

Help-seeking measures in mental health: a rapid review

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An **Evidence Check** review brokered by the Sax Institute
for *beyondblue*

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This rapid review was brokered by the Sax Institute.

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CONTENTS

EXECUTIVE SUMMARY	6
1 Background	8
2 Introduction	9
History of help-seeking as a concept	10
Dimensions of help-seeking	10
Aims of the review	11
3 Methodology	13
Search strategy	13
4 Nature Of The Evidence	15
Origin of the evidence	15
Study sample characteristics.....	16
Study design	18
5 Help-seeking definitions	21
Standardised measures	22
Non-standardised measures.....	23
Help-seeking in the National Survey of Mental Health and Wellbeing.....	24
Elements of help-seeking	25
6 Conclusions	28
Common elements of help-seeking definitions and measures in Australia/New Zealand	28
7 Recommendations	30
Proposed definition	30
Implementation issues.....	32
References	34

EXECUTIVE SUMMARY

beyondblue commissioned this literature review to identify and synthesise key resources that define the term 'help-seeking behaviour' in the context of mental health and wellbeing. There is currently no agreed and commonly used definition of help-seeking, and the purpose of the review is to support recommendations for development of a standardised definition of help-seeking behaviour applicable to the Australian mental health context.

A database search revealed a very high level of research activity in the field, and restriction to the terms 'help', 'seek' and 'mental' was required to generate a manageable review. This generated 316 articles, which were systematically reviewed. Almost half the publications originated from the USA, but second most common were Australian publications, which comprised 15%. Publications ranged back to 1971, but there has been a surge in interest since 2005.

The review confirmed that there is no commonly referred to definition of help-seeking, and that most articles did not explicitly define the term but took its definition to be self-evident. Nevertheless, in the mental health context, help-seeking has been characterised primarily as an adaptive coping response to mental health problems that comprises a search for assistance from external sources.

There were no psychometrically sound measures of help-seeking that were routinely used in the literature. Most studies developed their own measures. The most commonly used standardised measures were the Attitudes Toward Seeking Professional Psychological Help Scale¹, which measures attitudes, and the General Help-Seeking Questionnaire², which measures intentions to seek future help and past help-seeking experiences.

There were few elements of help-seeking that were common across all definitions and population sub-groups, and no patterns were evident whereby particular elements were common to specific population sub-groups. The most common element was a focus on formal help-seeking sources, rather than informal sources, although studies did not assess a common set of professional sources—each study addressed an idiosyncratic range of formal sources.

Similarly, the studies considered help-seeking for a range of mental health problems and no consistent terminology was applied. The most common mental health problem investigated was depression, followed by use of generic terms such as mental health problem, psychological distress, or emotional problem.

On the basis of the results of the review, it is evident that a simple definition of help-seeking is much needed, along with development of psychometrically valid measures. It is recommended that help-seeking be defined as:

In the mental health context, help-seeking is an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern.

To enable consistency and the ability to compare study results, researchers need to be encouraged to consider and make explicit the following elements:

1. **Process** (and respective **timeframe**) refers to the part of the process that is of interest: whether the focus is on a general orientation or attitudes toward obtaining assistance; future behavioural intentions; or observable behaviour (either in the past or prospectively in the future)

2. **Assistance** is the **source** and **type** of assistance that is sought. **Source** of assistance needs to clearly distinguish:
 - a. professional health service providers with a specified role in delivery of mental health care (formal)
 - b. service providers and professionals that do not have a specified role in delivery of mental health care (semi-formal)
 - c. informal social supports (informal)
 - d. self-help resources (self-help)
3. **Concern** refers to the type of mental health problem for which help is being sought. This needs to be clearly defined and made explicit.

Finally, to develop a psychometrically sound measure of help-seeking that could be commonly applied across a range of studies and that clearly addresses each of the elements referred to above, a research project needs to be undertaken. This would provide clear examples of valid and reliable ways to operationalise help-seeking. In the meantime, using the general definition presented here and encouraging researchers to consider the major conceptual elements described above will begin to provide a guide to standardised outcome measurement, program development, resource allocation and assist stakeholders to communicate in this relation to this critical health care process.

1 Background

beyondblue, a leading Australian national stakeholder in mental health, has commissioned this literature review on the topic of help-seeking behaviour. The aim of the review is to identify and synthesise key resources that define the term 'help-seeking behaviour' in the context of mental health and wellbeing to make recommendations for development of a standardised definition of help-seeking behaviour applicable to the Australian mental health context.

A standardised evidence-informed definition of help-seeking behaviour in mental health has not been developed for the Australian context, nor internationally. This review will inform an important benchmarking initiative aiming to develop a consensus umbrella definition of help-seeking behaviour, with potential tailored application to priority population sub-groups. The consensus definition needs to have operational value to be able to guide program development, resource allocation, standardised outcome measurement, and assist stakeholders to communicate.

The audience for this review is primarily the senior policy makers and program managers within *beyondblue*, but it may be disseminated more broadly across the Australian mental health sector in the medium to longer term.

The major questions the review addresses are:

1. How has help-seeking behaviour been defined in the mental health context?
2. Which elements for definitions of help-seeking behaviours in mental health are common across all definitions and population sub-groups? Likewise, which elements for definitions of help-seeking behaviours are specific for population sub-groups or interventions (help type)?

Evidence related to these questions is used to address the main aim of the review, which is to:

3. Provide an evidence-informed expert recommendation, applicable to the Australian setting, on the feasibility and (if considered feasible) the potential content for a universal operational definition of help-seeking behaviour in the mental health context.

2 Introduction

Mental health is a major health priority area for Australia. The 2007 National Survey of Mental Health and Wellbeing found that almost half (45.5%) of Australians aged 16 to 85 experience a mental illness at some stage in their lives, with about one in five experiencing mental illness in any given year³. This rate increases to one in four for those aged 16 to 24⁴, and adolescence and young adulthood are acknowledged as critical life stages for mental health.

Despite the high prevalence of mental illness, most people do not access professional health care for mental health problems. It might be expected that the high prevalence of mental disorder should be matched by a high level of service use and associated help-seeking behaviour; but rather there is a marked mismatch between the prevalence of disorder and the level of professional help-seeking. Figure 1 shows the extent of this mismatch. It plots the percentage of Australians experiencing mental disorder within a 12-month period and the relative proportion of those with disorder who sought professional help.⁴ At all ages there is a much higher prevalence than there is service use, although the mismatch is greatest where the prevalence is highest—for those aged 16–24—and decreases with age. In the 16–24 year age group, for males, there were 23% who reported mental disorder, but only 3% of these young men had sought professional help (about 3% overall); for the females in this age group, 31% experienced mental disorder and 30% of these young women had sought professional help (about 10% overall).

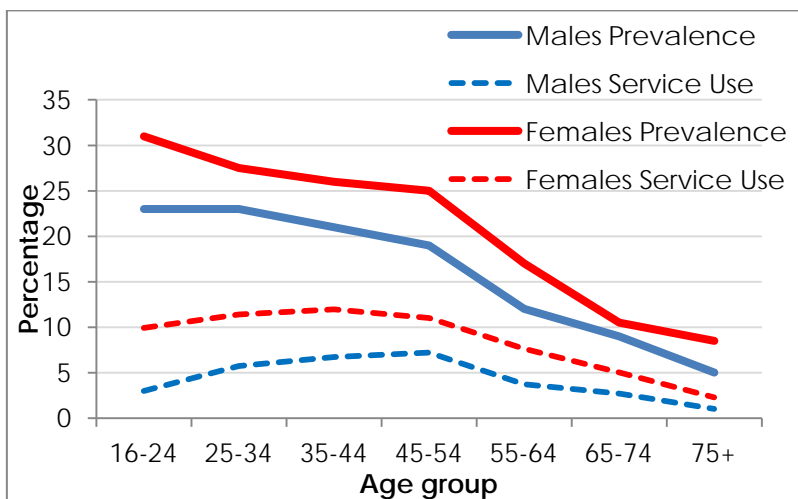


Figure 1. Prevalence of 12-month mental disorder and relative proportion who had sought professional help, by gender and age group

Consequently, a focus on understanding and encouraging help-seeking behaviour, particularly for young people, has emerged and become a growing priority for research, policy and program initiatives. For example, a major aim of *beyondblue* is raising awareness and improving mental health literacy to improve help-seeking behaviour; similarly a primary function of the headspace National Youth Mental Health Foundation is to increase young people's help-seeking behaviour for mental health problems.⁵

History of help-seeking as a concept

Despite the rapidly expanding research and intervention focus on help-seeking, there is no agreed definition of the term. At face value, its definition is self-evident. Using the Oxford Dictionary it can be defined as an 'attempt to find' (seek) 'assistance to improve a situation or problem' (help).

Within the health research context, the term originates from the medical sociology literature examining illness behaviour. 'Illness behaviour' is a term that was introduced by David Mechanic in 1962⁶ to refer to human health behaviour, incorporating the way people monitor their bodies, define and interpret their symptoms, take preventive or remedial action, or utilise the health care system⁷. The study of illness behaviour developed in response to recognition that people do not consult health care professionals whenever they experience symptoms. As far back as 1976, it was reported that people consult a doctor for only about one in 10 medically significant symptoms they experience⁸. Illness behaviour includes the many factors that determine how people respond to health symptoms and use health care.

A further rationale for studying illness behaviour is that the nature of health conditions has changed over time, particularly during the last half of the 20th century. Prior to that, acute and infectious diseases were the most prevalent; such diseases had symptoms that were easily recognised, were seen as a problem that was appropriate to be taken to the doctor, and the symptoms were expected to be cured or alleviated by medical treatment⁹. Around 1976, chronic illness, disabilities, mental disorders and living problems began to be recognised as the major health concerns for primary care¹⁰. Such conditions have symptoms that are not easily recognised and often have a gradual onset; they can be difficult to identify and interpret as something appropriate for medical attention. For these health conditions, the decision to consult a health professional is less influenced by the nature of the illness itself than by a voluntary help-seeking process.¹¹

Early models of illness behaviour were put forward by Mechanic⁶, Suchman¹², Aday and Andersen¹³, and others. Seeking help was conceptualised as one part of the illness behaviour process. However, even though it comprises part of the illness behaviour process, help-seeking is also conceptualised as a dynamic process itself.

One of the earliest definitions of help-seeking was provided by David Mechanic, who saw it as an adaptive form of coping. Later, help-seeking was defined as the behaviour of actively seeking help from other people.¹⁴ It was deemed to be about communicating with others to obtain assistance in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience. As such, it was a form of active and problem-focused coping, which relied on external assistance from other people.

Dimensions of help-seeking

Help can be sought from a wide range of external sources, including people who occupy different roles and who vary in terms of their relationship with the person seeking help. Two main types of help-seeking have been delineated—formal and informal:

- *Formal help-seeking* is assistance from professionals who have a legitimate and recognised professional role in providing relevant advice, support and/or treatment. Formal help-seeking is itself diverse and includes a wide range of professions. These include specialist and generalist health care providers, but also non-health professionals, such as teachers, clergy, community and youth workers. The term 'treatment-seeking'

has recently begun to be used to delineate seeking help from specific health treatment providers and seeking help from generic support and community services

- *Informal help-seeking* is assistance from informal social networks, such as friends and family. It comprises sources of help that have a personal, and not a professional, relationship with the help-seeker.

Most recently, *self-help* has emerged as an area of attention. This has occurred because of the rapidly growing opportunities to use computer mediated communication technologies to support mental health.¹⁵ Help-seeking can now include assistance from sources that do not comprise communication with an actual person. Sophisticated and dynamic help-seeking options are increasingly available through online and computer-mediated processes. Such options make an interpersonal component less critical in the help-seeking process.

There are, therefore, multiple—and expanding—**sources of help**, which can be categorised in different ways, including formal, informal and self-help.

Help can be sought for any **type of health problem**. Within the mental health field, this comprises a very wide range of potential issues. Mental health problems and mental disorders span many diverse conditions, and also comprise both emerging and mild conditions without specific diagnoses as well as very specific categories of illness diagnosed according to agreed criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD).

The **type of assistance** sought is also broad and can include almost anything that entails actively seeking assistance to address a problem or situation. Assistance can include: information, understanding, general support, advice, general or specific treatment in response to a particular problem or set of problems.¹⁴ The type of assistance sought can, therefore, range from entirely non-specific (help) in the form of some type of adaptive coping, to engagement of social support, through to an action that is very specific in terms of service use from a specific service provider, such as seeking a prescription from a general practitioner (GP).

Help-seeking occurs within a **timeframe**. It has been conceptualised as not being simply the act of responding to symptoms by accessing a source of health care, but rather as a complex process that take place over a period of time.

Finally, because help-seeking is a process, it is not just actual observable behaviour, such as specific acts of service use. Potential dimensions of the process can vary from actual behaviour to intentions to behave in certain ways through to more general orientations to behave in certain ways. The different parts of the behavioural process include dispositions, beliefs, attitudes, intentions and behaviours.

Aims of the review

The term help-seeking, while widely used, is not clearly defined and there is no current consensus on its definition or its measurement. The aim of this paper is to review and address this issue. It is evident that measurement of help-seeking requires, at a minimum, consideration of a number of elements, which can be summarised as:

1. Process – specific part of the behavioural process (attitude, intention, behaviour)
2. Source – source of assistance (formal, informal, self-help)
3. Problem – type of mental health problem
4. Assistance – type of assistance, from generic to specific

5. Timeframe – temporal constraints.

The aim of this study is to review the current state of the literature to determine how help-seeking has been conceptualised and measured. It will determine whether there is any consensus in the way the concept has been operationalised in the literature, and how the five elements outlined above have been addressed.

3 Methodology

A systematic review of the literature was undertaken by reviewing studies that met the selection criteria designed to generate the relevant literature on seeking help for mental health problems.

Search strategy

Initially, a broad search strategy was implemented covering all studies published in English prior to the search date of 13 June 2012. The following EBSCO databases were searched: Academic Search Complete, CINAHL Plus, MEDLINE, PsycINFO.

Initial searches using relevant terms yielded a huge number of articles. For example:

- Requesting 'help*' and 'seek*' in the title and 'mental*' or 'emotional' or 'psychological' in subject terms, resulted in 424,902 articles
- Requesting 'help*' and 'seek*' in the title and 'emotional' or 'psychological' in subject terms, resulted in 124,331 articles
- Requesting 'help*' and 'seek*' in the title and 'emotional' or 'psychological' in subject terms and 'mental*' to NOT be in the search resulted in 109,034 articles
- Requesting 'help*' and 'seek*' in title and 'emotional' or 'psychological' to be in the title (rather than subject terms) resulted in 36,865 articles.

These searches reveal the huge amount of interest in the area of help-seeking within the mental health field; however, the output from these searches was unmanageable for a review.

A more manageable search strategy was shown to be using the terms 'help*' and 'seek*' in the title and 'mental*' in the subject term, which resulted in 939 articles. When the search was limited to articles that were reported in English, were peer-reviewed, were related to only human behaviour, and duplicate MEDLINE results were removed from CINAHL, 480 articles remained. These results were exported to Endnote, and 84 further duplicates were removed, resulting in 396 articles. Seventeen of these articles were review articles, and seven were proposed models of help-seeking, which were removed to a subfolder, resulting in 372 articles. A review of titles and abstracts revealed that there were 62 non-relevant articles, which included seeking help for job hunting, asylum seeking, grieving, and for medical problems such as irritable bowel syndrome, tinnitus, premenstrual syndrome, and HIV/AIDS.

The final result yielded 310 relevant articles. These were supplemented by a search of the Cochrane database, using the same search terms. This yielded 64 articles, of which one was relevant, after duplicate articles from the previous search and articles not relevant were removed. Finally, a search of PubMed, available through CareSearch, as well as a search of major agency reports (i.e. World Health Organization, Australian Institute of Health and Welfare) was conducted, resulting in 1488 articles. These were limited to human, clinical trial, meta-analysis, randomised control trial, systematic review and review, resulting in 257 articles, of which 231 were not relevant to mental health help-seeking. Of the 26 relevant articles, 13 had already been identified in the previous searches, seven were review articles and one was a proposed model of help-seeking. This resulted in an additional five articles.

It should be noted that this search strategy was highly targeted and, therefore, not exhaustive. It did not produce all the relevant articles on help-seeking within the mental health context. In fact, many seminal articles were not captured by the search (i.e.^{16,17,18}). However, a preliminary

investigation of the articles that were produced showed that the help-seeking measures that were used in the well-known seminal articles that were not captured had been picked up. Consequently, the search strategy is argued to be effectively comprehensive for the aim of determining the ways that help-seeking has been conceptualised and measured within the mental health field.

The final combined search of relevant articles yielded 316 articles. Each of these articles was read by one of the authors and its details entered into a spreadsheet. There were 25 different characteristics of the studies considered and recorded. A random sample of 15% of the articles was rechecked by another author.

4 Nature of the Evidence

A brief summary of the general characteristics of the evidence generated by the review search is provided below. This includes the origin of the evidence, the main characteristics of the study populations, and the types of designs of the studies.

Origin of the evidence

Country of origin

It is evident from Figure 2 that most of the publications originate from the USA, followed by Australia. Almost half (45%) of the publications were from the USA; 15% from Australia; 8% from the UK; 6% from Canada; 4% from the Netherlands; and 3% from New Zealand. A diverse range of other countries made up the remaining 18% of the publications, but there were fewer than 2% of articles from any particular country.

There were 58 publications that were from Australia or New Zealand.

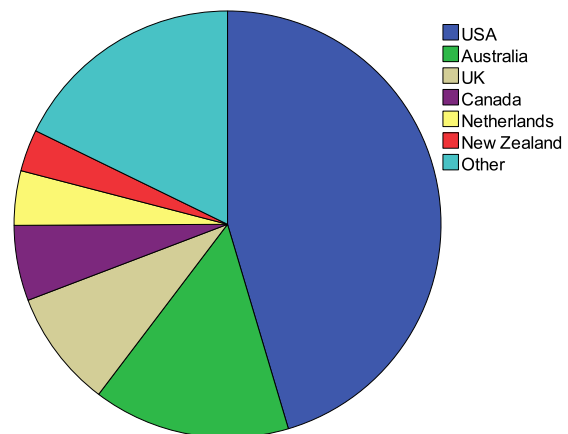


Figure 2. Country of origin of publication

Year of publication

The year in which the articles were published is presented in Figure 3. This shows the large growth in interest in the help-seeking area. Publications generated by the database search went back to 1971, and a major surge in interest is evident from 2005. A similar pattern was evident for the Australian/New Zealand articles, the first of which was published in 1974, and half were published after 2005.

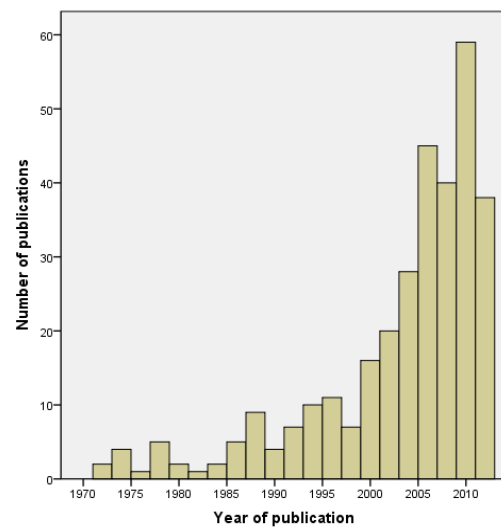


Figure 3. Year of publication

Study sample characteristics

Age of participants

Age group of the participants in the review studies is presented in Figure 4. This shows that just over half the studies (51%) were of general adult populations, aged 18 years and over. The next most common were studies of early adults aged 18–25 (14%), followed by teenagers aged 12–18/9 (12%), parents of children and adolescents (8%), and middle-aged adults (4%). There were very few studies of children (2%) or adults aged over 65 years (2%).

In the Australian and New Zealand studies (Figure 5), there was a much greater proportion of articles focussed on teenagers and youth (40%), and none on children or older adults.

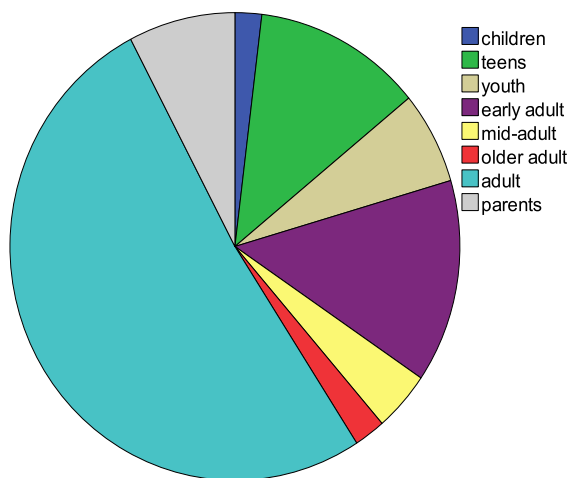


Figure 4. Age group of study participants

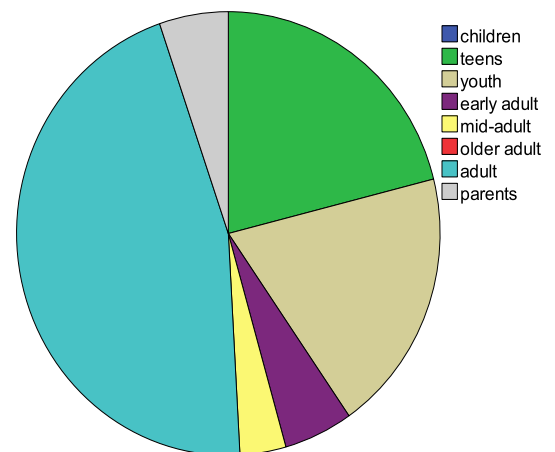


Figure 5. Age group of study participants (Aust/NZ)

Gender of participants

Most studies had an equivalent number of male and female participants (56%), as shown Figure 6. Otherwise, the studies had either a majority (14%) or were predominantly (9%) or completely (8%) female sample groups. There were 4%, 1% and 7% where the sample was mostly, predominantly or completely male, respectively.

A relatively similar pattern was evident for participants in the Australian/New Zealand studies (Figure 7), although there was a higher proportion of studies with more female participants.

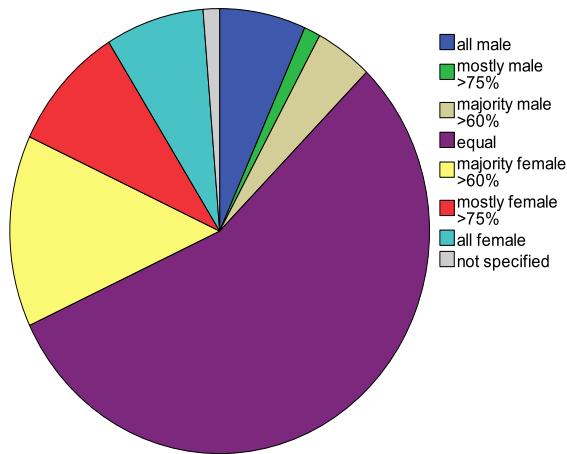


Figure 6. Gender of study participants

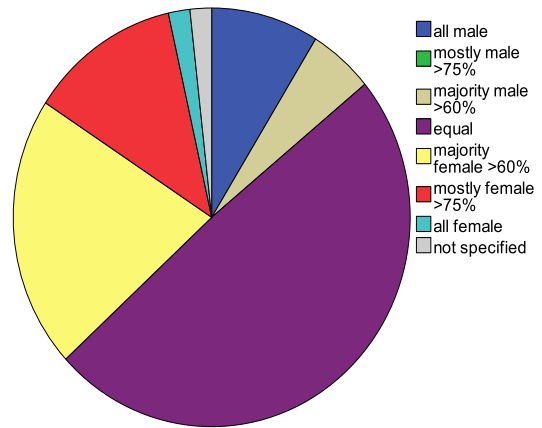


Figure 7. Gender of study participants (Aust/NZ)

Regional setting of participants

The regional setting of study participants is presented in Figure 8. This shows that over half the studies (54%) were of urban or inner urban populations. The next most common were studies where the setting was not specified (18%), followed by studies that ranged across urban, regional and rural settings (16%). There were 6% of studies in each of regional and rural settings, and only one study that was specifically of participants from a remote setting.

For the Australian and New Zealand studies (Figure 9), there were more where the setting was not specified (28%), and relatively fewer that were of urban or inner urban only (44%). There were 12% that were regional or rural, but no studies of participants specifically in remote locations.

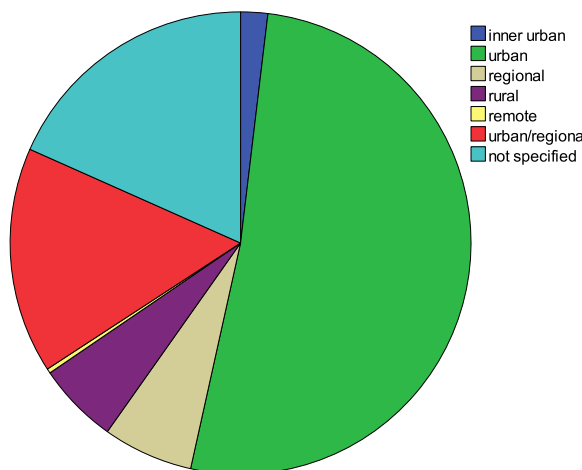


Figure 8. Regional setting of study participants

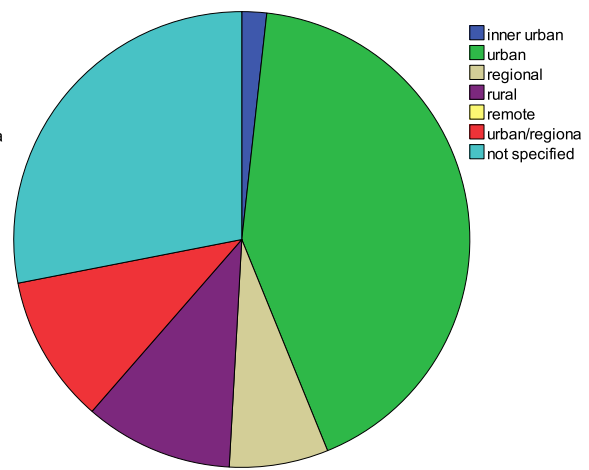


Figure 9. Regional setting of study participants (Aust/NZ)

Type of participant sample

The type of study participants is presented in Figure 10. This shows that most of the studies were of general community-based samples (41%). The next most common was studies of college/university students (20%), followed by mental health service population groups (12%). There were 10% of studies based on school students. About 8% of studies were of general health

or community services populations, and 6% were of very specific types of community groups. A very small number of studies were of samples from inpatient services and prisons (1.6% each).

In the Australian and New Zealand Studies (Figure 11), a similar proportion was of the general community (42%), but more were school student population groups (23%).

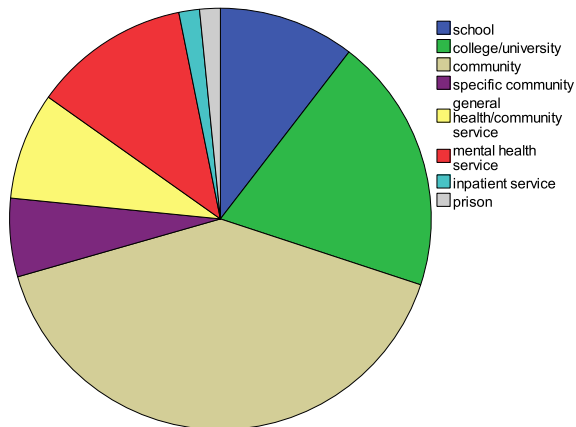


Figure 10. Type of study participants

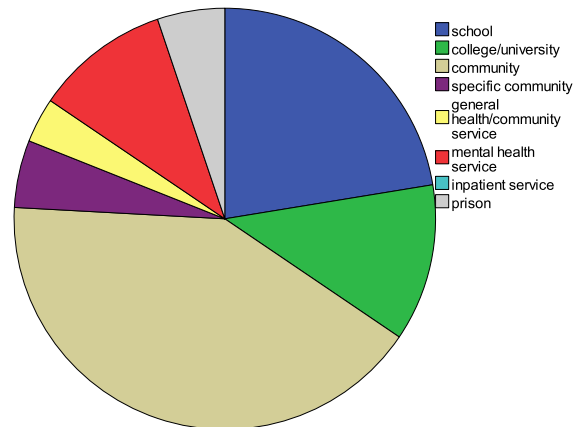


Figure 11. Type of study participants (Aust/NZ)

Cultural background of participants

The cultural background of the participants was generally not specified; this was the case for almost half the studies (47%). For those studies where cultural background of participants was specifically noted, the majority were of general USA population groups (23%), followed by African American samples (15%), reflecting that most studies originated in the USA. Overall, there was a wide range of cultural backgrounds studied; investigating the help-seeking behaviour of particular Culturally and Linguistically Diverse (CALD) groups is of considerable interest, particularly in the USA.

For the Australian and New Zealand studies, a large proportion did not specify the cultural background (65%). There were 14% that were of general New Zealand cultural background and 13% that were of general Australian or Caucasian background.

An important aspect related to cultural background that was evident, however, was the sources of help that were provided as options in various studies. Although difficult to quantify because of the lack of specific information on cultural background, the different sources of help tended to vary according to the nature of the population groups being studied. For example, 'prayer' appeared to be included more often as a source of help within the US studies compared with the Australian and New Zealand studies. Traditional healers were included as a source of help in studies that included population groups for whom such roles are an important, and often formal, source of support.

Study design

The studies were examined for their sample size, type of design, level of evidence and the conceptual frameworks that were applied.

Sample size

There was a large range in sample size amongst the studies. The smallest sample size was n=10 from a qualitative study comprising interviews with parents who had sought help for children with early signs of mental disorder in Canada¹⁹; the largest was a nation-wide epidemiological study—the Canadian Community Health Survey—with n=123,543.²⁰

Sample size of the Australian and New Zealand studies ranged from n=16 from a study of that investigated barriers to help-seeking for mental health concerns and explored the role of psychological mindedness using semi-structured interviews with 16 adults in a South Australian rural centre²¹ to a study of n=966²² randomly selected secondary school students from across New Zealand who participated in the Youth2000 Health and Wellbeing Survey.

Type of design

In terms of overall study design, the majority of studies were cross-sectional designs. This was followed by qualitative studies. There were few longitudinal or prospective studies.

Table 1 shows the percentage of studies that used each type of design.

Table 1. Percentage of studies by type of design

Type of design	All studies	Aust/NZ studies
Cross sectional	73	69
Qualitative	14	17
Longitudinal	6	7
Intervention	3	5
Prospective	4	2

Level of evidence

Overwhelmingly, the level of evidence produced by the studies according to NHMRC criteria²³ was very low (Table 2). The vast majority were descriptive studies of population groups with no comparisons. There were only two randomised controlled trials (RCT).

One of the RCTs was Australian²⁴, and comprises a randomised controlled trial of 1094 persons randomly selected from the community who screened positive for depressive symptoms. Participants were mailed either an evidence-based consumer guide to treatments for depression or, as a control, a general brochure on depression. Outcomes were the rated usefulness of the information provided, changes in attitudes to depression treatments, actions taken to reduce depression, and changes in depressive symptoms, anxiety symptoms and disability. The results showed that the participants rated the evidence-based consumer guide as more useful than the control brochure, and that attitudes to some treatments changed. Improvements in symptoms and disability did not differ significantly between interventions.

The other RCT study²⁵ examined barriers to seeking mental health care reported by individuals in a rural impoverished population. There were 646 randomly selected adults screened for depression, anxiety, and alcohol abuse. Respondents who screened positive were randomly assigned to: no intervention, an educational intervention alone, or the educational intervention in the presence of a significant other. Virtually all respondents said they would seek mental health care if they thought mental health services would help them. Respondents who received the

educational intervention endorsed several barriers at significantly lower rates in the follow-up than prior to the intervention.

Table 2. Percentage of studies by level of evidence

NHMRC Level of evidence		All studies	Aust/NZ studies
II	Randomised controlled study	0.6	1.7
III.II	Comparative study: non-randomised	1.7	1.7
III.III	Comparative study: non-control	7.6	7.6
IV	Case study: non-comparative	90.2	87.9

Conceptual framework

Finally, the studies were examined for the conceptual frameworks they applied. Overwhelming, the studies were descriptive and applied no conceptual framework (81%). The most common conceptual framework used was the Theory of Planned Behaviour/Reasoned Action²⁶ (TPB) (4%). There were about 3% that used Andersen and Aday's²⁷ service utilisation framework, 1.3% that applied one of the stages of help-seeking models¹⁴, and just over 1% that used the Network Episode Model.²⁸ Another 10% used a range of other conceptual frameworks, each of which was unique to the study and not a specific help-seeking model.

Similar patterns were evident for the Australian and New Zealand studies, although there was a slight preference for the Theory of Planned Behaviour/Reasoned Action (7%). This focus on the TPB is important to note because the theory proposes that actual behaviour is a rational decision that is made according to intentions to behave in a particular way, and that intentions are in turn determined by attitudes, as well as subjective norms and perceived behavioural control (which can also have a direct effect on behaviour). This conceptual framework supports a focus on the three different processes—attitudes, intentions and behaviour. It is important to note, however, that the strength of associations between attitudes, intentions and behaviour is typically weak²⁹, particularly for the relationship between intention and behaviour, and in the study of help-seeking for mental health problems compared with other health-related issues.³⁰

5 Help-seeking definitions

The review revealed that many different definitions have been applied in the mental health context and there is no commonly referenced single definition that is routinely referred to.

Overall, almost half the studies provided no clear definition of what they meant by help-seeking (46%). Many studies provided minimal definitions, such as 'visiting a doctor', 'utilisation of care', 'seek advice and assistance' and 'willingness to seek help'.

One of the most comprehensive attempts to define help-seeking comes from a World Health Organization study of adolescent help-seeking³¹, which defined it as:

- *Any action or activity carried out by an adolescent who perceives herself/himself as needing personal, psychological, affective assistance or health or social services, with the purpose of meeting this need in a positive way. This includes seeking help from formal services—for example, clinic services, counsellors, psychologists, medical staff, traditional healers, religious leaders or youth programmes—as well as informal sources, which includes peer groups and friends, family members or kinship groups and/or other adults in the community. The 'help' provided might consist of a service (e.g. a medical consultation, clinical care, medical treatment or a counselling session), a referral for a service provided elsewhere or for follow-up care or talking to another person informally about the need in question. We emphasize addressing the need in a positive way to distinguish help-seeking behaviour from behaviour such as association with anti-social peers, or substance use in a group setting, which a young person might define as help-seeking or coping, but which would not be considered positive from a health and well-being perspective.*

Other definitions include:

- *The active search for resources that are relevant for the resolution of that problem*³²
- *Help-seeking behaviours involve a request for assistance from informal supports or formalised services for the purpose of resolving emotion, behavioural, or health problems*³³
*The decision to seek some form of professional assistance and the choice of a particular help source*³⁴
- *The first stage of the social support process; that is, to a person, the recipient, taking the initiative and communicating with others to request any kind of support, whether affective, valuative, or instrumental.*³⁵

For the Australian and New Zealand studies, over one-third of the studies provided no definition of help-seeking (38%). Of those that did, some of the more comprehensive attempts included:

- *A request for assistance with problems that the individual does not have the personal resources to solve on their own*³⁶
- *An active process of using assistance from other people to solve problems*³⁷
- *The extent to which individuals utilise different sources of support for overcoming personal difficulties.*³⁸

Standardised measures

A minority of the studies used a standardised measure (31%). The most commonly used standardised measure was the attitude measure published in 1970 by Fischer and Turner—the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS)³⁹ and its adaptations, including its short form. This was used by 17% of studies overall, and comprised 55% of those that used a published standardised measure. Another 10% of studies used some type of published measure, but these were generally unique to the study, and did not comprise measures with reported psychometric properties; there were 24 different named measures, only one of which was used by more than two studies. Consequently, the next most common measure, which was used by 3% of studies overall, and 10% of those with a standardised measure, was the General Help-Seeking Questionnaire (GHSQ).^{2,14}

Among the Australian and New Zealand studies, there were 32% that used a standardised measure; half (16%) used the ATSPPHS and the other half used the GHSQ.

Attitudes Toward Seeking Professional Psychological Help Scale

The Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS)³⁹ is made up of 29 items designed to assess general attitudes toward seeking professional psychological help for psychological problems and issues. The full scale has four factors: recognition of personal need for psychological help (8 items); stigma tolerance associated with psychological help (5 items); interpersonal openness regarding one's problems (7 items); and confidence in mental health professionals (9 items). Items are rated on a 4-point Likert-type scale ranging from (0) *disagree* to (3) *agree*. Items include, "If I believed I was having a mental breakdown, my first thought would be to get professional attention". Note that a large number of adaptations of the measure have been developed, and very few studies are fully compliant with the original measure. A brief 10-item version has also been developed⁴⁰, but again many researchers adapt the language used in the measure.

With regard to the elements of help-seeking identified in the introduction as important to consider, the ATSPPHS covers the following:

- Process – general attitudinal orientation
- Source – unspecified professional sources; wording in items varies, including 'psychiatrist', 'psychologist', 'counselling', and 'professional help'
- Problem – unspecified psychological problems; items use several different terms to refer to psychological problems including: 'mental breakdown', 'worried or upset for a long time', 'personal and emotional problems', and 'emotional difficulties'
- Assistance – not specified
- Timeframe – not specified.

General Help-Seeking Questionnaire

The General Help-Seeking Questionnaire was developed in Australia (GHSQ).^{2,14} It assesses future help-seeking intentions and recent and past help-seeking experiences. Often the intentions measure is referred to as the General Help-Seeking Questionnaire and the past help-seeking experiences as the Actual Help-Seeking Questionnaire (AHSQ).

Intentions are measured by listing a number of potential help sources and asking participants to indicate how likely it is that they would seek help from that source for a specified problem on a 7-point scale ranging from (1) *extremely unlikely* to seek help to (7) *extremely likely* to seek help.

Note that the specific sources of help listed, the future time-period specified and the type of problem can be modified to be appropriate to the particular research objectives. For example, school counselors or internet sources can be made specific sources of help if these are a research focus.

With regard to the important elements of help-seeking, the GHSQ covers the following:

- Process – future behavioural intentions ('likelihood' of behaviour)
- Source – measure can be adapted to list specific sources, including formal, informal and self-help
- Problem – measure can be adapted for different types of problems; it has often been used referring to 'personal or emotional problems'
- Assistance – not specified
- Timeframe – measure can be adapted for different time periods.

Past help-seeking behaviour is operationalised by asking whether professional help has been sought in the past for a specified problem and, if help has been sought, how many times it was sought, what specific sources of help were sought, and whether the help obtained was evaluated as worthwhile on a 5-point scale indicating more or less helpfulness.

Recent help-seeking behaviour is determined by listing a number of potential help sources and asking whether or not help has been sought from each of the sources during a specified period of time for a specified problem. Note that the specific sources of help listed, the time period specified and the type of problem can be modified to be appropriate to the particular research objectives.

To provide additional descriptive information and to ensure that participants are responding in the appropriate way, participants are asked to briefly elaborate on the nature of the problem for which help was sought. Participants can also indicate that they have had a problem, but have sought help from no one.

With regard to the elements of help-seeking identified in the introduction as important to consider, the AHSQ has the following characteristics:

- Process – recent and past behaviour
- Source – needs to be specified, and measure can be adapted to list specific sources, including formal, informal and self-help
- Problem – needs to be specified, and measure can be adapted for different types of problems; it has often been used referring to 'personal or emotional problems'
- Assistance – not specified
- Timeframe – needs to be specified, and measure can be adapted for different time periods.

Non-standardised measures

Over half the studies (52%) developed self-report questionnaire-based questions specifically for the study. Another 11% developed interview questions specifically for the study; a further 4% developed focus group questions related to help-seeking; and 2% used behavioural indicators from a database. Among the Australian and New Zealand studies, a similar proportion (48%) used

self-report questionnaire-based questions developed specifically for the study. Another 12% used interview questions specific to the study, and 9% developed focus group questions.

Items related to attitudes toward seeking particular types of formal help generally used a 4-point response scale from *strongly disagree* to *strongly agree* to determine the direction and strength of the evaluation of that source of help. Very often multiple sources of help were investigated.

Studies investigating actual behaviour of seeking particular sources of help generally used a dichotomous *yes/no* response format. Either one particular source of help was of interest or several different sources of help were investigated.

The remainder of the studies used interview-type questions that determined either a general evaluation of a source of help or whether that particular type of help had been sought in the past. More in-depth information related to unique help-seeking experiences was revealed by these studies.

Help-seeking in the National Survey of Mental Health and Wellbeing

The measures of help-seeking used in the National Survey of Mental Health and Wellbeing (NSMHWB) are worth special mention because these results are frequently used to show the low level of help-seeking for mental health problems among Australians (i.e. Figure 1). Note, however that these measures were not used in any of the reviewed studies.

Many different types of detailed questions were used in the NSMHWB, but with regard to the important elements of help-seeking, the questions generally consider the following:

- Process – past behaviour
- Source:
 - friends or family
 - telephone counselling
 - the internet
 - doctors or professionals:
 - general practitioner
 - psychologist
 - psychiatrist
 - mental health nurse
 - other mental health professional
 - other specialist doctor
 - other health professional who provide general services including social workers, occupational therapists or counsellors
 - complementary or alternative therapist
- Problem – ‘mental problems such as stress, anxiety, depression, or dependence on drugs or alcohol’
- Assistance:
 - information about mental illness, its treatment and available services
 - medicine or tablets
 - psychotherapy – discussion about causes that stem from the past
 - cognitive behaviour therapy—learning how to change your thoughts, behaviours and emotions
 - counselling – help to talk through your problems

- help to sort out housing or money problems
 - help to improve your ability to work, or to use your time in other ways
 - help to improve your ability to look after yourself or your home
 - help to meet people for support or company
 - other – specify
- Timeframe–most questions were framed as ‘In the past 12 months’, but some asked about lifetime (‘ever’).

Elements of help-seeking

Process

Overall, most studies used a measure of past behaviour (48%). Next most common were measures of attitudes toward help-seeking (44%). There were 12% of studies that measured orientation, 12% that measured intentions, and 8% that measured current behaviour. Almost a quarter of the studies (22%) measured more than one dimension, most often both attitude and past behaviour.

Among the Australian and New Zealand studies, there were more that used measures of attitudes (51%) and 39% focussed on past behaviour. Intentions were also more commonly studied (33%). A similar proportion examined orientation (10%), and very few measured current behaviour (4%). Just over one-third (35%) measured more than one dimension, most commonly attitudes and some other dimension.

A small proportion of the studies (about 10%) used vignettes to examine hypothetical help-seeking attitudes or intentions. Vignettes allow people to *anticipate* what they would do *if* they were experiencing the symptoms described in the vignette. Such measures are useful in studies of non-clinical populations to attempt to determine what people who are not experiencing symptoms would do if they were to experience symptoms. Vignettes have been used more often in the Australian and New Zealand studies (about 20% of studies), possibly because the vignettes are often based on Jorm’s work on mental health literacy⁴¹, which originated in Australia and is often incorporated as a predictive factor in studies of help-seeking.

Source of help

The majority of studies were of formal help-seeking behaviour (66%) and a further 32% were of both formal and informal; only 2% were of informal help-seeking only. A similar pattern was evident for the Australian and New Zealand studies. No studies generated by this review were directly related to self-help; studies with such a focus would be more likely to be generated by different search terms (i.e. specifically ‘self-help’).

Examining sources of help in more detail revealed that a wide range of sources of help were investigated and rarely were exactly the same sources of help examined over several studies. The common terms used were:

- **Informal** – most studies referred to friend and family, but also included parents, mother, father, peer, partner, relative, sibling, neighbour, colleague, social network, lay support, close friends
- **Formal** – many studies used the generic term mental health professional, and also common were the specific terms of counselor, psychologist and psychiatrist. Other terms included:
 - clinical psychologist, social worker, therapist

- o GP, family doctor, family physician, doctor, nurse, paediatrician
- o school counselor, guidance officer, teacher, school staff, school supports, school psychologist
- o academic advisor, university counselor, student advisor, professor
- o help-lines, phone help, internet resources, website
- o clergy, minister, traditional healer, faith healer, spiritual support, religious leader, folk healer, prayer, priest/minister/rabbi, spiritual healer, church member, religious counselor, chaplain
- o work supports, manager
- o herbalist, acupuncturist
- o coach, youth worker, police
- o mental health service, professional psychological help, health services centre, community mental health service, psychiatric outpatient clinic, primary health care, social agencies, support group, school health service, family counselling service, accident and emergency, psychiatric hospital, inpatient unit, outpatients.

It is important to acknowledge that the distinction between formal and informal sources of help varies depending on the population group and context under consideration. For example, a traditional healer could be a critical source of formal health care in a traditional indigenous population group, but not so in a study of a mainstream urban 'western' population. The great diversity of health care providers, other types of service providers and different types of professionals means that the terms 'formal' or 'professional' need to be explained. In the mental health context, it can be useful to distinguish between formal service providers that have a clearly identified and specific professional mental health care role, such as a psychologist, and other professionals who might have a semi-formal role in the help-seeking process, such as a teacher.

Problem

For types of mental health issue, about half the studies listed more than one type of mental health problem as their focus; this comprised 46% of the total studies and 57% of the Australian and New Zealand studies. Those that listed only one problem type, most often used a generic term such as 'mental health problem'. There were a small number of studies that focussed on a very specific mental health problem or mental disorder (such as ADHD, eating disorder, schizophrenia).

Table 3 shows the percentage of studies that focused on different types of mental health problems. Overwhelmingly, depression was the mental health problem that was most commonly studied. Studies using generic terms of 'mental health problem' or 'personal or emotional problem' or 'psychological or emotional distress', comprised 35% of studies overall, and 23% of the Australian and New Zealand studies. Anxiety was the most commonly studied specific mental health problem after depression.

Suicide-related issues were a focus on 10% of studies overall, and slightly more of the Australian and New Zealand studies (16%).

More serious mental illness, such as psychosis and schizophrenia, as well as use of the term 'mental illness' were foci in a minority of studies. Similarly, alcohol and other drug use was in the minority – however, this can be attributed to use of the specific search term 'mental'.

Table 3. Percentage of all studies and Aust/NZ studies by type of mental health issue

Mental health issue	All studies	Aust/NZ studies
Depression	30	40
Mental health problem	19	10
Anxiety	17	21
Personal/emotional problem	15	10
Suicidal ideation/suicide/self-harm	10	16
Psychosis/schizophrenia	8	5
Alcohol or other drug use	7	5
Psychological/emotional distress	6	3
Mental illness	5	5

Type of assistance

The specific type of assistance sought or provided was very rarely made explicit. It was not specified what form of assistance was specifically sought in terms of issues such as information, advice, therapy, general support, etc. In particular, the questionnaire-based studies did not drill down to this level of detail. Qualitative studies were more likely to investigate the type of assistance that was sought or received, although these were not rigorously described or categorised.

Timeframe

In the vast majority of studies the timeframe was either not specified in the measure or not made clear in the study methodology; this was the case for 70% of all studies and 76% of the Australian and New Zealand studies. Just over 1% of all studies had a one week timeframe; 3% of all studies and of the Australian and New Zealand studies had a one month timeframe; 5% of all studies and of the Australian and New Zealand studies had a 2–6 month timeframe; there were 16% of all studies and 12% of the Australian and New Zealand studies that had a 12-month time frame; 3% of all studies and of the Australian and New Zealand studies had around a 2-year time frame; and 3% of all the studies, but no Australian and New Zealand studies had a lifetime timeframe.

6 Conclusions

Overall, the main conclusions to be drawn from this review are that no clear definition of help-seeking has been applied within this literature area and there are no commonly applied, well-developed measures in use. This is despite a very large number of publications in the area and rapidly growing interest in the field. Consequently, the development of a workable definition and some agreed and psychometrically sound measures is long overdue.

Even though a consensus definition is lacking, a common component evident in help-seeking definitions or implicit in their application, is that help-seeking is an active and adaptive process of attempting to cope with problems or symptoms by using external resources for assistance. The lack of consensus comes about through wide variation in how the different elements of such a broad definition are operationalised: the focus of the process varies from hypothetical attitudes to specific past behaviour; the types of problems or symptoms are wide-ranging and can include very specific mental health problems/diagnoses or generic terms for psychological or emotional distress; and there are many potential external sources of help. Elements that are very poorly operationalised include timeframe, which is often not clearly specified or very imprecise (i.e. 'ever'); and the type of assistance sought, which is generally not ascertained, probably because there are so many potential forms of assistance and they have not been systematically categorised (information, support, therapy, etc.).

Common elements of help-seeking definitions and measures in Australia/New Zealand

For the studies that originated in Australia and New Zealand specifically, there was little consistency in application of definitions or measures of help-seeking. Some of the more common characteristics were:

Definition of help-seeking:

- No clear definition of help-seeking evident, but an implicit or explicit understanding that help-seeking was an active process of using the resources of other people to deal with problems.

Population groups studied:

- While almost half the studies focused on general adult populations, a substantial proportion (40%) were of teenagers or youth; there were no studies of older adults and very few of children
- Most studies comprised equivalent numbers of males and females, or had a higher proportion of females
- The majority of studies were of urban population groups, although often the regional setting was not clearly stated; there were no studies of people in remote areas
- Most studies were of general community populations (non-clinical groups), but the next most common participant type was high school students, followed by university students
- Cultural background was generally not specified; where it was, the study population group was usually described as mostly Caucasian or Australian.

Study designs:

- Most studies were cross-sectional, questionnaire-based descriptive studies

- Few applied a clear conceptual framework, being largely descriptive
- The most common conceptual framework was the Theory of Planned Behaviour.

Measures of help-seeking:

- Few studies used a standardised measure and most developed a measure for the specific study
- Where a standardised measure was used, it was either the ATSPPHS or the GHSQ
- Most studies focused on attitudes toward seeking particular types of support using an past behaviour was also a strong focus, usually using a response scale format of whether help had been sought or not
- All studies focused on formal help-seeking, usually examining mental health professionals, GPs, psychologists and psychiatrists; informal supports of friends and families were often included in the list of potential sources, but were not the primary focus
- The main mental health problem of interest was depression, followed by generic terms indicating psychological or emotional problems or distress; anxiety was the next most common mental health problem indicated, and almost 20% of studied included suicidal ideation as an issue
- The type of assistance sought or obtained was rarely specified.

Most studies did not specify or report a timeframe; where timeframes were evident, this was usually over the past 12 months.

7 Recommendations

An agreed definition of help-seeking within the mental health context is much needed and long overdue. To take the field forward and be able to compare the findings of studies over time and across different population groups, there needs to be an agreed understanding of what is being measured. This would guide program development, resource allocation, standardised outcome measurement, and assist stakeholders to communicate.

Proposed definition

While challenging, due to the broad nature of the process of help-seeking and diversity in how it has been investigated to date, it is feasible to develop a universal operational definition because most studies have a similar underlying implicit definition. However, a universal definition needs to incorporate the diverse aspects of the help-seeking process of interest to specific research and practice applications. A definition that enables consistency and comparability, but also allows a focus on specific aims and aspects of help-seeking, will greatly advantage the field.

A proposed general definition is as follows:

In the mental health context, help-seeking is an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern.

This definition is made up of three main elements, and each of these needs to be explicitly considered in help-seeking measures:

1. **Process** (and respective timeframe) refers to the part of the behavioural process that is of interest—whether the focus is on a general orientation or attitude toward obtaining assistance, future behavioural intentions, or observable behaviour (either in the past or prospectively in the future). It is essential that studies are explicit about which part of the process they are focused on, which can be one of the following components:
 - a. General orientation or attitude toward obtaining assistance
 - b. Future behavioural intention
 - c. Observable behaviour—either in the past or prospectively in the future.

Note that attitude, or general orientation, is not truly a measure of help-seeking in the sense of an active coping attempt. However, because attitudes have been such a large focus in the literature, it is not possible to exclude attitudinal approaches from conceptualising a measure. Attitudes are relevant as part of a general orientation or propensity to seek help, rather than comprising actual help-seeking itself. The expected process is that attitudes would predict intentions, which would predict behaviour, consistent with the Theory of Planned Behaviour. It is essential that future research fully investigate the strength of relationships between orientation/attitudes, intentions, and actual behaviour to determine the usefulness of each part of the process for understanding behaviour and avenues for effective intervention.

- **Timeframe** – a course of action takes place within a particular timeframe, and this needs to be clearly specified. The better defined the timeframe, the better respondents are able to provide a reliable and valid response. Timeframes can be retrospective or prospective. Many studies have examined a 12-month period, but timeframes need to be able to vary to suit the purposes of different research aims.

2. **Assistance** – refers to the characteristics of the assistance that is sought, including the source and the form (or type) of assistance.
- **Source** of assistance varies according to the level of professional expertise and relationship with the person seeking help, as well as the origin of the resource (i.e. online). Sources need to be clearly specified. Then, because there are so many potential single sources of assistance, it is useful to be able to aggregate related sources into categories of ‘formal’, ‘semi-formal’, ‘informal’ or ‘self-help’ resources. Such classifications are not absolute, however, and will vary depending on cultural context and other factors. Consequently, it is preferable for sources of help to be specifically and individually listed; classification of the sources should then be carefully considered and choice of category explained. Useful general classifications for the mental health field include:
 - a. Professional health service providers with a specified role in delivery of mental health care (formal) – i.e. psychiatrist, psychologist, GP, mental health nurse
 - b. Service providers and professionals that do not have a specified role in delivery of mental health care (semi-formal) – i.e. teacher, work supervisor, academic advisor, youth worker, coach
 - c. Informal social supports (informal) – i.e. friend, partner, parent
 - d. Self-help resources (self-help) – i.e. unguided website use.
 - **Type** of assistance refers to the form of actual support that is sought, such as psychoeducation, referral, supportive counselling, therapy, etc. This element has not been well developed to date in the literature and it is not currently possible to identify relevant dimensions. However, it would be helpful for research to begin to explore the actual forms of help that are sought to start to develop relevant categories of types of assistance.

Research from the social support field provides some guidance. For example, social support has been categorised into the following four categories³¹:

- Instrumental support – financial assistance, transport
- Informational support – health-related information, referral information
- Affiliative support – peer support
- Emotional support – support for emotional wellbeing.

A further category for the mental health context could be type of treatment or health service provision:

- Treatment – type of treatment or therapy.

It is likely that much of the time people seeking help may not know exactly what type of assistance they are seeking – they just want to alleviate their distress or symptoms by whatever means. This help-seeking element is currently unexplored in the literature, however, and it may be – particularly as people’s mental health literacy increases—that they do know what it is that they are looking for, or have a preference for a particular type of assistance.

3. **Concern** refers to the type of mental health problem for which help is being sought. This needs to be clearly defined, particularly use of generic terms such as ‘mental health problem’, ‘emotional problem’ or ‘psychological distress’. It would be helpful for the field to examine help-seeking separately for different types of mental health problems and mental disorders, rather than grouping a wide range of problems together, which makes it difficult to compare between studies and over different types of mental health issues. If

more general terms are used, these need to be clearly defined for those responding to questionnaires as well as those using the results in practice.

Figure 12 outlines a framework for the decisions that need to be made when conceptualising help-seeking and determining a way to measure it. Researchers, evaluators, program planners and policy makers need to be very clear and explicit about what part of the help-seeking process they are interested in, over what timeframe, from what sources of assistance, and for which mental health problems. Note that Type of assistance is faded out slightly because this element is currently the least well investigated and able to be measured.

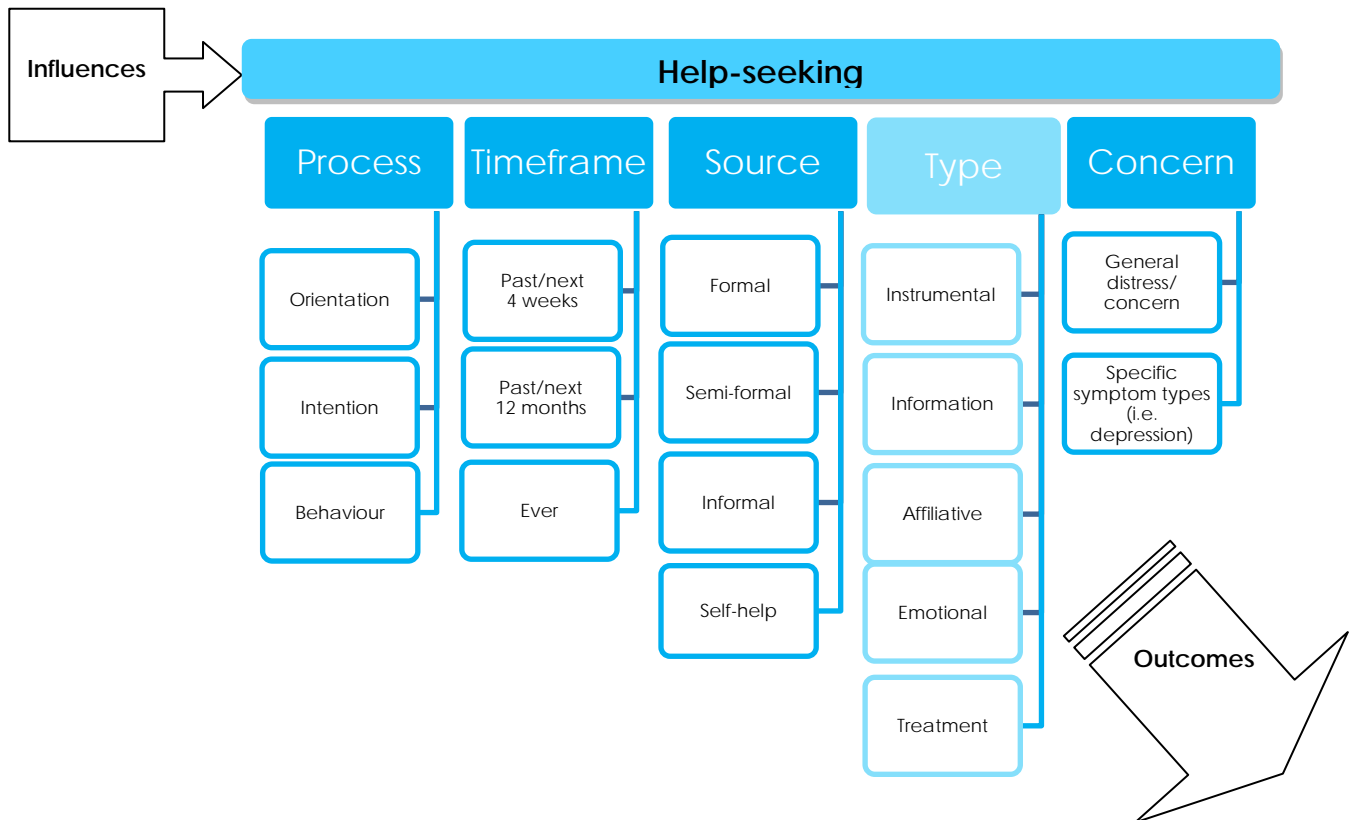


Figure 12. Help-seeking measurement framework

Implementation issues

To implement the proposed universal definition and the framework shown in Figure 12, a number of issues need to be addressed. The main barrier to achieving consistency in this field is the many diverse contexts in which help-seeking is of interest. Many investigations are interested in a very specific application, which has led to wide variability in sources of help, timeframes and types of mental health problems. This means that we cannot easily compare service needs or gaps for different age groups, identify common predictive factors, or evaluate the impact of different interventions. A consistent measurement approach is needed to be able to compare the results of different descriptive and intervention studies and policy approaches.

To move forward, research needs to be undertaken to develop operational measures that have demonstrated reliability and validity. These measures must be versatile, however, so that they can be adapted to the different contexts of interest. No single, simple questionnaire or measure is

going to be able to be used routinely in all research, intervention or policy contexts. However, research could develop a series of standardised measures that could be used in many contexts.

In the interim, however, the first step is to use the definition and framework proposed here to support a more consistent approach to defining and measuring help-seeking. This will ensure that all the relevant help-seeking elements are considered and clearly described. This will enable researchers, evaluators, policy makers and program providers to better understand the help-seeking needs of different population groups and compare different approaches to improving help-seeking behaviour in the critical area of mental health.

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