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**Parents' and adolescents' perceived influences
and barriers to mental health services**

A thesis presented in partial fulfilment of the requirements of the degree of
Doctor of Psychology (Clinical) at the University of Wollongong

Tim J. Wahlin

2007

Abstract

Many young people with mental health problems do not seek professional help and remain at risk of suicide and adult psychopathology. The present research investigates the barriers that impede the help seeking of parents and their children and the sources of influence that assist young people to access clinical services. Study 1 uses archival data from a recent survey of non-clinical samples of young people between 15-25 years of age who attended Technical and Further Education (TAFE) colleges ($n = 137$) or accessed neighbourhood centres ($n = 49$). Respondents completed measures of psychological distress, suicidal ideation, perceived help seeking barriers and intentions to seek professional help for personal-emotional problems and suicidal thoughts. In TAFE students, psychological and practical barriers were related to intentions to seek help for personal-emotional problems and thoughts of suicide. There was also a positive association between help seeking barriers and the level of suicidal ideation. In the youth centre sample, those in greater distress and therefore most in need, reported more obstacles to obtaining help. There was also evidence of help negation. Higher levels of suicidal ideation were associated with lower levels of intent to seek out professional help.

Study 2 examined the relative influence of parents and others on the decision of a young person to access professional help and the relative strength of the barriers faced by parents seeking help for their children. The sample comprised 122 parents and 131 adolescents who attended an initial clinical assessment interview with a Child and Adolescent Mental Health Service (CAMHS) in Sydney or the Illawarra region of New South Wales. Parents completed measures of help-seeking barriers and influences and the Strength and Difficulties Questionnaire (SDQ; Goodman, 1997). The adolescents completed a measure of help-seeking influences and the self-report SDQ (Goodman, Melzer, & Bailey, 1998).

Ninety-four percent of young people reported that others had influenced their decision to access help. Almost 87% were influenced by multiple sources but parents were the single strongest source of influence. Parents and children indicated that parents were more influential in the decision to seek help when there was greater disagreement between parent and child on the extent of the young person's overall and externalising difficulties on the SDQ. Positive relationships emerged between parent-rated influence

variables and parent scores on the Total Difficulties and Externalising SDQ scales. Youth-rated total and externalising difficulty scores were positively related to greater self-involvement in accessing help.

Parents rated the strongest barriers to accessing help as; help was too expensive, the wait was too long, not knowing where to get help, thinking that they could solve their child's problem without help and, their child not wanting help. The findings are consistent with contemporary process models that suggest help seeking is a social process and that young people in particular are highly dependent on parents to access help (Cauce et al., 2002; Logan & King, 2001). In addition, it highlights the need to better promote local services and in particular increase awareness that public services are no-fee. Providing parents and their adolescents with strategies for managing differences, in perceptions of problem severity, during the waiting period may reduce both the wait time barrier and effects of problem perception discrepancies on the social influence process.

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Overview

The Australian nationwide survey of mental health and well-being involving 4,500 children and adolescents from 4-17 years old, found a high prevalence of mental health problems among young people in Australia (Sawyer et al., 2000). However, only 52% of the children and adolescents who were experiencing serious mental health problems had attended any treatment in the preceding six months (Sawyer et al., 2000). There are clear risks associated with untreated mental health problems. First, there is evidence that psychopathology in adolescence increases the risk of having a psychiatric disorder as an adult (Hofstra, van der Ende, & Verhulst, 2001). Second, having mental health problems can significantly increase a person's risk of suicide. Psychological autopsy studies have consistently shown that 90% of suicide victims in all age groups have had a psychiatric disorder (see Brent, 1995; Gould & Kramer, 2001; Graham et al., 2000). Mood disorders in particular have been implicated as a risk factor for suicide (Graham et al., 2000).

Many young people who may benefit are not seen by clinical services. Therefore, attention must turn to improving our understanding of the processes by which young people do reach clinical care. The present research addresses this need in two related studies. The first study uses archival data from TAFE students and a potentially more marginalised sample of young people accessing neighbourhood youth centres. This study aims to extend past findings on help negation and investigate the impact of level of psychological distress and perceived barriers on the intentions of young people to seek out professional mental health care. The second study involves young people from a clinical population and their parents. The influence of parents and others on the decision of young people to access professional help and the practical and psychological barriers faced by parents seeking help for their child are examined.

The scope of mental health problems among young people

In the Australian survey of the mental health of young people, parent reports indicated that 14% of children and adolescents were suffering emotional and behavioural problems. Significantly, 19% of adolescents themselves revealed that they were experiencing mental health problems (Sawyer et al., 2000). A parallel survey of young Australian adults showed 27% of young people between 18-24 years of age endured at least one mental disorder in the past year (Andrews, Hall, Teesson, & Henderson 2001). Moreover, in line with other predominantly English-speaking countries in the world, suicide rates in Australia have risen dramatically in the past twenty years. Most striking has been the doubling of the rate of male suicides for 15-24 year olds, while the female rate for those of the same age has remained relatively steady (Mitchell, 2000). By 1998, suicide deaths of young men outnumbered those of young females by over four to one (Mitchell, 2000).

The problem is even more extensive when one considers the number of suicide attempts that do not end in death. Consistently, in Australian studies derived from hospital admissions, a ratio of suicide attempts to completed suicides of 9:1 has been found across all age groups, with the ratio 15:1 for those aged 15-24 years old (Graham, et al., 2000). The likelihood is that these admission figures underestimate the true rate of deliberate self-harm and attempted suicide among the young because those who do not reach hospital, are not included. Worryingly, as with others suffering mental health problems, many young people who attempt or die from suicide are unlikely to have been in recent contact with a mental health professional. For example, studies of adolescent suicides in the USA show that only 7 to 20% had received a mental health service in the previous 1-3 months (Brent, 1995).

Risk and protective factors in the development of mental health problems

Potentially, mental health problems may develop from an array of individual, family, interpersonal, socio-cultural and situational vulnerability factors. These factors can act to increase the risk that a disorder will occur and add to the burden of the disorder.

Conversely, protective factors may reduce the occurrence of mental health problems and work to ameliorate the possible debilitating effects of risk factors (Rutter, 1985). Many of these risk and protective factors commonly accepted as being probable influences on the development of mental health problems have become the focus of national strategies of health promotion, prevention, and early intervention in Australia (Commonwealth Department of Health and Aged Care, 2000; New South Wales Health, 2000). One of the central aims of the programs being implemented is to ensure that mental health services are available, accessible and utilised across the community. To make the structural changes necessary for this to happen, a population health approach (Raphael, 2002) has been adopted to target institutional barriers to equitable mental health service provision that operate at population, smaller community or individual levels.

While Government policy initiatives, changes to the infrastructure of service delivery, increased resources and a diversity of evidence-based clinical practices testify to the imperative of having mental health care available for young people, these “supply side” public health responses have not been sufficient. As shown, many young people with mental health problems do not obtain formal help. Clearly, there remains a compelling need to identify the factors that facilitate and impede the professional help seeking of young people.

Demographic influences on formal help seeking

Age

Past research has investigated the impact of the individual characteristics of age and gender on the help seeking of young people but the findings have been inconclusive. In Australia, the peak national health and welfare statistics and information agency defines the youth of Australia as being 12-24 years of age (Australian Institute of Health and Welfare, 2003). In this developmental period, a child makes the transition to early adolescence, negotiates adolescence and becomes a young adult, all amidst a maelstrom of change (Steinberg, 2005). There is considerable physical growth and change that accompanies puberty, a variety of changes in social status, and the young person develops

increasingly able and sophisticated, thinking and reasoning skills (e.g., see Holmbeck et al., 2000). In adolescence, the young person individuates from parents and family, expects greater behavioural autonomy and may assume increasing responsibility for help seeking tasks such as making their own doctor's appointments (Daddis & Smetana, 2005). Consistent with this common developmental trajectory of adolescence, there is evidence that suggests that the help seeking intentions and actions of young people differ with age (Deane, Wilson, Ciarrochi, & Rickwood, 2002; Rickwood & Braithwaite, 1994; Rickwood, Deane, Wilson, & Ciarrochi, 2005). In particular, girls have been found to increase their formal help seeking behaviour over their time at high school, as they reduce their dependence on their parents and family (Rickwood, et al., 2005). However, there is also contrary evidence that suggests that school year does not predict help seeking behaviours and that male and female patterns of help seeking are fixed prior to entering high school (Boldero & Fallon, 1995).

Gender

Nonetheless, there has been speculation that the formal help seeking of young males is affected by societal norms and culture which dictate that males must be tough, suppress their feelings and restrict their emotional expression (e.g., see Good & Sherrod, 2001; Rickwood & Braithwaite, 1994). Certainly, there is evidence that young men who hold traditional attitudes toward the male role and are emotionally restrictive have negative attitudes toward seeking psychological help. For example, young men with a traditional view of the male role are less likely than other young males to have sought formal help in the past or to have the intention to seek out professional help in the future (Good, Dell, & Mintz, 1989). Moreover, there is evidence that young female undergraduates (Oliver, Reed, Katz, & Haugh, 1999) and high school students (Schonert-Reichl & Muller, 1996) are more likely than their male counterparts are to talk to formal sources of help such as teachers, student counsellors and professional clinicians. However, Deane and others (2002) found that the intention of young people to seek help from professional sources was uniformly low, and that girls were no more likely than boys were to express the intention to seek formal sources of help when troubled by personal and emotional

problems. Similarly, Rickwood and Braithwaite (1994) report no effect for gender among Australian high school students who sought professional help for emotional problems. The inconsistent findings on gender trends in help seeking by young people may be related to studies not controlling for different rates of diagnoses between young males and females (Logan & King, 2001). However, in sum, the specific demographic characteristics of age and gender do not appear to account fully for the variability in the formal help seeking of the young.

Psychological distress and formal help seeking

In addition to demographic influences, the effect of psychological distress on help seeking has been investigated. The overall pattern of findings in non-clinical samples suggests that for the majority of young people, level of distress is related to the decision to seek formal help. There is evidence that university students with higher levels of internalised distress are more likely to turn to counsellors (Oliver et al., 1999) and that school students with more symptoms of distress are more likely to seek out mental health professionals than rely on informal sources of support (Rickwood & Braithwaite, 1994). Yet, there is also evidence that for many high school students having moderate to severe symptoms of distress (Rickwood & Braithwaite, 1994) or being “considerably distressed” (Boldero & Fallon, 1995) is not sufficient reason to look for any help. Moreover, Carlton and Deane (2000) found that in a high school population, level of psychological distress was not a unique predictor of help seeking intentions for either “personal-emotional” problems or suicidal thoughts. Of further concern is that there have been findings of a negative association between suicidal ideation and intentions to seek formal help amongst adolescents (Carlton & Deane, 2000; Saunders, Resnick, Hoberman & Blum, 1994). That is, as suicidal ideation increases, intentions to seek help for these suicidal thoughts decreases.

Help negation and formal help seeking

The refusal to accept or access available professional help when experiencing a suicidal crisis has been termed help negation (Rudd, Joiner & Rajab, 1995). There is evidence of help negation in clinical populations. Rudd and others (1995) found that of 188 young adults (18-26 years of age) referred for assessment and outpatient treatment for suicidal ideation or following a suicide attempt, 45 (24%) individuals withdrew before formally beginning treatment. Subsequent research has also found evidence of help negation in non-clinical samples of high school students (Carlton & Deane, 2000; Deane et al., 2002; Saunders et al., 1994), and tertiary students (Deane, Wilson & Ciarrochi, 2001). Clearly, refusing help carries grave risks for young people who are contemplating suicide. At lower levels of suicidal ideation, help negation has implications for the design and implementation of mental health education and suicide prevention programs. The findings suggest that programs must target and inform parents and student bodies that young people experiencing suicidal thoughts are potentially at risk of suicide and may need assistance in finding help. However, the help negation process has not been widely researched and remains poorly understood. Originally, theorists asserted that help negation arose from pessimism and hopelessness, and while there is some empirical support for this argument in clinical samples (Rudd et al., 1995), recent work suggests that neither these psychological factors nor the quality of prior help fully account for the help negation process in non-clinical samples (Deane et al., 2001). Help negation by young people at risk merits further research. To extend past findings, the current study investigates whether help negation is present among diverse non-clinical samples of young people.

Youth barriers to formal help seeking

Findings regarding help negation suggest that being in suicidal crisis impedes the help seeking of young people. Individual attitudinal and structural barriers may also restrain young people from looking for help (Barker, Olukoya, & Aggleton, 2005). A number of the help seeking barriers identified across studies broadly converge. For example, a

frequently cited barrier is the desire of young people to solve their own problems (Sawyer et al., 2000; Wilson & Deane, 2001; Wilson et al., 2002). Thirty-eight per cent of adolescents in the Australian National Survey of Mental Health and Wellbeing (NSMHWB) endorsed this barrier (Sawyer et al., 2000). Likewise, in an earlier study of rural adolescents in the USA who had mental health problems, between 75%-85% of the young people said that they could best handle the problem they were experiencing on their own (Dubow, Lovko & Kausch, 1990). Similarly, “thinking that nothing could help”, which was the second most endorsed youth barrier (18%) in the NSMHWB (Sawyer et al., 2000), replicated earlier findings (Dubow et al., 1990). Thinking that nothing could help was also often nominated as a barrier by high school students in focus groups (Wilson & Deane, 2001). Moreover, the item “nothing will change the problems I have”, on a self-report measure of help seeking barriers completed by a large sample of high school students had a strong inverse relationship with intentions to seek mental health assistance (Wilson et al., 2002).

In addition to the similar findings across studies, other barriers have been found using different measures. For example, the instrumental barrier of not knowing how or where to access mental health services was the third most frequently endorsed barrier (approximately 16%) by young people in the NSMHWB (Sawyer et al., 2000). Other barriers identified include embarrassment (e.g., Wilson et al., 2002), being afraid of what people might think (e.g., Sawyer et al., 2000) and concern that the problem was too personal to share with anyone (e.g., Dubow et al., 1990). However, while many barriers have been identified, there remains a need to explore the relationship between the level of psychological distress experienced by a young person and the barriers that inhibit formal help seeking, using measures consistent with past research.

Study 1:

Psychological distress, help negation and barriers to professional help

Study 1 involved students of Technical and Further Education (TAFE) Colleges and a small sample of young people accessing neighbourhood youth centres. A sample of TAFE students was approached because TAFE students potentially differ in interests and attributes from those attending university where many of the prior studies have been conducted (e.g., Deane et al., 2001). Those enrolled at universities pursue academically rigorous studies and often aspire to professional qualifications and careers. TAFE Colleges more often attract students interested in obtaining trade and vocational qualifications through apprenticeships and traineeships. These methods of training often mean that the young person leaves school earlier and enters the formal workforce at a younger age than students' first undertaking university studies. In addition to TAFE students, a sample of young people who accessed neighbourhood youth centres was also approached. Those attending TAFE colleges are in mainstream education and presumably mainstream society. When distressed, they have ready access and proximity to counselling staff that have referral links to general practitioners and specialist mental health clinicians. In contrast, the young people who "drop in" to youth centres have often "fallen through the cracks" and may be homeless, without family supports, and at risk of marginalisation (Burke & Evans, 2000; Keys Young, 1997). Consequently, they may live a life apart from their age peers in formal education or work, and outside the infrastructure of formal mental health care.

Aim

1. To extend past findings on the relationship between psychological distress, help negation and barriers to professional help seeking in high school and university students, to other non-clinical samples of young people.

Hypotheses

1. Barriers to help seeking and psychological distress will predict help seeking intentions for a personal emotional problem;
2. Barriers to help seeking and suicidal ideation will predict help seeking intentions for suicidal thoughts; and
3. There will be an inverse relationship between suicidal ideation and professional help seeking intentions for suicidal thoughts, consistent with the help negation relationship.

Method

Participants and procedures

The first study used archival data from two samples that had not been previously analysed. The samples were drawn from a cross-sectional survey of mental health help seeking in young people, conducted by Deane and others (2002). In the first sample, participants were 15-25 years old and attended a Technical and Further Education College (TAFE), in the Illawarra region of New South Wales. The TAFE sample comprised 137 students (96 males, 41 females) with an average age of 18.45 years ($SD = 2.18$ years). The responses of young adults over 25 years old were not included as the focus of the study was the professional help seeking intentions of youth. There were two TAFE colleges represented in the sample. Once permission was obtained from the Principal of the TAFE College, the researcher coordinated data collection, in collaboration with the Head of Counselling and the Head of Teaching. Respondents were recruited with the assistance of teachers at each college. First, teachers were approached and asked if they would be involved in the research. Teachers who agreed to assist received detailed information on the aims and procedures of the study and were instructed in how to introduce the research to their students. The teachers were asked to explain the nature of the study and that participation was voluntary and anonymous before distributing the study research pack to potential respondents. The research pack included an Information Sheet, Consent Form, study questionnaire, and Debrief Sheet together with two return envelopes (one for the completed Consent Form and one for the completed research questionnaire). Completed forms were returned in the sealed envelopes to the teachers and collected by the Head of Counselling and the researcher.

The second data set was a convenience sample of 49 young people (21 males, 28 females) who attended neighbourhood youth centres in the Illawarra region. The centres are administered by the city council and offer young people between 12-25 years access to sport and leisure activities. The centres attract a range of young people and while the centres are not specifically designed to provide health services, centre staff may provide an informal gate keeping function for those who may need help. Respondents ranged in

age from 13 to 25 years old. The average age was 17.8 years ($SD = 2.85$ years). The first step in finding respondents was to invite youth workers from youth centres to attend workshops that detailed the aims and procedures of the research. Youth workers who were willing to be involved in the study were then asked to recruit young people as participants. The youth workers received instructions in how to introduce the study and explain to potential subjects that participation was voluntary and anonymous, before giving young people the questionnaires to complete. Seven youth centres were represented in the sample but participation rates were low. Youth workers estimate that only 5%-10% of young people who were eligible to participate took part in the study.

Measures

The questionnaire used in the first study comprised three self-report scales: a shortened form of the Barriers to Adolescents Seeking Help Questionnaire (BASH; Kuhl, Jarkon-Horlick & Morrissey, 1997; the Hopkins Symptom Checklist-21 (HSCL-21; Green, Walkey, McCormick, & Taylor, 1988); and the Suicidal Ideation Questionnaire (SIQ; Reynolds, 1988). Four items that asked respondents about their professional help seeking intentions were also included. Participants were asked if they would seek help from doctors/general practitioners or mental health professionals, when experiencing personal emotional problems or having suicidal thoughts. These items were extracted from the General Help Seeking questionnaire (GHSQ; Deane, et al., 2001; Wilson, Deane, Ciarrochi & Rickwood, 2005).

Barriers to help seeking

A 12-item abbreviated version (BASH-B; Deane et al., 2002) of the original 37-item BASH questionnaire (Kuhl et al., 1997) was used. Statements on the self-report BASH-B were selected by eliminating redundant items from the longer scale and then choosing those that target barriers to seeking formal psychological help. Items on the BASH-B include, “I think I should work out my own problems”, “If I went to a therapist, I might find out I was crazy”, and “If I had a problem and told a therapist, they would not keep it

secret". Participants rated each item on a 6-point Likert scale (1 = "strongly agree", 6 = "strongly disagree") and items were scored so that higher scores reflect greater perceived barriers to help seeking. The BASH is internally consistent (Cronbach α = .91) and has good test-retest reliability (r = .91) (Kuhl et al., 1997). An abbreviated BASH scale comprising 11 of the 12 items used in the present study has also shown good internal consistency (Cronbach α = .83) (Wilson et al., 2005). In the present study, the Cronbach alpha coefficient of the BASH-B was .85 with TAFE students and .69 with youth centre respondents. There is evidence that supports the validity of the full scale BASH. In developing the BASH, Kuhl and colleagues (1997) found that lower BASH scores were associated with a prior or current history of treatment and a positive perception of help givers, such as teachers and school counsellors. Similarly, the finding by Wilson and others (2005) that BASH-B scores on the 11-item scale are negatively related to intentions to seek help from a mental health professional for suicidal ideation supports the validity of the BASH-B.

Psychological Distress

The HSCL-21 (Green et al., 1988) is a self-report symptom inventory used to assess the psychological distress experienced by respondents over the preceding seven days. The measure comprises 21 items from the Hopkins Symptom Checklist (Derogatis, Lipman, Rickels, Uhlenhuth & Covi, 1974). Items are rated on a 4-point scale from one (not at all) to four (extremely likely). The HSCL-21 has a stable and discrete three-factor structure, represented by the 7-item subscales of General Feelings of Distress (GFD), Somatic Distress (SD) and Performance Difficulty (PD) (Green et al., 1988). When all 21 items are summed, a Total Distress Score is obtained. The Total Distress Score was used in the present study of TAFE students and youth centre participants. Sound reliability and validity data support the use of the HSCL-21. The internal consistency of the HSCL-21 has been established with non-clinical (Cronbach α = .90; Green et al., 1988) and clinical samples (Cronbach α = .89; Deane, Leatham & Spicer, 1992). Deane and others (Deane et al., 1992) found that clients presenting to an outpatient psychology clinic scored higher on the HSCL-21 than subjects in a non-clinical sample which provides evidence of the

construct validity of the HSCL-21. The HSCL-21 also has good concurrent validity (Deane et al., 1992). Clients attending an outpatient clinic completed the HSCL-21 and the State-Trait Anxiety Inventory Form Y (STAI-Y; Spielberger, 1983) and there was a strong correlation between the scores on each measure. The Cronbach alpha reliability coefficient of the HSCL-21 in the present study was .92 with the TAFE sample and .92 for the youth centre sample.

Suicidal Ideation

The SIQ (Reynolds, 1988) is a 30-item self-report measure that assesses suicidal ideation. Each item is a specific thought about death or suicide (e.g., “I wished I was dead”, “I thought that killing myself would solve my problems”) that is scored on a seven-point scale (0 = I never had this thought before, 6 = Almost every day) to indicate how often that thought has occurred in the preceding month. Higher scores on the SIQ indicate more frequent suicidal ideation. The SIQ has shown good internal reliability when used with a non-clinical high school population (Cronbach α = .97; Reynolds, 1988; Mazza & Reynolds, 2001) and a clinical adolescent population (Cronbach α = .97; Pinto, Whisman & McCoy, 1997). There is evidence of adequate construct validity. The SIQ standardisation sample of non-clinical high school students obtained scores that were associated with measures of depression, hopelessness and learned helplessness (Reynolds, 1988; 1989; Mazza & Reynolds, 2001). In addition, Pinto and others (1997) have demonstrated the concurrent validity of the SIQ using contrasting groups (suicide attempters, suicide ideators and psychiatric controls) of adolescents hospitalised in a psychiatric unit. In the present study, the Cronbach alpha reliability coefficient of the SIQ was .98 with the TAFE sample, and .99 for the youth centre sample.

Help Seeking Intentions

The GHSQ (Deane et al., 2001; Wilson, Deane, Ciarrochi, & Rickwood, 2005) is a measure of current intentions to seek help. Different problem types and help sources can be targeted using a standard prompt (Wilson, Deane, Ciarrochi, & Rickwood, 2005). In

Study 1, the focus was on intentions to seek professional help for “personal emotional problems” and “suicidal thoughts”. The prompt structure was “If you were having a personal-emotional problem, how likely is it that you would seek help from the following people?” Participants were asked to rate their intention to seek help from doctors/general practitioners and mental health professionals, on a 7-point Likert scale (1 = extremely unlikely; 7 = extremely likely). Higher scores suggest a stronger intention to seek help. Responses to these two items were combined to form a mean rating of help seeking intentions from professional sources. For the problem prompt, “personal emotional problem”, the correlation and Cronbach alpha coefficients for the doctor and mental health professional items were $r = .61$ ($p < .001$) and $\alpha = .75$ for the TAFE sample and $r = .68$ ($p < .001$) and $\alpha = .81$ for the youth centre sample. While for the problem prompt, “suicidal thoughts”, the correlation and Cronbach alpha coefficients for the doctor and mental health professional items were $r = .68$ ($p < .001$) and $\alpha = .81$ for the TAFE sample, and $r = .50$ ($p < .001$) and $\alpha = .67$ for the youth centre sample.

Results

TAFE sample

Data screening

Scores on the BASH-B, HSCL, SIQ and items measuring professional help-seeking intentions for personal emotional problems and suicidal ideation were examined prior to analyses. Using SPSS programs, the accuracy of data entry, missing values and the fit between the distribution of scores and the assumptions of the multivariate analyses used were investigated. The sample comprised 137 TAFE students. Within this sample, only cases where 80% or more of the items on a scale were answered were included in analyses. To best represent individual respondents, the mean of the available items on each scale for each participant was used. Any case where less than 80% of the items on a scale had been answered was deleted from analyses of that variable. As a result, 21 cases (15.3%) were excluded from analyses involving suicidal ideation, 19 cases (13.9%) were omitted when psychological distress was subject to analyses, 11 (8.0%) when barriers to help seeking intentions were involved in analyses. Otherwise, 5 cases (3.6%) were excluded from analyses involving professional help seeking intentions when experiencing suicidal thoughts and 2 (1.5%) from analyses involving professional help seeking intentions when having personal emotional problems.

The psychological distress, suicidal ideation and intentions to seek professional help variables were not normally distributed, producing Kolmogorov-Smirnov statistics with Lilliefors significance levels below .05 (Coakes, Steed, & Dzidic, 2005). Each of these variables was positively skewed. That is, most participants had low levels of psychological distress, suicidal ideation and intention to seek professional help, as would be expected in nonclinical samples. A transformation of these variables was attempted but the original distributions were not substantially improved. Consequently, the original scores were used. Standard regression analyses were conducted and then a precautionary bootstrapping resampling was undertaken for each regression model because the distribution of variables departed from normality. Bootstrapping is a recommended

procedure for multivariate nonnormal data (e.g., see Byrne, 2001; Efron & Tibshirani, 1993; Zhu, 1997). With bootstrapping, the parent sample is assumed to represent the population and multiple subsamples are drawn randomly, with replacement, from this original sample. This generates data for the investigation of parameter estimates and regression models (Byrne, 2001; Efron & Tibshirani, 1993).

Data analysis

Table 1 presents the mean and standard deviation scores obtained by TAFE participants on each variable. The Cronbach alpha reliability coefficient is also noted for each scale used. As the focus of the research is on intentions to seek professional help, professional help-seeking intention variables were formed by combining responses to the single items that ask participants if they would seek help from doctors/general practitioners or mental health professionals when experiencing personal emotional problems (PHS-PE) or having suicidal thoughts (PHS-SUI).

Table 1.

Means, standard deviations and Cronbach alpha reliability coefficients for barriers (BASH), psychological distress (HSCL), suicidal ideation (SIQ), professional help seeking intentions for a personal-emotional problem (PHS-PE) and professional help seeking intentions for suicidal thoughts (PHS-SUI) in a TAFE sample

Variable	Mean	SD	α	n
BASH	3.55	.98	.85	126
HSCL	1.91	.66	.92	118
SIQ	.91	1.32	.98	116
PHS-PE	2.24	1.39	.75	135
PHS-SUI	2.34	1.66	.81	132

Two regression models were generated to examine data from the TAFE sample further. When intentions to seek help for personal-emotional problems was the dependent variable, the independent variables entered were the BASH and the HSCL. In the second equation, when intention to seek professional help for suicidal thoughts was the dependent variable, the independent variables were the BASH and the SIQ. Table 2 provides the intercorrelations between the variables in the first regression model. Among TAFE students, there was no significant relationship between psychological distress and intentions to seek professional help or between psychological distress and perceived barriers to seeking professional help. However, the more barriers to seeking help that were perceived by TAFE students, the less intent to seek out professional help. Table 2 also shows the standard multiple regression of barriers to help seeking and psychological distress variables on intentions to seek professional help when experiencing a personal-

emotional problem. The regression was significantly different from zero, $F(2,113) = 3.16$, $p = .05$, with barriers contributing to the prediction of professional help seeking intentions. However, the independent variables only explained 5% (4% adjusted) of the variance in intentions to seek professional help for personal emotional problems.

Table 2.

Correlations and standard multiple regression for barriers (BASH) and psychological distress (HSCL) variables on professional help seeking intentions for personal-emotional problems (PHS-PE) in a TAFE sample ($n = 116$)

Variables	BASH	HSCL	B	S. E. M.	Beta
1. PHS-PE (DV)	-.23**	-.03			
2. BASH	-	.14	-.30*	.12	-.23
3. HSCL		-	.00	.19	.00

* $p \leq 0.05$, ** $p \leq 0.01$ (one tailed).

R Square = .05 for personal emotional problem. Adjusted R Square = .04

Table 3 shows the intercorrelations between variables when help-seeking intentions for suicidal thoughts is the dependent variable. There is no significant relationship between levels of suicidal ideation and intentions to find professional help. However, more perceived barriers to seeking professional help are significantly associated with higher levels of suicidal ideation. Greater perceived help seeking barriers are also significantly related to fewer intentions to seek professional help. Table 3 provides the second regression model. The dependent variable is professional help seeking intentions for suicidal thoughts. The regression equation was significant $F(2,110) = 3.40$, $p = .04$, and barriers contributed to the prediction of intentions to seek help for suicidal thoughts but together the independent variables only accounted for 6% (4% adjusted) of the variance in professional help seeking intentions for suicidal thoughts.

To further test for the help negation effect, the mean help seeking intentions of those who scored in the highest quartile on the SIQ ($n = 29$, $M = 2.31$, $SD = 1.70$) were compared to those who had scored in the lowest quartile ($n = 33$, $M = 2.47$, $SD = 1.78$). However, there was not a significant difference between the groups, $t(60) = 0.36$, $p > .05$.

Table 3.

Correlations and standard multiple regression for barriers (BASH) and suicidal ideation (SIQ) variables on professional help seeking intentions for suicidal thoughts (PHS-SUI) in a TAFE sample (n = 113)

Variables	BASH	SIQ	B	S. E. M.	Beta
1. PHS-SUI (DV)	-.20*	.10			
2. BASH	-	.17*	-.37*	.16	-.22
3. SIQ		-	.17	.12	.14

*p ≤ 0.05,

R Square = .06 for suicidal thoughts. Adjusted R Square = .04

Youth centre sample

Data screening

A convenience sample of 49 young people who attended youth centres completed the same questionnaire as TAFE participants. As with the TAFE sample, the variables measuring intentions to seek professional help were formed by combining the single items on intentions to seek help from doctors/general practitioners and mental health practitioners, for personal emotional problems and suicidal thoughts. Only cases where 80% or more of the items on a scale were answered were subject to analyses and the mean of the available items on each scale for each respondent was used. Cases where less than 80% of the questions on a scale had been answered were not included in analyses of that variable. This resulted in 7 cases (14.3%) being omitted from analyses involving suicidal ideation, 5 cases (10.2%) being excluded when psychological distress was subject to analyses, and 5 cases (10.2%) when barriers to help seeking intentions was involved in analyses. While 6 cases (12.2%) were omitted from analyses involving professional help seeking intentions when experiencing suicidal thoughts, and 3 cases (6.1%) from analyses involving professional help seeking intentions when having personal emotional problems.

In the youth centre sample, the suicidal ideation and intentions to seek professional help variables were not normally distributed but positively skewed (Lilliefors significance <.05). This indicates that most youth centre participants reported low levels of suicidal ideation and intention to find professional help. The distribution of these variables could not be substantially improved with transformation and so the original scores were used. Standard regression analyses were undertaken and bootstrapping resampling was conducted for each regression model (Byrne, 2001; Efron, & Tibshirani, 1993). Table 4 shows the mean, standard deviation scores and reliability coefficients for the youth centre sample.

Table 4.
Means, standard deviations and Cronbach alpha reliability coefficients for barriers (BASH), psychological distress (HSCL), suicidal ideation (SIQ), professional help seeking intentions for a personal-emotional problem (PHS-PE) and professional help seeking intentions for suicidal thoughts (PHS-SUI) in a youth centre sample

Variable	Mean	SD	α	n
BASH	3.34	.80	.69	44
HSCL	1.70	.56	.92	44
SIQ	.59	1.25	.99	42
PHS-PE	2.15	1.55	.81	46
PHS-SUI	2.74	1.81	.67	43

Data analysis

Consistent with the TAFE analyses, two regression models were examined. In the first, the dependent variable was the intention to seek help for personal emotional problems, while the independent variables were the BASH and the HSCL. The intercorrelations between the variables in this equation are presented in Table 5. There is no significant association between professional help seeking intentions when experiencing personal emotional problems and either perceived barriers to help seeking or level of psychological distress. However, when more distressed, the young people from youth centres were significantly more likely to perceive more barriers to finding professional help. Table 5 also shows the standard multiple regression of barriers to help-seeking and psychological distress on professional help seeking intentions for youth centre respondents when experiencing personal emotional problems. The regression is not significantly different from zero, $F(2,40) = 1.40$, $p = .26$. The model explains 7% (2% adjusted) of the variance in intentions to seek professional help for personal emotional problems.

Table 5.

Correlations and standard multiple regression for barriers (BASH) and psychological distress (HSCL) variables on professional help seeking intentions for personal-emotional problems (PHS-PE) in a youth centre sample ($n = 43$)

Variables	BASH	HSCL	B	S. E. M.	Beta
1. PHS-PE (DV)	.07	.25			
2. BASH	-	.43**	-.10	.34	-.05
3. HSCL		-	.77	.48	.27

* $p \leq 0.05$, ** $p \leq 0.01$ (one tailed).

R Square = .07 for personal emotional problem. Adjusted R Square = .02

For the second regression equation, the dependent variable was professional help seeking intentions for suicidal thoughts and the independent variables were the BASH and the SIQ. The intercorrelations from this model are below in Table 6. Among the

youth centre respondents, there was no significant relationship between perceived barriers to seeking help and intentions to seek professional help when having suicidal thoughts. However, there was evidence of help negation. Higher levels of suicidal ideation were significantly associated with lower levels of intent to seek out professional help. Higher levels of suicidal ideation were also significantly related to more perceived barriers to help seeking. The regression model when the dependent variable was professional help seeking for suicidal thoughts is presented in Table 6. Again, the regression equation is not significantly different from zero, $F(2,34) = 1.55$, $p = .23$. It accounts for only 8% (3% adjusted) of the variance in intentions to seek professional help for suicidal thoughts.

Table 6.

Correlations and standard multiple regression for barriers (BASH) and suicidal ideation (SIQ) variables on professional help seeking intentions for suicidal thoughts (PHS-SUI) in a youth centre sample (n = 37)

Variables	BASH	SIQ	B	S. E. M.	Beta
1. PHS-SUI	-.21	-.28*			
2. BASH	-	.48***	-.21	.39	-.10
3. SIQ		-	-.36	.30	-.23

* $p \leq 0.05$, ** $p \leq 0.01$, *** $p \leq .001$ (one tailed).

R square = .08 for suicidal thoughts. Adjusted R Square = .03

Comparison of TAFE and Youth Centre samples

In an exploratory post hoc analysis, the mean scores of TAFE and youth centre participants on the variables of BASH, HSCL, SIQ and intentions to seek professional help for personal emotional problems or suicidal thoughts were compared. The Mann-Whitney U test for independent non-parametric samples was used. The two groups did not differ significantly on perceived barriers to help seeking ($Z = -1.20$, $p = .27$) or the degree of psychological distress experienced ($Z = -1.84$, $p = .07$). However, TAFE respondents did report significantly higher levels of suicidal ideation than their youth centre counterparts, $Z = -2.27$, $p = .02$. Although, there was not a corresponding

difference between the two groups on intentions to seek professional help when having suicidal thoughts, $Z = -1.54$, $p = .13$. Nor did the groups differ in intentions to seek professional help if having personal emotional problems, $Z = -.73$, $p = .47$.

Discussion

As expected, there was a significant relationship between barriers to seeking help and professional help seeking intentions for a personal-emotional problem for TAFE participants. When TAFE students perceived more barriers to finding professional help, they had less intention to seek the formal help of doctors/general practitioners and mental health professionals. However, the extent of the barriers perceived by TAFE respondents was not associated with their level of psychological distress. For TAFE students, barriers to help seeking contributed to the prediction of professional help seeking intentions for a personal emotional problem. Similarly, as hypothesised, barriers to seeking formal help predicted the professional help seeking intentions of TAFE students for suicidal thoughts. There was a negative association between perceived help seeking barriers and intentions to seek professional help. There was also a relationship between perceived barriers to finding help and the level of suicidal ideation reported. Students with higher levels of suicidal ideation perceived greater help seeking barriers. However, for TAFE students there was no evidence of help negation in that no significant association was found between levels of suicidal ideation and the intent to seek help for suicidal thoughts.

In contrast, for youth centre participants there was no significant relationship between perceived barriers to help seeking and the intention to find professional help, when experiencing a personal emotional problem or having suicidal thoughts. One explanation for this result might be that the young people who access youth centres have become skilled and accustomed at seeking help, as reflected in their capacity to attend a youth centre. Arguably, even more marginalised youths might not have the practical (e.g., transport) or social-emotional (e.g., shyness, anxiety) skills to access youth centres. However, in the youth centre sample, greater barriers to finding formal help were associated with higher levels of psychological distress. In addition, greater barriers to finding formal help were associated with higher levels of suicidal ideation.

The absence of a significant relationship between the level of distress reported by TAFE students and intentions to seek professional help for a personal emotional problem was an unanticipated result. As was the finding in the regression analyses, that level of psychological distress did not predict professional help seeking intentions. Past research

suggests that increasing levels of psychological distress gives impetus to the formal help seeking of high school students (e.g., Offer, Howard, Schonert, & Ostrov, 1991; Rickwood & Braithwaite, 1994) and university students (Oliver et al., 1999). For example, young people with moderate to severe psychological impairment (Rickwood & Braithwaite, 1994) and those who report a significant degree of emotional disturbance (Offer et al., 1991) have indicated they would turn to professional rather than informal sources for help. Therefore, one explanation for the lack of relationship between psychological distress and professional help seeking in the TAFE sample might be the relatively low level of overall distress experienced by most TAFE participants. Possibly, a distress threshold must be reached before professional help can even be contemplated. Although, when this hypothesis was explored further by comparing the help seeking intentions for a personal-emotional problem of those who reported distress levels in the highest quartile of scores on the HSCL-21 (PHS-PE; $M = 2.08$), with those who reported distress levels in the lowest quartile (PHS-PE; $M = 2.07$), the level of intentions for each group was almost identical. However, this finding may reflect the restricted range of scores on the HSCL-21. Another explanation might be that irrespective of the distress of the participants, a personal emotional problem was not the type of problem that TAFE students thought appropriate to take to a professional. There is evidence that high school students are significantly less likely to seek formal help for a personal emotional problem than for suicidal thoughts (Carlton & Deane, 2000). Moreover, as argued by Rickwood and Braithwaite (1994), many young people may believe that health professionals view the personal and emotional problems of the young, as simply a part of growing up.

Another unexpected result was that there was no evidence of help negation among TAFE students. One reason for such a finding might be that in this sample of TAFE students, the level of professional help seeking intentions was relatively low for personal emotional problems ($M = 2.24$) and suicidal thoughts ($M = 2.34$), which may have made it difficult to detect any help negation effect. Where help negation has been found in comparable non-clinical samples, there have been higher levels of intent to seek professional help. For example, university students have reported higher levels of professional help seeking intentions for personal emotional problems ($M = 2.68$) and suicidal thoughts ($M = 3.30$) (Deane et al., 2001). Possibly, TAFE students

characteristically differ from other young adults in their approach to help seeking. For example, it might be that the attitudes of TAFE students toward mental health services reflect that of those from lower socio-economic backgrounds. Alternatively, it might be that TAFE participants in the present study differ from other young people but as help negation has been a robust finding across other non-clinical samples (see e.g., Carlton & Deane, 2000, Wilson, Deane, & Ciarrochi, 2005) future investigation of the help seeking of TAFE students is warranted.

Limitations

Study 1 has several limitations. First, it is unclear how representative the samples in the study are of TAFE and youth centre populations. Indeed, as the participation rate from youth centres was low the youth centre sample may not be representative of those who attended the youth centres involved in the study. Participation was voluntary and possibly those who chose to be involved, viewed professional help seeking differently from non-respondents or were less distressed. Further, the youth centre sample was small and may not as anticipated represent more marginalised young people. As noted, those who participated from the neighbourhood youth centres have demonstrated their capacity to be connected with a support agency (youth centre) and this may well mean that they feel more confident or adept at accessing professional help.

An unexpected finding was the very low amount of variance in help seeking intentions (2%-4% adjusted) in both samples, that was explained by similar independent variables that in comparable previous research, using different populations, have accounted for 20%-40% of the variance in professional help seeking intentions (e.g., see Carlton & Deane, 2000). As noted, this may be due to relatively low intentions to seek help, particularly in the TAFE sample. TAFE students and those who attend youth centres might also be different from high school and university students with regard to the strength and types of beliefs that influence help seeking tendencies. To help clarify these issues further, future research could replicate the current study with different TAFE and youth centre samples.

Another limitation of the present research is that participants were asked to anticipate their intentions should they have a personal emotional problem or suicidal thoughts and there is evidence that help seeking intentions may differ from actual professional help seeking behaviour (Bayer & Peay, 1997). In addition, this study only uses youth self-report measures. No independently rated measures of psychological distress or suicidal ideation are used.

Implications and future directions

This study identifies the potential importance of perceived barriers to the professional help seeking of young people. The three main barriers endorsed were “If I had a problem, I would solve it myself; “I think I should work out my own problems; and “If I had a problem, my family would help me more than a therapist”. Respondents agreed or strongly agreed that these were barriers to help seeking. A possible way to attenuate these barriers, which are related to a belief in self-reliance, and the family, might be to advertise to young people that, at times, it is necessary to reach out for help.

Overall, barriers made a significant contribution to the prediction of professional help seeking intentions for TAFE students. When more barriers were perceived, the intention to seek help was less. Of particular concern, is that TAFE students and youth centre respondents with higher levels of suicidal ideation reported more barriers to accessing help. This suggests that young people in greater distress and greater need of help see more barriers on the pathway to professional help. Clearly, there is a need in future research to address what might enable young people in distress, to overcome help seeking barriers. Toward this end, Study 2 further extends the understanding of potential barriers to care by examining perceptions of barriers in parents who are assisting their adolescent children to access help. In addition, the influence of parents and others in facilitating help seeking from mental health services is explored.

Study 2:

Barriers to help seeking and parental influence on pathways to care

Traditional models of help seeking behaviour

In traditional adult-based models of health care utilisation, the emphasis is on the reasoned decision-making of the individual rather than on barriers or other environmental influences. For example, there are models that focus on the cognitive cues that determine an individual's decision to seek help (e.g., Fisher, Weiner, Abramowitz, 1983) or the actual help seeking behaviour, precipitated by a self-determined need for a health service (e.g., Anderson, 1995). In the Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980), a person's evaluation of the opinion of others toward help seeking is incorporated into the decision making process but it is not considered to be the primary determinant of the person's help seeking behaviour. In the TRA, attitudes toward a behaviour and the perceived social influence of others (subjective norms) are thought to shape a person's intentions of whether or not to perform that behaviour. Then, the person's intentions become the immediate determinant and best predictor of whether they carry out the behaviour. Attitudes toward the behaviour are believed to be the product of a person's evaluation of the worth of performing the behaviour while subjective norms relate to whether others who are important to the person would approve of the behaviour. The Theory of Planned Behaviour (TPB; Ajzen, 1991) is an adaptation of the TRA (Ajzen & Fishbein, 1980). Central to the TPB is that if people perceive that they have sufficient control over the planned behaviour (Perceived Behavioural Control) they will act in accordance with their intentions. However, the relative influence of perceived behavioural control, attitudes and subjective norms on intentions is thought to vary between individuals and across behavioural domains.

Contemporary models of help seeking behaviour

In contrast to earlier models, contemporary, dynamic models of health care utilisation place greater emphasis on the influences that may shape an individual's decision to seek

help. Help seeking is viewed as a protracted social process (Cauce et al., 2002; Pescosolido, Gardner & Lubell, 1998; Pescosolido & Boyer, 1999) involving the family, social networks and the community. However, to date, the extent of the influence has not been quantified. The work of Cusack and colleagues (2004) illustrates the importance of external influences on the decision of adults to seek formal help. They surveyed a sample of 70 Australian men who had recently attended or were currently attending outpatient psychological services and found that 96% of respondents made their decision to seek help after some influence by others (Cusack, Deane, Wilson & Ciarrochi, 2004). A majority of the men (64%) reported multiple sources of influence on their decision to seek help but intimate partners (60%) and general practitioners or other health professionals (55%) influenced more men to find help than did friends (43%) or parents and other relatives (42%).

Influence of parents and others on young people accessing professional help

The developmental goals in adolescence of greater autonomy, increased self-reliance and the development of peer relationships (Holmbeck et al, 2000; Steinberg, 2005) may inhibit self-initiated professional help seeking (Garland & Zigler, 1994; Logan & King, 2001). As noted, the desire of young people to solve their own problems or their tendency to turn to friends for help decreases the likelihood that they will seek formal help on their own. Moreover, adolescents may face practical barriers that constrain independent help seeking. For example, younger teenagers may be dependent on others for transport or not have their own Medicare card or the funds to access help. Conceivably, parents, relatives, friends, the school system and general practitioners play an important role in obtaining formal help for adolescents with psychological problems. Consistent with contemporary process models of help seeking, Logan and King (2001) have proposed a model of a parent-mediated pathway to mental health services for young people. The model incorporates the potential role of others in facilitating help for distressed young people but assumes that parents are most influential in the decision of adolescents to accept formal help. Following the work of Prochaska and colleagues (Prochaska, Redding & Evers, 1997), the model proposes a contemplation stage, in which parents develop an

awareness of a young person's distress, recognise the psychological nature of the problem and consider alternative courses of action. This is followed by the action stage, when parents develop an intention to seek formal help, attempt to find clinical services and then obtain professional help for their child (Logan & King, 2001).

Logan and King (2001) acknowledge that parental help seeking may not be straightforward. At each step in the contemplation and action stages, the model recognises that other factors (such as barriers) may affect a parent's progress toward accessing services for their child. Indeed, an initial barrier may be a parent's perception of their child's problem. Many parents of children with mental health disorders do not perceive a problem (Sayal, 2006; Teagle, 2002). Moreover, there is evidence of a public perception that adolescence is typically a time of turmoil. Studies have found that parents agree that, "early adolescence is a difficult time of life for children and their parents" (Buchanan et al., 1990) and consider that adolescents are more likely than younger children to have emotional difficulties (Buchanan & Holmbeck, 1998).

Past research suggests that parental recognition of child psychological difficulties is related to the nature of the disorder, the severity of the child's symptoms and impairment, and the consequent burden that parents experience (Angold et al., 1998; Logan & King, 2001; 2002; Sayal, 2006; Teagle, 2002). As Logan and King (2001) note, the manifest symptoms of externalising disorders are likely to be noticeable and have an impact on parents. In contrast, the internalised symptoms of disorders such as depression or anxiety may be more difficult for parents to recognise in their children and be less burdensome (Angold et al., 1998; Logan & King, 2002).

There is evidence that parental recognition and perceived burden of a child's problems predicts parent-initiated service seeking for children (Angold, et al., 1998; Teagle, 2002), which suggests that parents influence the help seeking of young people. For example, in a large-scale longitudinal study of the development of psychiatric disorder and service utilisation among children 9-13 years, Angold and colleagues (1998) found that parental burden associated with child symptoms and functional impairment predicted specialty mental health service use. Conversely, if no parental burden was reported, fewer than 2% of children with a diagnosis or impairment accessed a clinical service (Angold et al., 1998). However, there is no data on the relative influence of

parents and others on young people seeking help. For young people in conflict with parents and family or those young people who are more self reliant and peer oriented, significant people outside the family may be most influential in the young person's decision to access clinical services. While adult men were influenced to seek formal help by trusted and knowledgeable general practitioners and health professionals (Cusack et al., 2004), it is likely that young people are more influenced by parents and other sources such as friends, teachers and school counsellors.

Parent influence and parent-child disagreement

Problem type

The level of parent influence necessary to have a young person attend a clinical service is likely to be related to the extent to which parent and child agree about the nature and severity of the child's problems. Arguably, young people who acknowledge difficulties will respond more readily to parent initiated attempts to access help and require less coercion. To date, a common finding has been that parent and youth ratings of the social, emotional and behavioural problems in young people are discrepant (see reviews: Achenbach, McConaughy, & Howell, 1987; De Los Reyes & Kazdin, 2005). As noted by Yeh and Weisz (2001), structured diagnostic interviews have shown limited parent-child agreement on whether children have emotional or behavioural problems (Herjanic & Reich, 1997; Tarullo, Richardson, Radke-Yarrow & Martinez, 1995). While studies using emotion and behaviour checklists have found only a modest relationship between the reports of adults and young people (Achenbach et al., 1987; Phares, Compas, & Howell, 1989; Yeh & Weisz, 2001). Indeed, there is often disagreement on whether problems even exist. For example, in an outpatient clinic population of 381 parent-child pairs, Yeh and Weisz (2001) found that 63% could not agree on a single problem and that even when problems were more broadly categorised, over 33% of the parent-child pairs still could not agree on a problem area.

Past research suggests that parent-child agreement on problems in children is associated with problem type. There is evidence teenagers are less likely than their

parents to report externalising behaviour (e.g., Youngstrom, Loeber, & Stouthamer-Loeber, 2000) but overall there is greater agreement on observable or externalising problems in children, such as oppositional behaviour or hyperactivity, than problems like anxiety or depression (e.g., Achenbach et al., 1987; De Los Reyes & Kazdin, 2005). Of concern, are the findings that in comparison to externalising behaviour, parents are poor at recognising emotional problems in their children (Kolko & Kazdin, 1993; Sourander, Helstelä & Helenius, 1999). It may be that young people do not discuss “personal” or emotional issues, and parents are unaware of their child’s problems, or have a different view of the symptoms that are manifest (Sourander, et al., 1999; Wisdom, Clarke, & Green, 2006). Alternatively, parents may overlook internalising disorders such as anxiety and depression because the impact on others is less than externalising problems (Wisdom et al., 2006; Wu, et al., 1999).

The available evidence on the relationships between child problem type, parent and child problem recognition, and help seeking is mixed (see review: Zwaanswijk, Verhaak, Bensing, van der Ende, & Verhulst, 2003). Epidemiological studies that have relied on parent and child rated measures of child psychopathology have found no differential effects for externalising and internalising problems on service use (Sourander, et al., 2001; Verhulst & van der Ende, 1997). While, Wu and others (1999) who interviewed 1285 parent-child (9-17 years) pairs in a community sample, found that externalising problems were significantly related to children’s use of mental health services but depressive disorders were not. In the same study, parents reported a greater need for mental health services for young people with externalising disorders than for those with depression. In contrast, the children saw a greater need for services for depression (Wu et al., 1999).

Psychological distress

The findings of Wu and colleagues (1999) support the hypothesis that parents are influential in children attending mental health services and suggest too, that parent rather than child perceptions of the need for help, determine if help is sought. As shown, many young people do not seek formal help when moderately or even seriously distressed

(Rickwood & Braithwaite, 1994; Saunders et al., 1994). Yet, young people who acknowledge the need for help when experiencing greater symptoms of distress recognise the need for professional help, rather than the assistance of friends (Rickwood & Braithwaite, 1994). It may be that these young people would be amenable to seeing a clinician if parents facilitated it but if parents have a different view of their child's symptoms this would likely prove a barrier to the young person accessing professional help (Wu et al., 1999). In contrast, young people with externalising problems are not likely to be distressed to the same extent by their behaviour, as their parents. Parent and child might agree on the nature of the child's problems but not the need for help. If this is the case, parent influence or the influence of others is likely to be necessary before the young person accesses help.

Researchers have recommended further work on the role of parent perceptions in determining help seeking decisions (Sayal, 2006). The present study seeks to explore the relationships between parent and child perceptions of child problems and distress, and parent influence in the help seeking process.

Parent perceived barriers to professional help for young people

In the model of a parent-mediated pathway to clinical services for adolescents, parents make the decision to find help for their child and then initiate help seeking action (Logan & King, 2001). However, before accessing help, parents must overcome perceived practical or structural barriers such as, long waiting times, and not knowing where to go for services. Attitudinal barriers about mental health services (e.g. child not wanting help, stigma of using professional help) and mental health problems (e.g., belief that problem does not need treatment) may also impede parent help seeking (Owens, et al., 2002; Sawyer et al., 2000).

Table 7 presents comparative data from a sample of studies, on the barriers to professional help reported by young people, adults and parents of children with identified mental health problems. Few studies have directly asked parents about perceived barriers to mental health services for children (Kerkorian, McKay, & Bannon, 2006). The findings from two of these studies are included in Table 7. The structural and attitudinal

barriers listed are drawn from the child and adolescent component of the Australian National Survey of Mental Health and Wellbeing (NSMHWB; Sawyer et al., 2000). Some of the studies did not include an equivalent barrier for each of the barriers in the national survey. Barriers present in other studies, but not specified in the Australian survey, have been grouped with “other reasons”.

Table 7.

Barriers to accessing mental health services identified by young people, adults and parents with mental health problems in selected community and clinical samples

Help seeking barriers ⁺	% Identified as Barrier ⁺⁺					
	Young People		Adults		Parents	
	1 ^a	2 ^a	3 ^a	4 ^b	5 ^a	6 ^a
<i>Structural</i>						
Wait for help too long	0.0	-	1.9	-	38.0	6.0
Help too expensive	-	52.0	2.6	1.2	50.0	10.3
Didn't know where to get help	17.0	29.0	3.3	12.0	50.0	15.5
Asked for help but didn't get it	0.0	2.0	-	-	42.0	-
Thought services too far away	0.0	10.0	1.4	-	23.0	6.9
<i>Perception of Service</i>						
Afraid of what people think	14.0	5.5	3.7	12.7	6.0	2.6
Treatment would not help	18.0	7.0	2.5	17.3	21.0	5.2
I/Child did not want help	-	-	-	-	25.0	10.3
<i>Perception of Problem</i>						
Solve my/child problem on own	38.0	21.0	6.6	11.6	46.0	17.2
Problem would resolve itself	-	-	-	27.2	2.0	20.7
<i>Other reasons</i>	10.0	17.0	10.4	18.0	18.0	50.8

Note: ⁺Barriers from National Survey of Mental Health and Wellbeing (NSMHWB; Sawyer et al., 2000) Equivalent barriers not present in all studies; ⁺⁺Percentage of sample identified as barrier; ^a Community, ^b Clinic sample

1. Young people (13-17 years), (n = 4,700; 4-17 years) Interview; Mental health problems; Not using clinical services: Multiple barriers assigned (NSMHWB; Sawyer et al., 2000).
2. Young people (15-17 years), (n = 254) Questionnaire; Use by some of clinical services prior 12 months Any barriers to psychologist/psychiatrist from 9 alternatives (Sheffield, Fiorenza, & Sofronoff, 2004)
3. Older youth and adults (over 15 years), (n = 4094) Interview; Depressive, anxiety or substance related disorders; No service use; Forced choice of 13 alternative barriers (Wang, 2006)
4. Adults (18-77 years), (n = 174) Questionnaire; Anxiety and/or mood disorders; Clinic sample; Forced choice of 9 alternative barriers (Thompson, Hunt, Issakidis, 2004)
5. Parents (n = 4,500) of young people (4-17 years) with mental health problems; Interview; Not attending services Multiple barriers assigned (NSMHWB; Sawyer et al., 2000)
6. Parents (n = 116) of children (Year 7); Interview; Mental health problems; Not attending services; Any barriers to services from 15 alternative barriers (Owens, et al., 2002).

Table 7 suggests that practical reasons prevented most parents in the NSMHWB from accessing a mental health service for their child. Many parents (46%) also believed that they “could handle the problem alone”. Another common reason was that their “child did not want to attend” (25%) which is consistent with the view that parent influence is necessary for many young people to reach professional help (Sawyer et al., 2000). Of interest, is that American parents of children with mental health problems (Owens, et al., 2002), did not report practical barriers to help seeking to the same extent as the Australian parents in the NSMHWB (Sawyer et al., 2000). Surprisingly, in Australia where government funded help is available at no cost, through community based child and adolescent mental health services, 50% of parents surveyed said help was too expensive. In contrast, only 10% of American parents saw professional help as too expensive. Moreover, Australian parents (21%) were relatively pessimistic about the value of professional help in comparison to American parents (5%) (Owens, et al., 2002; Sawyer et al., 2000).

Knowing the obstacles that deter parents from seeking help is an important first step but there is also a need to clarify the relative impact of specific barriers on parents. The Australian survey allowed parents to nominate more than one reason for why they did not seek help. Parents were not asked to rate the extent to which each barrier was an impediment to help seeking (Sawyer et al., 2000). Owens and others (2002) used a similar method, with parents able to endorse multiple barriers from 15 specified alternatives. To clarify and extend past findings, the present research asks parents who have accessed adolescent mental health services to rate the degree to which each of the barriers identified in the NSMHWB affected their decision to access a clinical service for their child.

Aims

- 1 To examine the relative influence of parents and others on the decision of young people to accept formal help.
- 2 To investigate the relationship between the level of difficulties and the nature of psychological problems experienced by young people who attend a clinical service and the degree of influence necessary to have young people access professional help.
- 3 To examine the relative impact of the barriers that parents face in facilitating access to mental health care for their children.

Hypotheses

- 1 Young people will endorse parents as the strongest source of influence on their decision to access clinical services.
- 2 When parents perceive the young person's problems as more severe than the young person does, the greater the disagreement between parent-perceived difficulties and self-reported difficulties, the higher the parent and child ratings of parental influence to access clinical services.
- 3 When parents perceive the young person's problems as less severe than the young person does, the greater the disagreement between parent-perceived difficulties and self-reported difficulties, the lower the parent and child ratings of parental influence to access clinical services.
- 4 The more that parents perceive their child as having externalising difficulties, the higher the parent and child ratings of parental influence to access clinical services.

Method

Ethical considerations

The University of Wollongong, Human Research Ethics Committee (HREC) provided separate ethical reviews of Study 1 and Study 2. Before proceeding with the second study, ethical approval was received from the University of Wollongong, HREC and the New South Wales Department of Health ethics committees responsible for overseeing clinical research in the two Child and Adolescent Mental Health Services involved in the study. The committees were the Northern Sydney Area Health Service, HREC and the Illawarra Area Health Service, HREC. To minimise the impact on the clients and staff of each participating Child and Adolescent Mental Health Service (CAMHS), the research procedures of the study were designed to fit within the standard intake practices of the CAMHS teams. The research design also addressed a number of necessary ethical considerations. Paramount was the need to ensure that participation was voluntary and only undertaken after being informed of the nature of the study. Young people under 14 years of age were excluded from the study because they were thought to be less likely to be able to give fully informed consent. Another ethical imperative was to ensure that potential participants understood that data for the study would be obtained not only from a specific research questionnaire but also from a standard assessment measure used routinely by the CAMHS. A third ethical consideration was the need to maintain the confidentiality of the responses of participants on the questionnaires used in the research. At the request of the Northern Sydney Area Health Service HREC, the anonymity of clients from the Sydney CAMHS who participated was maintained.

Participants

The sample comprised 122 parents, 7 other adult relatives and 131 young people (84 females, 47 males) from 139 families who attended an initial clinical assessment interview with a CAMHS in Sydney (72 parents, 81 young people) or the CAMHS in the Illawarra region of New South Wales (50 parents, 50 young people). Eight parents

(Sydney CAMHS = 2, Illawarra CAMHS = 6) who attended for an interview chose to be involved in the study but their children declined to participate. Similarly, 10 young people (Sydney CAMHS = 5, Illawarra CAMHS = 5) whose parents did not participate, volunteered for the study. An adult relative other than a parent accompanied seven participating young people (Sydney CAMHS = 6, Illawarra CAMHS = 1). In each case, the adult relative agreed to complete the parent questionnaire. The age range of the total youth sample was 14-18 years of age and the average age was 15.50 years. From the consecutive, new and eligible client families of the Sydney CAMHS, 51.6% of parents and 53.7% of young people participated in the research. Of those families who attended an initial clinical interview with the Illawarra CAMHS, 47.6% of parents and young people attending their visit during the study period, volunteered for the study.

Procedures

The Sydney and Illawarra CAMHS teams notify all newly referred clients of their initial appointment by mail. The timing of the consultation depends on the urgency of the presenting problem and the availability of clinicians. In the data collection period, the first interview was generally offered within 4-6 weeks of a young person's referral to the team. The standard letter from each of the CAMHS teams, notifying new clients of their appointment, was modified to include a reference to the parent and youth research questionnaires accompanying the Strength and Difficulties Questionnaires (SDQ; Goodman, 1997). The parent and youth Strength and Difficulties Questionnaires form part of the standard outcome assessment procedures for NSW State CAMHS and are routinely sent to all CAMHS clients. In the same package, eligible clients of each CAMHS received parent and youth information sheets (see Appendix II), which detailed the auspice and nature of the study and stated that participation was voluntary. Clients who did not wish to take part in the study were made aware in the information sheet that their decision would not affect the service they received. The information sheets posted to Sydney CAMHS clients also informed potential participants that the study was anonymous but that consent to use the information supplied on the research questionnaire and the SDQ was implied if the research questionnaire was completed. Parent and youth

consent forms were sent to Illawarra CAMHS clients. All parent and youth research questionnaire sets were coded, which ensured that when anonymous data was received from families it could be matched appropriately.

Prior to data collection commencing, the 19 clinicians in the Sydney CAMHS were approached and told individually of the aims, objectives and procedures of the research. All clinicians agreed to collect data and were prepared to answer any questions raised by clients about the study. To maintain the anonymity of participants, the clinicians on the Sydney CAMHS team agreed to make copies of the SDQ, after deleting any identifying information, and to store these copies with the corresponding research questionnaires, until collected by the researcher. In the information sheets sent to clients of the Illawarra CAMHS, any one who had questions about the research was invited to contact the researcher. Clients of the Illawarra CAMHS who participated were also asked in the information sheet to return the completed consent form, research questionnaire and SDQ when they attended for their initial consultation interview. These forms were then stored until collected by the researcher.

Measures

The parent questionnaire (see Appendix II) comprised two self-report scales: the Strength and Difficulties Questionnaire for parents of adolescents 11-17 years of age (SDQ; Goodman, 1997) and the Parent Help-Seeking Barriers and Influences Questionnaire (HSBIQ-P) specifically designed for the study. The youth questionnaire (see Appendix II) consisted of the self-report SDQ for adolescents 11-17 years old (Goodman, Melzer, & Bailey, 1998) and the Youth Help-Seeking Influences Questionnaire (HSIQ-Y) adapted from the Help-Seeking Influences Questionnaire (HSIQ; Cusack et al., 2004).

Parent measures

Strength and Difficulties Questionnaire.

The SDQ (Goodman, 1997) is a brief behavioural screening questionnaire that assesses the adjustment and psychopathology of young people (11-17 years) in the preceding 6 months. There are near identical parental and youth self-report versions of the SDQ (Goodman et al., 1998). The 25 core items of the parent SDQ provide scores on five scales comprising five items each. The items depict specific behavioural, emotional or relationship-oriented attributes that were chosen to reflect the nosological concepts that underlie current classifications of psychopathology in children (i.e. Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV), American Psychiatric Association, 1994; and the ICD-10, World Health Organisation, 1994). The items were also determined by factor analyses (Goodman & Scott, 1999). The scales are Emotional Symptoms, Conduct Problems, Hyperactivity-Inattention, Peer Problems and Prosocial Behaviour. Sample items from each scale are “Often complains of headaches, stomach-aches, or sickness” (Emotional Symptoms scale); “Often loses temper” (Conduct Problems scale); “Easily distracted, concentration wavers” (Hyperactivity-Inattention scale); “Picked on or bullied by other young people” (Peer Problems scale); and “Kind to younger children” (Prosocial Behaviour scale). Respondents rate the extent to which each attribute applies to their child on a 3-point Likert scale (0 = not true; 1 = somewhat true; 2 = certainly true). One item on the Conduct Problems scale, two items on the Peer Problems scale and two items on the Hyperactivity- Inattention scale are reverse scored. A Total Difficulties score is obtained by summing scores on the four scales of negative attributes. Responses on the Prosocial Behaviour scale are not included in the Total Difficulties score. Higher Total Difficulties scores indicate greater difficulties in psychological adjustment. While higher combined scores on the Conduct Problems and Hyperactivity-Inattention scales suggest externalising problems (Goodman, 2001; Goodman & Scott, 1999). Higher scores on the Emotional Symptoms scale indicate greater internalising problems (Goodman, 2001; Goodman & Scott, 1999).

An extended version of the parent SDQ that included the 25 core items and eight supplementary “impact” questions was used. The impact items first enquire about whether parents think that their “Child has difficulties in any of the following areas: emotions, concentration, behaviour or being able to get along with people”. This Perceived Difficulties item is scored on a 4-point Likert scale (0 = No; 3 = Yes-severe difficulties). Parents who believe that their child has difficulties are then asked to indicate how long these difficulties have been present (Chronicity) and rate the child’s resultant distress (“Do the difficulties upset or distress your child?”) and impairment in home life, friendships, classroom learning and leisure activities. The final item on the impact supplement asks parents “Do the difficulties put a burden on you or the family as a whole?” Parents indicate the chronicity of the perceived difficulties on a 4-point scale (1 = less than a month; 4 = Over a year). The distress item, the four social incapacity items and the burden question are scored on a different 4-point Likert scale (0 = Not at all; 4 = A great deal). When summed, the distress and four social incapacity items provide an Impact score that can range from 0-15.

As shown in a nationwide British epidemiological sample of ($n = 10,438$) 5-15 year old children, the internal reliability of the individual scales on the extended parent SDQ scales are satisfactory (mean $\alpha = .72$), and the composite Total Difficulties ($\alpha = .82$) and Impact scales ($\alpha = .85$) have good internal consistency (Goodman, 2001). The concurrent validity of the standard parent rated SDQ with 25 core items has also been established. There is evidence of a high correlation between the Total Difficulties score on the SDQ and total scores on the comparable, Rutter questionnaire (Elander & Rutter, 1996; Goodman, 1997) and the Child Behaviour Checklist (CBCL; Achenbach, 1991; Goodman & Scott, 1999). There is also evidence of moderate to high agreement between clinician and SDQ generated diagnoses of Hyperactivity disorder (Kendall’s tau-b = .44, $p < .001$), Conduct disorder (Kendall’s tau-b = .56, $p < .001$) and Emotional disorder (Kendall’s tau-b = .39, $p < .001$) in an Australian study of consecutive, new referrals, aged 4-15 years, to an Australian community CAMHS (Mathai, Anderson & Bourne, 2004). Moreover, the epidemiological study by Goodman (2001) demonstrates the predictive validity of the extended parent SDQ. Children who received parent rated SDQ scale scores above the 90th percentile had an increased probability of being independently

diagnosed with a psychiatric disorder (Goodman, 2001). Another validation study has shown that the measures of Perceived Difficulties, Impact and Burden on the extended parent rated SDQ, can discriminate between 5-15 year olds from a community sample and those from a psychiatric clinic sample (Goodman, 1999). The Burden rating derived from a single item on the extended SDQ also correlates well with an interview rating of burden based on the Child and Adolescent Burden Assessment (CABA; Messer, Angold, Costello & Burns, 1996).

Parent Help-Seeking Barriers and Influences Questionnaire.

The Parent Help-Seeking Barriers and Influences Questionnaire (HSBIQ-P) had four components. First, demographic information is collected. Then, parents are asked whether they have obtained mental health care in the past for any of their children and whether that care was helpful. The next section consists of 11 statements that reflect the barriers that parents may confront when seeking mental health help for their children. These items were derived from the barriers to obtaining help for children and adolescents with mental health problems identified in the nation wide survey of the mental health of young people in Australia (Sawyer et al., 2000). Example items are, “I did not know where to get help”; “I thought help was too expensive”; and “I thought treatment would not help”. Parents are asked to indicate on a 6-point Likert scale (1 = strongly disagree; 6 = strongly agree), the extent to which they agreed or disagreed that each statement represented a barrier that they had encountered in finding help for their child. Higher scores reflected greater perceived barriers to finding help. The final three questions of the HSBIQ-P tap the extent to which parents have been influenced to find help for their children by others (e.g. “To what extent was your decision to seek mental health help for your child your own decision?”). These final questions were drawn from the HSIQ, which was constructed originally to measure the influences on a client’s decision to seek help (Cusack, et al., 2004).

Youth measures

Strength and Difficulties Questionnaire.

The youth self-report SDQ has almost identically worded items to the parent SDQ. Twenty-five core items on the youth SDQ measure the same attributes as the parent rated SDQ and there is a set of impact questions. The method of scoring the youth SDQ matches that of the parent SDQ and produces parallel scales. The youth SDQ provides a self-report measure of the Total Difficulties, Emotional Symptoms, Conduct Problems, Hyperactivity-Inattention, Peer Problems and Prosocial Behaviour of the young respondent in the preceding 6 months. A measure of the Chronicity, Impact and Burden of the Perceived Difficulties of the young person in the same 6-month period is also obtained. As shown in an epidemiological study of British youth, the Total Difficulties (Cronbach $\alpha = .80$) and Impact scales (Cronbach $\alpha = .81$) of the youth self-report SDQ have good internal consistency while the Emotional Symptoms (Cronbach $\alpha = .66$), Conduct Problems (Cronbach $\alpha = .60$), Hyperactivity-Inattention (Cronbach $\alpha = .67$) and Prosocial Behaviour (Cronbach $\alpha = .66$) scales have moderate internal consistency. In contrast, the self-report Peer Problems scale (Cronbach $\alpha = .41$) has relatively poor internal reliability (Goodman, 2001). The British study has also shown that the youth SDQ has predictive validity. Youth self-rated SDQ scores above the 90th percentile on the negative attribute scales predicted an independent diagnosis of psychiatric disorder (Goodman, 2001). While there is evidence that the Perceived Difficulties, Impact (distress plus social incapacity items) and Burden measures on the youth SDQ can discriminate between young people from community and clinic samples (Goodman, 1999).

Youth Help-Seeking Influences Questionnaire.

The Youth Help-Seeking Influences Questionnaire (HSIQ-Y) used the three core questions of the Help Seeking Influences Questionnaire (HSIQ; Cusack et al., 2004). On the first item, participants were asked to rate on a 7-point Likert scale (1 = “totally others

decision”; 7 = “totally my decision”) how much their decision to seek professional help was their own or influenced by others. On the second item, participants were asked to rate on a 5-point Likert scale (0 = “not at all”; 4 = “a great deal”), “how much each of the specific people listed below influenced your decision to seek professional help on this occasion”. Included in the list of 10 help sources were Parents, Friends, Teachers, School Counsellors and “Others”. Specific help sources were listed if considered relevant to young people. Therefore, the help sources contained on the HSIQ-Y were more detailed than the sources listed on the HSIQ (Cusack et al., 2004). The final item on the HSIQ-Y asked participants, “If your decision to seek help was influenced by others, do you think you would have sought help without their influence?” Respondents then indicated “yes” or “no”.

Results

Data screening

Scores on the individual youth influence and parental barriers items, mean youth and parent total difficulties scores on the SDQ and mean difference scores between parents and their children on the SDQ total difficulties scale were examined prior to analyses. Using SPSS programs, the accuracy of data entry, missing values and the fit between the distribution of scores and the assumptions of the analyses used were investigated and the details are elaborated below.

Help seeking influences on youth attending CAMHS

Table 8 shows the extent of missing data from the Youth Help-Seeking Influences Questionnaire (HSIQ-Y) and the youth SDQ. To ensure a valid measure of the relative impact of each source of influence, the only source of influence scores used in analyses were those from participants who had indicated the degree of influence of all of the specified sources ($n = 121$). Responses on the source of influence items were not normally distributed (Lilliefors significance $< .05$). Scores on the “parents” influence item were negatively skewed which suggests that respondents most typically indicated high levels of parental influence on the decision to seek professional help. While on all other specified sources of influence items, respondents most commonly indicated low levels of influence and the distributions of scores were positively skewed. As the scores were not normally distributed, the data was analysed using non-parametric statistics.

Only eight (6%) respondents indicated being influenced by sources of influence other than those specified. The other influences reported were boyfriend/girlfriend ($n = 5$), counsellor/psychologist ($n = 2$) and caregiver ($n = 1$). Since very few endorsed this item, it was not subjected to any further analyses. The small numbers endorsing “other” influences indicates that the specified sources covered the main categories of influence. It also suggests that “boyfriend/girlfriend” might be included in future versions of the HSIQ-Y.

Table 8.

Number and percentage of youth respondents from total sample (n = 131) who completed items on the Youth Help-Seeking and Influences Questionnaire (HSIQ-Y) and Strength and Difficulties Questionnaire (SDQ)

Variables	Completed		Did not complete	
	N	%	N	%
<i>Youth-rated influence variable</i>				
Youth’s own decision to seek help	119	90.8%	12	9.2%
<i>Sources of influence</i>				
Parents	128	97.7%	3	2.3%
Other Relatives	124	94.7%	7	5.3%
Friends	127	96.9%	4	3.1%
Doctor	125	95.4%	6	4.6%
Teacher	125	95.4%	6	4.6%
School Counsellor	125	95.4%	6	4.6%
Legal Professionals	124	94.7%	7	5.3%
Youth Worker	123	93.9%	8	6.1%
Dept of Community Services	122	93.1%	9	6.9%
<i>All specified sources of influence</i>	121	92.4%	10	7.6%
<i>Nominated other influences</i>	8	6.1%	123	93.9%
<i>Independent/Influenced</i>				
Sought help without influence	106	80.9%	25	19.1%
<i>SDQ</i>				
All 20-Difficulty items	123	93.9%	8	6.1%

Perceived barriers, past help seeking and influences on parents attending CAMHS

Table 9 indicates the extent of missing data from the Parent Help-Seeking Barriers and Influences Questionnaire (HSBIQ-P) and the parent SDQ. Of the 129 parents and carers who participated in the study, 107 (82.9%) completed all of the ten items that specified potential barriers parents seeking help for their child may experience. The distribution of scores for each specified barrier was positively skewed which indicates that most participants did not strongly agree that the specified barriers were barriers to finding help (Lilliefors significance $< .05$). One hundred and twenty four parents or carers (96.1%) responded when asked if they had “obtained mental health help in the past”. Of the 77 parents or carers who had accessed professional help in the past, the vast majority ($n = 73$, 94.8%) indicated they had found the visit to the mental health professional helpful. Scores on this item were negatively skewed, suggesting that most respondents found past visits to mental health professionals to have been helpful (Lilliefors significance $< .05$).

Table 9.

Number and percentage of parents from total sample (n = 129) who completed items on the Parent Help-Seeking Barriers and Influences Questionnaire (HSBIQ-P) and Strength and Difficulties Questionnaire (SDQ)

Variables	Completed		Did not complete	
	N	%	N	%
<i>Past help seeking</i>				
Obtained mental health help in past	124	96.1%	5	3.9%
<i>Barriers</i>				
Didn't know where to get help	121	93.8%	8	6.2%
Health professionals could not assist me to find help	120	93.0%	9	7.0%
Worried what people would think	121	93.8%	8	6.2%
Solve child's problem on own	123	95.3%	6	4.7%
Help too expensive	122	94.6%	7	5.4%
Child did not want help	121	93.8%	8	6.2%
Thought treatment would not help	120	93.0%	9	7.0%
Thought wait for help too long	117	90.7%	12	9.3%
Problem would resolve itself	121	93.8%	8	6.2%
Thought services too far away	121	93.8%	8	6.2%
Other unspecified reasons	4	3.1%	125	96.9%
<i>All specified barriers</i>	107	82.9%	22	17.1%
<i>Parent-rated influence variables</i>				
Parent's decision or others decision	120	93.0%	9	7.0%
Parent influence on child attendance	117	90.7%	12	9.3%
<i>SDQ</i>				
All 20-Difficulty items	119	92.2%	10	7.8%

Parent and youth total SDQ difficulties and difference scores

Mean total parent and youth difficulties scores were obtained from the 119 adult and 123 young people who completed all 20-difficulty items on the SDQ. Difference scores were calculated from the 119-matching adult and youth pairs by subtracting mean total youth self-report scores from mean total parent rated difficulty scores. An examination of z scores on each variable showed that there were no outlying scores on the parent or youth difficulties variables, or the difference variable (Tabachnick, & Fidell, 2001). The parent difficulties scores were normally distributed while the youth difficulties scores were positively skewed (Lilliefors significance level $<.05$) indicating relatively low levels of self-reported difficulties. The difference scores were negatively skewed (Lilliefors significance level $<.05$) suggesting that most parent child difference scores were positive. This indicates that when parents and their children had discrepant scores parent-reported difficulties were higher than self-reported difficulties.

Data analyses

Influences on youth help seeking

One hundred and twelve (94.1%) youth respondents reported that others had influenced their decision to seek help. For 11 (9.2%) of these young people, the decision to seek help had been totally the decision of someone else. While only seven (5.9%) indicated that the decision to access help had been totally their own decision. Moreover, when participants were asked to separately rate the degree to which nine specified sources influenced their decision to access help, only two (1.7%) young people indicated that none of the specified sources had been influential in their decision to seek help.

Table 10 presents the mean source of influence and standard deviation scores obtained by youth participants from the Sydney and Illawarra CAMHS who completed all specified influence items. Total sample scores ($n = 121$) are presented as a series of non-parametric Mann-Whitney U tests did not reveal any significant differences between the Sydney and Illawarra samples on mean influence scores for any of the specified sources

of influence. Table 10 also shows the percentage of participants who endorsed each potential source of influence, as an influence on their decision to seek help. To determine the relative impact of each influence source, a non-parametric Friedman test was performed. The significant result, $\chi^2(8, N = 121) = 340.8, p < .001$, indicates differences in the degree of influence, of each influence source, on the decision to seek help.

Table 10.

Mean source of influence and standard deviation scores, mean ranks and percent of total youth sample who endorsed specified sources of influence (n = 121)

Source of influence	Mean ⁺	SD	Mean rank	Endorsed (%) ⁺⁺
Parents	2.53	1.30	7.71 ^a	90.9%
School Counsellor	1.31	1.51	5.77 ^b	52.1%
Doctor	1.23	1.42	5.66 ^b	50.4%
Friends	1.02	1.31	5.43 ^{bc}	47.5%
Other Relative	.69	1.23	4.70 ^{cd}	30.6%
Teacher	.59	1.15	4.49 ^d	25.6%
Legal Professional	.24	.83	3.81 ^e	9.9%
Youth Worker	.18	.56	3.76 ^e	11.6%
Dept of Community Services	.12	.52	3.65 ^e	5.8%

Note. ⁺Scores ranged from 0-4; higher scores represent greater levels of influence

⁺⁺Sources of influence were endorsed if influence scores greater than 0 (“not at all”).

^{a,b,c,d,e} Mean ranks that differ from each other at $p < .01$, do not share a letter.

Table 10 shows the mean rank for each source of influence. To investigate the differences between sources of influence, a series of Wilcoxon signed-rank tests were conducted. To control for the effects of multiple comparisons, the Wilcoxon tests were two-tailed and a significance level of $p < .01$ was used. The results in Table 10 indicate that parents were significantly more influential in the decision of young people to seek help than any other influence source. The mean rank findings also suggest that school

counsellors, doctors and friends were more influential than teachers, legal professionals, youth workers and the Department of Community Services in influencing young people to access help. Moreover, the influence of school counsellors and doctors was significantly more than the degree of influence reported for other relatives. However, the extent of the influence of friends and other relatives did not differ significantly.

Of the total youth sample, 86.8% (n = 105) reported that they had been influenced by more than one source to seek professional help. While 36.3% (n = 44) indicated some degree of influence from four or more of the nine specified influence sources. Fifty-nine percent of young people (n = 63) indicated that they would not have accessed help without the influence of others (Influenced group). The remaining 41% (n = 43) reported that they would have sought help independently of the influence of others (Independent group).

In order to explore whether the various levels and sources of influence were related to independent or influenced group membership, a series of Mann-Whitney U tests were conducted between the groups. Table 11 provides mean scores for the Influenced and Independent groups, on the overall mean amount of influence reported, the number of sources who were influential in the decision to seek help and the intensity of the influence experienced, as measured by the highest influence rating attributed to a single specified source of influence. There were no significant differences between the groups on any of the influence variables. However, Mann-Whitney U tests did indicate there was a significant difference between groups on the extent to which young people reported that it was their own decision to seek help. Table 11 shows that the Independent group believed it was more their own decision to seek help than the Influenced group, $Z = -4.57$, $p < .001$. There was also a significant difference on parent ratings. Parents of the Influenced group, reported having greater influence on the decision to access services, $Z = -2.63$, $p = .008$.

Table 11.

Mean and standard deviations on influence variables for influenced and independent youth groups (n = 106)

Influence	Influenced Group (N = 63)		Independent Group (N = 43)	
	Mean	SD	Mean	SD
Level of influence ^a	0.99	0.73	0.89	0.48
Number of influence sources ^b	3.13	1.56	3.50	1.86
Intensity of influence ^c	3.47	0.82	3.19	0.91
<i>Youth-rated influence variable</i>				
Youth's own decision ^d	3.30	1.57	4.76**	1.21
<i>Parent-rated influence variable</i>				
Parent influence on decision ^e	4.53*	1.80	3.55	1.75

Note. *p≤0.01, **p≤0.001

^aLevel of influence = mean of all help sources, ^bNumber of influence sources = number of endorsed influence sources, ^cIntensity of influence = mean of the single highest source of help

^d “How much you think the decision to seek professional help was your own or influenced by others?” (1 = totally others decision; 7 = totally my decision).

^e “To what extent did you influence your child’s attendance today for professional help?” (1 = totally child’s decision; 7 = totally my decision).

Influences on parents seeking help for young people

Self-reported parental influence scores ranged from 1 (totally child's decision) to 7 (totally my decision). The mean parental influence score was $M = 4.35$ ($SD = 1.90$). Only 14 (12%) parents indicated that they had not influenced their child's decision to access professional help to some degree while 20% ($n = 23$) reported that their child was not a part of the decision to seek help at all. Parent and child reports of parental influence had a significant positive relationship (Spearman's $\rho = .20$, $p = .017$). The mean level of influence by others reported by parents was $M = 5.15$ ($SD = 1.78$). These influence scores ranged from 1 (totally others decision) to 7 (totally my decision). Forty-four parents (36.7%) reported that it was their decision alone to seek help for their child while 76 parents (63.3%) indicated a degree of influence from others in deciding to access professional help. Only 5% ($n = 6$) of parents said that the decision to seek mental health care for their child had been entirely the decision of someone else. Table 12 shows that the most often nominated sources of influences on the decision of parents to seek help were school counsellors, doctors and the young person themselves.

Table 12.
 Parent nominated sources of influence on the decision to seek professional help for child

Source of Influence	Nominated as Influence ⁺	
	n	% ⁺⁺
School Counsellor	18	15.0%
Doctors	16	13.3%
Child attending CAMHS	7	5.8%
Relatives	6	5.0%
Partners	5	4.2%
Teachers	2	1.7%
Police	2	1.7%

Note. ⁺ “If someone else did influence your decision to seek professional mental health help for your child’s problems who had the greatest influence on your decision (Please specify relationship)”

⁺⁺ Percentage of parents who responded to the item “To what extent was your decision to seek mental health help for your child your own decision” (n = 120) and nominated greatest source of influence

Parent barriers to seeking help

Table 13 presents the mean barrier and standard deviation scores for the 107 adult respondents who attended the Sydney or Illawarra CAMHS and completed all of the specified barrier items. A series of non-parametric Mann-Whitney U tests were conducted to compare strength of barriers between the Illawarra and Sydney CAMHS. There was only one barrier which differed between the two sites, with Illawarra respondents rating the wait for professional help ($M = 4.07$, $SD = 1.39$) significantly higher than participants from Sydney ($M = 2.88$, $SD = 1.36$), $Z = -4.23$, $p < .001$. As no other mean barrier scores were significantly different, the mean barrier scores for the full sample are presented.

Table 13.

Mean perceived barrier and standard deviation scores, mean ranks and percent of total parent sample who endorsed specified barriers to seeking help (n = 107)

Barrier perceived by parent	Mean ⁺	SD	Mean rank	Endorsed ⁺⁺	NSMHWB ⁺⁺⁺
Wait for help too long	3.28	1.48	6.72 ^a	44.9%	38.0%
Help too expensive	3.28	1.68	6.67 ^a	50.5%	50.0%
Child did not want help	3.09	1.53	6.50 ^{ab}	41.1%	25.0%
Didn't know where to get help	3.03	1.54	6.29 ^{abc}	40.2%	50.0%
Solve child's problem on own	2.97	1.50	6.30 ^{abcd}	41.1%	46.0%
Problem would resolve itself	2.74	1.49	5.71 ^{bcd}	36.4%	2.0%
Health professionals could not assist me to find help	2.29	1.37	4.68 ^{ef}	18.7%	42.0%
Thought services too far away	2.02	0.95	4.22 ^{fg}	8.4%	23.0%
Worried what people would think if going to therapist	1.99	1.20	4.04 ^{fg}	14.0%	6.0%
Treatment would not help	1.86	0.92	3.87 ^g	6.5%	21.0%

Note. ⁺ Scores ranged from 1-6; higher scores represent greater perceived barrier

^{a,b,c,d,e,f,g} The mean ranks that differ from each other at p < .01, do not share a letter.

⁺⁺ Barriers were endorsed if the barrier score was four ("somewhat agree") or greater.

⁺⁺⁺ Percentage of respondents who endorsed as barrier in the Child and Adolescent component of the National Survey of Mental Health and Well Being (NSMHWB; Sawyer et al., 2000).

Table 13 shows the percentage of respondents who agreed that the specified barrier was a barrier they faced in finding help for their child. To explore the relative impact of each barrier, a non-parametric Friedman test was conducted. The significant result, $\chi^2(9, N = 107) = 178.2, p < .001$, indicates that parents rated some barriers higher than others. Table 13 presents the mean ranks for each barrier. A series of two-tailed Wilcoxon signed-rank tests, with a significance level of $p < .01$, were performed to investigate the different strengths of each barrier. The findings suggest that parent perceptions that they

could solve their child’s problem alone, their child did not want help, help was too expensive, the wait for help was too long and that they did not know where to find help were equally the most significant barriers to parents. The least significant barriers to parents were the thought that services were too far away, the worry over what others would think if professional help was sought and the perception that treatment would not help.

Eighty seven percent of parents (n = 93) reported at least one barrier in finding professional help for their child while 43 (40.2%) endorsed four or more of the 10 specified barriers at some level. Three (2.8%) parents indicated experiencing eight different barriers in finding help. Of the parents who completed the barrier items, 70 (55.7%) had obtained mental health care in the past for their children and 35 (47.6%) had not received prior professional help for any of their children. A series of Mann-Whitney U tests were performed to compare the prior help and no prior help groups on the number of barriers experienced and the overall barrier effect of the barriers faced (all $p > .01$). The analyses revealed that the experienced help-seeking group did not differ from the inexperienced group on the number or level of barriers faced. The strength of each barrier reported by the two groups was also compared using Mann-Whitney U tests but no significant differences emerged between the two groups on mean barrier scores for each specified barrier (all $p > .01$).

Parent-rated and self-rated youth difficulties

Table 14 presents the parent and youth self-reported mean scores, on the 20-item, Total Difficulties scale of the Strength and Difficulties Questionnaire (SDQ), for the total sample of matching adult and youth participants (n = 119). The Total Difficulties scale of the SDQ is comprised of the Conduct Problems, Hyperactivity/Inattention, Emotional Symptoms and Peer Problems subscales, which each have 5-items. Table 14 also shows the parent and self-rated, mean Externalising and Internalising difficulty scores. The mean Externalising score is the mean of the Conduct Problems and Hyperactivity/Inattention scores combined, while the mean Internalising score is the equivalent to the mean Emotional Symptoms score.

Table 14.

Mean and standard deviation scores on the parent and self-rated youth Total Difficulties scale and the Externalising and Internalising subscales of the SDQ (n = 119)

SDQ Scales	Parent-rated		Youth-rated	
	Mean	SD	Mean	SD
Total Difficulties	0.87	0.33	0.90	0.33
Externalising*	0.86	0.46	0.95	0.43
Internalising	1.19	0.51	1.12	0.53

Note. Higher scores indicate greater difficulties

*p < .05; Significant difference between parent and youth rated externalising scores

Total Difficulties = Total Difficulties Scale on the Strength and Difficulties Questionnaire (SDQ); Externalising = Externalising subscale (Composite scale comprising Conduct Problems and Hyperactivity/Inattention subscales) on the SDQ; Internalising = Internalising subscale (equivalent to emotional symptoms subscale) on the SDQ.

Paired t-tests were conducted on parent and youth scores on the Total Difficulties scale and the Externalising and Internalising subscales of the SDQ to determine if parent and self-rated difficulties scores differed. However, the only significant difference to emerge was on the Externalising subscale where young people indicated having greater difficulties than reported by their parents, $t(118) = -2.30, p < .05$. Parent and youth mean scores were not significantly different on the Total Difficulties scale or the Internalising subscale, which suggests that parents and their children generally agreed on the overall level of difficulty being experienced by the young person, and the extent to which the young person had emotional difficulties.

Youth difficulties and parent influence on youth help seeking

The final set of analyses explored the relationships between the level and nature of self-reported and parent-rated youth difficulties, and the influences on the decision of

parents and their children to access professional help. Table 15 provides Spearman correlations between mean parent and child scores on the Total Difficulties, Externalising and Internalising scales of the SDQ, and parent and youth influence variables. One-tailed correlations were calculated as the direction of the association between variables was hypothesised. It was anticipated that higher parent-rated difficulty scores would be associated with (i) parents reporting greater influence on the decision to seek help and (ii) young people indicating higher parental involvement in the decision to access professional help. Similarly, it was expected that higher self-rated difficulty scores would be related to young people being more influential in the decision to seek help.

The findings in Table 15 show that the direction of the association between parent-rated influence variables and parent-rated difficulty scores was as hypothesised.

Table 15.
Spearman’s correlations for parent and youth-rated influence variables, and mean scores on parent and youth-rated difficulties scales on the SDQ (n = 119)

	Mean parent SDQ scores			Mean youth SDQ scores		
	Total	Extern	Intern	Total	Extern	Intern
<i>Youth-rated influence variables</i>						
Youth’s own decision ^a	.13	.12	.12	.24**	.19*	.15
Parent influence on decision ^b	.22**	.09	.17*	-.13	-.11	.01
<i>Parent- rated influence variables</i>						
Parent’s own decision ^c	.20*	.16*	.06	-.14	-.16*	-.09
Parent influence on decision ^d	.21*	.22*	.04	-.15	-.09	-.16

Note. *p < .05, **p < .01

Total = Total Difficulties Scale on the Strength and Difficulties Questionnaire (SDQ); Extern = Externalising subscale (Composite scale comprising Conduct Problems and Hyperactivity/Inattention subscales) on the SDQ; Intern = Internalising subscale (equivalent to Emotional Symptoms subscale) on the SDQ.

^a“How much you think the decision to seek professional help was your own or influenced by others?” (1 = totally others decision; 7 = totally my decision).

^b “How much did parents influence your decision to seek professional help on this occasion?” (0 = not at all; 4 = a great deal).

^c “To what extent was your decision to seek mental health help for your child your own decision?” (1 = totally others decision; 7 = totally my decision).

^d “To what extent did you influence your child’s attendance today for professional help?” (1 = totally child’s decision; 7 = totally my decision).

Significant positive relationships emerged between the parent-rated influence variables and parent scores on the Total Difficulties and the Externalising SDQ scales. However, parent influence variables were not significantly related to parent scores on the Internalising scale. Interestingly, a different pattern of relationships emerged between parent scores on the SDQ scales and the youth-rated influence variables. Higher parental ratings of total difficulties were significantly associated with youth respondents reporting greater parental influence on the decision to seek help. However, there was no significant relationship between parent influence in the decision to access professional help and self-rated externalising difficulties. Yet, youth-reported parent influence in the decision to seek help was significantly and positively associated with youth-rated internalising difficulties.

As anticipated, Table 15 shows that youth-rated difficulty scores were positively related to greater self-involvement in the decision to seek help. The greater that the young people perceived difficulties, the more they rated independently making the decision to access help. Consistent with these findings, the direction of the relationship between self-reported total difficulties, and externalising difficulties, with youth reports of parental influence in accessing help was negative.

Discrepancies in problem severity and perceptions of influence

Table 16 presents Spearman correlations between mean parent and child difference scores on the Total Difficulties, Externalising and Internalising scales of the SDQ, and parent and youth-rated influence variables. Difference scores reflect the disagreement between parents and their children on the extent to which youth respondents are experiencing difficulties. Following the general method of Yeh and Weisz (2001), and Youngstrom and colleagues (2000), difference scores were calculated by subtracting mean self-rated youth scores from mean parent-rated scores on the Total Difficulties, Externalising and Internalising scales of the SDQ. Therefore, difference scores above zero indicate that parent ratings of their child's difficulties are higher than the young person's rating of their own difficulties while difference scores below zero indicate the self-reported difficulties of the child are higher than parent-rated child difficulties. The

further that positive and negative scores are from zero indicates greater disagreement between parent and child on the level of the young person's difficulties.

It was hypothesised that differences between parents and children on the level of the child's difficulties would be associated with parent and child reports of parental influence in the decision to seek professional help. Similarly, it was expected that where parents indicated their child as having greater difficulties than recognised by the young person, parents would report that the decision to seek help was more their own than a decision influenced by others.

Table 16 shows that as anticipated, young people and their parents reported more parent influence on the decision to seek help when there was greater disagreement between parent and child on the extent of the child's difficulties. There were significant positive relationships between parent-child difference scores on the Total Difficulties and Externalising scales of the SDQ and youth reports of parent influence on the help seeking decision. There were also significant and positive associations found between parent-child difference scores on the Total Difficulties, Externalising and Internalising scales of the SDQ and parent ratings of parental influence on the decision to access professional help. Moreover, as expected, parent-child difference scores were related to the extent that parents made their own decision to seek help for their child. When parents believed their child to have greater Total difficulties or Externalising difficulties than the young person indicated, parents also reported that the decision to find help was more their own than a decision influenced by others. There was no significant relationship between parent-child differences scores on the Internalising scale of the SDQ and parent reports on whether the decision to seek help was their own decision.

Conceivably, parent influence on the decision to access professional help for a child experiencing difficulties may be related to the age of a young person. For example, older children may be better able to find and access help independently of parents. Therefore, as a precaution, the Spearman's correlations provided in Table 16 were calculated while controlling for the age of the youth respondent. However, the same pattern of relationships emerged. Indeed, the relationships between parent and youth-rated influence variables and parent-child difference scores on the SDQ were strengthened when the age of the youth respondent was controlled in the analyses.

Table 16.

Spearman’s correlations for parent and youth-rated influence variables, and mean difference scores on parent and youth-rated difficulties scales on the SDQ (n = 119)

	<i>Mean parent-child difference scores on SDQ</i>		
	Total	Extern	Intern
<i>Youth rated influence variables</i>			
Youth’s own decision to seek help ^a	-.05	-.05	-.01
Parent influence on decision ^b	.26**	.19*	.15
<i>Parent rated influence variables</i>			
Parent’s own decision to seek help ^c	.27**	.34***	.11
Parent influence on decision ^d	.31**	.35***	.19*

Note. *p < .05, **p < .01, ***p < .001

Total = Total Difficulties Scale on the Strength and Difficulties Questionnaire (SDQ); Extern = Externalising subscale (Composite scale comprising Conduct Problems and Hyperactivity/Inattention subscales) on the SDQ; Intern = Internalising subscale (equivalent to emotional symptoms subscale) on the SDQ.

^a“How much you think the decision to seek professional help was your own or influenced by others?” (1 = totally others decision; 7 = totally my decision).

^b “How much did parents influence your decision to seek professional help on this occasion?” (0 = not at all; 4 = a great deal).

^c “To what extent was your decision to seek mental health help for your child your own decision?” (1 = totally others decision; 7 = totally my decision).

^d “To what extent did you influence your child’s attendance today for professional help?” (1 = totally child’s decision; 7 = totally my decision).

Discussion

Ninety-four percent of the young people involved in this research reported being influenced to some degree in their decision to seek professional help. As expected, most youth participants were influenced by multiple sources. Parents were clearly more influential in the decision of youth respondents to seek help than any other source. School counsellors, doctors and friends were more influential than teachers, legal professionals, youth workers and Department of Community Services' staff in having youth respondents' access help. Almost 60% of youth participants indicated that they would not have sought help if others had not influenced them. Unexpectedly, this influenced group did not differ significantly from the independent group (who indicated they would have sought help regardless of the degree of influence) on measures of overall level of influence, the number of influence sources and the intensity of influence experienced. One possible explanation for this finding is that the decision of those in the independent group to access help was less to do with the amount of influence reported and more related to a sense of autonomy. To investigate this further, future research into influences on the help seeking of young people might include a measure of the beliefs of young people toward autonomy.

Eighty-eight per cent of parents indicated that they influenced their child to some degree to access help. Overall, there was a positive, although modest relationship between parent and child reports of parental influence on youth help seeking. The majority of parents (63%) also reported being influenced by others in deciding to find help for their child. The most frequently endorsed sources of influence were school counsellors, doctors and the young person themselves. As anticipated, the level of parental involvement in the decision to seek help and the degree to which parents' exerted influence on their children to access help were related to parent ratings of their child's total difficulties and the young person's externalising behaviour. However, the low to moderate strength of these relationships must be noted and the findings considered tentative until replicated in future research. Yet seemingly, parents intervened more actively to find help when their child had conduct or hyperactivity problems than when the young person had emotional problems. The finding that parent ratings of youth

internalising difficulties was not related to how much parents influenced their child to seek help suggests that they may be less concerned about or unaware of these problems. As with parents, young people who reported more total difficulties and externalising difficulties indicated greater independence in making the decision to find help.

When there was greater parent-child disagreement on the level of the young person's total difficulties, externalising problems and emotional symptoms, parents reported being more influential in the decision to seek help. Yet, parent-child disagreement on the extent of the young person's emotional symptoms was not significantly related to whether parents made their own decision to seek help. Almost all parents (87%) endorsed at least one barrier in finding help and many (40%) experienced multiple barriers. The most significant barriers to parents were, not knowing where to find help, perceptions that they could solve their child's problems on their own, their child not wanting help, the wait for help being too long, and that help was too expensive.

Influence of others on the professional help seeking of young people

The finding that almost all the young people in this study were influenced by others to access help is consistent with models of help seeking that contextualise the decision to seek help and recognise that help seeking is often a social process involving family, friends and community networks (e.g., Cauce et al., 2002; Pescosolido et al., 1998; Pescosolido & Boyer, 1999). However, the extent to which young people are influenced in this process to seek help had not been previously quantified. Cusack and colleagues (2004) found that 96% of the men they surveyed, who had recently attended or who were currently attending outpatient psychological services, sought help only after some influence by others. They also found that the majority of men reported multiple sources of influence on their decision to seek formal help. The present study replicates and extends these results to adolescent males and females, in an outpatient clinic population.

As noted, there is evidence that parents often facilitate access to professional help for children (Angold et al., 1998), but there is no data on the relative influence of parents and others on the formal help seeking of young people. The current study suggests parents are the most significant influence on a young person's decision to access mental health

services and that school counsellors, doctors and friends are other important sources of influence when young people have difficulties. In this study, legal professionals, youth workers and Department of Community Services' staff were less influential. A likely explanation for this finding is the relatively low frequency of contact between these sources and the young people in this research. Encouragingly, 41% of the young people in this study reported they would have independently sought help if not influenced by others. Although, despite this stated intention it may be that they cannot easily access professional help without the support, information and resources of adults.

Parent influence on the professional help seeking of young people

The significant help seeking influence of parents, found in this study by child and parent report, supports the conceptualisation of Logan and King (2001) that young people primarily access mental health services via parent-mediated pathways. In the initial contemplation stage of the Logan and King (2001) model, parents become aware of the extent and psychological nature of their child's distress, recognise the need for formal help and consider the options. Parents then develop the intention to seek professional help and act to find appropriate services (Logan & King, 2001). Consistent with this model, parental influence or parents acting to facilitate their child's help seeking was related to parent ratings of the young person's overall difficulties and externalising problems.

However, there was no significant relationship between parental influence and the magnitude of *emotional* difficulties experienced by the child. There are several possible explanations for this finding. It may be that young people who experience emotional symptoms require less parental influence to access professional help. To relieve their own distress, emotionally troubled youth respondents may have been more willing participants in seeking help. Yet, somewhat inconsistent with this hypothesis was the finding that youth reports of emotional problems were not related to reports of greater independence in deciding to find help. A parent actively intervening to find help when their child has externalising difficulties is understandable. Conduct and hyperactivity problems are observable and may adversely affect the parent and others in the family (Angold et al., 1998). Emotional symptoms are likely to be more internal experiences and less evident to

others. The internalised distress of emotional symptoms may make problem recognition more challenging for parents (Logan & King, 2002). This may be particularly so for young people who fear being seen as “not coping” or for those who do not confide easily in their parents. Therefore, even though parents may realise that there are emotional problems, the degree of distress expressed as a function of these internal experiences may be perceived as low and therefore urgency or demands to seek help may be reduced. Another possibility is that, as noted, the threshold beyond which parents intervene is higher for emotional problems than for externalising behaviours because having emotional issues in adolescence is viewed as “part of growing up” (Logan & King, 2001). In sum, it appears that a parent simply being aware of the increasing emotional difficulties of their child is not sufficient motivation for the parent to find help.

Parent influence and parent-child disagreement

In the present study when there was greater disagreement between parent and child on the young person’s overall, externalising and emotional difficulties, parents became more involved and exerted more influence on their child to access help. Put simply, parents may react more strongly when they believe that their child is not sufficiently acknowledging their problems and need for help. This finding emphasises the interactional nature of the help seeking process for young people, as suggested by Logan and King (2001). The help seeking actions of a parent are likely to be affected by the attitude of the young person toward seeking help. Clearly, parents and independently minded teenagers may have different views on what constitute psychological problems that merit professional attention. Moreover, previous research shows that adolescents are resistant to accessing formal help (e.g., Boldero & Fallon, 1995), and this study suggests that it is relatively unlikely that young people will independently self-refer to mental health services. When faced with a young person resistant to help parents will be compelled to bring more influence to bear to have the young person access services or consider other options to alleviate the young person’s problems.

From a developmental perspective, parents and children expect that as a child grows older that child will have greater behavioural autonomy and make decisions

independently from parents (e.g., see Daddis & Smetana, 2005). However, in this study the age of the young person did not change the pattern of findings. Consistent with past research (White, 1996), parent influence was an enabling factor that allowed younger and older adolescents to overcome perceived barriers and access professional help.

Parent barriers to seeking professional help for young people

Parents face obstacles in finding help for their children. In the present study, almost all parents reported at least one help seeking barrier and many confronted multiple barriers. This study extends the findings of the child and adolescent component of the National Survey of Mental Health and Well-Being (NSMHWB) (Sawyer et al., 2000). In the NSMHWB, parents who had not sought help for a child in need of professional intervention were asked to explain why they had not attended a clinical service. The parents interviewed were able to describe multiple barriers. In the present study, parents rated how much each of the barriers was an obstacle to accessing help. This allowed comparison between barriers with regard to their relative strength.

The most often described barriers in the national survey were the structural barriers of service cost, not knowing where to get help, asking for help and not getting it, and long waiting times for professional help. Parental beliefs that they “could handle” their child’s problem was also frequently nominated as a barrier (Sawyer et al., 2000). These same help seeking barriers were the most difficult obstacles for parents in this study to overcome. “My child did not want professional help” was also a barrier for many parents (41%) in the present research. However, in contrast, this obstacle was only a barrier for approximately 25% of respondents in the NSMHWB (Sawyer et al., 2000). That parents face a significant barrier in children not wanting professional help is consistent with the findings in this study on the importance of parent influence in young people accessing services. Parent belief that their child’s problem would resolve itself was the next highest rated barrier. In contrast, in a somewhat counterintuitive finding, very few respondents in the NSMHWB nominated the equivalent barrier of seeing the problem as transient (Sawyer et al., 2000). Of course, the implication of parents adopting the attitude that their child’s problem would resolve without intervention is that parents delay seeking help.

Finding appropriate help with the assistance of health professionals, thoughts that services were too far away, and concerns that treatment would not help were not rated highly as barriers in the present study. In contrast, more than 20% of parents in the NSMHWB described each of these as an obstacle to help (Sawyer et al., 2000). Worry “about what people would think if I went to a therapist” was also not rated highly as a barrier to help in the present research although 14% of parents did endorse this as a help seeking barrier. In comparison, concern about what others would think was described as a barrier by only 6% of parents in the NSMHWB.

The different samples in this study and the NSMHWB may account for the different findings. It is likely that parents in the present research reported on the barriers they actually confronted and overcame in finding help. In contrast, parents in the national survey may not have sought help. Certainly, they had not obtained help. Conceivably, the parents surveyed reported on hypothetical help seeking. Therefore, for example, they may not have fully experienced how strongly their child would oppose seeking help or examined their feelings about having their child see a therapist. Knowing the barriers that may stop the actual help seeking of parents is important. However, it is also important to understand the barriers encountered by parents who have accessed services.

Implications

This study has implications for the delivery of mental health services to young people. First, at the level of therapist and client, the findings indicate that teenagers may initially be difficult to engage in a therapeutic relationship. It is likely that a young person who has at least partly been coerced into attending will be a reluctant client and any resentment the young person may feel at being compelled to see a clinician might intrude on the therapy. Certainly, formulating the goals of therapy will be difficult if parent and child disagree on the nature and extent of the problem and the need for therapy (e.g., see Yeh & Weisz, 2001). Moreover, the influential role played by parents in obtaining help for their child may be an impediment to conjoint therapy. Future research might target how the process and outcome of therapy is affected when a young person only accesses help after being influenced by others.

Second, at a service level, the findings suggest there is a great need to promote parent awareness that free professional help is available for young people. A major barrier for 50% of parents was that “help was too expensive”. Yet, these parents were attending a government funded no fee service. Clearly, some parents have inaccurate perceptions about local clinical services. Advertising in the local media, school newsletters and in the surgeries of general practitioners may help to inform the community of the range, nature and location of services and correct any misperceptions about cost. Future studies might also attempt to clarify what gives rise to the perception that professional help is “too expensive”. For example, is it that parents have an initial preference for private services, which may be expensive, and the local CAMHS is viewed as a poor alternative? Alternatively, does it reflect that parents consider the “hidden costs” of attending a clinical service, such as the expense of travel and time away from work as being too costly?

Another major barrier for many parents was the perceived long waiting time to access services, and in some regions, the average waiting time for an initial appointment has reached 7-9 months (Walz et al., 2005). To enable local services to be appropriately responsive to their community there may be a need for more clinical staff or a change in procedures that decrease the perception of parents that they are “just waiting”. One CAMHS has implemented and advertised new triage, assessment and therapy procedures that have reduced waiting times to 2-4 weeks (Walz et al., 2005). Alternatively, a service may provide a rapid initial screening interview and periodic monitoring of clients awaiting treatment.

This study shows that school counsellors and general practitioners influence young people to access clinical services. Therefore, at a local level, there remains a clear need for a continuing liaison between mental health services and these fellow professionals. One program that has shown promising results in improving communication and referral practices between education and health staff is the recent “School Link” initiative (Jones et al., 2002; Maloney & Walter, 2005). The “School-Link” program focuses on prevention, early intervention, and service access and aims to formalise local partnerships between schools, Technical and Further Education (TAFE) Colleges, and mental health services in New South Wales.

Finally, at a state and federal level, the findings indicate a need to increase mental health literacy in the community, that is, the awareness of the nature and treatment of mental health problems (Jorm et al., 1997; Jorm, 2000). Worryingly, this study suggests that parents and children are prepared to wait for the problem to resolve itself rather than seek help. In addition, there is evidence that young people in Australia are confused about what mental health is and is not, and how to respond to peers with mental health problems (Keys Young, 1997). Widely targeted health promotion activities that highlight the signs and symptoms of mental health problems, the advantages of early professional intervention and the potential risks of delaying or not seeking help may help to improve community understanding of mental health problems (Lincoln, Harrigan, & McGorry, 1998). For example, mental health information could be provided to young people through the school curricula. Young people may then be better able to recognise when they are in need of professional help or when their friends need help. These programs could be modelled on the comprehensive school-based programs that focus on the identification and appropriate referral of troubled and at risk youth, through complementary staff, parent and student training, that have been developed and implemented with encouraging results (see review, Kalafat, 1997).

Limitations

There are a number of methodological and design limitations to consider when interpreting the findings from the present study. First, as the sample is drawn from a clinical population, it does not represent all young people with psychological problems and their parents. Epidemiological research shows that many young people who need psychological help do not access available services (e.g., Sawyer et al., 2000). There may also have been sampling bias in the data collection process. All clients attending an initial assessment interview with their local child and adolescent mental health service (CAMHS) were eligible to take part in the study, but as participation was voluntary, those who chose to participate may not have been representative of the CAMHS client population. For example, young people with greater psychological difficulties, or those from families with greater chaos and disruption may have declined to participate. The

characteristics of the participant and non-participant groups could not be compared because no information was available on those who declined to take part in the research. Moreover, there was no data available on the potential clients who had initiated help seeking, scheduled an appointment, received the research questionnaires but did not attend for their first appointment at the CAMHS.

Second, the parent and youth questionnaires contained some single item measures of unknown reliability. The parent questionnaire included the Parent Help-Seeking Barriers and Influences Questionnaire, which was specifically designed for this study. Although the 12 barrier statements were derived from the NSMHWB (Sawyer et al., 2000) and others have adapted similar barrier statements from the NSMHWB for use with adolescents in prior research (Sheffield, et al., 2004), the measure has unknown reliability characteristics. Third, the research is cross sectional in design and the findings are correlational, which limits the conclusions that can be drawn. For example, causal inferences cannot be made about the relationship between a young person's difficulties, reported by child or parent, and the extent of parental influence on the decision to seek help.

Conclusions and future directions

Many young people in Australia with mental health problems do not access clinical services and remain at risk of developing a psychiatric disorder and suicide. The aim of the present research was to improve our understanding of the factors that enable young people in need to reach professional help. One of the findings from Study 1 suggests that practical and psychological barriers impede help seeking. For TAFE students, perceived barriers were related to the intention to seek help for personal emotional problems or thoughts of suicide. Among youth centre participants, those in greater distress saw more obstacles to obtaining help. Consistent with contemporary process models, Study 2 shows the importance of the influence of others in enabling young people to overcome help seeking barriers. Almost all the young people in a clinical sample reported that others had influenced their decision to access help. Many were influenced by multiple sources. School counsellors, doctors, friends, other relatives and teachers were all influential but

parents were the strongest source of influence. As anticipated, parents and their children indicated that parents were more influential in the decision to seek help when there was more disagreement between parent and child on the level of the child's difficulties. Past research has identified the barriers that have prevented parents from attempting to find help for their child. Study 2 shows the relative strength of these barriers. Parents who sought help for their child's difficulties and attended a mental health service reported that the greatest barriers to obtaining help were that the wait was too long, the help was too expensive, they didn't know where to get help, they could solve their child's problem without help and that their child did not want help.

The present research identifies the importance of the influence of others in enabling young people to access professional help. The next step is to investigate how young people are influenced to accept help. Other areas of research that warrant attention have been noted. Future studies might also address the question of what it is in the influence process that prompts a young person to attend clinical services. There remains a need to understand for example, whether it is the intensity of the influence, or the cumulative effect of a number of influence sources. Clearly, parents are important sources of influence to their children. Future research into the influence process might also ask parents of their experience of attempts to influence their child to access help. In particular, the relationships between the nature of a child's difficulties, parent and child recognition and agreement on the level of a child's distress, and parents acting to influence their child to accept the need for professional help, merits additional attention.

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Appendix I

Study 1:

Distress, suicidal ideation, help seeking barriers and intentions to seek professional help in non-clinical samples of young people

- **Research measures**
 - BASH-B
 - HSCL-21
 - SIQ

BASH-B

DIRECTIONS:

Below are a number of statements relating to seeking help.

Read each statement carefully and indicate the extent to which you agree or disagree with each statement. Circle the appropriate number for each item.

Please express your honest opinion in rating the statements. There are no wrong answers. The only right answers are whatever you honestly feel or believe.

	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 keep it secret	1	2	3	4	5	6
5. A therapist might make me do or say something that I don't won't 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. Adults really can't understand the problems that kids have.....	1	2	3	4	5	6
8. Even if I had a problem I'd be too embarrassed to talk to a therapist about it.....	1	2	3	4	5	6
9. No matter what I do, it will not change the problems I have	1	2	3	4	5	6
10. If I went to a therapist, I might find out I was crazy	1	2	3	4	5	6
11. I could not afford to see a therapist even if I wanted to.....	1	2	3	4	5	6
12. I think I should work out my own problems.....	1	2	3	4	5	6

HSCL - 21

DIRECTIONS:

We would like to know how you have been feeling over the past seven days, including today. Below is a list of things you may have been feeling over this time.

Circle the number that best describes how distressing you have found these things over this time.

	Not at all	A little	Quite a bit	Extremely
1. Difficulty speaking when you are excited	1	2	3	4
2. Trouble remembering things	1	2	3	4
3. Worried about sloppiness or carelessness.....	1	2	3	4
4. Blaming yourself for things	1	2	3	4
5. Pains in the lower part of your back	1	2	3	4
6. Feeling lonely	1	2	3	4
7. Feeling blue	1	2	3	4
8. Your feelings being easily hurt	1	2	3	4
9. Feeling others do not understand you or are unsympathetic	1	2	3	4
10. Feeling that people are unfriendly or dislike you ...	1	2	3	4
11. Having to do things very slowly in order to be sure you are doing them right	1	2	3	4
12. Feeling inferior to others	1	2	3	4
13. Soreness of your muscles	1	2	3	4
14. Having to check and double check what you do ...	1	2	3	4
15. Hot or cold spells	1	2	3	4
16. Your mind going blank	1	2	3	4
17. Numbness or tingling in parts of your body	1	2	3	4
18. A lump in your throat	1	2	3	4
19. Trouble concentrating	1	2	3	4
20. Weakness in parts of your body	1	2	3	4
21. Heavy feelings in your arms and legs	1	2	3	4

SIQ

DIRECTIONS:

Below is a list of thoughts that people sometimes have. Read each thought carefully. √ the circle that best describes your thoughts in the past month.

This thought was in my mind:	I never had this thought	I had this thought before but not in the last month	About once a month.	Couple of times a month.	About once a week.	A couple of times a week.	Almost every day.
1. I thought it would be better if I was not alive.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I thought about killing myself.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I thought about how I would kill myself.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I thought about when I would kill myself.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I thought about people dying.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I thought about death.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I thought about what to write in a suicide note.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I thought about writing a will.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I thought about telling people I plan to kill myself.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I thought that people would be happier if I were not around.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I thought about how people would feel if I killed myself.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I wished I were dead.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. I thought about how easy it would be to end it all.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. I thought that killing myself would solve my problems.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. I thought others would be better off if I was dead.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. I wished I had the nerve to kill myself.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. I wished that I had never been born.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. I thought if I had the chance I would kill myself.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. I thought about ways people kill themselves.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. I thought about killing myself, but would not do it.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. I thought about having a bad accident.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. I thought that life was not worth living.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. I thought that my life was too rotten to continue.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. I thought that the only way to be noticed is to kill myself.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. I thought that if I killed myself people would realize I was worth caring about.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. I thought that no one cared if I lived or died.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. I thought about hurting myself but not really killing myself.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. I wondered if I had the nerve to kill myself.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. I thought that if things did not get better I would kill myself.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. I wished that I had the right to kill myself.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Appendix II

Study 2:

Barriers to help seeking and parental influence on pathways to care

- **Protocol**

- Parent information sheets
- Parent consent form
- Help Seeking Barriers and Influences Questionnaire
- Parent SDQ
- Youth information sheets
- Youth consent form
- Youth Help Seeking Influences Questionnaire
- Youth SDQ

AN ANONYMOUS RESEARCH STUDY

Pathways to Professional Help for Young People

Parent Information Sheet

Dear parent,

The Illawarra Institute for Mental Health, at the University of Wollongong, invites you to participate in an **anonymous** study designed to find out more about the influences on young people and their parents that affect the process of seeking treatment from mental health services.

Who is running this study?

Tim Wahlin is conducting this research study as part of a Doctor of Psychology degree, at the University of Wollongong. Professor Frank Deane will supervise the research.

What is this study about?

- The first aim of this study is to understand the barriers parents experience when looking for mental health care for their children.
- The second aim of this study is to explore the influence of parents in bringing young people to mental health services.
- The third aim of this study is to find out whether the degree that parents and teenagers agree about the nature of the problem is related to how much parents influence their child to get help.

Who can take part in the study?

Any parent who has a child 14 years of age and older and is attending their first appointment with the Child and Adolescent Mental Health Service is eligible to participate in this research.

What do participants in the study have to do?

If you would like to volunteer for this study, you need to fill out the one-page research questionnaire that asks you about the different barriers that you may have encountered when seeking professional help for your child. There are also questions that ask if others influenced your decision to find help. This brief questionnaire is in addition to a standard assessment questionnaire called the Strengths and Difficulties Questionnaire or SDQ that you would normally fill out for the Child and Adolescent Mental Health Service. Your responses on the Strength and Difficulties Questionnaire will also be used in the research. Both questionnaires will take about 15 minutes to complete.

If you choose not to participate in this study it will not affect your contact with the Child and Adolescent Mental Health Service in any way but if you are interested in taking part, please complete and return the questionnaires to the Child and Adolescent Mental Health Service when you attend for your first appointment. If you have any questions about this study please ask the clinician that you will be seeing. You may also contact Tim Wahlin, during business hours, on Tel: 4221 3747. He will be happy to explain any details of the study. If you have any questions about the conduct of this research please contact the Secretary of the University of Wollongong Human Research Ethics Committee on 4221 4457

Completion and return of the research questionnaire implies your consent to participate in the research. However, once the questionnaires are returned you will not be able to withdraw your consent to participate, as all identifiable information on the questionnaires will be removed before the data is stored, to ensure that the study is completely anonymous.

Thank you for taking time to participate in this study.

Yours Sincerely

Tim Wahlin

Pathways to Professional Help for Young People

Parent Information Sheet

Dear parent,

The Illawarra Institute for Mental Health, at the University of Wollongong, invites you to participate in a study designed to find out more about the influences on young people and their parents that affect the process of seeking treatment from mental health services.

Who is running this study?

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- The third aim of this study is to find out whether the degree that parents and teenagers agree about the nature of the problem is related to how much parents influence their child to get help.

Who can take part in this study?

Any parent who has a child 14 years of age and older who has a first appointment scheduled with the Child and Adolescent Mental Health Service is eligible to participate in this research.

What do participants in this study have to do?

If you would like to volunteer for this study, you need to fill out the brief one-page research questionnaire that accompanies this information sheet. The questionnaire asks you about the different barriers that you may have encountered when seeking professional help for your child and whether others influenced your decision to find help. You also need to complete the standard assessment questionnaire called the Strengths and Difficulties Questionnaire or SDQ, which also accompanies this information sheet. You would normally fill out the SDQ for the Child and Adolescent Mental Health Service. You must also complete the enclosed consent form if you choose to participate in this research. The consent form asks your permission to use your responses on the Strengths and Difficulties Questionnaire in this study. The research questionnaire and the SDQ will take about 15 minutes to complete.

What can participants expect from the researchers?

If you participate in the study, you have the right to:

- Refuse to answer any particular question and to withdraw from the study at any time without it affecting your contact with the child and adolescent mental health team;
- Be informed of the findings from the study when it is concluded; and
- Provide information on the understanding that it will be coded and that it will not be possible to identify you in any reports that arise from the study. Your responses will be confidential.

If you are interested in taking part, please complete and return the consent form and questionnaires to the Child and Adolescent Mental Health Service. If you have any questions about this research, please contact Tim Wahlin, during business hours, on Tel: 02 4221 3747. If you have any questions about the conduct of this research please contact the Secretary of the University of Wollongong Human Research Ethics Committee on 02 4221 4457.

Thank you for taking time to participate in this study.

Yours Sincerely

Tim Wahlin

Pathways to Professional Help for Young People

Parent Consent Form

I have read the Parent Information Sheet for this study. I understand that I will be required to complete a questionnaire about my decision to seek professional help for my child and the barriers I have experienced in finding that help. I also understand that the Strength and Difficulties Questionnaire (SDQ) I will fill out for the Child and Adolescent Mental Health Service as a part of the team's standard assessment practice will be used in the research.

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 treatment that I receive 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 I will not be identified in any publication of the results.

I understand that if I have any questions about the research I can contact Tim Wahlin, during business hours on Tel: 02 4221 3747. In addition, 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, during business hours on Tel: 02 4221 4457.

I wish to participate in this study under the conditions set out on the information sheet.

Name: _____

Signed: _____

Date: _____

Parent Questionnaire

Child's age: _____ Child's gender: _____ Your relationship to child: _____
 Marital Status: _____ Occupation: _____ How long did you wait for an appointment? _____

- Have you obtained mental health help in the past for any of your children? Yes / No
- How helpful was the visit to the mental health professional?

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

Directions

Below are a number of statements that reflect different barriers people have experienced in obtaining mental health help for their children. Read each statement carefully. Please indicate the extent to which you agree or disagree that each of these were barriers to you getting professional help for your child's mental health problems. Circle the appropriate number for each item.

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
3. I did not know where to get help.....	1	2	3	4	5	6
4. Health professionals I contacted could not assist me to find help	1	2	3	4	5	6
5. I was worried about what people would think if I went to a therapist.....	1	2	3	4	5	6
6. I thought I could solve my child's problems on my own.....	1	2	3	4	5	6
7. I thought help was too expensive	1	2	3	4	5	6
8. My child did not want professional help ...	1	2	3	4	5	6
9. I thought treatment would not help.....	1	2	3	4	5	6
10. I thought the wait to get professional help was too long	1	2	3	4	5	6
11. I thought the problem would resolve itself over time	1	2	3	4	5	6
12. I thought services were too far away ...	1	2	3	4	5	6
13. Other reasons (describe).....	1	2	3	4	5	6

14. To what extent was your decision to seek mental health help for your child your own decision

Totally others Half my decision Totally my
 Decision Half others decision Decision
 1 2 3 4 5 6 7

15. If someone else did influence your decision to seek professional mental health help for your child's problems who had the greatest influence on your decision (Please specify relationship) _____

16. To what extent did you influence your child's attendance today for professional help

Totally child's Half my decision Totally my

Please see print copy for image

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AN ANONYMOUS RESEARCH STUDY

Pathways to Professional Help for Young People

Youth Information Sheet

Dear participant,

The Illawarra Institute for Mental Health, at the University of Wollongong invites you to participate in an **anonymous** study designed to find out more about what brings young people to mental health services.

Who is running this study?

Tim Wahlin is conducting this research study as part of a Doctor of Psychology degree at the University of Wollongong. Professor Frank Deane will supervise the research.

What is this study about?

- The first aim of this study is to understand what makes it difficult for parents to find professional help for their children.
- The second aim of this study is to understand how much other people influence young people to get mental health services.
- The third aim of this study is to find out how much parents and teenagers agree about what the problem is and whether this is related to how much parents influence young people to seek help.

Who can take part in the study?

If you are 14 years of age or older and you are attending your first appointment with the Child and Adolescent Mental Health Service you can take part in this study.

What do participants in the study have to do?

If you agree to take part in the study, you will need to fill out a one-page questionnaire that asks about your decision to seek professional help. You also need to fill out the Strength and Difficulties Questionnaire or SDQ, which is a standard questionnaire you would normally complete for the Child and Adolescent Mental Health Service. Your responses on the SDQ will also be used in the study. Both questionnaires will take about 15 minutes to complete.

If you choose not to participate in this study it will not affect your contact with the Child and Adolescent Mental Health Service in any way but if you are interested in taking part in the study, please complete and return the questionnaires to the Child and Adolescent Mental Health Service when you attend for your first appointment. If you have any questions about this study please ask the clinician that you will be seeing. You may also contact Tim Wahlin, during business hours on Tel: 4221 3747. He will be happy to explain any details of the study. If you have any questions about the conduct of this research please contact the Secretary of the University of Wollongong Human Research Ethics Committee on Tel: 4221 4457.

Completion and return of the research questionnaire implies your consent to participate in the study. However, once the questionnaires are returned, you will not be able to withdraw your consent to participate, as all identifiable information on the questionnaires will be removed before the data is stored, to ensure that the study is completely anonymous.

Thank you for taking time to participate in this study.

Yours Sincerely

Tim Wahlin

Pathways to Professional Help for Young People

Youth Information Sheet

Dear participant,

The Illawarra Institute for Mental Health, at the University of Wollongong invites you to participate in a study designed to find out more about what brings young people to mental health services.

Who is running this study?

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- The third aim of this study is to find out how much parents and teenagers agree about what the problem is and whether this is related to how much parents influence young people to seek help.

Who can take part in this study?

If you are 14 years of age or older and you have a first appointment booked with the Child and Adolescent Mental Health Service you can take part in this study.

What do participants in this study have to do?

If you want to take part in this study, you need to fill out the brief one-page research questionnaire that came with this information sheet. The questionnaire asks about your decision to seek professional help. You also need to fill out the Strength and Difficulties Questionnaire or SDQ, which is a standard questionnaire you would normally complete for the Child and Adolescent Mental Health Service. You must also complete the consent form that is enclosed with the questionnaires if you would like to participate in this study. The consent form asks your permission to use your responses on the SDQ in this research. Both questionnaires will take about 15 minutes to complete.

What can participants expect from the researchers?

If you participate in the study, you have the right to:

- Refuse to answer any particular question and to withdraw from the study at any time without it affecting your contact with the child and adolescent mental health team;
- Be informed of the findings from the study when it is concluded; and
- Provide information on the understanding that it will be coded and that it will not be possible to identify you in any reports that arise from the study. Your responses will be confidential.

If you are interested in taking part, please complete and return the consent form and questionnaires to the Child and Adolescent Mental Health Service. If you have any questions about this research, please contact Tim Wahlin, during business hours on Tel: 02 4221 3747. If you have any questions about the conduct of this research please contact the Secretary of the University of Wollongong Human Research Ethics Committee on Tel: 02 4221 4457

Thank you for taking time to participate in this study.

Yours Sincerely

Tim Wahlin

Pathways to Professional Help for Young People

Youth Consent Form

I have read the Youth Information Sheet for this study. I know that if I agree to take part in the study, I will be required to complete a questionnaire on how I reached my decision to look for help with the Child and Adolescent Mental Health Service.

I also understand that the Strength and Difficulties Questionnaire (SDQ) I will fill out for the Child and Adolescent Mental Health Service, as a part of the team’s standard assessment practice, will be used in the research study.

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 treatment that I receive 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 I will not be identified in any publication of the results.

I understand that if I have any questions about the research I can contact Tim Wahlin, during business hours on Tel: 02 4221 3747. In addition, 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 Tel: 02 4221 4457.

I wish to participate in this study under the conditions set out on the information sheet.

Name: _____

Age: _____

Signed: _____

Date: _____

Youth Questionnaire

Age: _____ (years) Gender: Male/Female (Please circle one)

We are interested in finding out more about how young people experiencing problems find professional help. To help us to understand how young people reach help we would like you to think about who influenced you to attend the appointment you have today with the Adolescent Mental Health Service and answer the following questions.

Directions

1. Please circle the number on the scale below which indicates how much you think your decision to seek professional help was your own or influenced by others

Totally others Decision							Totally my Decision
1	2	3	4	5	6	7	

Directions

Please indicate how much each of the specific people listed below influenced your decision to seek professional help on this occasion.

	Not at all	Somewhat	Moderately	Very much so	A great deal
2. Parents	0	1	2	3	4
3. Other Relatives	0	1	2	3	4
4. Friends.....	0	1	2	3	4
5. Doctor.....	0	1	2	3	4
6. Teacher.....	0	1	2	3	4
7. School Counsellor.....	0	1	2	3	4
8. Legal Professionals (e.g., police, court officials, probation officers)	0	1	2	3	4
9. Youth Worker	0	1	2	3	4
10. Department of Community Services (DCS)	0	1	2	3	4
11. Other Please Specify_____	0	1	2	3	4

12. If your decision to seek help was influenced by others, do you think you would have sought help without their influence? (please circle) Yes / No

Thank you for participating

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