking among young people.

Youth workers may be able to facilitate help-seeking with young people through their knowledge of youth and adult help-seeking barriers and intentions. For example, this group indicated that they were less likely to seek help from parents or other family members for suicidal thoughts, and this pattern appeared to be similar to samples of young people. Youth workers can use this information to normalise a young person's reluctance to seek help from a mental health professional; with a statement such as "it is not uncommon for young people to be reluctant to seek help from an adult, or a mental health professional". The young person's perspective could be normalised further by linking this to some adult's help-seeking tendency "even some adults are reluctant to ask for help at times". Finally, a statement could be made about the potentially negative effect of not seeking appropriate help, and that adults and young people can both benefit from seeking professional assistance; " seeking professional help is not what you necessarily think of first, however professionals provide help for young people and adults, they provide help for certain problems like....". By being aware of their own help-seeking barriers youth workers may be able to more effectively identify young people's barriers (e.g., using the

BASH-B), and facilitate problem solving strategies to overcome them. Finally, specific identification of barriers (e.g., cost, stigma) may provide youth workers with an indication of the type of referral information that a young person may need (e.g., inexpensive services, a preliminary meeting with a potential mental health professional).

5.5 Conclusion

This study was intended as an evaluation of a gatekeeper training program. Youth workers' personal help-seeking was investigated, since there is little data on youth workers as a gatekeeper group. It was also intended as a preliminary investigation of the potential impact of personal help-seeking for mental health issues on professional practice, and there is no known data regarding this specific research question. While this study provided insight into this group of youth workers, and their personal predisposition toward help-seeking, many complexities arose in evaluating the effect of personal characteristics on professional skill. Despite methodological limitations, the study raised useful directions for future research in gatekeeper training and evaluation strategies. Future research with a focus on more rigorous experimental designs may provide further evidence to support the efficacy of gatekeeper training, and the potential for training to become part of youth worker competency and accreditation. In conclusion, evaluation of the training workshops in the present study provided some evidence that gatekeeper training has the potential to be effective as a strategy for early and indicated prevention of mental health problems.

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APPENDIX A

Pre-intervention materials

- 1) Workshop brochure
- 2) Front and contents pages of the series of three gatekeeper workshops
- 3) Information and consent
- 4) Help-seeking and referral questionnaire (administered at Time 1 and 2)

Y.E.S! Workshops

Around the Illawarra and the South Coast, there are high numbers of distressed teens and youth. While this is not news to anyone who works with youth, many Youth Workers have been at a loss to know what to do to challenge this situation. The *YES!* Workshops have been developed to address this need. They are based on the premise that to prevent youth distress, it is important for Youth Workers to be equipped with some understanding of the common signs of distress as well as practical strategies for dealing with at-risk youth.



The *Y.E.S!* workshops are a collaboration between:

Illawarra Institute for Mental Health
University of Wollongong



Illawarra Division of General Practice

Lifeline South Coast



Adolescent Mental Health Service
Illawarra Area Health Service

Youth Empowerment Series!



For further information contact:
Kristine Smith on 42267 052

Youth Empowerment Series!

Y.E.S!



**Practical
Strategies for
dealing with
at-risk youth**

- * help-seeking
- * social problem solving
- * adolescent mental health

Coming to a venue near you!

➤ **Youth Empowerment Series (Y.E.S!)**

WORKSHOP 1: Strategies to facilitate appropriate help-seeking.

Presented by Coralie Wilson (Illawarra Institute for Mental Health).

Appropriate help-seeking is the best way to protect at-risk youth against becoming severely depressed or suicidal. Unfortunately, many youth don't seek the best kinds of help, if they seek help at all. This workshop examines youth opinions about help-seeking, particularly from professional sources. Practical strategies covered include exploring and correcting distorted help-seeking attitudes, identifying different youth problems, effective referral to appropriate help-sources, and dealing with expectations about help-seeking.

WORKSHOP 2: Strategies to facilitate effective youth problem-solving.

Presented by Diane Booth (Suicide Prevention Educator, Lifeline) and Coralie Wilson.

Research tells us that most depressed and suicidal youth have difficulty solving social problems effectively. This workshop presents effective social problem solving strategies that can be used with and taught to at-risk youth. Participants will be given the opportunity to rehearse the specific problem-solving steps. Strategies will be provided for developing youth programs that are based on effective problem-solving.

WORKSHOP 3: Strategies to identify youth mental health needs and facilitate appropriate help-service engagement.

Presented by Adolescent Mental Health Service and Coralie Wilson.

Youth depression and mental health problems are prevalent in our society. Unfortunately, the common signs that indicate youth distress often go unrecognised or misunderstood. This workshop presents an overview of the signs of common youth mental health problems. Participants will be given the opportunity to rehearse the identification of different youth mental health problems and apply strategies for appropriate referral and help-service engagement.

Venues

North

Bellambi Neighbourhood Centre
Cawley Rd, Bellambi
Central

Wollongong Youth Centre
Burelli St, Wollongong
South

Blackbutt Youth Centre
Cvanet Ave, Blackbutt

Time

9am - 1pm

Morning Tea provided.

Cost

Free!

Youth Empowerment Series!

Each workshop stands alone as an independent training resource. However, the workshops have been designed as a training series so that skills gained in one workshop will be applied in the following workshop.

Registration

Please tick (✓) the days you will be attending each session. The workshops are being held during October and November 2000.

	Wollongong	Bellambi	Blackbutt
1) Help-seeking	<input type="checkbox"/> 9/10	<input type="checkbox"/> 5/10	<input type="checkbox"/> 6/10
2) Social Problem Solving	<input type="checkbox"/> 16/10	<input type="checkbox"/> 19/10	<input type="checkbox"/> 27/10
3) Adolescent Mental Health	<input type="checkbox"/> 30/10	<input type="checkbox"/> 2/11	<input type="checkbox"/> 3/11

Name(s): _____

Name(s): _____

Service: _____

Address: _____

Phone: _____

Fax: _____

RSVP by September 22nd 2000



Send registrations to: YES/Workshops
c/- Illawarra Division of General Practice
PO Box 1198, South Coast Mail Centre, 2521.
or REGISTER on the WEB at:

Y.E.S!

Youth Empowerment Series!

*Training Workshops for
Community Gatekeepers*



Practical Strategies for dealing with at-risk youth

- ▶ * **help-seeking**
- * social problem solving
- * adolescent mental health

The *Y.E.S!* Workshops are produced by:

The Illawarra Institute for Mental Health (iiMH),
The Illawarra Division of General Practice (IDGP),
Lifeline South Coast.

Workshop 1:

Strategies to facilitate appropriate help-seeking.

Presented by:
Ms Coralie Wilson (Illawarra Institute for Mental Health)

Appropriate help-seeking is the best way to protect at-risk young people against becoming severely depressed or suicidal. Unfortunately, many young people don't seek the best kinds of help, if they seek help at all. This workshop examines young people's opinions about help-seeking, particularly professional sources. Practical strategies covered include exploring and correcting distorted help-seeking attitudes, identifying different youth problems, effective referral to appropriate help-sources, and dealing with expectations about help-seeking.

YES! Workshop Rationale

Around the Illawarra and the South Coast, there are high numbers of distressed teens and youth. While this is not news to anyone who works with youth, many Community Gatekeepers have been at a loss to know what to do to challenge this situation. The *YES!* Workshops have been developed to address this need. They are based on the premise that to prevent youth distress, it is important for Gatekeepers to be equipped with some understanding of the common signs of distress as well as practical strategies for dealing with at-risk youth.

CONTENTS

Section 1: Help-Seeking Overview

- Help-Seeking Facts
- Appropriate Help-Seeking and Suicide
- Help-Seeking Barriers to Professional Psychological Help

Section 2: A Theory of Help-Seeking

- The Theory of Planned Behaviour (Ajzen, 1991)
- The TPB and Appropriate Help-Seeking

Section 3: Strategies for Increasing Appropriate Help-Seeking

1. Challenge Attitude and Belief Barriers Through Normalisation.
2. Increase Perceived Control with Knowledge about Appropriate Help-Seeking.
3. Increase Perceived Control with Ways to Deal with Aversive Emotion.

Appendices

Appendix A: Categories of Young People's Barriers to Professional Psychological Help-Seeking.

Appendix B: Thoughts that stop you seeking help.

Extract from the *Do It Together Kit* (Illawarra Institute for Mental Health & Dapto High School, 2000)

Appendix C: Ways to deal with thoughts that stop you seeking help.

Extract from the *Do It Together Kit* (Illawarra Institute for Mental Health & Dapto High School, 2000)

Appendix D: Young people's help-seeking experiences

Extract from the *Do It Together Kit* (Illawarra Institute for Mental Health & Dapto High School, 2000)

Appendix E: Feelings that stop you seeking help.

Extract from the *Do It Together Kit* (Illawarra Institute for Mental Health & Dapto High School, 2000)

Appendix F: Ways to deal with distressing feelings.

Extract from the *Do It Together Kit* (Illawarra Institute for Mental Health & Dapto High School, 2000)

SUGGESTED CITATION:

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Y.E.S!

Youth Empowerment Series!

***Training Workshops for
Community Gatekeepers***



Practical Strategies for dealing with at-risk youth

- * help-seeking
- ▶ * **social problem solving**
- * adolescent mental health

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RECOMMENDED CITATION:

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CONTENTS

Section 1: Help-Seeking Overview

- Suggestions for reducing help-seeking barriers

Section 2: Social Problem-Solving Theory

- Definitions
- D' Zurilla's (1986) Social Problem-Solving Model

Section 3: Strategies for Increasing Social Problem-Solving Competencies

Part 1: Problem Orientation

Part 2: Problem Solving Skills

Competency A: Controlling emotions during problem-solving

Competency C: Generation of Alternative Solutions

Competency D: Decision Making

Competency E: Solution Implementation & Verification

Appendices

Appendix A: Models of Positive and Negative Cognition Orientation.

Extract from *Problem-Solving Training for Effective Stress Management & Prevention* (CD Zurilla, 1990)

Appendix B: Feelings that stop you seeking help.

Extract from the *Do It Together Kit* (Illawarra Institute for Mental Health & Dapto High School, 2000)

Appendix C: Ways to deal with distressing feelings.

Extract from the *Do It Together Kit* (Illawarra Institute for Mental Health & Dapto High School, 2000)

Appendix D: Problem-focused & Emotion-focused Goal Setting.

Extract from *Problem-Solving Training for Effective Stress Management & Prevention* (CD Zurilla, 1990)

Appendix E: Thoughts that stop you seeking help.

Extract from the *Do It Together Kit* (Illawarra Institute for Mental Health & Dapto High School, 2000)

Appendix F: Ways to deal with thoughts that stop you seeking help.

Extract from the *Do It Together Kit* (Illawarra Institute for Mental Health & Dapto High School, 2000)

Appendix G: Basic Principles of Alternative Problem Solution Generation.

Extract from *Problem-Solving Training for Effective Stress Management & Prevention* (CD Zurilla, 1990)

Y.E.S!

Youth Empowerment Series!

***Training Workshops for
Community Gatekeepers***



Practical Strategies for dealing with at-risk youth

- * help-seeking
- * social problem solving
- ▶ * **adolescent mental health**

The **Y.E.S!** Workshops are produced by:

The Illawarra Institute for Mental Health (iiMH),
The Illawarra Division of General Practice (IDGP),
Lifeline South Coast.

RECOMMENDED CITATION:

Wilson, C.J., Pickard, J., & Deane, F.P. (2000) Strategies to identify youth mental health needs and facilitate appropriate help-service engagement. Youth Empowerment Series (**YES!**): Practical Workshops for Dealing with At-Risk Youth. Handbook 3. Illawarra Institute for Mental Health, University of Wollongong, Wollongong, Australia.

Workshop 3:

Strategies to identify youth mental health needs and facilitate appropriate help-service engagement.

Presented by:

Ms Coralie Wilson (Illawarra Institute for Mental Health)

Youth depression and mental health problems are prevalent in our society. Unfortunately, the common signs that indicate youth distress often go unrecognised or misunderstood. This workshop presents an overview of the signs of common youth mental health problems. Participants will be given the opportunity to rehearse the identification of different youth mental health problems and apply strategies for appropriate referral and help-service engagement.

YES! Workshop Rationale

Around the Illawarra and the South Coast, there are high numbers of distressed teens and youth. While this is not news to anyone who works with youth, many Community Gatekeepers have been at a loss to know what to do to challenge this situation. The *YES!* Workshops have been developed to address this need. They are based on the premise that to prevent youth distress, it is important for Gatekeepers to be equipped with some understanding of the common signs of distress as well as practical strategies for dealing with at-risk youth.

CONTENTS

Section 1: Common youth mental health needs and indicators

- Your role as community gatekeepers
- Common behavioural and physical indicators of mental health needs
- Common needs overview and indication checklist

Section 2: A theory for needs identification and referral

- Maslow's Hierarchy of Needs

Section 3: Strategies for needs identification and referral

- Strategies for identification
- Strategies for referral

Appropriate Help-Seeking and Youth Services

Information and Instruction Sheet 1

Who is running this study?

This research study is being run by Coralie Wilson, Tania Cartmill, and Professor Frank Deane as part of a larger project that is being funded by the National Health and Medical Research Council.

What is this study about?

- The first aim of this study is to explore how Youth Worker's mental health and help-seeking barriers, intentions and behaviours contribute to young people's use of healthcare services when they are distressed or unhappy or when they experience suicidal thoughts.
- The second aim of this study find out about ways to increase and promote the use of helping services by young males. We are particularly interested in Youth Worker's current practices of youth need's assessment, problem identification, referral, assertive outreach, follow-up, and relationship building.

Am I eligible to take part?

You are eligible to take part in this study if you are a Youth Worker.

What would I have to do?

If you agree to take part, you would need to:

- Complete the accompanying consent form,
- Complete the accompanying questionnaire. This will take approximately 30 minutes.

What can I expect from the researchers?

This study is voluntary. If you choose to take part in the study, you have the right to:

- Refuse to answer any particular question, and to withdraw from the study at any time,
- Ask any further questions about the study that occur to you during your participation,
- Be informed of the findings from the study when it has concluded, and
- Provide information on the understanding that it is completely confidential to the researchers. All records will be identified by a code number, and will be seen only by the researchers. It will not be possible for you or your Youth Centre to be identified in any reports that result from the study.
- The results will form part of a report to the NHMRC, will form a Doctor of Psychology thesis for Ms Cartmill, and may be published as a scholarly journal article. No individual participant will be identified in any reports.

It is important to emphasise that this study will not offer advice about your physical or mental health. If you have any concerns about your health, please contact a help-service listed in "The Frog".

If you have any questions about this research, please call Coralie Wilson, Tania Cartmill or Prof. Frank Deane on Tel. (02) 4221-4523 during business hours or email Tania Cartmill at tkc02@uow.edu.au She will explain any details of the study. If you have any questions regarding the conduct of this research please contact the secretary of the University of Wollongong Human Research Ethics Committee on (02) 4221-4457.

Tania Cartmill

(For the intervention group at time 1)

Appropriate Help-Seeking and Youth Services

Consent Form 1

I have read the Information and Instruction Sheet for this study. I understand that I will be required to complete a questionnaire about my mental health and help-seeking.

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

I agree to provide information to the discussion leader and researcher on the understanding that it is completely confidential.

I understand that if I have any questions regarding the research I can contact Coralie Wilson, Tania Cartmill or Professor Frank Deane on (02) 4225-4523. Also, if I have any questions regarding the conduct of the research I can contact the secretary of the University of Wollongong Human Research Ethics Committee on (02) 4221-4457.

I wish to participate in this study under the conditions set out on the Information Sheet.

Name: _____

Signed: _____

Date: _____

Part 1: Help-seeking and referral

DIRECTIONS: Please indicate (✓) or fill in the category that applies to you.

Male ☐ Female ☐ Age: _____

Place of work (please only tick one main area):

- Community center ☐ • Health agency ☐ • Welfare agency ☐
- Education and training ☐ • Outreach ☐
- Other ☐ Please specify _____

Work load: Full time ☐ Part time ☐ Casual ☐

Type of work: Paid ☐ Volunteer ☐

Type of training:

- Youth / Welfare Certificate ☐
- Youth / Welfare Diploma ☐
- Disabilities certificate ☐
- Related Degree
(eg, Social Science) ☐
- Unrelated Degree ☐
- Workplace training ☐
- Other _____

Do you speak a language other than English ?

Yes ☐ No ☐

If 'Yes' please specify _____

What is your country of origin ?

Do you view yourself as Aboriginal or as
having other strong cultural influences ?

(eg. Italian, Macedonian)

Please specify _____

Have you commenced any other study?

(including workplace training courses)

Yes ☐ No ☐

If yes, what course(s)?

Where are you studying ?

Main social supports:

Please tick any supports
relevant for you

- Family ☐
- Partner ☐
- Friends ☐
- Work Colleagues ☐
- Work supervisor ☐
- GP ☐
- Counsellor ☐
- Religious leader ☐
- Other _____

Please turn over to begin the questions on help-seeking and referral.

Actual Help-Seeking Questionnaire (AHSQ)

DIRECTIONS:

Below is a list of people that you may seek help from for a personal-emotional problem. Please indicate whether you have sought advice or help from any of these people over the past 5 months.

Please tick (✓) YES or NO for every person in the list.

If you ✓ YES, **please write the specific service or person** you sought help from (e.g., the doctor or the priest).

	NO	YES:	Specific Person or Service
a. Intimate partner (eg. husband, wife, boyfriend or girlfriend)	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Friend (not related to you)	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Parent	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. Other relative/family member	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. Mental Health Professional (e.g., School Counsellor, Psychologist, Psychiatrist)	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. Phone help line (e.g., Lifeline, Kids Help Line)	<input type="checkbox"/>	<input type="checkbox"/>	_____
g. Doctor/GP.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
h. Teacher (Year Advisor, Head Teacher of Welfare, Class Teacher)	<input type="checkbox"/>	<input type="checkbox"/>	_____
i. Paster/Priest	<input type="checkbox"/>	<input type="checkbox"/>	_____
j. Youth Worker/ Youth Group Leader	<input type="checkbox"/>	<input type="checkbox"/>	_____
k. Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

General Help-Seeking Questionnaire (GHSQ)

DIRECTIONS:

Read each statement carefully.

Circle the number that most closely answers each question.

1) If you were having a personal-emotional problem, how likely is it that you would seek help from the following people?

	Extremely Unlikely						Extremely Likely
a. Intimate partner (e.g., significant boyfriend or girlfriend, husband, wife)	1	2	3	4	5	6	7
b. Friend (not related to you)	1	2	3	4	5	6	7
c. Parent	1	2	3	4	5	6	7
d. Other relative/family Member	1	2	3	4	5	6	7
e. Mental Health Professional (e.g., School Counsellor, Counsellor, Psychologist, Psychiatrist)	1	2	3	4	5	6	7
f. Phone help line (e.g., Lifeline)	1	2	3	4	5	6	7
g. Doctor/GP	1	2	3	4	5	6	7
h. Teacher (Year Advisor, Classroom Teacher, Support Staff)	1	2	3	4	5	6	7
i. Pastor/Priest	1	2	3	4	5	6	7
j. Youth Worker/Youth Group Leader	1	2	3	4	5	6	7
k. I would not seek help from anyone	1	2	3	4	5	6	7
l. Other not listed above (Please list)_____ (If no other, leave blank.)	1	2	3	4	5	6	7

2) If you were experiencing suicidal thoughts, how likely is it that you would seek help from the following people?

	Extremely Unlikely						Extremely Likely
a. Intimate partner (e.g., significant boyfriend or girlfriend, husband, wife).	1	2	3	4	5	6	7
b. Friend (not related to you)	1	2	3	4	5	6	7
c. Parent	1	2	3	4	5	6	7
d. Other relative/family Member	1	2	3	4	5	6	7
e. Mental Health Professional (e.g., School Counsellor, Counsellor, Psychologist, Psychiatrist)	1	2	3	4	5	6	7
f. Phone help line (e.g., Lifeline)	1	2	3	4	5	6	7
g. Doctor/GP	1	2	3	4	5	6	7
h. Teacher (Year Advisor, Classroom Teacher, Support Staff)	1	2	3	4	5	6	7
i. Pastor/Priest	1	2	3	4	5	6	7
j. Youth Worker/Youth Group Leader	1	2	3	4	5	6	7
k. I would not seek help from anyone	1	2	3	4	5	6	7
l. Other not listed above (Please list)_____ (If no other, leave blank.)	1	2	3	4	5	6	7

3a) Have you ever seen a mental health professional (e.g., School Counsellor, Counsellor, Psychologist, Psychiatrist) to get help for personal problems? (√) ☐ Yes ☐ No

If you circled “yes” please complete 3b, 3c, and 3d below.

3b) What type of health professional(s) you’ve seen (e.g., School Counsellor, Counsellor, Psychologist, Psychiatrist).

3c) How many visits did you have with the health professional(s) _____

3d) How helpful was the visit to the mental health professional? (Please circle)

Extremely Unhelpful						Extremely Helpful
1	2	3	4		5	

Barriers to Adolescents Seeking Help-Brief Version (BASH-B)

DIRECTIONS:

Below are a number of statements relating to seeking help.

Read each statement carefully. Please express your honest opinion. The only ‘right’ answers are what you honestly feel or believe.

Circle the number that BEST describes how much you agree or disagree with each statement.

	Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree
1. If I had a problem, I would solve it myself	1	2	3	4	5	6
2. If I had a problem, my family would help me more than a therapist	1	2	3	4	5	6
3. Even if I wanted to, I wouldn't have time to see a therapist	1	2	3	4	5	6
4. If I had a problem and told a therapist, s/he would not keep it secret	1	2	3	4	5	6
5. A therapist might make me do or say something that I don't want to	1	2	3	4	5	6
6. I'd never want my family to know I was seeing a therapist	1	2	3	4	5	6
7. Even if I had a problem, I'd be too embarrassed to talk to a therapist about it	1	2	3	4	5	6
8. No matter what I do, it will not change the problems I have	1	2	3	4	5	6
9. If I went to a therapist, I might find out I was crazy	1	2	3	4	5	6
10. I could not afford to see a therapist even if I wanted to	1	2	3	4	5	6
11. I think I should work out my own problems.....	1	2	3	4	5	6

Social Problem Solving Inventory for Adolescents – short version (SPSI-A)

DIRECTIONS:

Below are statements that reflect how you respond to problems and how you think and feel about yourself afterward. You should think of **serious problems** that are related to your family, health, friends, school, and sports. You should also try to think about a serious problem that you had to solve recently as you reply to these statements.

Read each statement carefully. **Think about how you usually think, feel, and behave** when you face these types of problems. Circle the number that best describes how true the statement is of you.

	Not at All True of Me	Slightly True of Me	Moderately True of Me	Very True of Me	Extremely True of Me
1. When I have a problem, I think of the ways that I have handled the same kind of problem before.	0	1	2	3	4
2. To solve a problem, I do what has worked for me in the past.	0	1	2	3	4
3. When I solve a problem, I use the skills I have developed that have worked for me in the past.	0	1	2	3	4
4. When I can't solve a problem quickly and easily, I think that I am stupid.	0	1	2	3	4
5. I often doubt that there is a good way to solve problems that I have.	0	1	2	3	4
6. When faced with a hard problem, I believe that, if I try, I will be able to solve it on my own.	0	1	2	3	4
7. I feel afraid when I have an important problem to solve.	0	1	2	3	4
8. Complex problems make me Very angry or upset.	0	1	2	3	4
9. I often become sad and do not feel like doing anything when I have a problem to solve.	0	1	2	3	4
10. I put off solving a problem for as long as I can.	0	1	2	3	4
11. I avoid dealing with problems in my life.	0	1	2	3	4
12. I put off solving problems until it is too late to do anything about them.	0	1	2	3	4

Please turn over to continue the questions about responding to problems.

	<u>Not at All True of Me</u>	<u>Slightly True of Me</u>	<u>Moderately True of Me</u>	<u>Very True of Me</u>	<u>Extremely True of Me</u>
13. When I have a problem, I find out if it is part of a bigger problem that I should deal with.	0	1	2	3	4
14. I try to solve a complex problem by breaking it into smaller pieces that I can solve one at a time.	0	1	2	3	4
15. Before I solve a problem, I gather as many facts about the problem as I can.	0	1	2	3	4
16. When I solve a problem, I think of a number of options and combine them to make a better solution.	0	1	2	3	4
17. I try to think of as many ways to approach a problem as I can.	0	1	2	3	4
18. When I solve a problem, I think of as many options as I can until I can't think of any more.	0	1	2	3	4
19. When I decide which option is best, I predict what the outcome will be.	0	1	2	3	4
20. I weigh the outcomes for each of the options I can think of.	0	1	2	3	4
21. I think of the short-term and long-term outcomes of each option.	0	1	2	3	4
22. Before I try to solve a problem, I set a goal so I know what I want to achieve.	0	1	2	3	4
23. Before solving a problem, I practice my solution to increase my chances of success.	0	1	2	3	4
24. I write a specific objective down so I know how to solve my problem.	0	1	2	3	4
25. After solving a problem, I decide if the situation is better.	0	1	2	3	4
26. After I solve a problem, I decide if I feel better about the situation.	0	1	2	3	4
27. I often solve my problems and achieve my goals.	0	1	2	3	4
28. If the solution to a problem fails, I go back to the beginning and try again.	0	1	2	3	4
29. When a solution does not work, I try to determine what part of the process went wrong.	0	1	2	3	4
30. I go through the problem-solving process again when my first option fails.	0	1	2	3	4

i) REFERRAL & MANAGEMENT PRACTICES

Below are some statements about what you might do if you are working with a young person to try and convince them to seek help from a mental health professional. Circle the number that most closely describes what you currently do.

	1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
a) I would be willing to accompany a young person to their first appointment with a mental health professional	1	2	3	4	5
b) I would make a telephone call <u>with</u> the young person in order to schedule an appointment with a mental health professional	1	2	3	4	5
c) Identify and discuss the benefits of seeing a mental health professional	1	2	3	4	5
d) Inform the young person about any costs they might incur	1	2	3	4	5
e) Inform the young person about the need to share information with the mental health professional	1	2	3	4	5
f) Allow the young person to specify any information they do not want shared	1	2	3	4	5
g) Obtain and record the young person's consent to be referred	1	2	3	4	5
h) Develop a list of problems with the young person to specify their mental health needs and goals	1	2	3	4	5
i) Organise an appointment for the young person with a mental health professional	1	2	3	4	5
j) Discuss issues of confidentiality and any concerns that the young person might have about privacy in their mental health consultation	1	2	3	4	5
k) Let the young person know that they have a choice about whether they see a mental health professional or not	1	2	3	4	5
l) Let the young person know why I think that seeing a mental health professional might be helpful	1	2	3	4	5
m) Explain to the young person what is involved in their first visit with a mental health professional	1	2	3	4	5
n) Explain to the young person what the probable benefits and success rates are in seeing a mental health professional	1	2	3	4	5
o) Explain how long a visit with a mental health professional is likely to take	1	2	3	4	5
p) Let the young person know that even though they will be seeing a mental health professional, I will continue to be there for them	1	2	3	4	5
q) I might not be willing to refer a young person to a mental health professional because I don't think it will help	1	2	3	4	5
r) I might not be willing to refer a young person to a mental health professional because I think it will take too long to get an appointment	1	2	3	4	5

Below are some questions concerning young people. Please answer each question as accurately as you can.

ii) **ESTIMATES**

The following questions seek to ascertain the extent of youth mental health problems that you encounter in your work place. **Please circle the number that most closely reflects your situation.**

1. On average how many young people do you see in your workplace each day: _____
2. Estimate how many young people you have identified as being suicidal over the last 3 months: _____
3. Estimate how many young people you talk to each week about each of the following problems:
 - a) Difficulties managing emotions _____
 - b) Disturbing thoughts _____
 - c) Relationships _____
 - d) Drug/alcohol abuse _____
 - e) Problem behaviours _____
4. Estimate the percentage of young people who come to your workplace each week that you refer to other services for help with psychological difficulties: _____ %
5. Estimate the percentage of young people you see with mental health problems that you think are helped by seeing a health professional: _____ %
6. Estimate the percentage of young people you see with mental health problems that you think get better without help from a mental health professional: _____ %

APPENDIX B

Post-intervention materials

- 1) Letter to intervention group and information sheet
- 2) Letter to control group and information sheet
- 3) Consent form for intervention and control groups at Time 2
- 4) Knowledge questions at Time 2 only



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Email: iiMH@uow.edu.au
[Http://www.psyc.uow.edu.au/iimh/](http://www.psyc.uow.edu.au/iimh/)

April 12, 2001

Dear

This survey is to evaluate the Youth Empowerment Series (*YES!*) Workshops that you attended in October / November last year. You indicated at the workshops that you could be contacted and informed of the evaluation stage. There are two parts to the survey:

Part 1 will ask questions about your beliefs and practices about help seeking and referral. This part will take about 15-20 mins to complete.

Part 2 will ask questions on how much you remember from the workshops, what information was important to you, and how much of the information you have applied in your work with young people. This part will take about 5-10 mins to complete.

To start the survey you need to carefully read through the information sheet attached. If you decide to participate, please sign the consent form enclosed.

Your feedback is vital to finding out what information was useful to you, and to find out if you have used any of the strategies in your work with young people in the last five months.

Thank you for your time.

Yours sincerely,

Tania Cartmill
Researcher

Appropriate Help-Seeking and Youth Services

Information and Instruction Sheet 2

Who is running this study?

This research study is being run by Tania Cartmill, Coralie Wilson, and Professor Frank Deane as part of a larger project that is being funded by the National Health and Medical Research Council.

What is this study about?

- The first aim of this part of the Appropriate Help-Seeking and Youth Services study is to evaluate the YES! Workshops. We are interested in how much you remember from the workshops and how much information you have applied in your practices with youth.
- The second aim of this part of the study is to find out if the YES! Workshops have influenced your mental health or help-seeking.

Am I eligible to take part?

You are eligible to take part in this study if you are a Youth Worker.

What would I have to do?

If you agree to take part, you would need to:

- Complete the accompanying consent form,
- Complete the accompanying questionnaire. This will take approximately 30 minutes.
- Return the questionnaire and consent form by mail in the accompanying return-addressed envelope.

What can I expect from the researchers?

This study is voluntary. If you choose to take part in the study, you have the right to:

- Refuse to answer any particular question, and to withdraw from the study at any time,
- Ask any further questions about the study that occur to you during your participation,
- Be informed of the findings from the study when it has concluded, and
- Provide information on the understanding that it is completely confidential to the researchers. All records will be identified by a code number, and will be seen only by the researchers. It will not be possible for you or your Youth Centre to be identified in any reports that result from the study.
- The results will form part of a report to the NHMRC, will form a Doctor of Psychology thesis for Ms Cartmill, and may be published as a scholarly journal article. No individual participant will be identified in any reports.

It is important to emphasise that this study will not offer advice about your physical or mental health. If you have any concerns about your health, please contact a help-service listed in "The Frog".

If you have any questions about this research, please call Coralie Wilson, Tania Cartmill or Professor Frank Deane on Tel. (02) 4221-4523 during business hours or email at cwilson@uow.edu.au. They will explain any details of the study. If you have any questions regarding the conduct of this research please contact the secretary of the University of Wollongong Human Research Ethics Committee on (02) 4221-4457.

Tania Cartmill



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[Http://www.psyc.uow.edu.au/iimh/](http://www.psyc.uow.edu.au/iimh/)

April 12, 2001

Dear Youth Worker,

I am interested in your view of help-seeking practice, and your work with young people. Your feedback involves filling in the questionnaire attached.

This study is part of research run by the Illawarra Institute for Mental Health and Wollongong University, investigating the help-seeking practices of young people who are distressed or suicidal. This study is investigating your own view of mental health help-seeking practices, and your knowledge of help-seeking for youth mental health issues. There are two parts to the questionnaire.

Overall the questionnaire takes about 15-20 minutes to complete. Your assistance with this research would be appreciated.

If you do not wish to participate, please list your name in the space provided, and send the questionnaire back in the pre-paid envelope so I do not resend it to you.

Name: _____

To start the questionnaire, you need to read through the information sheet attached. If you decide to participate, please sign the consent form enclosed.

If you have any queries about the study, please contact me via the Illawarra Institute for Mental Health (ph) 4221 4207.

Thank you for your time.

Yours sincerely,

Tania Cartmill
Researcher

Appropriate Help-Seeking and Youth Services

Information and Instruction Sheet 3

Who is running this study?

This research study is being run by Tania Cartmill, Coralie Wilson, and Professor Frank Deane as part of a larger project that is being funded by the National Health and Medical Research Council.

What is this study about?

- The first aim of this study is to explore how Youth Worker's mental health and help-seeking barriers, intentions and behaviours contribute to young people's use of healthcare services when they are distressed or unhappy or when they experience suicidal thoughts.
- The second aim of this study find out about ways to increase and promote the use of helping services by young males. We are particularly interested in Youth Worker's current practices of youth need's assessment, problem identification, referral, assertive outreach, follow-up, and relationship building.

Am I eligible to take part?

You are eligible to take part in this study if you are a Youth Worker.

What would I have to do?

If you agree to take part, you would need to:

- Complete the accompanying consent form,
- Complete the accompanying questionnaire. This will take approximately 30 minutes.
- Return the questionnaire and consent form by mail in the accompanying return-addressed envelope.

What can I expect from the researchers?

This study is voluntary. If you choose to take part in the study, you have the right to:

- Refuse to answer any particular question, and to withdraw from the study at any time,
- Ask any further questions about the study that occur to you during your participation,
- Be informed of the findings from the study when it has concluded, and
- Provide information on the understanding that it is completely confidential to the researchers. All records will be identified by a code number, and will be seen only by the researchers. It will not be possible for you or your Youth Centre to be identified in any reports that result from the study.
- The results will form part of a report to the NHMRC, will form a Doctor of Psychology thesis for Ms Cartmill, and may be published as a scholarly journal article. No individual participant will be identified in any reports.

It is important to emphasise that this study will not offer advice about your physical or mental health. If you have any concerns about your health, please contact a help-service listed in "The Frog".

If you have any questions about this research, please call Coralie Wilson, Tania Cartmill or Prof. Frank Deane on Tel. (02) 4221-4523 during business hours or email at tkc02@uow.edu.au. They will explain any details of the study. If you have any questions regarding the conduct of this research please contact the secretary of the University of Wollongong Human Research Ethics Committee on (02) 4221-4457.

Tania Cartmill

(For the intervention and control groups at time 2)

Appropriate Help-Seeking and Youth Services

Consent Form 2

I have read the Information and Instruction Sheet for this study. I understand that I will be required to complete a questionnaire about my mental health and help-seeking.

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

I agree to provide information to the researcher on the understanding that it is completely confidential.

I understand that if I have any questions regarding the research I can contact Tania Cartmill, Coralie Wilson or Professor Frank Deane on (02) 4225-4523. Also, if I have any questions regarding the conduct of the research I can contact the secretary of the University of Wollongong Human Research Ethics Committee on (02) 4221-4457.

I wish to participate in this study under the conditions set out on the Information Sheet.

Name: _____

Signed: _____

Date: _____

Part 2: Knowledge questions

YES! Help-Seeking: Please tick

	YES	NO	Don't Know
Is an increase in a young person's emotional distress a barrier to them seeking help from a professional ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are a young person's peers generally able to give useful advice on where to seek help if the young person is in distress ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are young people more at risk of attempting suicide if they do not receive help?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can thoughts of suicide be stopped by seeking help?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The Theory of Planned Behaviour predicts that social pressure will influence help seeking ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you tell a young person not to worry about their distress, will that encourage them to seek help?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is it useful to explain to a young person that by recognising their feelings, this will help them identify a problem ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would you start helping a young person by asking them about their emotional problems? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When a young person is distressed, should you wait for them to come to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The Theory of Planned Behaviour indicates that the <u>immediate</u> cause for help seeking behaviour is a person's attitudes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please circle the response that BEST applies to you in the last 5 months.

	Never	Rarely	Some- times	Often	Very often
How often do you encourage help-seeking?	0	1	2	3	4
How often do you normalise a young person's distress ?	0	1	2	3	4
How often do you help a young person describe their problem in their terms ?	0	1	2	3	4
How often do you help a young person identify negative thoughts that may be acting as barriers to seeking appropriate help?	0	1	2	3	4

YES! Social-Problem Solving: Please tick

	YES	NO	Don't Know
In general, do young people who are distressed know how to use social problem solving skills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Should you talk about problems as a normal part of life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is 'problem orientation' the motivation to solve a problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the first task of problem solving to generate alternate solutions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When first problem solving with a young person, do you talk with them to form a relationship ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When defining a problem with a young person, is it important to help them gather as much information as possible?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is leaving the problem until later helpful for solving a problem in the end?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Should you point out to a young person what you think an effective solution to their problem would be?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is it useful to encourage the young person to do concrete activities to see if a solution is helpful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If a young person feels that a solution does not work for one problem, should you encourage them to move on to looking at a new problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please circle the response that BEST applies to you in the last 6 months

	Never	Rarely	Some-times	Often	Very often
How often do you encourage social problem solving?	0	1	2	3	4
How often do you help a young person to assess their motivation to solve a problem (including their thoughts, feelings and behaviours) ?	0	1	2	3	4
How often do you follow the four main problem solving steps (including definition, finding alternative solutions, decision making and solution implementation) ?	0	1	2	3	4
How often do you work with young people teaching them the skill of self monitoring their coping ?	0	1	2	3	4

YES! Adolescent Mental Health: Please tick

	YES	NO	Don't Know
Is a community gatekeeper a person who can help young people get appropriate help ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In general, are young people good at recognising and expressing their needs ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can aggression, stealing and using drugs be indicators of mental health needs ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are adults with depression more prone to being suicidal than young people with depression ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A young person starts to sweat, tremble, and feel their heart race - is it likely that they are depressed ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over the last 10 years have rates of young male suicide increased ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are poor social supports and alcohol misuse considered to increase risk for suicidal behaviour ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are aggression and agitation common indicators of stress ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you help a young person best by addressing all their needs at the one time ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Half of young sex abuse victims are in their mid teens when the first incident occurs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please circle the response that BEST applies to you in the <u>last 6 months</u>	Never	Rarely	Some-times	Often	Very often
How often do you actively try to recognise that a young person may need help for their problems?	0	1	2	3	4
How often do you refer a distressed young person on to appropriate professional help ?	0	1	2	3	4
How often do you use the ‘indicators of needs’ as a guide to approaching young people who may need help ?	0	1	2	3	4
How often do you explain to young people that professional psychological help may be the most appropriate form of help for their problem ?	0	1	2	3	4

APPENDIX C

Descriptive data for help-seeking and referral measures

- 1) Actual Help Seeking (AHSQ)
- 2) Barriers (BASH-B)
- 3) Social Problem Solving (SPSI-A)
- 4) Referral skill (YRS)

1) *Actual Help-Seeking (AHSQ)*

Percentages of youth workers’ actual help-seeking from different help sources.

Help sources	% Actual Help-Seeking	
	Intervention (n = 47)	Control (n = 26)
Intimate partner	48	59
Friend	52	66
Parent	13	25
Non-parent family member	20	39
Mental Health Professional	17	25
Phone Help-Line	2	8
Doctor/GP	24	37
Teacher	4	4
Religious leader	0	4
Youth Worker	7	4

2) Barriers (BASH-B)

Means (M) and standard deviations (SD) of barriers (BASH-B₁) to seeking help from a therapist for a mental health issue.

Barriers	M	SD
1. If I had a problem I would solve it myself	3.38	1.42
2. If I had a problem, my family would help more than a therapist	3.43	1.46
3. Even if I wanted to, I wouldn't have time to see a therapist	3.37	1.52
4. If I had a problem and told a therapist, s/he would not keep it a secret	3.01	1.99
5. A therapist might make me do or say something that I don't want to	3.12	1.95
6. I'd never want my family to know that I was seeing a therapist	3.13	1.58
7. Even if I had a problem, I'd be too embarrassed to talk to a therapist about it	3.03	1.63
8. No matter what I do, it will not change the problems that I have	3.18	1.96
9. If I went to a therapist, I might find out I was crazy	3.24	1.98
10. I could not afford to see a therapist even if I wanted to	3.41	1.64
11. I think I should work out my own problems	3.01	1.18

Note. N = 73. Evaluations were made on a 6 point scale (1 = “strongly disagree”, 6 = “strongly agree”). Lower scores reflect lower barriers.

¹BASH-B refers to the Barriers to Adolescents’ Seeking Help Brief version of the scale (Rickwood, Wilson, Deane & Ciarrochi, 2001).

3) *Social Problem Solving (SPSI-A)*

Means (M) and standard deviations (SD) for the Social Problem Solving Inventory (SPSI-A) short version, with subscales.

Social Problem Solving scales and subscales	M	SD
1. Automatic Process	2.63	.65
When I have a problem, I think of the ways that I have handled the same kind of problem before	2.76	.70
To solve a problem, I do what has worked for me in the past	2.22	.92
When I solve a problem I use the skills I have developed that have worked for me in the past	2.89	.83
2. Problem Orientation	2.99	.70
When I can't solve a problem quickly and easily I think that I am stupid	.78	1.05
I often doubt that there is a good way to solve the problems that have	.78	1.05
When faced with a hard problem I believe that if I try I will be able to solve it on my own	2.15	1.04
I feel afraid when I have an important problem to solve	1.11	.94
Complex problems make me very angry or upset	1.22	1.14
I often feel sad and do not feel like doing anything when I have a problem to solve	1.00	1.16
I put off solving a problem for as long as I can	1.04	1.17
I avoid dealing with problems in my life	.76	1.04
I put off solving problems until it is too late to do anything about them	.50	.82

3. Problem Solving Skill

	2.43	.68
When I have a problem I find out if it is part of a bigger problem that I should deal with		
	2.16	.98
I try to solve a complex problem by breaking it into smaller pieces that I can solve one at a time	2.53	.96
Before I solve a problem I gather as many facts about the problem as I can	2.71	.98
When I solve a problem I think of a number of options and combine them to make a better solution		
	2.46	1.03
I try to think of as many ways to approach a problem as I can	2.75	.89
When I solve a problem I think of as many options as I can until I can't think of any more	2.38	1.01
When I decide which option is best, I predict what the outcome will be		
	2.48	1.07
I weigh up the outcomes for each of the options I can think of	2.62	.96
I think of the short-term and long-term outcomes of each option	2.60	1.08
Before I try to solve a problem I set a goal so I know what I want to achieve	2.20	1.14
Before solving a problem I practice my solution to increase my chances of success	1.66	1.10
After solving a problem I decide if the situation is better	2.45	.81
After I solve a problem I decide if I feel better about the situation	2.56	.80
I often solve my problems and achieve my goals	2.61	.86
If the solution to a problem fails I go back to the beginning and try again	2.40	.99
When a solution does not work I try to determine what part of the process went wrong	2.64	.98
I go through the problem-solving process again when my first option fails	2.56	.96

Note: Sample sizes ranged from n = 73 to n = 64. Evaluations were made on 5 point scale (0 = "not at all true of me" to 4 = "extremely true of me"). Negative items are reversed so that each score can be interpreted as higher scores indicate more social problem solving skill.

4) Referral skill (YRS)

Means (M) and standard deviations (SD) of referral skill.

Referral skill	M	SD
1. I would be willing to accompany a young person to their first appointment with a mental health professional	4.08	1.04
2. I would make a telephone call with the young person in order to schedule an appointment with a mental health professional	4.32	.98
3. Identify and discuss the benefits of seeing a mental health professional	4.31	.76
4. Inform the young person of any costs that they may incur	4.18	1.13
5. Inform the young person about the need to share information with the mental health professional	4.17	.89
6. Allow the young person to specify any information they did not want shared	4.33	.86
7. Obtain and record the young person's consent to be referred	4.18	1.11
8. Develop a list of problems with the young person to specify their mental health needs and goals	3.35	1.07
9. Organise an appointment for the young person with a mental health professional	3.93	1.21
10. Discuss issues of confidentiality and any concerns that the young person might have about their privacy in the mental health consultation	4.33	.83
11. Let the young person know that they have a choice about whether they see a mental health professional or not	4.40	.84
12. Let the young person know why seeing a mental health professional might be useful	4.44	.76
13. Explain to the young person what is involved in their first visit with a mental health professional	4.13	.99
14. Explain to the young person what the probable benefits and success rates of seeing a mental health professional	3.74	1.15
15. Explain how long a visit with a mental health professional is likely to take	3.62	1.11
16. Let the young person know that even though they will be seeing a mental health professional, I will continue to be there for them	4.57	.59

17. I might not be willing to refer a young person to a mental health professional because I don't think it will help	2.16	1.50
18. I might not be willing to refer a young person to a mental health professional because I think it will take too long to get an appointment	1.82	1.30

Note. Sample sizes ranged from n = 62 to n = 59.
Evaluations were made on a 5 point scale (1 = “never” to 5 = “always”).