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Accessing Mental Health Support: Where do Young Adults Seek Help and What Barriers Do They Face?

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Abstract

Over half of all lifetime mental health disorders emerge during early adulthood and is associated with many adverse outcomes including: lower educational achievement, substance misuse and premature death. Despite the prevalence and burden of mental health problems, young adults with mental health needs are the least likely to seek professional help.

This study aimed to gain a better understanding of help-seeking among young adults aged 18-25 and aimed to identify the factors that can delay or prevent access to mental health support. Quantitative and qualitative data was collected from young adults in the community using an anonymous online survey.

The results of the study showed that approximately a third of participants did not seek any help for an emotional or mental health difficulty and of those who sought help the majority had accessed help from their friends or their GP. Intention to seek professional help was significantly association with satisfaction from services and perceived stigma, however psychological distress revealed a non-significant relationship.

Thematic analysis revealed that stigmatising beliefs, perceiving the problem as not serious, a preference for self-reliance and difficulty in accessing help or communicating concerns were common barrier themes. Facilitator themes highlighted the importance of having a flexible and confidential service.

The clinical implications of the results are discussed as well as consideration for future research.

CHAPTER 1. INTRODUCTION

Context of the Current Study

Young adults aged 18-25 account for 11% of the total population in the United Kingdom (UK) (ONS, 2014). This period in life has been termed *'emerging adulthood'* (Arnett, 2000) and it has been characterised as a time of transition marked by young people separating from parents and living independently. It is also a time when young people are often faced with important decisions regarding their education, career and intimate relationships. However, for many young people living in the UK, this transition into adulthood and independent living has become increasingly challenging. For example, recent data from the Labour Force Survey (LFS) shows that 54% of all individuals aged 18-25 were living in their parental home at the time of the analysis in 2014 (ONS, 2015).

In the UK, rates of unemployment also saw a significant rise during the economic crisis and the number of young people unemployed is almost three times higher than the general population. According to the ONS, in 2014, 16% of all young people aged 18-24 were Not in Education Employment or Training (NEET) (ONS, 2015b, ONS, 2015). Unemployment can lead to financial hardship and poverty, which are risk factors associated with poor mental health (Mental Health Foundation, 2007). This was highlighted in a recent report by The Prince's Trust Macquarie Youth Index 2014, where it was found that 40% of unemployed young people were experiencing symptoms of mental health problems, which they felt was a direct result of their unemployment (The Prince's Trust, 2014).

Young adulthood is a critical life stage, not only do young people face important developmental decisions, but it is also a period in life when 75% of lifetime mental health disorders first emerge (Kessler et al., 2007). For young people, poor mental health can cause an adverse impact on their future and it is associated with lower educational achievement, vocational difficulties, substance use and violence (Patel, Flisher, Hetrick, & McGorry, 2007). In order to minimise these affects it is essential that young people's wellbeing is fostered and appropriate support and services are available for those experiencing difficulties.

In recent years; improving wellbeing and access to mental health services have become a key agenda in government policies and campaigns. For example, in 2011 the Department of Health (DoH) released the '*No Health Without Mental Health'* document which outlined a cross-government mental health strategy to improve mental health and wellbeing for people of all ages (Department of Health, 2011). In a more recent policy in 2014, the DoH published the document '*Closing the gap: priorities for essential change in mental health'* which outlined key targets aimed at improving wellbeing and access to mental health services

(DoH, 2014). The document identified that inequalities associated with services need to be addressed, particularly for people from black and minority ethnic (BME) communities who are least likely to use psychological therapies. Furthermore, it was recognised that for young people who transition from Child and Adolescent Mental Health Services (CAMHS) to adult mental health services, the process is often problematic and can lead to many people becoming 'lost' to the system or disengaging from adult services (DoH, 2014). The policy identified the need to improve this transition from CAMHS and improve mental health services for those aged 15-24 (DoH, 2014).

Whilst guidelines have been developed to improve services, access to mental health support is complex and involves an interaction between societal, organisational and individual factors. Research has shown that young people face barriers that can arise at any stage in the help-seeking process, which can cause delay or prevent access to appropriate support. Biddle *et al*, (2004) showed that rates of help-seeking among young people living in the UK were low even when their mental health problems are severe. Given the adverse impact of poor mental health, developing a better understanding of the support that young people require and the barriers they face when seeking help is essential. The study seeks to contribute to the understanding of help-seeking behaviour among young people and the difficulties that they may encounter in this process.

In the following sections, a review of the current literature and theoretical background to the study will be presented. This will begin with a description of terminology, followed by a review of epidemiological studies on the prevalence of mental illness among young people. An overview of help-seeking behaviour will follow and a discussion of the factors found to impact help-seeking among young people will be presented.

Literature Search Strategy

A systematic literature search was conducted using a range of databases and search engines, a description of the search terms used can be found in Appendix 1. Papers that were generated from the search results were scanned for relevance and citations from articles were also screened in order to identify any further papers. Studies that were included in the present study focused predominantly on mental health help-seeking in a community sample of young adults, aged 18-25, living in the UK. As the majority of the literature in this field is based internationally, these studies were also included in the literature search. Both quantitative and qualitative studies were selected and in keeping with the research question; articles were excluded if the study participants focused exclusively on military populations.

Terminology

Help-Seeking

In this study the term '*help-seeking'* will refer to the multi-step process of actively seeking support from others for one's own mental health difficulties. It is a form of coping that often relies on communicating with other people to obtain advice, information or treatment (Rickwood, Deane, Wilson, & Ciarrochi, 2005). However, help can also be sought in ways that does not involve contact with others, for example information and advice can be sought from the internet.

The term '*help-seeking'* entails both formal and informal help-seeking. Where formal help-seeking involves seeking support from professionals e.g. GP, psychologist, mental health nurse, teachers. Informal help-seeking captures the process of seeking support from friends, family, or through social networks and online forums.

Help-Seeking Barriers / Treatment Barriers

The terms 'help-seeking barriers' or '*treatment barriers'* are used to describe the factors that may hinder or prevent people from engaging in the help-seeking process. Barriers can be divided into structural barriers (availability, accessibility and affordability of services) and non-structural barriers (stigma, low emotional competence, trust, preference to rely on self) (Gulliver, Griffiths, & Christensen, 2010).

Mental Health Difficulty / Mental Health Problem / Emotional Difficulty

The terms '*mental health difficulty*', '*mental health problem'* and '*emotional difficulty'* will be used interchangeably throughout this study. The terms will be used to denote a wide range of difficulties that interfere with an individual's cognition, behaviour and emotions and have an impact on their functioning.

Mental Health Professional

The term '*mental health professional',* will describe any person who has received training to work with people with mental health difficulties. This includes: GPs, psychologists, psychiatrist, mental health nurse and mental health social workers.

Young People/ Young Adult

The terms '*young people'* and '*young adult'* will be used interchangeable throughout this study and will refer to any person aged 18-25, unless specified otherwise. It is important to acknowledge that variations exist in how these terms have been used in research and policy

documents. For example, the term '*young people'* has been used to capture any person aged 16-24 (Office for National Statistics, 2014), however the term has been used to represent individuals aged 16-25 (Graham *et al;* 2014) as well as people aged 14-15 (Leavey, Rothi, & Paul, 2011). The heterogeneity that is captured within the terms 'young adult' and 'young person' reflects that it is socially constructed and its definition differs between cultures, generations and societies.

Mental Health and Young Adults

Mental health is a complex issue that can cause significant burden upon individuals and impact the wider society. In order to develop interventions aimed at promoting mental-wellbeing and improving access to services for young adults, it is necessary to identify the prevalence and impact of mental health problems.

Prevalence of Mental Health Disorders Among Young Adults

In a study conducted by Kessler *et al.,* (2007) exploring the age of onset for common mental health disorders, it was found that half of all lifetime mental health disorders start by mid-teens and 75% present by the age of 25. The study reviewed data collected from the World Mental Health survey conducted across 16 countries and focused on commonly occurring mental health disorders, such as mood disorders and psychosis. Although one of the strengths of the study was its large sample size of 82,052 participants, the authors reported that there was considerable cross-national variation in the results. Furthermore, no data was collected from the UK and therefore the generalisability of the findings may be limited.

There have however been a number of epidemiological studies conducted in England. For example, the Adult Psychiatric Morbidity Survey, was a national survey conducted in 2007 that aimed to identify the prevalence of mental health problems among adults aged 16 and over living in private households in England (McManus *et al,* 2009). Data was collected using interviews and the authors reported that 13% of males and 22% of females aged 16-24 experienced a common mental disorder in the past week of the assessment. Women aged 16-24 were more likely to have previously engaged in self-harm (12%), experienced suicidal thoughts (22%) and screened positive for an eating disorder (20%), than men or any other age group (McManus et al., 2009).

The survey also found that the prevalence of drug use was greater in younger men and declined thereafter. The second highest rate of alcohol dependency was found among men aged 16-24 (13%), however 42% of young males engaged in 'hazardous and harmful drinking'. The highest prevalence rate of psychotic disorder was observed in individuals aged 35-44 years at 0.9%, compared to 0.2% between the ages of 16-24. These results are however inconsistent with previous reports that suggests that the incidence rates for psychosis peak for men and women in their twenties (Kirkbride et al., 2012; Mental Health Foundation, 2007)

The observed differences in prevalence rates could be accounted for by the way in which the sample was selected and the measures used to assess the presence of a mental health difficulty. For example, a significant methodological limitation of the Adult Psychiatric

Morbidity Survey was the study excluded people who were homeless, living in an institution, seeking treatment in hospital or not living in a private household. Given that the incidence of mental health disorders are particularly high in the prison population (Light *et al,* 2013) and among people who are homeless (Mental Health Foundation, 2007), these findings are likely to reflect an under-estimate of the prevalence rates of mental health disorders in England.

Ethnicity and Mental Health

Identifying the prevalence of mental health problems across ethnic groups is an ongoing challenge. Although there is some evidence to suggest that people from certain Black and minority ethnic (BME) groups are more likely to experience poor mental health than the white British population, there is also evidence to show that some groups have lower incidence of mental health disorders (Weich et al., 2004).

Furthermore, few studies exist on the prevalence of mental health difficulties in younger people from BME communities and data that is available is inconsistent which make it difficult to draw reliable conclusions (Dogra et al; 2012). For example, in a review conducted by Patel *et al.*, (2007) it was reported that the prevalence of mental health problems were higher in younger people of English origin compared to those of Indian origin. However, Cooper et al., (2010) conducted a study comparing the incidence of self-harm reported by different minority ethnic groups across England. They found that Black females aged 16-34 years were more likely to present with self-harm compared with White females of the same group. Taking into consideration that only one in eight young people who self-harm will present in hospital (Hawton, Saunders, & O'Connor, 2012), these findings may not accurately reflect the prevalence of self-harm among BME groups in the community.

Mental Health and Risk Factors

Although research on the prevalence of mental health among young adults living in the UK is limited and somewhat inconsistent, there is however a large body of research identifying the risk factors associated with mental health. These risk factors are multifaceted and have been shown to be related to the individual, their family, or wider society.

There is evidence to suggest that mental health disorders are disproportionately represented across gender. For example, studies looking at gender and mental health, suggests that females are more likely to be diagnosed with an eating disorder, anxiety disorder and self-harm (McManus et al., 2009). However, suicide is believed to be the most common cause of death in men under the age of 35 and rates of substance misuse are also greater in males (Mental Health Foundation, 2007).

Research suggests that younger people living in families with parental mental health problems, substance abuse and domestic violence are themselves at an increased risk of developing mental health difficulties (Patel et al., 2007). There is also evidence to suggest that unemployment, poverty, exposure to racial discrimination are factors associated with an elevated risk of experiencing a mental health problem (Lavis, 2014; Mental Health Foundation, 2007). These findings have also been replicated in recent reports, for example in a study of young people aged 16-25 who were living in the UK, it was suggested that young people who grew up in poverty were more likely to have experienced mental health difficulties, including self-harm and suicidal thoughts (The Prince's Trust Macquaire, 2014).

Impact of Mental Health Disorders

In a publication by the Royal College of Psychiatrists (RCP) , it was suggested that '*mental illness is the largest single source of burden of disease in the UK'* (RCP, 2010, pp 7.). The authors reported that 23% of the total disease burden in 2003 in the UK was attributed to mental illness, compared with 16% for cancer. Mental health problems can have a significant impact on a broad range of domains and evidence exists to show that mental health disorders among adults is associated with social exclusion, deprivation, a three-fold increased risk of unemployment and reduced life expectancy (RCP, 2010)

Although the estimated prevalence of mental health disorders among young people is varied, studies have suggested that poor mental health can cause significant disability in young people and if left undiagnosed and untreated it can lead to long-term difficulties (Patel et al., 2007). Mental health problems can affect all aspects of a young person's life, contributing towards a poor quality of life and affecting a young person's self-esteem, identity and relationship with others (The Prince's Trust, 2014). Research also suggests that poor mental health among young people is associated with antisocial behaviour, substance misuse (Royal College of Psychiatrist, 2010) and an increased risk of self-harm and suicide (Hawton et al., 2012).

Suicide and self-harm among young people are major public health concerns, with suicide being the second most common cause of death in young people worldwide (Hawton et al., 2012). Although there are many risk factors associated with suicide, evidence shows that rates of suicide are higher in young people who have a mental illness and self-harm (Department of Health, 2012).

Whilst mental health problems can cause immediate challenges and distress to the individual, including stigma, discrimination and social exclusion, poor mental health in early life can also have profound long term consequences. For example, mental health difficulties in early childhood and adolescence are associated with poor health outcomes in adulthood,

including an increased risk of developing additional mental health problems. This was highlighted in a study conducted by Richards & Abbotts (2009) where the long-term consequences of mental health among children and adolescents were assessed. The study analysed data from three cohorts in the UK and the authors found that those who experienced an adolescent emotional problem, were up to three times more likely to have emotional difficulties in adulthood. They also reported that lower levels of educational attainment and economic inactivity were found in those who had conduct disorder in early life; however these patterns were not observed among those with an adolescent emotional problem (Richards et al., 2009).

A limitation with any correlational study is that one cannot draw any causality between factors of interest. Therefore it is important to acknowledge that whilst mental health problems may be associated with unemployment and social exclusion, it is likely that each factor has an impact on each other. For example, poor mental health may precipitate premature job loss, but prolonged unemployment is also linked to poverty and an exacerbation of mental illness.

Access to Mental Health Support and Help-Seeking Behaviour

Prompt access to mental health services is deemed to be an essential step in the recovery process. Receiving effective and timely treatment is important in the prevention and early detection of mental health problems; it reduces the risk of suicide and self-harm; furthermore it can also reduce the number of hospital admission (Department of Health, 2014). Accessing mental health services involves a complex interplay of multiple factors; however the act of seeking help is considered to be an important step in this process.

Help-Seeking as an Adaptive Behaviour

Help-seeking has been described as an adaptive coping strategy that involves the active seeking of help from other people. Help-seeking relies on communicating with others in order to receive help, advice, treatment or general support for a problem (Rickwood et al; 2005). Help can be sought in different contexts and from varying sources, such as ‘formal’ help-seeking from professionals and ‘informal’ help-seeking from friends or family.

Research indicates that young people are more likely to approach informal sources of help when managing mental health problems (Leavey et al., 2011; Mackenzie, Gekoski, & Knox, 2006). Although help-seeking from a professional source is deemed to be a crucial step for the prevention, early detection and recovery of mental disorders, evidence suggests that as few as one-third of adolescents and young adults with a diagnosable mental disorder will seek professional help (Vanheusden et al., 2008). When individuals delay or avoid seeking

professional help, it can lead to problematic outcomes such as worsening of symptoms and poorer quality of life. For adults suffering from psychosis, a delay in treatment is associated with involuntary hospital admission and increased risk of engaging in risky behaviours (RCP , 2010). Studies have shown that patterns of help-seeking vary according to the type of mental health difficulty experienced, gender and the age of the individual. These factors will be discussed in further detail in the section below.

Help-Seeking and Young People

The evidence indicates that despite the prevalence and burden of mental health disorders, young people are among those who infrequently seek support from mental health professionals (Bebbington et al., 2000; Rickwood et al., 2005), this is evident even when their mental health problems are severe (Biddle et al; 2004).

Most of the research that exists on help-seeking in young people have been conducted internationally. For example, Vanheusden *et al.*, (2008) showed that only 28% of young adults aged 19-25 with a mental health difficulty had consulted with mental health services compared to 43% of participants aged 26-32. Similar patterns were shown in a European study that explored the utilisation of health services across six countries, where it was found that older participants were more than twice as likely to consult with formal services than participants aged 18-24 (Alonso *et al*., 2004).

Although there is general consensus that younger people are reluctant to consult with mental health professionals, a possible explanation for this observation is that young people prefer to approach informal sources, such as friends and family. For example, Rickwood *et al*; (2005) undertook a series of studies with young people in Australia and found that informal sources of help were preferred to professional sources among males and females. Furthermore, they also reported that younger females prefer to seek help from friends and help-seeking from family gradually declined with an increase in age. The authors suggested that this pattern of help-seeking may be associated with a developmental trend that involves a gradual separation from parents, whereby younger people begin to look outside of the family for support (Rickwood *et al*., 2005). However, it appears that help-seeking among young people is a complex process, as Rickwood *et al.,* (2005) also found that when young people were experiencing suicidal thoughts they preferred to consult with mental health professionals and phone help-lines rather than access help from informal sources.

Although there is evidence from international studies to suggest that help-seeking from professional sources as low among young people, taking into account the differences in the health care structure and provision between countries, these findings have somewhat limited generalisability to young people living in the UK. Therefore it is important to explore the

evidence from studies conducted in the UK. Although research in this area is limited in the UK, Oliver *et al*; (2005) investigated the pattern of informal and formal help seeking in men and women aged 16-64 years. The authors found that 23% of females and 33% of males (aged 16-24) with a GHQ-12 score of ≥ 12, did not seek help from anyone and only one in six young people had sought help from a GP. They also reported that participants aged 55-64 who were experiencing psychological distress were three times more likely to seek help from their GP compared to younger people. However, patterns of help-seeking did not significantly differ with age when other sources of help, such as friends and family, were considered. Whilst the observed pattern of low help-seeking from primary care services is consistent with the research literature (Biddle et al., 2004; Rickwood et al., 2005), a significant limitation of this study related to the way in which help-seeking for mental health was operationalised and measured. Due to the stigma associated with 'mental health', the authors made the decision to operationalise the construct in terms of 'stress and strains'. Therefore the construct validity of their measure and the reliability of their findings are somewhat limited.

Other studies in the UK have indicated that younger people are more reluctant to consult with mental health professionals than older people. For example, Bebbington *et al*., (2000) utilised data from the National Survey of Psychiatric Morbidity to explore how a range of demographic variables including age, influenced help-seeking from a GP. The researchers found that participants aged 16-24 were less likely to consult with their GP than older participants aged 25-64. A limitation of the study was that the authors only explored help seeking from professionals and in order to develop a better understanding of help seeking across age groups, it would be important to explore both informal and formal help-seeking behaviour. Whilst there is some evidence to show that adolescents and young adults in the UK prefer to approach friends or family for help with emotional and mental health difficulties (Biddle et al., 2004; Leavey et al., 2011) the findings are limited and variable. The inconsistent estimates are likely to be due, in part, to the age of participants, the recruitment strategy and how help-seeking was operationalised and measured in the studies. Therefore obtaining an accurate estimate of how many young people seek help remains an ongoing challenge.

Gender Differences in Help-Seeking Behaviour

Research exploring gender differences and help-seeking behaviour have consistently found that lower rates of help-seeking are most evident in males, particularly among younger males (Biddle et al; 2004; Oliver et al; 2005). In a population based study in the Netherlands, the authors reported that 41% of females and 27% of males aged 19-32 who were experiencing mental health problems had sought professional help (Vanheusden et al., 2008). However,

one of the significant limitations of their study was the low number of participants, which reduces the reliability of their findings.

Although research is limited in the UK, Biddle et al., (2004) conducted a cross-sectional survey in England, collecting data from 1,276 young adults aged 16-24. The survey included measures for assessing psychological distress along with past and current help-seeking behaviour. The authors found that only 20% of females and 11% of males had sought help in the past 4 weeks of the survey for a psychological problem that they were currently experiencing. The authors acknowledged limitations imposed by the low response rate in the study and suggested that non-responders were more likely to be male, older and living in more socially deprived areas. Therefore, identifying help-seeking patterns of young men from deprived communities would be an important contribution to research in this area.

Although the evidence indicates that males are less likely to seek help, there is some discrepancy in the reported rates of help-seeking for males and females. These differences could in part be accounted for by the way in which studies measure 'help-seeking', for example studies have reported that although males are less likely to seek help from mental health professionals, they are more likely to confide in friends or family (Rickwood et al., 2005). Furthermore, the findings also indicate that males are often under-represented in studies looking at help-seeking, therefore it is difficult to accurately identify the rates of help-seeking across gender. One could hypothesis that the above mentioned findings are in fact an over-estimated rate of help-seeking, as those who do not seek help may also be less likely to engage in a study that involves disclosing sensitive information about psychological distress.

Mental Health Disorders and Help-Seeking

There is evidence to suggest that help-seeking behaviour also varies according to the type of mental health problem experienced and the severity of the problem. For example, Biddle et al; (2004) reported that psychological distress, measured using the GHQ-12, was the strongest predictor of participants seeking help from a GP. Similar findings were also reported in population based study of adults living Britain (Bebbington et al., 2000).

Wright, Bewick, Barkham, House, & Hill,(2009) investigated the prevalence of self-harming behaviour and eating disorder among students in a UK university and found that the number of students who had sought help for their difficulties was very low, especially for those who disclosed an eating disorder (0-3.9% sought help).

During the Adult Psychiatric Morbidity Survey, respondents who disclosed that they had engaged in self-harm were also asked whether they had received any medical attention or professional support for their self-harm (McManus et al; 2009). The study found that approximately half of all participants over the age of 16 (58% of males and 47% of females) did *not* seek any medical or psychological help. However the pattern of help-seeking following an attempted suicide was found to be greater and varied with age, whereby 70% of young adults aged 16-34 sought help compared with 55% those aged 35-54 (McManus et al; 2009). Taking into consideration the social desirability effect of using face-to-face interviews (Bowling, 2005) and only a small proportion of adolescents who self-harm present to hospital (Hawton et al., 2012) these findings must be interpreted with caution as it is possible that these findings are an over-estimate of the number people who seek professional help.

Factors Influencing Help-Seeking for Mental Health

There are many different factors that can influence whether a person seeks help for their mental health concerns. Whilst some factors relate to the individual's age, gender and the problem experienced, the following section will address how perceived barriers can influence whether or not help is sought from mental health services.

Barriers to Seeking Help

A number of studies have sought to explain why people may avoid or delay seeking professional help for common mental health disorders. Identifying the factors that can impede help seeking is considered an important step towards developing effective interventions aimed at improving access to mental health services and promoting wellbeing. Gulliver, Griffiths, & Christensen, (2010) conducted a systematic literature review aimed at identifying the perceived barriers to help seeking in adolescents and young adults. The authors identified a number of key themes including: public and perceived stigma, self-reliance, emotional competence, availability and knowledge of mental health services.

Public, Perceived and Self-Stigmatising Attitudes

Thornicroft, (2008) defined stigma as a concept that consists of three elements; ignorance, prejudice and discrimination. There is evidence to suggest that people with mental illness, experience more stigma than those with other health concerns (Lai, Hong, & Chee, 2001) and younger people compared with adults, hold more negative attitudes towards seeking help for mental health problems (Mackenzie et al., 2006).

Stigma and discrimination surrounding mental health is a significant issue that has been raised at a government level and documents such as *'No Health Without Mental Health'* as

well as the '*Time to Change'* campaign have stipulated targets aimed at reducing mental health stigma within society (Department of Health, 2011). Given the prominence of stigma and discrimination within society, identifying the extent to which stigma prevents or delays individuals from utilising mental health services is an essential area of research. Studies that have explored the association between stigma and help-seeking behaviour have indeed suggested that public and self-stigma present as common barriers for people seeking help for mental health (Andrade et al., 2013; Golberstein, Eisenberg, & Gollust, 2008; Thornicroft, 2008).

Clement et al., (2014) conducted a systematic review on the impact of mental health-related stigma on help-seeking and found that internalised sigma (holding stigma views about oneself) and treatment stigma (stigma associated with seeking or receiving treatment) have a small but consistently negative association with mental health help-seeking from services. They reported that stigma ranked as the fourth highest barrier and concerns about disclosure and confidentiality were the most frequently reported stigma-related barrier. Clement et al., (2014) also reported that stigma had a disproportionate effect on help-seeking in certain populations, specifically among males, ethnic minority groups and young people.

Although a particular strength of the review was that it included both quantitative and qualitative data, a significant disadvantage, is that majority of the studies that were reviewed were conducted in the USA or Canada, and only 7% of the data were from studies carried out in Europe. The precise number of studies conducted in the UK and the specific age of the population in the studies were not adequately reported. Given that stigma related to mental illness is likely to vary between cultures it is difficult to ascertain the extent the findings can be extrapolated to young people living in the UK. Nonetheless, their review highlighted a negative association between various types of stigma on help-seeking for mental health problems and these findings are in line with other studies that have explored barriers to mental health treatment (Andrade et al., 2013).

Similar findings on the negative impact of stigma on help-seeking was also identified in a literature review by Gulliver et al., (2010), which investigated variables influencing help-seeking among adolescents and young adults. The study found that stigma and embarrassment about seeking help emerged as the most common barrier, the second most common theme was concerns about confidentiality and trust with regards to the potential source of help, which may be indirectly related to stigma. The authors suggested that fears regarding confidentiality may be linked to the fear of stigma should peers or family find out that they had sought help for a mental illness (Gulliver et al., 2010).

Studies that have assessed reasons for not seeking help have shown that stigma can impact on help-seeking in different ways. For example, in a population based study with 19-32 year olds, it was found that 32% of young adults with clinical levels of “psychopathology” who did not seek help, were concerned about what others may think if they sought help. A further 40% of young people held negative beliefs about help-seeking, believing that it was a sign of weakness (Vanheusden et al., 2008). Research with adults have also suggested that people may also avoid seeking help from mental health professionals because of the stigma associated with having a formal diagnosis of a mental health disorder (Howerton et al., 2007). Young adults can fear the negative consequences that a formal diagnosis can have on their job prospects (Chew-Graham, Rogers, & Yassin, 2003) and relationships with family and friends (Vanheusden et al., 2008) .

Although studies exist investigating the prevalence of stigmatising beliefs in British school children (Rose, Thornicroft, Pinfold, & Kassam, 2007), as well as the negative impact of stigma on help-seeking in adults from BME communities in London (Shefer et al., 2012), few investigators have explored the role of stigma associated with mental health help-seeking among a community population of young adults in the UK. However, in a British qualitative study investigating young adults’ perception of GPs as a source of help for mental health problems, it was found that half of the participants had fears of being stigmatised, dismissed by the GP and labelled as a ‘time waster’, the authors suggested that these beliefs contributed towards an avoidance in help-seeking (Biddle, Donovan, Gunnell, & Sharp, 2006).

Overall, there is a wealth of evidence to suggest that one of the common reasons why people do not seek professional help for their mental health difficulties, is due to the stigma associated with mental illness (Clement et al., 2014; Thornicroft, 2008; Vogel & Wade, 2009). However, limitations in the findings exist, for example there is no widely accepted measure of treatment stigma that is applicable to all mental health conditions, all types of care-seeking or all forms of stigma (Clement et al., 2012). Furthermore, the majority of investigators have focused on help-seeking from formal sources and it is likely that these findings will differ to stigma associated with seeking help from friends and family. It is also possible that the impact of stigma will vary across the different points in the help-seeking process, vary according to the mental health problem experienced and the age of the individual. Therefore, further investigations are necessary to better understand how different types of stigma act as a barrier to help-seeking in different contexts and at different stages in the help-seeking process across age groups.

Self-Reliance and Subjective Need

Young adulthood is a period of transition marked by separation from parents and increased independence. It is also a period in life when young people begin to assume increased responsibility for their own health choices and they begin to look beyond parents and family members for support with their mental health concerns (Rickwood et al; 2005). Whilst research shows that young adults prefer to seek help from friends than parents, there is also evidence to indicate that young people prefer to handle problems on their own. Studies have shown that a preference for self-reliance is a common barrier that prevents or delays help-seeking in adults (Andrade et al., 2013) and young people (Gulliver et al., 2010).

An Australian study investigated help-seeking in adolescents aged 15-17. During the study participants were asked to indicate which potential barriers from a list of items would stop them from seeking help if they were to experience a mental health problem (Sheffield, Fiorenza, & Sofronoff, 2004). The investigators reported that the most commonly endorsed barrier to seeking help from a school counsellor was the preference to manage problems on their own and this was cited the second largest barrier to help-seeking help from a doctor, and the third most commonly cited barrier to seeking help from a psychologist. Other studies have also indicted that whilst young adults may recognise their distress, some may believe that their problem will improve by itself and consequently they do not perceive the need for professional support (Biddle et al., 2006).

A preference for self-reliance and a lack of perceived need for support may also reflect the negative impact of social, cultural and family norms as well as social stigma. Help-seeking behaviour can be conceptualised as a dynamic process that is shaped by the individual's society and context. Young people may prefer to manage their difficulties on their own because of the stigma and discrimination associated with seeking help. This may also account for why males are less likely to seek help (Rickwood et al., 2005; Yap, Reavley, & Jorm, 2013), as males may internalise the gender norms that is associated with masculinity (Möller-Leimkühler, 2002).Therefore, male social norms may promote self-reliance and consequently serve as barriers that impede young males from acknowledging that they require professional help.

Accessibility, Availability & Knowledge of Help Sources

Barriers to help-seeking can present at any stage in the help-seeking process. Whilst some young people may be competent in recognising their symptoms of distress and acknowledge that they require additional support, they may be faced with 'structural barriers' that hinder access to mental health support. Structural factors include lack of accessibility, availability

and affordability of mental health services (Gulliver et al., 2010); however given that young people prefer to seek support from friends and family, limited availability of social support can also present as structural barriers.

Lack of accessibility of mental health services is a particular concern for people in rural settings, where there are limited services for young people (Gulliver et al., 2010). However, in communities where services are readily available, it appears that some young people are unaware of the services that are available to them (Leavey et al., 2011). Furthermore, young people may not know when or how to access help from relevant services (Rickwood et al., 2005; Vanheusden et al., 2008).

In Britain, GPs are often the primary point of contact for professional support and GPs often serve as gatekeepers to accessing specialist mental health services. Therefore having the knowledge that one can approach a GP and discuss not only physical, but also mental health concerns is essential. However, in a qualitative study conducted by Biddle et al., (2006), it was found that three quarters of interviewees (n = 17, aged 16-24), believed that GPs were not an appropriate source of help to discuss their mental health distress. Interviewees associated their GP with treatment for physical health problems rather than mental distress, and when asked where they could seek help, most of the participants were unable to find an alternative avenue (Biddle et al., 2006).

In the UK it has also been recognised that the transition between children's and adult services can be very problematic (Lamb & Murphy, 2013) and the abrupt cultural shift from a child-centred to an adult care model can lead to difficulties in young adults accessing appropriate mental health support (Department of Health, 2014). As such, for young adults in the UK the accessibility of age-appropriate services appears to be a prominent barrier in the help-seeking process.

Structural barriers appear to have a disproportionate effect on help-seeking in certain populations. More specifically, individuals from BME communities are under-represented in mental health services (Department of Health, 2014). Although there are many factors that contribute towards inequality in access to services, one reason includes the limited availability of culturally sensitive services. Furthermore, individuals may initiate the help-seeking process, but face barriers from professionals that prevent or delay their access to the appropriate support (Street, Stapelkamp, & Taylor, 2005).

Knowledge and Recognition of Mental illness

Mental health help-seeking has been conceptualised as a relational process that relies upon the successful identification and communication of symptoms to others (Rickwood et al.,

2005). Early recognition of symptoms is believed to be an important step in accessing treatment and reducing the burden of mental distress. However, there is evidence to indicate that limited knowledge and awareness of mental illness and difficulties in identifying one's symptoms as a mental health issue; is common amongst young people. A number of studies have suggested that difficulties with identifying and communicating mental health symptoms can in part account for the low rates of help seeking observed among young people (Gulliver *et al.*, 2010).

For example, Wright et al; (2007) conducted a community survey with 1,207 young people (aged 12-25) living in Australia and investigated whether the accuracy of recognising and labelling depression and psychosis, is associated with appropriate help-seeking preferences. The study found that young people who accurately labelled the disorders more frequently identified appropriate help-seeking and treatment options. Although a limitation of the study is that it relied on case vignettes to assess help-seeking recommendations rather than actual help-seeing behaviour, the study nonetheless highlighted some important considerations between the role of mental health literacy and help-seeking.

In a population-based study that was conducted in Holland, barriers to seeking treatment for a mental health difficulty in young people aged 19-32 years were explored (Vanheusden et al., 2008). The investigators found that among those with clinical levels of psychological distress, 36% of participants did not admit to having a problem and this trend was more pronounced in males. These findings could be due to a difficulty in recognising and labelling their distress as symptoms of a mental health disorder, or reflect a reluctance in communicating their distress to others.

Biddle et al., (2007) also demonstrated similar findings in a qualitative UK-based study, whereby young people's perceptions of their mental distress and help-seeking were further investigated. They reported that participants struggled to recognise whether their distress constituted as "normal distress", or "real distress" that required help. For example, Biddle et al., (2007) reported that a female participant aged 18 stated:

> *"I wouldn't say I'm depressed, I would just say that I am really overstressed. But I suppose you could call it depressed because the thoughts [of suicide] I get sometimes with it…. I don't know because it's quite hard to decipher each one. I mean when do you say that stress is depression or depression is manic depression…." (pp 993)*

Overall, the evidence in the literature suggests that difficulties in accurately recognising and labelling distress as a mental health issue, can pose as a barrier for young people in accessing help from others. However, as previously discussed, once people have recognised

their symptoms they also require sufficient knowledge about the range of professional help that is available to them.

Additional Barriers

Studies that have investigated barriers to help-seeking among young people have identified additional factors that can hinder the process. Gulliver et al., (2010) reported that young people can hold concerns about the characteristic of the person potentially providing help, for example concerns about their race, credibility and expertise. Other studies have highlighted that young people may have concerns around being able to trust the source of help as well as worries around the act of seeking help (Street et al., 2005). Worries around help-seeking can be linked to the fear of burdening others, or fears about what might happen if they did seek help. Overall, the evidence indicates that there are multiple structural and individual variables that can interact and emerge as barriers at any stage in the help-seeking process.

Theoretical Perspective of Help-Seeking

A number of different theories and models have been applied to explain help-seeking behaviour for mental health problems, however there is no unifying theory that is widely accepted. In the following section, a summary of some of the key models that have been applied to explain help-seeking in young people will be presented.

Theory of Planned Behaviour (TPB)

Ajzen's Theory of Planned Behaviour (TPB, Ajzen, 1985, 1991) is a model that suggests that an individual's intention to carry out a behaviour, such as help-seeking, is the strongest predictor of the behaviour itself. The model (figure 1) also proposes that a person's intention is determined by their attitudes towards the behaviour, normative beliefs concerning the behaviour and perceived behavioural control, such as how easy or difficult it would be to carry out the specific behaviour. The theory has been applied help-seeking for mental health and studies have demonstrated that positive help-seeking attitudes are the strongest predictor of willingness to seek professional help (Schomerus, Matschinger, & Angermeyer, 2009). Although the TPB is an influential behaviour, one of the limitations is that it can only partially explain help-seeking behaviour (Armitage & Conner, 2001) and other variables outside of the model have also been shown to influence mental health help-seeking. For example, the model does not consider the influence of socio-demographic variables such as age, gender and emotional competence, which are also believed to determine whether or not a person seeks help (Mackenzie et al., 2006; Rickwood et al., 2005).

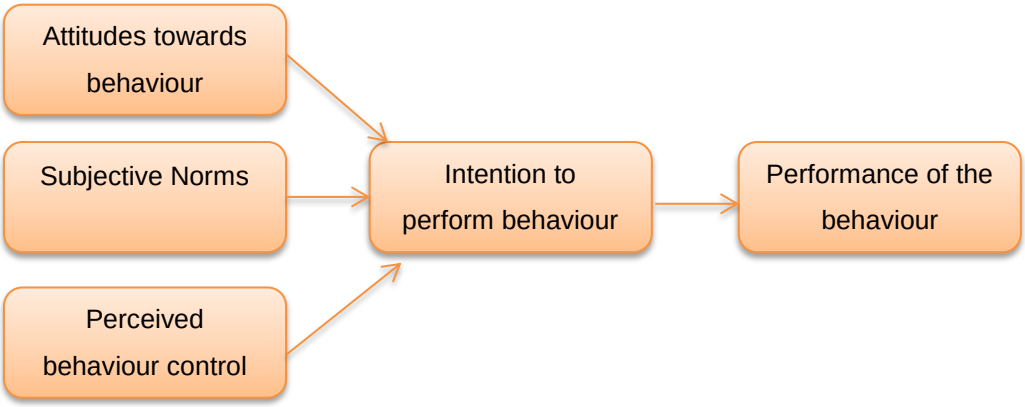

Figure 1. Theory of Planned Behaviour

Health Belief Model

The Health Belief Model (HBM, Rosenstock, 1974; Stretcher & Rosenstock, 1997) is an influential model explaining pro-active health-related behaviours such as treatment compliance, however it has also been used as framework to conceptualise the utilization of mental health services (Henshaw, Freedman-doan, & Michigan, 2009; O'Connor, Martin, Weeks, & Ong, 2014). As illustrated in figure 2, the model takes into account a number of variables which are omitted from the TPB. The HBM specifies that the likelihood of engaging in a proactive behaviour is determined by key factors including: the individual's perceived threat of the condition, the perceived benefits and barriers to engaging in the behaviour, as well as modifying variables such as socio-demographic factors (i.e. age, gender, education). Although few studies have applied the constructs of the model to help-seeking, there is however evidence to show that perceived barriers and facilitators are important in determining young people's willingness to seek help (O'Connor et al., 2014; Sheffield et al., 2004).

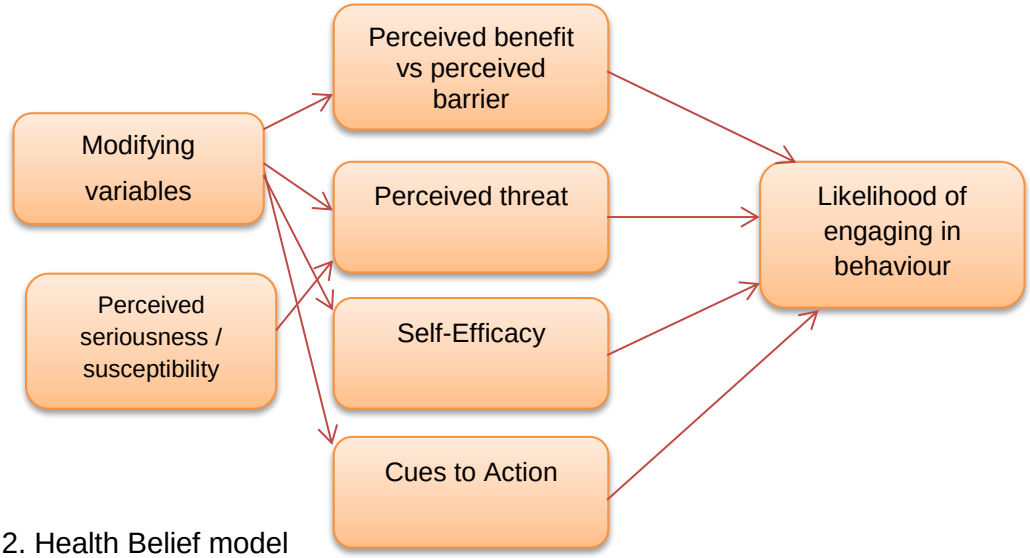

Figure 2. Health Belief model

Other models have recently been developed to explain mental health help-seeking behaviour. These models include the 'multi-step process' model (Rickwood et al., 2005) and the 'cycle of avoidance' (COA) model proposed by Biddle et al., (2007). The multi-step process model highlights the relational aspects of help-seeking, such that the source of help must be available and accessible and a person needs to be able to articulate their distress in a way that can be understood be others (Rickwood et al., 2005). One of the key limitations of the model is that it describes help-seeking as a sequential process. This is however, a key strength of the COA model, which describes non-help-seeking as a more dynamic and circular process of avoidance. Nonetheless the COA model focuses predominantly on explaining why people do not seek help for psychological distress and the model excludes important variables such as attitudes towards help-seeking and perceived barriers.

Despite the theories and models that have been developed to conceptualise help-seeking behaviour, none of the models or theories are universally accepted in the field. Further research is required to investigate the significance of the key variables that have been highlighted in the existing models, in doing so this can provide opportunities to develop effective interventions aimed at enhancing help-seeking behaviour among young people.

Rational for the Study

Despite the prevalence and burden of mental health disorders among young people, studies have consistently shown that young people are less likely to seek support when they are experiencing psychological distress. An avoidance or delay in accessing help is of concern, as poor mental health can have an adverse effect on young people's future.

In order to improve young people's access to services, it is necessary to identity the factors that may prevent or delay them from seeking professional help. Much of the existing literature has focused on help-seeking behaviour among adolescents or adults over 18 and studies have predominantly been conducted outside of the UK. Given the differences in service provisions and cultural variations, it is difficult to generalise these findings to young people living in the UK.

This research aims to explore the help-seeking behaviour of young people in the UK and aims to provide a better understanding of the barriers that young people face when accessing mental health support. Exploring help-seeking behaviour among young adults aged 18-25 is particularly important, as it has been recognised that the transition between children's and adult services is problematic and those who rely on the support from CAMHS can find themselves "lost" to services when they reach the age of 18 (DOH, 2014). Those affected are the most vulnerable and disadvantaged, and not receiving the intervention they

require can increase the risk of them being out of work, not in education and can result in a deterioration of physical health (DOH, 2014). As such, developing a better understanding of the difficulties that young adults face in accessing services can help us develop effective services that are tailored to meet young adults' needs.

Overall, there are many benefits to furthering our knowledge about the help-seeking preferences and obstacles faced by young adults in the UK. Most importantly, a young adult's ability to access early and effective support from appropriate resources, is essential to their current and future wellbeing.

Study Objectives

The aim of this study is to address the gap in the research literature concerning help-seeking among a community population of young adults aged 18-25 in the UK. The study seeks to identity where young people prefer to seek help and the barriers that can delay or prevent help-seeking for mental health difficulties. More specifically the study objectives are:

1. Establish the prevalence of mental health difficulty experienced by males and females within the sample.
2. Establish whether participants with a mental health difficulty were more likely to seek help, the type of help sought and the satisfaction with seeking help from mental health professionals.
3. Identify which socio-demographic variables were associated with previous help-seeking.
4. Identify young people's intention to seek help from different help-sources.
5. Identify prominent barriers and facilitators to help-seeking.
6. Identify the predictors of intention to seek help from mental health professionals.

CHAPTER 2: METHOD

Participants and Sampling

Participants

The study aimed to recruit from a non-clinical population of young adults living in the UK. In order to gather a representative sample, the inclusion criteria were intended to be as inclusive as possible and stipulated that participants were aged 18-25 years old and currently living in the UK. Literacy in English was assumed through the completion of the survey.

For the current study a general community sample was targeted, as opposed to a clinical population of young people known to have mental health difficulties. It was deemed that this would favour inclusion of young people who may experience mental health difficulties, but due to the stigma associated with the label, they may not identify themselves as having such difficulties. Furthermore, given that one of the main aims of the study were to identify the barriers that young adults face in seeking help from mental health services, it was deemed that recruiting from a clinical setting, such as the NHS, would not be suitable for the current study. In order to recruit participants who may struggle to access services, the present study targeted individuals from the general population.

Sampling

In order to maximise response rates and to gather a diverse sample of young adults aged 18-25, participants for this study were recruited from a range of settings, using convenience and snowball sampling techniques.

Participants were predominantly recruited from community organisations, educational settings and online networks as discussed below

Community Organisations

A charity organisation based in London, which provides educational, social and mentoring support for socially excluded young adults up to the age of 24 years agreed to assist with recruitment for the study. The organisation granted permission for an e-mail to be circulated among staff members at the organisation and a request was made for a poster advertising the study to be forwarded to the young adults they work with. Young adults were informed of the study using an e-mail that included a brief description of the study and link to the survey (Appendix 2). Posters were also attached to the e-mail and distributed at the organisation.

Permission was also granted for the researcher to recruit from the site of the organisation. The researcher attended the organisation and distributed flyers (Appendix 3) to potential participants, the flyer included a brief summary of the project and a link to the survey. Individuals were informed that the study was voluntary and they could, if they wished to, complete the survey on a computer that had been set up on site. Approximately 20 flyers were distributed on site.

Two additional charity organisations were also identified and contacted via email. The organisations agreed for information about the study to be shared on their social media website, including Facebook and Twitter. One of the organisations provides counselling, advocacy and advice for young people aged 18-25 years in a deprived community of London. The second organisation offers peer to peer support on range of issues affecting young people across the UK.

In order to access a representative sample of the target population, posters for the survey were also distributed on community notice boards in supermarkets, libraries and convenience stores. Furthermore, the researcher directly approached a jobcentre based in Hertfordshire, however due to their policy rules they were unable to advertise the study through their service.

Educational Settings

The researcher made contact via telephone and email with colleges across England that provide education for young adults over the age of 18 years. Colleges were informed about the study and provided a brief message containing a link to the survey (Appendix 4), with a request that this could be distributed to their students or advertised on their social media site, such as Facebook or Twitter. Student support services at three London based colleges; Hackney Community College, College of Haringey Enfield and North East London, and Croydon College agreed to distribute the posters of the survey at their college.

Unfortunately due to policy regulations, some of the colleges reported that they were unable to email a link containing the survey to their students.

Online Networks

Posters and links to the study were also advertised via social networking sites including Twitter and Facebook, as well as online forums used by individuals within the target group. Organisations offering mental health support, as well as youth-targeted groups that support young people affected by gangs and youth violence, agreed to advertise a link to the survey on their Twitter page

Snowballing

When recruiting from site, the researcher also asked individuals to inform their own contacts about taking part in the study. A number of personal contacts who were known to the researcher were also approached and invited to share details of the survey with potential participants.

Design

The present study employed a non-experimental research design, involving a cross-sectional survey that consisted of pre-existing and newly developed measures. Questionnaires, interviews and focus groups have previously been utilised in studies that have explored help-seeking for mental health among young people (Biddle et al., 2006; O'Connor et al., 2014; Rickwood et al., 2005). The potential benefits and drawback of using each methodological approach were considered. It was acknowledged that using interviews would enable a more in-depth exploration of experiences, they are also believed to be the least burdensome method of investigation for participants (Bowling, 2005). However, possible limitations of this approach include the lack of anonymity during the interview process, which can impact on participant's willingness to disclose sensitive information. This is a particular concern for the current study as existing research indicates that fears about a lack of confidentiality and trust, as well as stigma are prominent barriers that prevent young people from seeking help from mental health professions (Gulliver et al., 2010). For the current study, an online and anonymous self-administered questionnaire was therefore deemed a more feasible method of investigation. It was anticipated that this method of investigation would yield a higher response rate from participants who may otherwise be reluctant to engage directly with, and disclose sensitive information to, mental health professionals.

Anonymous surveys also eliminate the risk of interviewer bias and reduces the likelihood of participants being influenced by social desirability bias (Bowling, 2005). Given that 79% of young people aged 16-24 use the internet on a daily basis and 87% of young people have internet access on their phones (Office of National Statistics, 2014) it was anticipated that an electronic survey would facilitate recruitment from young adults who may otherwise be difficult to reach in the limited time frame of this study.

Consideration was given to the utilisation of a postal questionnaire, however given the low response rate for self-administered postal surveys (Bowling, 2005) and the financial costs involved in distributing questionnaires by post, it was deemed unfeasible for this study. Edwards et al., (2009) reported on a number of effective strategies that can be used to improve response rates to electronic questionnaires, these included: the offer of an incentive,

use of a short questionnaire, offering respondents the survey results and inclusion of pictures in email notifications. Accordingly, participants were offered the opportunity to enter into a single prize draw to win an Amazon voucher and the survey was advertised using posters and flyers that featured on a range of social media sites, community and educational settings.

Whilst surveys have been widely used to investigate help-seeking behaviour and access to services across different populations, to the best of the researcher's knowledge there are no existing studies in the UK that have also investigated barriers and facilitators to help-seeking among young adults aged 18-25. Taking the above factors into account, a survey methodology was deemed an appropriate approach to answer the questions of interest in this study.

Developing Measures and Piloting the Questionnaire

Several measures that were included in the survey were developed by the researcher, with input from 8 individuals aged 18-25. Two of the individuals were known to the interviewer and the remaining young adults were recruited from a charity organisation that supports young people from deprived communities in London. Consultations were held with these individuals to explore informal and formal sources of help that young adults would use, as well as key factors that they perceive would influence help-seeking among young adults. This information was then utilised to inform the measures that were designed and selected for the study.

Once the survey was compiled it was piloted with four service users from the above mentioned charity organisation. A focus group was used to pilot the survey, where the young people were invited to offer feedback on the survey. Feedback that was offered from these individuals included suggestions to shorten the length of the Information Sheet, as it was felt that it was lengthy and participants were unlikely to read it in full. Suggestions were also made about the wording of items. Several of the young people felt that the term 'mental health problem' was too stigmatising and it was suggested that 'emotional difficulty or emotional problem' was preferable. Feedback was also offered about making the length of the questions short and the language simple.

Further suggestions related to the inclusion of a list of mental health difficulties, as it was believed that potential participants may have limited awareness of such issues. Recommendations were also made to include optional open-ended questions, as it was believed that this would allow participants to expand upon their responses.

In light of the feedback provided during the focus group, amendments were made where possible. The survey was once again piloted with three individuals known to the researcher and feedback was also gathered regarding the length of time taken to complete the survey.

Feedback gathered from the consultation process and piloting of the survey was also used in order to assess the face validity of the questions that were developed by the researcher. Questions that were deemed ambiguous by the participants were changed accordingly and piloted a second time.

Questionnaire Measures

The online survey comprised of a brief welcome page (Appendix 5), an information sheet (Appendix 6) explaining the purpose of the survey, a consent form (Appendix 7), a questionnaire (Appendices 8-13), and an invitation to enter into a prize draw for a single Amazon Voucher of £30 (Appendix 14). At the end of the survey participants were presented with a debrief sheet (Appendix 15), which provided further information about the study, contact details of the researcher and a list of resources from which participants could seek further support.

The survey comprised a series of questionnaires, which included existing, validated measures that have been utilised in previous studies, as well as newly developed measures. Questions that were developed specifically for the present study were informed by existing studies and through a consultation process with individuals from the target population as described above.

Participants completing the survey were presented with the following series of questionnaires;

- Demographics
- General Self-Efficacy
- Presence of Mental Health Difficulty
- Prior Help-Seeking Experience
- Intention to Seek Help
- Factors Influencing Help-Seeking

In some of the questionnaires, the precise questions that were presented differed according to the responses that were made by participants. Further details of the questionnaires that were selected are discussed below.

Demographics

Given that the survey was completed anonymously, it was necessary to collect sufficient demographic information that would allow for a comprehensive description of the data. Demographic factors, such as age, gender and education have been shown to influence help-seeking behaviour for mental health difficulties (Mojtabai, Olfson, & Mechanic, 2002). Furthermore, demographic factors are also key component in the Health Belief Model (Rosenstock, 1974, 1990) which has been applied to explain mental health help-seeking behaviour in young people (O'Connor *et al.,* 2014).

All participants were therefore presented with a demographic questionnaire (Appendix 8), which included items that related to: participant's gender, age, marital status, length of time in the UK, ethnicity, religious affiliation, employment status, level of education, living arrangements, whether they had any dependents or received any state benefits.

The demographic questionnaire included key items that could provide an indication of social and economic deprivation, which are known risk factors associated with mental illness (Royal College of Psychiatrist, 2010). It was anticipated that this information also could be used to assess the relationship between social deprivation and help-seeking behaviour.

The English Indices of Deprivation (2010) was used as a guideline to inform the measures employed to assess the level of deprivation experienced by participants (Mclennan *et al;* 2011). The decision was taken to include measures that assessed deprivation of employment, education and income. The Office of National Statistics (ONS) Census (ONS, 2011) was used to inform the phrasing of items that were included in the demographic questionnaire, as this would enable a direct comparison between results from the current study and national data.

General Self-Efficacy

The 10-item General Self-Efficacy (GSE) Scale (Schwarzer *et al.,*1995) is a self-administered scale that was selected to measure participant's perceived self-efficacy. This instrument was developed to measure participants' perception in their ability to deal effectively with a variety of challenging situations and any associated set back (Schwarzer *et al.*, 1995). The scale was designed for the general adult population and is suitable for use with individuals above the age of 12. Participants are required to indicate the extent to which each statement applied to them, responses range on a 4-point scale, where 1 indicates 'not at all true' to 4 'exactly true'. An example of an item on the GSE scale includes; '*when I am confronted with a problem, I can usually find several solutions'*.

A higher composite score on the scale indicates a greater generalised sense of self-efficacy, which in turn is related to greater perceived competence to deal effectively with adversity (Schwarzer, 1997). As recommended by the author, a median split using a cut-off point of 30, can be used to dichotomise the sample into 'high' and 'low' self-efficacy.

Self-efficacy is also a component in the Health Belief Model (Rosenstock, 1974, 1990) and although this model has predominantly been applied to explain various health related behaviours such as adherence to medication (Janz & Becker, 1984; Stretcher & Rosenstock, 1997) it has also been applied to mental health help-seeking (O'Connor et al., 2014). For the current study the GSE scale (Schwarzer, et al; 1995) was utilised to explore whether there is an association between participant's help-seeking behaviour and perceived self-efficacy. The GSE scale was selected in order to allow for a comparison of results with the findings from O'Connor et al., (2014). Although the GSE scale was originally developed in Germany, the measure has since been adapted to 28 languages and studies have found the measure to have high reliability, stability and construct validity (Luszczynska, Scholz, & Schwarzer, 2005). As such the measure was deemed to be a suitable instrument for the current study.

Presence of Mental Health Difficulty

In order to assess the relationship between mental health difficulty and help-seeking behaviour, it was necessary to collect sufficient information related to participants' mental health. The 21-item Depression Anxiety Stress Scale (DASS-21) (Lovibond & Lovibond, 1995) was selected to assess the presence of mental health difficulties in the sample. The DASS-21 is a well-established instrument that was originally developed as a 42-item self-report measure of depression, anxiety and stress (Antony *et al;* 1998; Lovibond & Lovibond, 1995). Respondents were requested to indicate the extent to which the symptoms of depression, anxiety and stress were experienced in the past week, where responses range on a 4-point Likert scale ranging from 0 (did not apply to me at all) to 3 (Applied to me very much, or most of the time). Although the DASS-21 was not developed as a diagnostic instrument, it can provide a reliable and valid method of assessing features of depression, anxiety and stress, where higher scores indicate increased severity (Henry & Crawford, 2005). Lovibond & Lovibond, (1995) have also provided the following cut-off scores that can be used to describe the severity of symptoms within each of the three scales on the original 42- item DASS. In order to convert these cut-off scores for use on the DASS-21, the authors have recommended that the obtained scores are simply doubled and compared against the following categories (table 1).

Table 1. *Cut-off scores for DASS subscales.*

	Depression	Anxiety	Stress
Normal	0 - 9	0 - 7	0 -14
Mild	10 - 13	8 -9	15 -18
Moderate	14 -20	10 -14	19 -25
Severe	21 - 27	15 -19	26 -33
Extremely Severe	28+	20 +	34+

The DASS-21 was deemed a suitable instrument for the present study as it has been shown to have sufficient construct validity when compared with other existing validated measures of depression and anxiety such as the Beck Depression Inventory and the Beck Anxiety Inventory (Antony et al., 1998; Henry & Crawford, 2005). The original 42-item and 21-item version of the DASS have also been tested and shown to be a reliable and valid measure in clinical and non-clinical populations (Antony *et al*., 1998), across cultures (Norton, 2007) and ages (Szabó, 2010). Furthermore, Henry & Crawford, (2005) conducted a study using the DASS-21 and provided normative data using a sample of adults from a non-clinical population in the UK.

Whilst the three subscales are reported to measure distinct constructs, they have recently been shown to reflect a common factor of general psychological distress (Henry & Crawford, 2005). The DASS-21 has also been utilised as a measure of psychological distress in research exploring help-seeking behaviour among young people aged 15 – 17 years (Sheffield et al., 2004). In order to reduce the cognitive burden imposed on participants, the shorter version of the DASS-21 was favoured over original 42-item scale.

The General Health Questionnaire (GHQ-12, Goldberg & Hillier, 1979) is a widely used measure of psychological distress (Biddle et al., 2004; Oliver et al., 2005), was also considered for use in this study. However, the decision was taken to use the DASS-21 because it allows a more detailed screen of common mental health problems experienced by young adults.

Two additional questions (Appendix 10) were developed by the researcher in order to assess whether participants had ever experienced a mental health difficulty. Given that awareness of mental health issues can be limited among young people (Gulliver et al., 2010) one question consisted of a check-list of common mental health difficulties, the items of which were derived using findings from population studies examining the prevalence of common mental

health among the adult population (McManus et al., 2009). Participants were required to indicate whether they had experienced any of the mental health difficulties that were listed. An additional item for 'other mental health difficulty' was also incorporated in the list in order to ensure that all possible mental health difficulties were captured and therefore providing optimal content validity for the question

A second question was developed to measure whether participants were currently experiencing any form of mental health or emotional difficulty, including those not formally diagnosed. Participants who had answered 'yes' to having a current mental health difficulty were also presented with an open ended question to enable them to provide further detail of their difficulties.

Prior Help-Seeking Experience

Participants' prior help-seeking behaviour was assessed with a series of questions developed by the researcher (Appendix 11). The questions were developed using guidance from previously developed measures, such as the Actual Help-Seeking Questionnaire (AHSQ) (Rickwood *et al.*, 2005), which was designed to assess recent help-seeking for mental health problems. To ensure that the questions were relevant to the participants, only those who had previously disclosed a mental health or emotional difficulty were presented with a series of questions that assessed past help-seeking.

Participants were presented with an initial question that was designed to assess whether or not they had sought help for a mental health difficulty from any type of help source. Participants who indicated that help had been sought, were then asked to clarify whether help had been sought from a list of potential help sources that included: parents, family, friends, girlfriend, boyfriend, partner, G.P, mental health professional, university or college tutor, minister or religious leader, phone helpline, online forum, or other source of help. The content of the list was guided from the AHSQ (Rickwood et al., 2005) as well as using information gathered from the initial consultation process with young people.

For those who had sought help from a mental health professional such as a GP or psychologist, questions were included to explore whether participants were satisfied with the help they received. This was assessed using a 7-point scale question ranging from '*very dissatisfied'* to '*very satisfied',* an open-ended question was also included to elicit qualitative data about their satisfaction with services . Finally, for individuals who indicated that they did not seek any kind of support, a question was designed to explore the reasons behind this decision. In order to capture all reasons for why help had not been sought, an open-ended question was used to gather qualitative information. The face validity of the questions

developed by the researcher were all assessed during the consultation and piloting of the survey.

Intention to Seek Help for Mental Health Difficulties

In accordance with the TPB (Ajzen, 1985) a person's intention to carry out a behaviour is believed to be a good predictor of the actual behaviour occurring. Therefore, for the current study a series of questions were included to assess intention to seek help in the future (Appendix 12). All participants were presented with a question that was designed to measure the likelihood that help would be sought from a list of possible help sources. The list included informal and formal sources of help that were identical to the items used to measure prior help-seeking as detailed above. Intention to seek help was measured using a 5-point Likert scale, ranging from 'very unlikely' to 'very likely'.

The Inventory of Attitudes Towards Seeking Mental Health Services (IASMHS) (Mackenzie, et al 2004) is 24-item self-report measure, which was considered for the present study. However, for the aims of the study the IASMHS was felt to be limited, as the questionnaire items are focused on seeking professional help for a psychological problem e.g. '*If I were to experience psychological problems, I could get professional help if I wanted to'*. As such, the instrument does not enable the measure of other informal sources of help, such as family or friends, which have been identified as a key help source for young people (Vanheusden et al., 2008; Yap et al., 2013).

It was acknowledged that help-seeking can take place in many different contexts, ranging from statutory to voluntary services, through the internet and over the telephone. Therefore a question was designed to explore where participants would prefer to seek help in the future, which participants were required to indicate from a list of possible locations.

Previous research has also shown that social norms and social support can influence whether young people seek help (Addis & Mahalik, 2003., Sheffield et al., 2004). Therefore, four additional questions were designed to identify whether friends or family had sought help for a mental health difficulty and the extent that participants perceived whether their family or friends would endorse help-seeking. Family and friend's endorsement of help seeking was measured by the following item 'if I had a mental health difficulty my [friends / family] would recommend that I get professional help. The item was scored on a 5-point Likert scale, ranging from 'strongly agree' to 'strongly disagree'.

Factors Influencing Help-Seeking

The final section of the survey was aimed at assessing factors that influence access to mental health care, with an emphasis on barriers to seeking help (Appendix 13). Existing studies have utilised a number of different measures to explore facilitators and barriers to help-seeking. For example, in a study conducted by Sheffield *et al.,* (2004) and Vanheusden et al., (2008) participants were required to indicate which barriers, from a list provided, would stop them from seeking help. Other studies have used a vignette and an open ended question to elicit possible barriers to seeking help (Yap et al., 2013). Although measures such as the Barriers to Adolescent Seeking Help (BASH) scale (Kuhl, Jarkon-Horlick, & Morrissey, 1997) have been developed, it was deemed unsuitable for the present study as the instrument specifically measures barriers to seeking help from a therapist. An ongoing and significant challenge is therefore the limited availability of validated, reliable and suitable instruments that measure barriers to help-seeking, especially among young adults.

For the current study participants were presented with an open ended question designed by the researcher to identify factors that may facilitate help-seeking behaviour. This was followed by a modified version of the Barriers to Access to Care Evaluation scale (BACE), which is a 30-item self-report measure developed in the UK by Clement *et al.*, (2012). The BACE was designed to measure barriers to accessing mental health care experienced by adults at any stage in the health care seeking process, including those who have and have not made contact with services (Clement *et al*., 2012). Each item on the BACE corresponds to a possible barrier, such as 'feeling embarrassed or ashamed' and 'wanting to solve the problem on my own', participants are required to provide a response ranging from 0 (not at all) to 3 (a lot) with higher scores indicating a greater barrier. In order to assess barriers to seeking help in the future, permission was granted by the authors to modify the opening question from 'Have any of these issues ever stopped, delayed or discouraged you from getting, or continuing with, professional care for a mental health problem?' to 'if you were to experience an emotional or mental health difficulty, which of these issues would stop, delay, or discourage you from getting professional help' (Appendix 13b).

The BACE was deemed suitable for the present study as it enables a comprehensive assessment of barriers, which includes a 12-item subscale that measure stigma and discrimination related barriers. The instrument has the benefit that it can be utilised for research purposes with general population samples, as well as being suitable for use with individuals with any type of mental health condition. The BACE was developed in the UK and has been tested to have good reliability, internal consistency, content and construct validity (Clement *et al.*, 2012). When tested for readability the analysis indicated that the BACE can

be understood by the average 11 to 12 year old (Clement et al., 2012). Therefore it was considered to be less burdensome for participants to complete, which is an important factor to consider when designing a survey that will yield a higher response rate (Bowling, 2005).

Ethical Considerations

This study recruited from the general population, therefore ethical approval was sought and granted solely from the University of Hertfordshire, Health and Human Sciences Ethics Committee and Delegated Authority (ECDA) (see Appendix 16 for approval certificate). Potential participants were approached and data collected only once approval had been granted.

Although this study did not pose any significant ethical concerns, several ethical issues were considered and addressed, as discussed below.

Informed Consent

It was necessary to ensure that all participants gave their informed consent prior to taking part in the survey. At the start of the survey all participants were presented with a welcome page and a written information sheet (Appendix 5&6). Taking into consideration that young participants may not read a lengthy information sheet, the information was designed to be age-appropriate and concise. The information sheet informed participants of the purpose of the study, that their participation was entirely voluntary, they could withdraw at any time, that their information would be anonymous, stored confidentially and how their data would be used. Participants were also provided with the contact details of the researcher should they wish to discuss the study or withdraw. Participants could only take part in the study by giving their informed consent and agreement that they understood the information sheet, which was indicated using a tick box at the start of the survey (Appendix 7). Throughout the survey participants also had the opportunity to leave questions unanswered without having to give any reason.

Confidentiality and Anonymity

To ensure that all participants remained anonymous, participants were not required to provide their name, address or date of birth. At the end of the survey, if participants chose to take part in the prize draw, it was ensured that their e-mail address was stored separately to their responses.

All information gathered from the study remained confidential to the researchers and the data was stored on a secure password protected computer that could only be accessed by the researchers.

Debrief

It was acknowledged that for some participants, questions within the survey that were related to difficulties and mental health experiences could trigger feelings of distress. Furthermore, the survey could highlight mental health concerns that they were previously unaware of. In order to account for such possibilities, a debrief sheet (Appendix 15) was provided at the end of the survey which listed relevant services and resources from which they could seek further support.

Statistical Analysis

Statistical analysis was conducted using IBM SPSS Statistics for windows (v22). Socio-demographics and psychological distress were analysed using descriptive statistics and mean scores on the DASS-21 and GSE were compared across groups using an independent t-test (parametric test).

Chi Square analysis with Fisher's Exact test and Odds Ratio (OR) analysis were used to analyse the association between demographic factors and other key dichotomous variables with help-seeking and non-help seeking behaviour. A Bivariate Point-Biserial correlation analysis was also conducted to analyse the relationship between psychological distress and self-efficacy with previous help-seeking behaviour.

Although intention to seek help was measured on a Likert scale, the responses were dichotomised into categorical data in order to analyse the association between categorical variables on intention to seek help using a non-parametric test (Chi-Square with Fisher's Exact).

Descriptive statistics and independent t-test were used to investigate the prevalence of stigma-related and non-stigma related barriers, which was measured using the BACE scale.

The reliability of the DASS-21, GSE scale and the BACE stigma scale was determined using Cronbach's Alpha coefficients (α).

A binary logistic regression was conducted in order to develop a model to predict participant's intention to seek professional. For the regression analysis, variables that were measured using a Likert or continuous scale, were dichotomised and entered into the model as predictor variables.

In order to analyse participant's written feedback of their experience of services, perceived barriers and facilitators to help-seeking, a thematic analysis was conducted. Following guidelines from Braun & Clarke, (2006) the written responses were read and re-read at least

twice in order for the researcher to become familiar with the data set. During the third read through, initial codes, thoughts and reflections were written down next to the written responses. Codes were identified using an inductive approach and attempts were made to reduce any bias in the analysis that may emerge from the research question or theoretical underpinning of the study. Once the initial codes were identified across the entire data set, the next stage of the analysis involved identification of initial themes. This phase involved reading and sorting of the different codes into potential themes and sub-themes based on important patterns of meaning that emerged in the initial codes. The initial themes were reviewed and named according to the essence of what the themes were reflecting. The themes were reviewed and the reliability of the prominent themes assessed by the primary research supervisor.

CHAPTER 3: RESULTS

The results chapter will begin with a description of the socio-demographic profile of the sample, followed by the reporting of the results according to each of the study objectives that were set out in chapter 1.

Socio-Demographic Profile

A total of 203 people responded to the online survey; of these respondents 80% (*n* = 163) completed each question in the survey and 19% (*n* = 39) dropped out part way through. Approximately 900 people followed the online link to the survey, but did not take part.

Table 2 represents the frequencies and percentages of the demographic variables of the sample. The majority of participants were female (69%, *n* = 141) and the mean age of the overall sample was 20.6 years (*SD* = 2.39, *range* = 18-25).

Personal and Social Circumstances

The majority of participants were single (69%, *n* = 138), the remaining described their relationship status as either in a relationship (28%, *n* = 57), married (2%, *n* = 4), or 'other' (2%, *n* = 4).

Out of the 203 participants, the vast majority indicated that they were living with family (70%, *n* = 143) and the second most common living arrangement was in shared or student accommodation (13%, *n* = 27). Those who were living alone made up 5% (*n* = 11) of the sample, while only 1% (*n* = 3) had no fixed home address.

A high proportion of respondents were born in the UK (79%, *n* = 161). Of those who were born outside of the UK (21%, *n* = 42), the length of time they had lived in the UK ranged from 10 months to 20 years (*M* = 7.5, *SD* = 5.8).

A small proportion of participants reported that they had dependent children (4%, *n* = 9).

Ethnicity and Religion

The majority of participants identified their ethnicity as White British (55%, *n* = 111), the second highest ethnic group who took part in the survey were Asian / British Asian (17%, *n* = 34), followed by Black / Black British (9%, *n* = 19). The remaining participants were either of mixed ethnicity (7%, *n* = 14) or another ethnic group not listed (12%, *n* = 25).

Just under half of the young people who took part in the survey indicated that they had 'no religion' (47%, *n* = 95) while 32% identified their religion as Christian, and 12% were Muslim.

A small proportion of the sample were Hindu (3%, *n*= 7) or Buddhist (1%, *n* = 3). There were no Jewish or Sikh participants in the sample.

Employment and Education

Approximately half of the participants in the survey had completed their GCSEs or A-Levels (51%, *n* = 103). A further 29% of participants (*n* = 59) had completed a university degree, and the remaining sample indicated that they completed an NVQ, BTEC or HND qualification (16%, *n* = 32). Only one female participant reported that she had no qualifications.

With regards to employment status, two-thirds of the sample were students (*n* = 127). Almost a half were either working full time or part time (43%, *n* = 87) and 16% were employed and also studying (*n* = 33). As few as 8% of the sample reported that they were unemployed (*n* = 17).

A small proportion of the sample reported that they were receiving benefits (18%, *n* = 37) and 7% (*n* = 15) said they were unable to work due to sickness or disability.

Table 2. *Demographic characteristic of sample*

Socio-Demographic Characteristics		Male % (n)	Female % (n)	Total % (n)
Gender		31 (62)	69 (141)	100 (203)
Age	***18***	9.4 (19)	21.8 (44)	31.2 (63)
	19	3.0 (6)	7.9 (16)	10.9 (22)
	20	2.5 (5)	6.4 (13)	8.9 (18)
	21	2.5 (5)	10.9(22)	13.4 (27)
	22	4.5 (9)	5.0 (10)	9.4 (19)
	23	4.0 (8)	7.4 (15)	11.4 (23)
	24	2.5 (5)	3.5 (7)	5.9 (12)
	25	2.5 (5)	6.4 (13)	8.9 (18)
	Total	30.7 (62)	69.3 (140)	100 (202)
	Mean (SD): **20.6 (2.39)**		Range = **18 - 25**	
Relationship Status	***Single***	21.2 (43)	46.8 (95)	68.9 (138)
	Other	9.4 (19)	22.7 (46)	32.0 (65)
	Total	30.5 (62)	69.5 (141)	100 (203)
Living Arrangements				
	Live with family	19.9 (43)	46.3 (100)	66.2 (143)
	Live with friends	1.4 (3)	4.6 (10)	60.1 (13)
	Live with partner	1.4 (3)	5.6 (12)	6.9 (15)
	Live in shared/student accommodation	5.0 (11)	7.4 (16)	12.5 (27)
	Other living arrangement	2.3 (5)	6.0 (13)	8.3 (18)
	Total	30.0 (65)	69.9 (151)	100 (216)[a]

Table Continued				
Ethnicity				
	White British	11.8 (24)	42.9 (87)	54.7 (111)
	Black/Black British	5.4 (11)	3.9 (8)	9.4 (19)
	Asian/Asian British	5.9 (12)	10.8 (22)	16.7 (34)
	Mixed	3.4 (7)	3.4 (7)	6.9 (14)
	Other Ethnic background	3.9 (8)	8.4 (17)	12.3 (25)
	Total	30.5 (62)	69.5 (141)	100 (203)
Born in the UK	**Yes**	22.2 (45)	57.1 (116)	79.3 (161)
	No	8.4 (17)	12.3 (25)	20.7 (42)
	Total	30.5 (62)	69.5 (141)	100 (203)
Duration lived in UK	**≤ 12months**		2.4 (1)	
	1-5 Years		52.4 (22)	
	≥6 years		45.2 (19)	
	Total		100 (42)	
	Mean (SD): 7.5 (5.8) **Range:** 10 months – 21 years			
Religion				
	No Religion	14.3 (29)	32.5 (66)	46.8 (95)
	Christian	7.4 (15)	24.1 (49)	31.5 (64)
	Muslim	5.4 (11)	6.9 (14)	12.3 (25)
	Other	3.4 (7)	5.9 (12)	9.4 (19)
	Total	30.5 (62)	69.5 (141)	100(203)
Highest level of Education completed				
	No formal qualifications	0 (0)	0.5 (1)	0.5 (1)
	GCSEs/A-Level	11.4 (23)	39.6 (80)	51.0 (103)
	NVQ/BTEC/HND	5.9 (12)	39.6 (20)	15.8 (32)
	University degree	11.9 (24)	17.3 (35)	29.2 (59)
	Other Qualification	1.5 (3)	2.5 (5)	4.0 (8)
	Total	30.7 (62)	69.3 (140)	100 (202)
Employment Status				
	Unemployed	4.1 (11)	2.3 (6)	6.4 (17)
	Student	14.1 (37)	34.2 (90)	48.3 (127)
	Part-time work	5.3 (14)	14.4 (38)	20.0 (52)
	Full-time work	6.4 (17)	6.8 (18)	13.3 (35)
	Other (volunteer/unable to work)	2.0 (5)	10.3 (27)	12.2 (32)
	Total	31.9(84)	68.1(179)	100 (263)[b]
Receipt of benefits				
	Yes	4.9 (10)	13.3 (27)	18.2 (37)
	No	25.6 (52)	56.2 (114)	81.8 (166)
	Total	30.5 (62)	69.5 (141)	100 (203)
Dependent Children				
	Yes	1.5 (3)	3.0 (6)	4.4 (9)
	No	29.1 (59)	66.5 (135)	95.6 (194)
	Total	30.5 (62)	69.5 (141)	100 (203)

[a + b]Total is greater than 203 as participants could select more than one option

Objective 1: Prevalence of Psychological Distress and Self-Efficacy

Self-Reported Emotional or Mental Health Difficulty

Table 3 shows the self-reported emotional or mental health difficulty in the sample according to gender. Chi-Square analysis (with Fisher's Exact test) was used as a non-parametric test to identify whether there was any significant relationship between the two categorical variables; gender and self-reported mental health difficulty. Fisher's Exact test was considered a statistically robust analysis, as it can be used with small samples of nominal data. Odds Ratio (OR) was used to calculate whether the odds of participants reporting a mental health difficulty increased or decreased according to gender.

As shown in Table 3, there was an almost equal proportion of respondents who reported a current emotional or mental health difficulty (48%, *n* = 91) compared to those who did not (52%, *n* = 99). Based on participants' self-reports, there was a significant difference in the prevalence of mental health between males (21%, *n* = 19) and females (79%, *n* = 72), where females were 2.6 times more likely to report a current mental health problem than males (*Fisher's Exact, p* = .003, *OR* = 2.57, 95% *CI* = 1.35 – 4.90).

Estimates of the proportion of participants who experienced a mental health disorder in their lifetime were also calculated, the results suggest a prevalence of 65% in the overall sample (*n* = 123). A significant association was found between gender and self-reported lifetime mental health difficulty (*Fisher's Exact*, *p* = .032), where lifetime prevalence rates were found to be higher in females (74%, *n =91*) than males (26%, *n =32*), (*OR* = 1.92, *95% CI* = 1.02 – 3.62).

Depression was reported as the most prevalent lifetime mental health difficulty in the sample (48%, *n* = 91), this was followed by anxiety disorder (37%, *n* = 71) and self-harm (32%, n = 60). Significant differences were found in the reported rates of depression (*p* = .017), anxiety (*p* = .006), and self-harm (*p* < 0.001) across gender. Females were 6 times more likely to have self-harmed in their lifetimes than males, (*OR* = 6.20, 95% *CI* = 2.48 - 15.44).

No significant differences were found across gender and the reported prevalence of alcohol / substance misuse, eating disorder, OCD, psychosis and bipolar disorder. As few as 5% (*n* = 10) of the overall sample said they had a lifetime experience of bipolar disorder; 7% (n= 14) for psychosis; 12% (*n* = 22) reported problems with alcohol or substance misuse and 18% (*n* = 34) said they had, or were currently experiencing an eating disorder.

Ten percent (*n* = 20) of the sample indicated that they had experienced another mental health difficulty that was not listed. Written feedback indicated that 4% (*n* = 8) of the sample had borderline personality disorder (BPD), 3 people reported having Post Traumatic Stress

Disorder (PTSD), and 3 people indicated that they had symptoms of either anxiety, depression or OCD, but this was undiagnosed.

Table 3. *Self-Reported Mental Health difficulty by Gender*

Self-Reported Mental Health Problem		Male % (n)	Female % (n)	Total 100% (n)	OR (95% CI) Fishers Exact Test
Currently mental health problem	***Yes***	20.9 (19)	79.1 (72)	91	
	No	40.4 (40)	59.6 (59)	99	2.57 (1.35 – 4.90)
	Total	31.1 (59)	68.9 (131)	190	*P* = .003
Lifetime mental health problem	***Yes***	26.0 (32)	74.0 (91)	123	1.92 (1.02- 3.62)
	No	40.3 (27)	59.7 (40)	67	*P* = .032
	Total	31.1 (59)	68.9 (131)	190	
Anxiety Disorder					
	Yes	19.7 (14)	80.3 (57)	71	2.48 (1.24 – 4.95)
	No	37.8 (45)	62.2 (74)	119	*P* = .006
	Total	31.1 (59)	68.9 (131)	190	
Depression	***Yes***	22.0 (20)	78.0 (71)	91	
	No	39.4 (39)	60.6 (60)	99	2.31 (1.22 – 4.37)
	Total	31.1 (59)	68.9 (131)	190	*P* = .017
Alcohol / Substance Misuse					
	Yes	36.4 (8)	63.6 (14)	22	0.76 (0.30 – 1.93)
	No	30.4 (51)	69.6 (117)	168	*P* = .36
	Total	31.1 (59)	68.9 (131)	190	
Eating Disorder					
	Yes	20.6 (7)	79.4 (27)	34	1.93 (0.79 – 4.72)
	No	33.3 (52)	66.7 (104)	156	*P* = .10
	Total	31.1 (59)	68.9 (131)	190	
OCD					
	Yes	24.0 (6)	76.0 (19)	25	1.50 (0.57 – 3.97)
	No	32.1 (53)	67.9 (112)	165	*P* = .28
	Total	31.1 (59)	68.9 (131)	190	
Psychosis					
	Yes	35.7 (5)	64.3 (9)	14	0.80 (0.25 – 2.49)
	No	30.7 (54)	69.3 (122)	176	*P* = .45
	Total	31.1 (59)	68.9 (131)	190	
Bipolar					
	Yes	40.0 (4)	60.0 (6)	10	0.66 (0.18 – 2.43)
	No	30.6 (55)	69.4 (125)	180	*P* = .38
	Total	31.1 (59)	68.9 (131)	190	
Self-Harm	***Yes***	10.0 (6)	90.0 (54)	60	
	No	40.8 (53)	59.2 (77)	130	6.20 (2.48 - 15.44)
	Total	31.1 (59)	68.9 (131)	190	*P* < .001
Other mental health problem	***Yes***	25.0 (5)	75.0 (15)	20	
	No	31.8 (54)	68.2(116)	170	1.40 (0.48 – 4.04)
	Total	31.1 (59)	68.9 (131)	190	*P* = .62

Psychological Distress Indicated by DASS-21

Symptoms of depression, anxiety and stress were measured using the DASS-21 questionnaire. A total of 190 participants completed all the items on the DASS-21. Higher scores on the measure indicate increased severity of symptoms and greater psychological distress.

The means, medians, standard deviation and range for each of the subscales and total scores can be found in table 16 in Appendix 16. The distribution of scores in the overall sample is illustrated in the box plot as shown in figure 3. The scores on the DASS-21 appear to the eye to be positively distributed, however when a formal testing of normality was undertaken, scores were found to be normally distributed (*skew* = 0.33) and ranged from a minimum score of 0 to a maximum of 63.

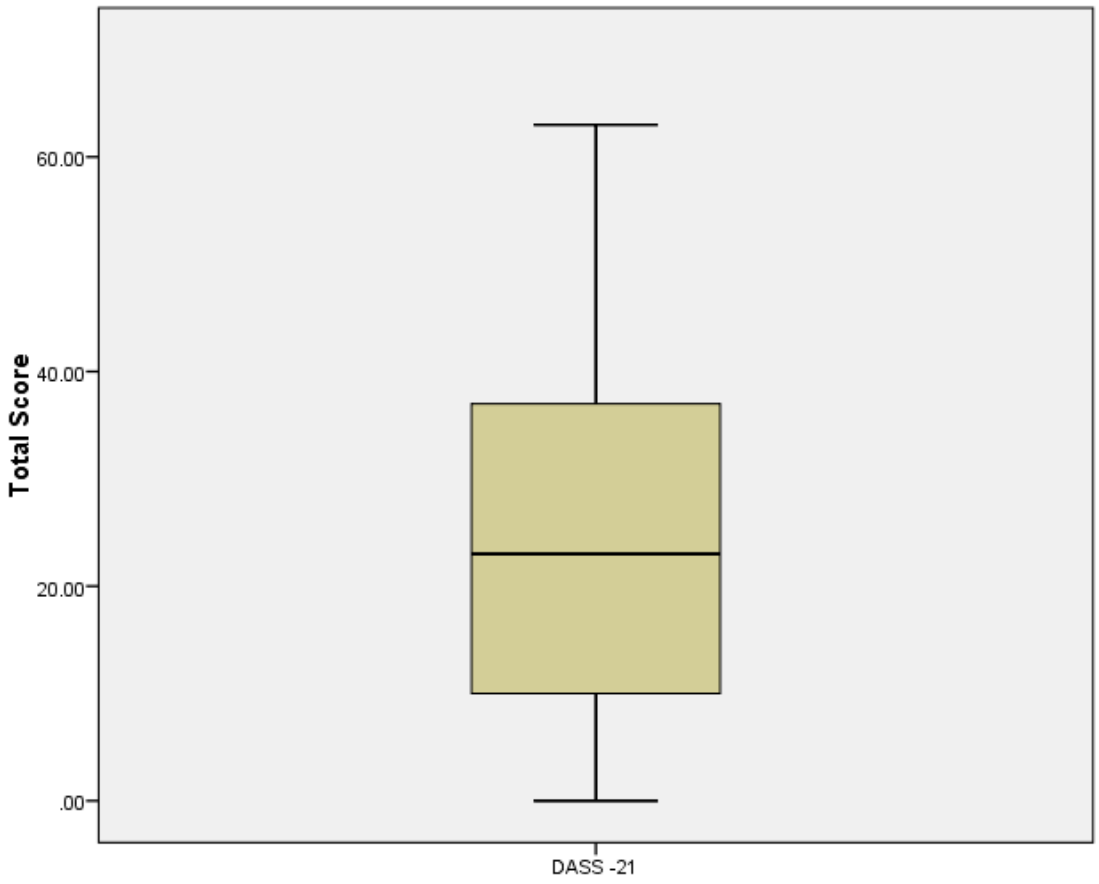

Figure 3. Distribution of DASS-21 scores in the overall sample

Distribution of DASS-21 Subscale Scores

As described in the methods chapter the scores on the three subscales of the DASS-21 can be categorised according to severity of symptoms ranging from 'normal' to 'extremely severe'. The proportion of the sample scoring within each range was calculated and is shown diagrammatically in figure 4. In the overall sample, 33% to 41% of participants scored within the 'normal' range across all of the subscales of the DASS-21. However, 27% (*n* = 51) of participants scored within the 'extremely severe' range for the depression subscale, 31% (*n* = 59) scored within the 'extremely severe' range for the anxiety subscale and 11% (*n* = 22) for the stress subscale. Further details of the scores across the subscales can be found in Appendix 18.

Cronbach's alpha was used to determine the reliability and internal consistency of the DASS-21 subscales. A Cronbach's α of 0.94 was obtained for the depression subscale, 0.90 for the anxiety subscale and 0.89 for the stress subscale. This is consistent with the literature and suggests that the scale has good reliability.

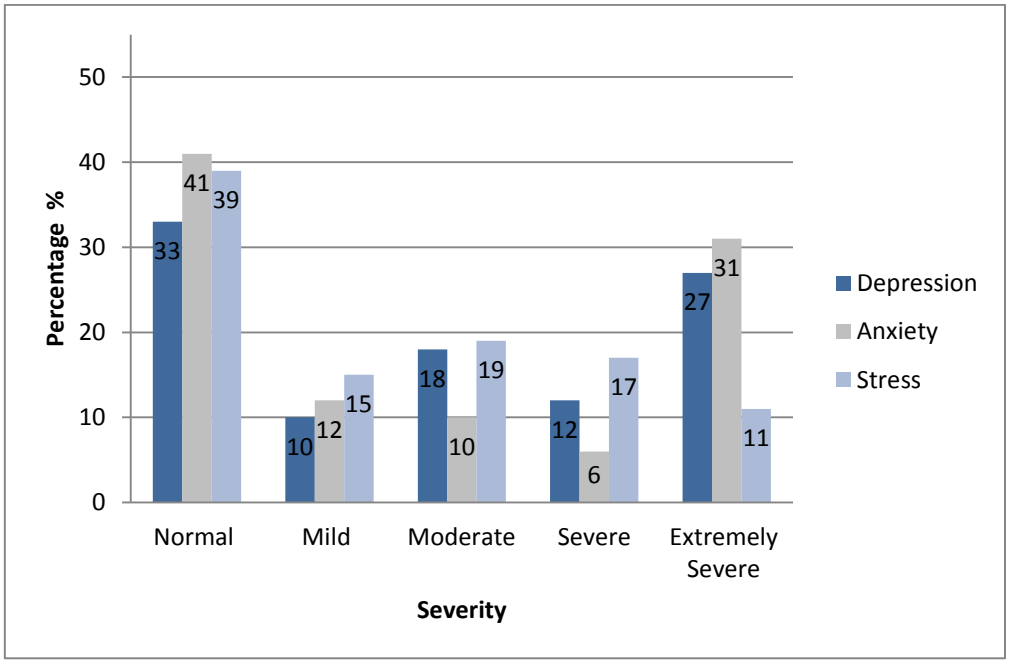

Figure 4. Percentage distribution of scores on each subscale of the DASS21

DASS-21 Scores and Self-Reported Distress

The distribution of scores on the DASS21 were analysed according to whether participants self-reported a current emotional or mental health difficulty, which is illustrated in figure 5. As shown in the boxplot, the scores appeared to the eye to be positively skewed but were found to be non-significant for each group (*skew* = 0.23 and 0.71). In order to examine whether or not the mean scores between the two groups were significantly different, an independent t-test was carried out. The results revealed that participants who reported a current emotional or mental health difficulty scored significantly higher on the DASS21 (M = 34.3, SD = 14.1, n = 89) than participants who did not disclose a current mental health difficulty (M = 15.7, SD = 13.2, n = 98), where the results of the t-test were found to be $t(185) = 9.28$, $p < 0.001$.

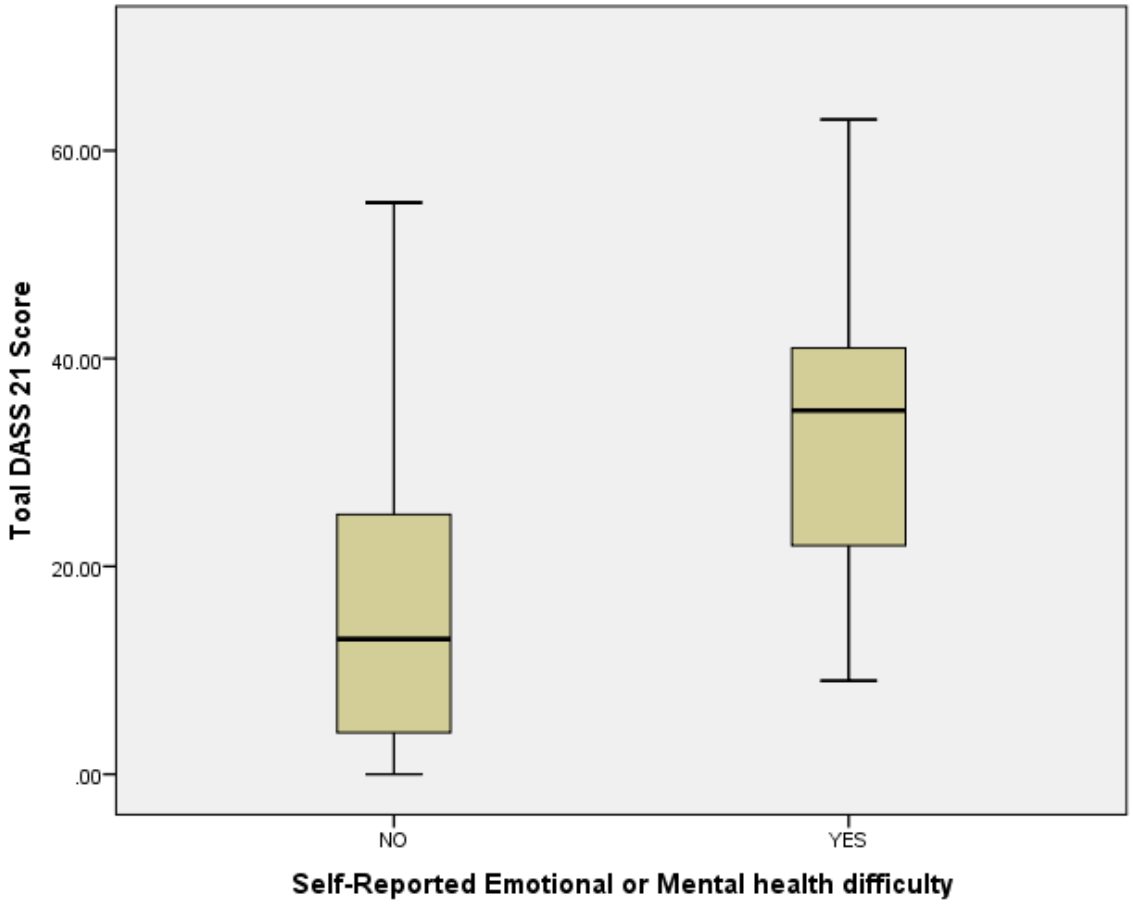

Figure 5: Boxplot of Total DASS 21 Scores according to whether participants self-reported a current emotional or mental health difficulty.

As shown in figure 5 there were a number of participants who did not self-report a current mental health difficulty, but who obtained a high score on the total DASS-21. In order to analyse this further, the proportion of participants who scored within the 'moderate to extremely severe' range of each subscale was calculated and presented in table 4. As shown in the table, between 28% and 33% of participants who obtained scores within the 'moderate to extremely severe' range did not self-report any current difficulties.

Table 4. *Percentage of participants scoring within the 'moderate – extremely severe' range on DASS-21 subscale according to whether they self-reported a current emotional or mental health difficulty*

Moderate – Extremely Severe Range	**Self-reported current emotional or mental health difficulty**		
	Yes % (n)	No % (n)	**Total % (n)**
Depression	67.3 (72)	32.7 (35)	100 (107)
Anxiety	71.3 (62)	28.7 (25)	100 (87)
Stress	71.6 (63)	28.4 (25)	100 (88)

The percentage of participants who scored within the 'severe to extremely severe' range on the DASS-21 subscale, but who did not disclose any current emotional or mental health difficulties were also calculated. The analysis revealed that of those who did not disclose a current metal health difficulty, 25% (*n* =18) scored within the 'severe to extremely severe' range of the depression subscale, 26% (*n* = 18) on the anxiety subscale and 22% (n=12) on the stress subscale.

General Self-Efficacy

The level of self-efficacy in the sample was measured using the General Self Efficacy (GSE) Scale, with higher scores on the scale indicating greater perceived general self-efficacy.

Figure 6 illustrates the distribution of scores in the overall sample, the data was normally distributed (*skew* = - 0.4) and the scores in the overall sample ranged from a score of 13 to 40 (*n* = 200), with a mean score of 28 (*SD* = 5.6).

The reliability of the GSE scale was determined using Cronbach's alpha, the scale was found to be highly reliable with a Cronbach's alpha of 0.90.

Although the sample was normally distributed, the analysis revealed that three of the scores were outliers as illustrated in Figure 6. The outliers were individually checked and they did not appear to be an erroneous response. The outliers appeared to be legitimate scores that corresponded to a difference in whether or not participant's experienced a mental health difficulty (see Figure 8).

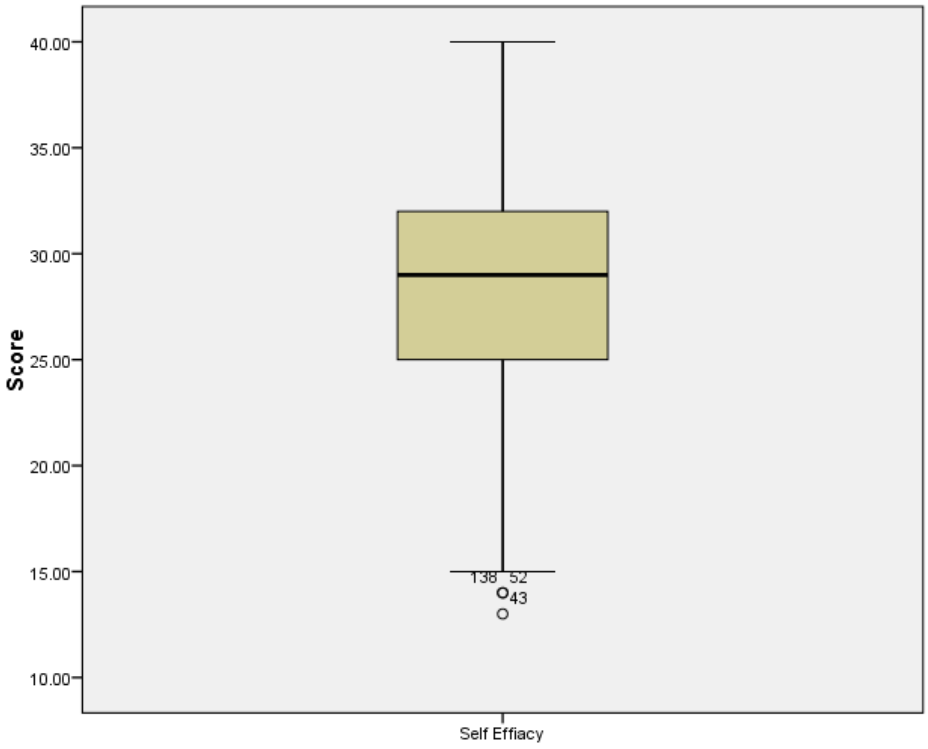

Figure 6. General Self-Efficacy Scores in overall sample.

Self-efficacy and Gender

The distribution of scores on the GSE scale were calculated across male and female participants and shown in figure 7. The scales were normally distributed across gender, however males obtained a significantly higher score on the GSE scale (*M* = 30, *SD* = 5.3, *n* = 61) than female participants (*M* = 28, *SD* = 5.6, *n* = 138). A t-test was performed showing t (197) = 2.36, p = .02.

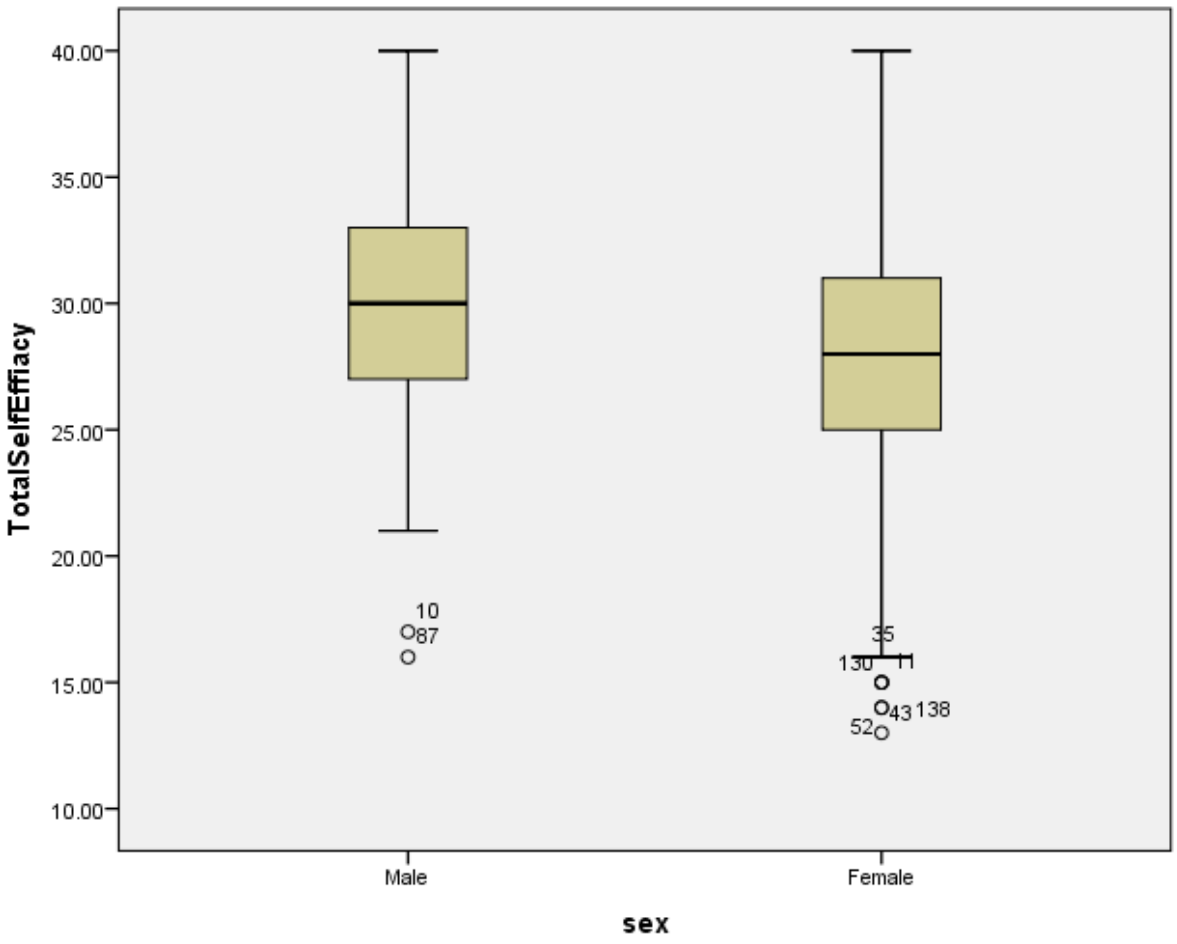

Figure 7. General Self-Efficacy Scores in overall sample across gender.

Self-Efficacy and Mental Health Difficulty

Scores on the GSE scales were further analysed according to whether participants reported any current emotional or mental health difficulty (figure 8). The majority of participants who did not report any current mental health difficulty scored in the range of 21- 40, with one person scoring 15[1]. Although the distribution of data within both groups were normally distributed, the spread of scores were greater among participants who self-reported a current mental health difficulty (*range* = 13 - 40). A comparison of the means between groups was carried out using a t-test and those who self-reported mental health difficulty had a significantly lower mean score on the GSE (*M* = 26.3, *SD* = 6.0, *n* = 92) than those who did not report any current difficulties (*M* = 30.1, *SD* =4.5, *n* = 99), where t-test revealed t(189) = 5.0, $p < .001$.

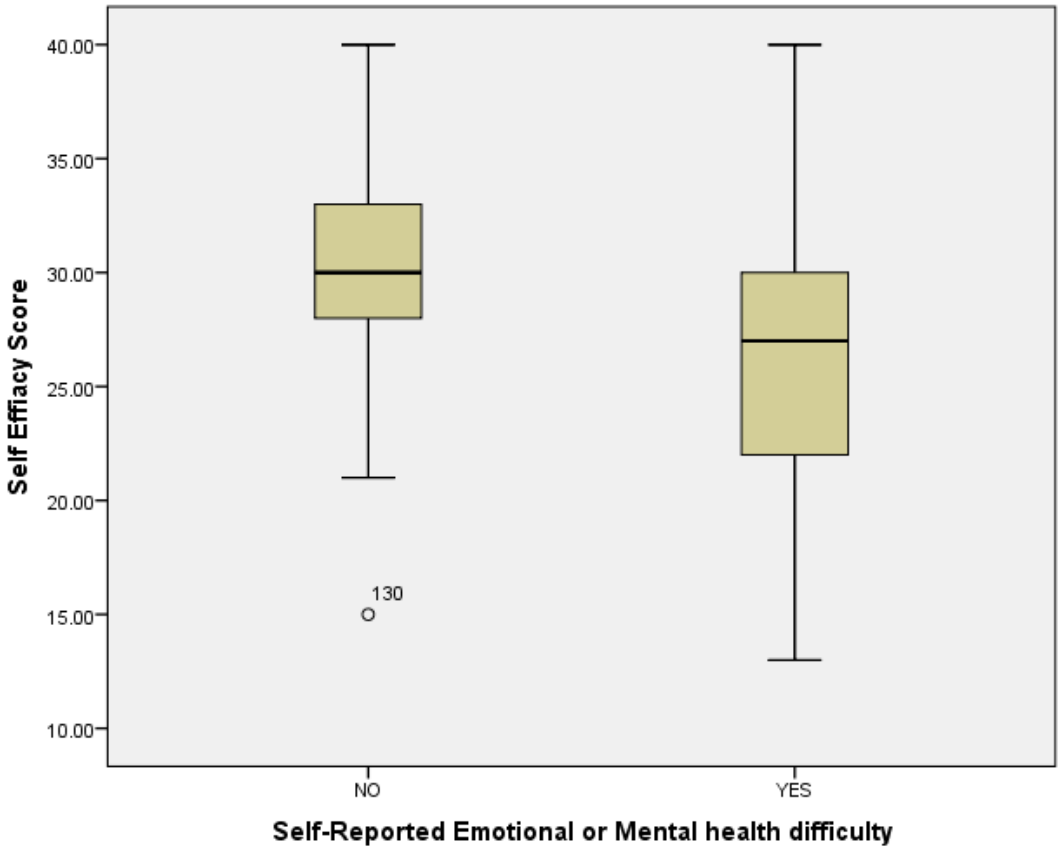

Figure 8 General Self-Efficacy Scores in overall sample according to self-reported emotional or mental health difficulty.

[1] Score did not appear to be erroneous and was included in the analysis.

Objective 2: Experience of Help-Seeking

Help-Seeking from Formal and Informal Sources

Participants who reported a previous or current mental health difficulty (*n* = 129), were asked whether they had sought any help for their difficulties. Table 5 shows the proportion of people who did and did not seek help according to the type of mental health difficulty they reported to have experienced. It is important to note that some of the participants indicated that they had more than one mental health problem.

Overall, 65% (*n* = 84) of participants said that they had sought help at some point from either formal or informal sources. However, approximately half of males who reported a mental health difficulty did not seek help (49%, *n* = 17) and almost one third of females did not seek any help (30%, *n* = 28). As shown in Table 5, 23% (*n* = 16) of participants who said they had suffered with anxiety did not seek any help and 28% (*n* = 25) of people who had depression did not seek any help.

Table 5. Help-Seeking according to self-reported mental health difficulty experienced.

Self - Reported Mental health difficulty	**Sought help % (n)**	**Didn't Seek Help % (n)**	**Total** (N)
Any Mental health difficulty	65.1 (84)	34.9 (45)	129
Anxiety	76.8 (53)	23.1 (16)	69
Depression	62.2 (56)	27.8 (25)	90
Alcohol /Drug Misuse	72.7 (16)	27.2 (6)	22
Eating Disorder	54.5 (18)	45.5 (15)	33
OCD	58.3 (14)	41.7 (10)	24
Bipolar	60.0 (6)	40.0 (4)	10
Psychosis	78.6 (11)	21.4 (3)	14
Self-Harm	82.7(48)	17.2 (10)	58
Other mental health problem	78.9 (15)	21.0 (4)	19

Type of Help Sought

Participants who had sought help for a mental health difficulty (*n* = 84), were asked to indicate who they had sought help from. Figure 9 illustrates the type of help-sources that participants utilised. Participants in the sample sought help from a range of 1 to 10 help sources, with an average of 5 different sources (*SD* = 2.2).

Of those who sought help, the majority (86%, *n* = 72) had accessed help from their GP and/or a mental health professional (i.e. psychologist, mental health nurse). Over half of young people (56%, *n* = 47) had sought help from online sources. Friends (61%, *n* = 51) and parents (50%, *n* = 42) were also commonly reported as informal sources of help. However, participants in the sample least commonly approached a minister or religious leader (7%, *n* = 6).

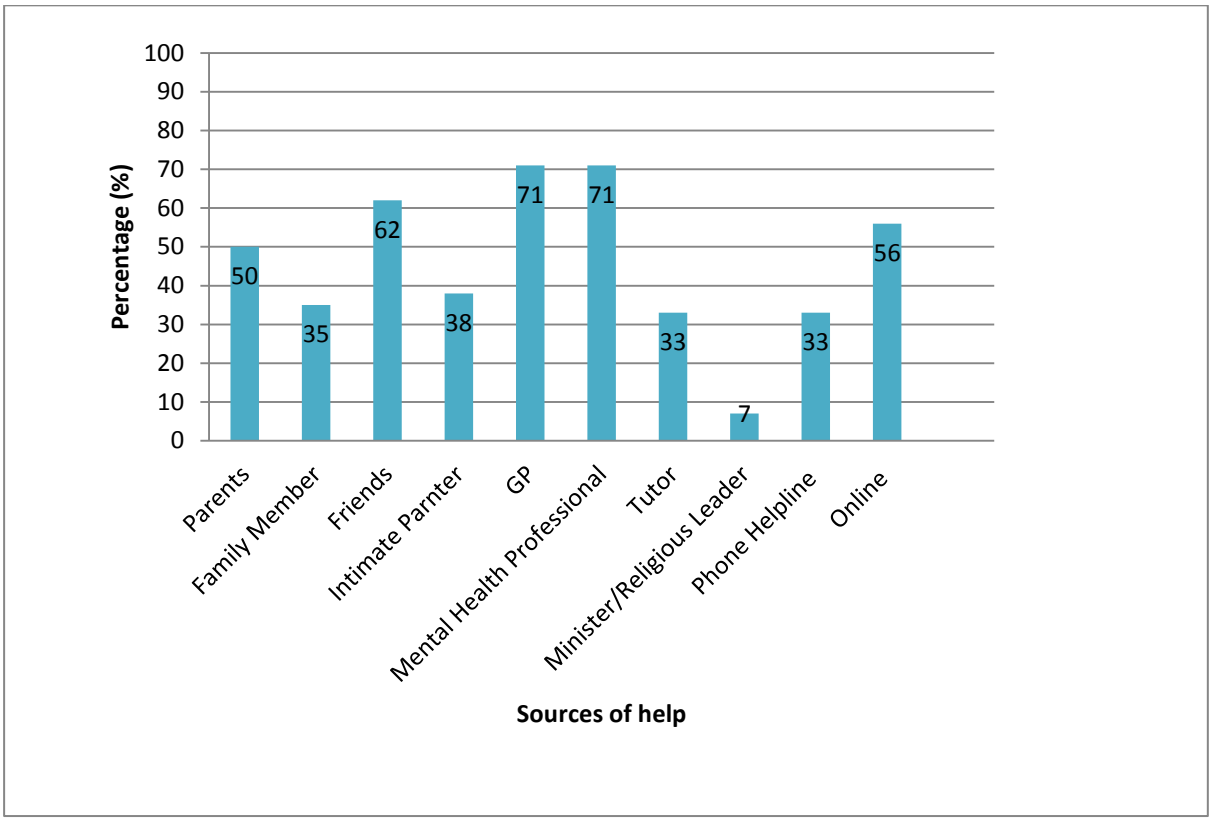

Figure 9. Source of help utilised among participants who reported that they had sought help for a mental health difficulty.

Type of help sought according to gender

In order to analyse whether there was any difference between where males and females sought help, a Chi Square analysis was conducted (see Appendix 19) and the percentages of those who sought help for each type of help-source are shown in figure 10. GPs were reported as the most common help-source for males, (67%, *n* = 12) and half of males (*n* = 9) had accessed help from friends or a mental health professional. Among female participants, 77% (*n* = 50) reported seeking help from a mental health professional, and the second most commonly cited help source among females was their GP (74%, *n* = 48). Chi Square and OR analysis showed that females were three times more likely to have sought help from a mental health professional than male participants, where *p* = .039, *OR* = 3.33, 95% *CI* = 1.12 – 9.91.

Although no significant differences were found between males and females when accessing other sources of help, as shown in figure 10, a higher percentage of females sought help online (60%, *n* = 39) and used phone helplines (39%, *n* = 25) than males.

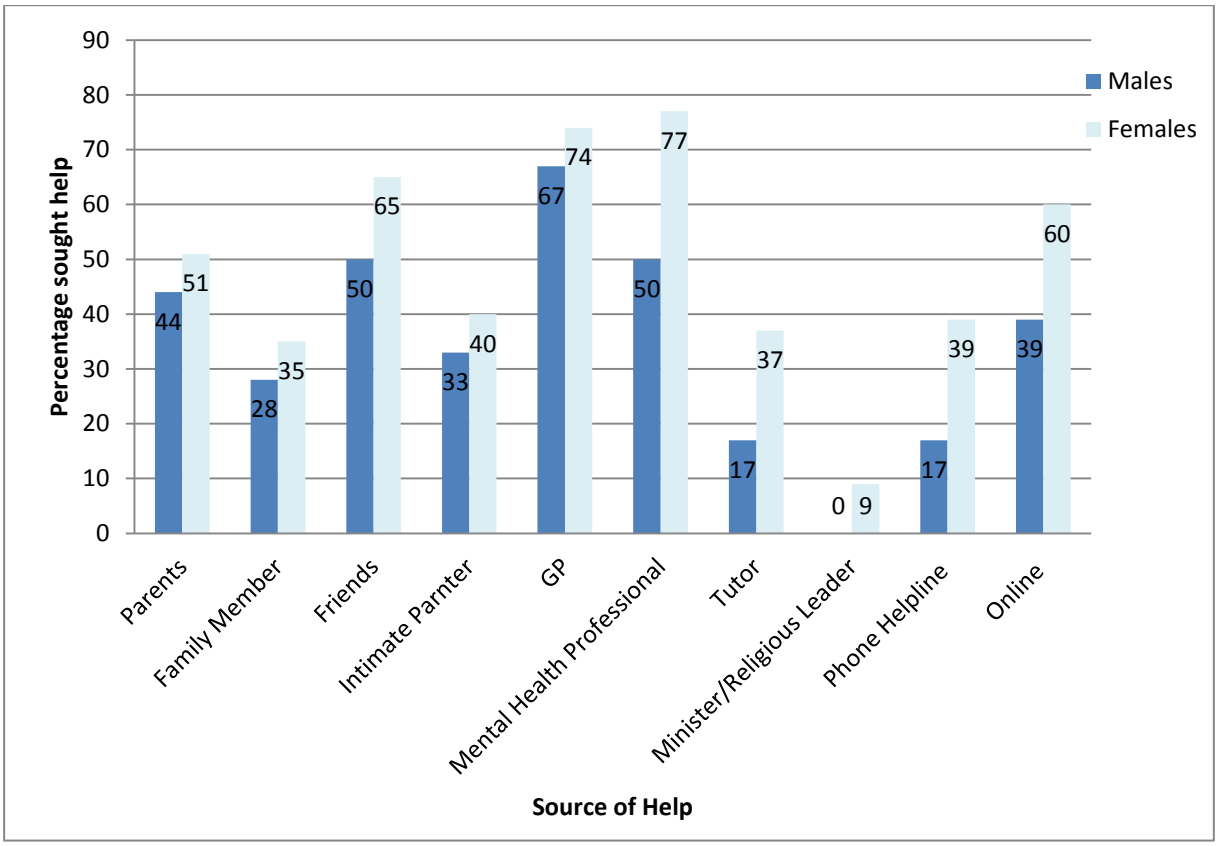

Figure 10 *Source of help utilised among male and female participants who reported they had sought help for a mental health difficulty.*

Satisfaction with Help received from Mental Health Professionals

Participants' experiences of seeking help from their GP or mental health professionals was assessed (Figure 11). Among the 69 people who provided quantitative feedback on their experience, 48% (*n* = 33) said that they were satisfied or very satisfied with the help that they received. However 32% (*n* = 22) indicated that they were either very dissatisfied or dissatisfied. Fisher's Exact Test and Odds Ratio (OR) were used to explore whether there was any significant difference in the satisfaction of help received from professionals across gender. Although a higher proportion of females reported satisfaction with professional care (37%, *n* = 25) than males (10%, *n* = 7), overall a low frequency of males had sought help from mental health professionals and no significant difference was found (*OR* = 0.58, 95% *CI* = 0.16 – 2.04, *p* = .29).

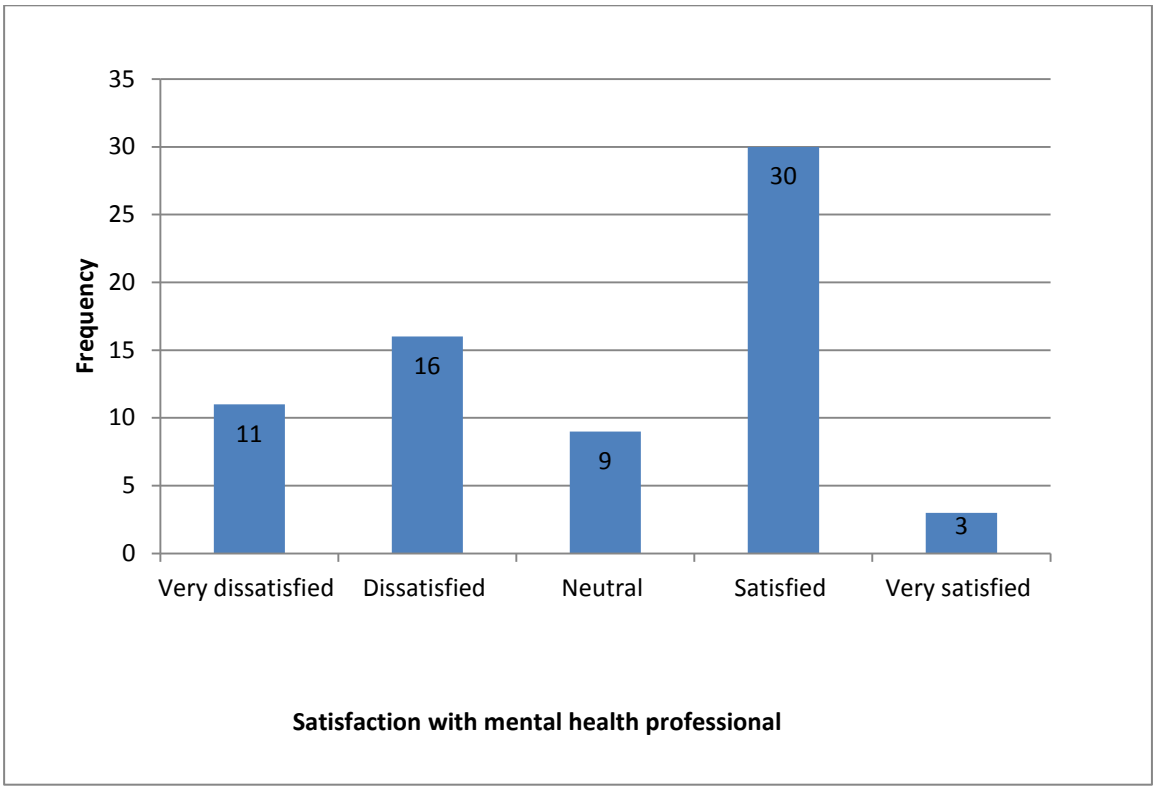

Figure 11. Satisfaction with service from GP or mental health professionals

Experiences of Seeking Professional Help

Participants who had sought professional help were also asked to provide additional feedback about how satisfied they were with the support that they received. Qualitative feedback was gathered from 29 participants and their responses were analysed using thematic analysis. Key themes were extracted from the data, which is presented in the following section.

Importance of Being Heard and Understood

One of the most prominent themes that emerged in the data was the importance of being heard and understood by professionals. Satisfaction with professional support was associated with being "*listened*" to and perceiving professionals as being "*empathic and understanding*". However, disappointment with help-seeking was often described in the context of their distress being "*ignored*", "dismissed", "*not taken seriously*" *or "believed*". One respondent commented on how their attempts to access help "*falls on silence",* which led them to believe that there is "*nothing out there to help*". Not feeling heard was also associated with professionals being described as lacking in "*empathy*" or having *little "understanding*" of their difficulties. One commented on how they were "*often told I wasn't actually feeling how I was"* and another respondent with a diagnosis of Emotionally Unstable Personality Disorder felt that professionals did not take time to understand "*why things are the way they are*".

The theme of being unheard is further illustrated in the following responses.

"…..Talking to the MHP felt akin to talking to a brick wall that occasionally nodded or made notes. The entire course felt like a complete waste of my time, and I felt perhaps even worse than when I started it because of the lack of empathy…."

…"I was taken to hospital ……for suicidal thoughts and was ignored completely by the psychiatrist who saw me in the morning and was taken home straight away without any other examination, even though I still felt suicidal and did not want to go home."

Importance of Active and Person – Centred Support

The importance of active and person-centred support emerged as a theme in the written feedback. A number of participants expressed satisfaction when they believed that "*something was being done"* such as being referred to other services, or being prescribed medication upon request. Other participants expressed satisfaction that their GP "*monitored*" them on a monthly basis, or when professionals were being "*reliable*".

In contrast, other participants who expressed dissatisfaction with services commented on being "*refused anti-depressants*" or taken off medication "*because of how long I had been on it rather than how it would affect me.*" Others reported on staff not having "*enough time*" to offer support, or there simply not being "*enough advice or support out there".*
Further examples of the importance of active and person centred support are illustrated in the extracts below.

"…I told my counsellor that I was depressed, had overdosed and she did nothing. No referral to get my bloods checked, no further support…. I believe if I'd been referred to the CMHT first, I may not have ended up in such a bad position"

"…There was no real support at all- they just logged what happened and occasionally said 'oh that must have been horrible' 'try and distract yourself'"

Feeling Judged

Analysis of the qualitative data also revealed that feeling judged was a key theme. Several participants described experiences where they sought professional help, but they encountered a somewhat judgemental response. Professionals were described as being "*condescending*", "r*ude*", "*patient-blaming"* or not believing the young person. One respondent said that they were informed that they were "*sad and 'acting out'*. A further young person commented that:;

"Most of my experience was good except one doctor who said "what would you ever have to be depressed about?" Which I thought was awful".

Preferred Means of Accessing Professional Help

All participants (*n* = 179) were asked to indicate where they would prefer to access professional support if they experienced a mental health difficulty in the future. Participants' preferences are shown in table 6, and the majority indicated more than one preference. A large proportion of respondents indicated that they had no preference as to where they saw a mental health professional (42%, *n* = 75). A third (33%, *n* = 59) of participants reported that they would prefer to access help at a CMHT and 31% preferred to access help at home or over the internet (*n* = 56). The least preferable means of accessing help from a mental health professional was over the telephone (16%, *n* = 28).

Table 6. *Preferred means of accessing help in the future from mental health professional or GP*

Preferred means of accessing professional help	Frequency	Percentage n = 179
At a hospital	46	25.7
At a CMHT	59	33.0
Over the telephone	28	15.6
Over the internet	56	31.3
At home	55	31.3
At Work/Educational setting	48	26.8
No preference	75	41.9
Other location not listed	14	7.8

Objective 3. Variables Associated With Previous Help-Seeking

In order to analyse which dichotomous variables were associated with whether or not help was sought from informal or formal sources, a Chi-Square and Odds Ratio (OR) analysis were conducted (table 7). For continuous data such as the DASS-21 and the GSE scale, a bivariate point-biserial correlational (r_{pb}) analysis was carried out. These findings are presented in table 8 and a positive correlation indicates an association with previous help-seeking.

As shown in the table 7, of those who said they had a previous or current mental health difficulty, a higher proportion of females (51%, *n* = 65) had sought help than males (14%, *n* = 18). There was a significant relationship between gender and whether or not participants reported seeking help (Fisher's Exact, *p* = .042). However the effect size which was analysed using the OR test revealed a non-significant effect (OR = 2.19, 95% CI = 0.99 -4.87).

With regards to ethnicity and previous help-seeking, there was a significant relationship between participants who were White British or Asian/Asian British and whether or not help was sought (Fisher's Exact, *p* = .001 and *p* = .01, respectively). Majority of White British participants reported help-seeking in the past (77%, *n* = 62), however fewer participants of Asian or Asian British ethnicity had sought help (35%, *n* = 6). Based on the odds ratio, the odds of participants reporting that they sought help was 4 times higher if they were not of Asian or Asian British ethnicity (OR = 4.2, 95% CI = 1.4 – 12.3).

Among the sample of participants who sought help for a mental health difficulty (n = 84), approximately two-thirds indicated that they had no religion (67%, *n* = 44). A higher proportion of Christian participants reported that they had sought help at some point (74%, *n* = 28) than those who were Christian and did not seek help (26%, *n* = 10). However, a reverse pattern was found among participants who were Muslim, whereby a greater percentage did not seek help (79%, *n* = 11). A significant association was found between being Muslim and help-seeking (Fisher's Exact, *p* = .001). The odds of seeking help was 9 times higher among participants who did not identify their religion as Muslim, than those who did (*OR*= 8.7, 95% *CI* = 2.3 – 33.3).

No significant relationship was found between the level of educational achievement or current employment status and whether or not participants had sought help in the past. However, over half of students said that they had previously sought help (58%, *n* = 42) and a large proportion of participants who were unable to work due to sickness or disability, also reported past help-seeking (87%, *n* = 13).

Table 7. *Variables related to formal and informal help-seeking among participant who reported a lifetime mental health difficulty*

Variables		Sought help % (n)	Did not Seek Help % (n)	Total (n)	Fishers Exact Test (P)	OR (95% CI)
Gender	Male	14.1 (18)	13.3 (17)			
	Female	50.8 (65)	21.9 (28)	128	P = .042	2.19 (0.99-4.87)
Ethnicity	White British	76.5 (62)	23.5 (19)	81	P = .001	0.26 (0.12– 0.56)[A]
	Black/Black British	50.0 (5)	50.0 (5)	10	P = .317	1.98 (0.54 - 7.22)
	Asian/Asian British	35.3 (6)	64.7 (11)	17	P = .012	4.21(1.44–12.30)
	Mixed Ethnic Group	50.0 (6)	50.0 (6)	12	P = .340	2.0 (0.61 – 6.60)
	Other Ethnic background	55.6 (5)	44.4 (4)	9	P = .719	1.54 (0.39– 6.05)
Religion	No Religion	66.7 (44)	33.3 (22)	66	P = .716	0.87 (0.42 -1.80)
	Christian	73.7 (28)	26.3 (10)	38	P = .227	0.57 (0.25– 1.32)
	Muslim	21.4 (3)	78.6 (11)	14	P = .001	8.74 (2.29-33.29)
	Other	81.8 (9)	18.2 (2)	11	P = .327	0.39 (0.08 -1.88)
Relationship Status						
	Single	43.4 (56)	28.7 (37)	129	P = .045	0.43 (0.18 -1.05)
	Other	21.7 (28)	6.2 (8)			
Highest level of Education completed						
	GCSEs/A-Level					
	NVQ/BTEC/HND	67.1 (49)	32.9 (24)	73	P = .578	1.26 (0.61-2.62)
	University degree	76.9 (10)	23.1 (3)	13	P = .541	1.92 (0.50-7.36)
	Other Qualification	56.8 (21)	43.2 (16)	37	P = .229	0.61 (0.28-1.35)
		60.0 (3)	40.0 (2)	5	P = 1.00	0.81 (0.13-5.01)
Employment Status						
	Unemployed	70.0 (7)	30.0 (3)	10	-	-
	Student	58.3 (42)	41.7 (30)	72	-	-
	Part-time work	64.5 (20)	35.5 (11)	31	-	-
	Full-time work	76.2 (16)	23.8 (5)	21	-	-
	Unable to work due to sickness/disability	86.7 (13)	13.3 (2)	15	-	-
	Other	76.9 (10)	23.1 (3)	13	-	-
Receipt of Benefits	Yes	73.3 (22)	26.7 (8)	30	P = .382	1.64 (0.66-4.06)
Dependent Children	Yes	80.0 (4)	20.0 (1)	5	P = .66	0.46 (0.05–4.19)
Self-Reported History of Mental health difficulty [B]		67.5 (81)	32.5 (39)	120	-	-
Currently experiencing mental health difficulty (self-reported)	Yes	48.1 (62)	22.5 (29)	129	P = .181	1.56 (0.71 – 3.39)
	No [C]	17.1 (22)	12.4 (16)			
Friends Sought help	Yes	64.3 (45)	18.6 (13)			
	No	10.0 (7)	7.1 (5)	70	P = .15	2.47 (0.67– 9.10)
Family sought help	Yes	69.2 (36)	23.1 (12)			3.00 (0.38–23.78)
	No	3.8 (2)	3.8 (2)	52	P = .29	
Friends Endorse Help-Seeking						
	Yes	50.4 (63)	25.6 (32)	125	P = .58	1.02 (0.43 -2.43)
	Other	16.0 (20)	33.3 (10)			
Family Endorse Help-Seeking						
	Yes	47.6 (60)	19.8 (25)	126	P = .08	0.53 (0.25– 1.15)
	Other	18.3 (23)	14.3 (18)			

[A] OR compared between White British and non-White British, this format is continued for ethnicity in this table

[B] Only participants who reported having a mental health difficulty were asked about help-seeking

[C] Refers to participants who reported a historical mental health difficulty

When exploring the relationship between whether friends or family had sought help and participants' help-seeking behaviour, 64% (*n* = 45) of participants who reported help-seeking also knew friends who sought help. Furthermore, 69% (*n* = 36) of participants who sought help were also aware of a family member who sought help. However, no significant relationship was found between these variables and participants' help-seeking. Approximately half of all participants sought help when they believed that their friends and family would endorse help seeking (50% and 48% respectively), however a non-significant association was observed between participants perceiving that others endorsed help-seeking and whether or not they sought help.

Psychological Distress, Self-Efficacy and Help-Seeking

A bivariate point-biserial correlational (r_{pb}) analysis was conducted in order to analyse the relationship between previous help-seeking experiences and scores on the DASS-21 and the GSE scale (table 8)

Table 8. *Relationship between help seeking experience and DASS-21 and General Self-Efficacy scores.*

	DASS Depression	DASS Anxiety	DASS Stress	DASS Total	General Self Efficacy
Help Seeking Behaviour n = 128	0.11	0.12	0.25**	0.17	- 0.24**

Note. Help sought coded 1, no help-sought coded 0

** Correlation significance at p < .001 (two-tailed)

As shown in Table 8, a non-significant relationship was found between the total DASS-21 score and previous help-seeking (r_{pb} = 0.17, *p* = .06). However, there was a modest but significant correlation found between GSE scale and the DASS-21 stress subscale, with help-seeking behaviour. Participants who scored higher on the stress subscale of the DASS-21 were more likely to have previously sought help, as indicated by the positive correlation coefficient (r_{pb} = 0.25, *p* < .001).

A t-test was conducted in order to identify the difference in mean sores on the stress sub-scale between those who did and did not seek help. The results of the t-test were; *t* (125) = -2.87, *p* = .005, where those who sought help scored significantly higher on the stress subscale (*M* = 12.2, *SD* = 5.1, *n* = 84) than those who did not seek help (*M* = 9.6, *SD* = 4.5, *n* = 43).

There was a significant but inverse relationship between scores on the GSE scale and previous help seeking behaviour, which was indicated by the negative correlation (r_{pb} = -0.24, p < .001). A t-test was conducted and the results showed that those who sought help obtained a significantly lower score on the GSE scale (M = 26.0, SD = 5.9, n = 84), than those who did not seek any help for a mental health difficulty (M = 28.9, SD = 4.7, n = 45), were; t (127) = 2.8, p = 0.007.

A pearson's correlation was conducted in order to further analyse the relationship between DASS-21 stress subscale and GSE scores. The results revealed that there was a significant but inverse relationship between GSE and DASS-21 stress scores, where r = - 0.394, *p= .001.*

Objective 4. Future Help-Seeking Intentions

All participants were asked to rate the likelihood that they would seek help from a variety of specified help sources should they experience a mental health difficulty in the future. The findings are summarised in figure 12. As illustrated in the graph, friends were rated as the most likely source of help that participants would approach in the future (64%, *n* = 118). Half of participants said that they were likely to seek help from their GP or Mental health professional (MHP) (50%, *n* = 93), however one-third said that they were unlikely to seek help from their GP (33.5%, *n* = 62). Seeking help from a minister or religious leader was the least preferred source of help among the sample (81%, *n* = 150, unlikely to seek help). Seeking help using phone helplines was also one of the least preferred options, with 65% indicating they were unlikely to seek help using a phone helpline. With regards to the internet as a source of help in the future, the findings revealed that there was an almost even distribution of people who were likely (44%, *n* = 81) and unlikely to seek help from the internet (41%, *n* = 75).

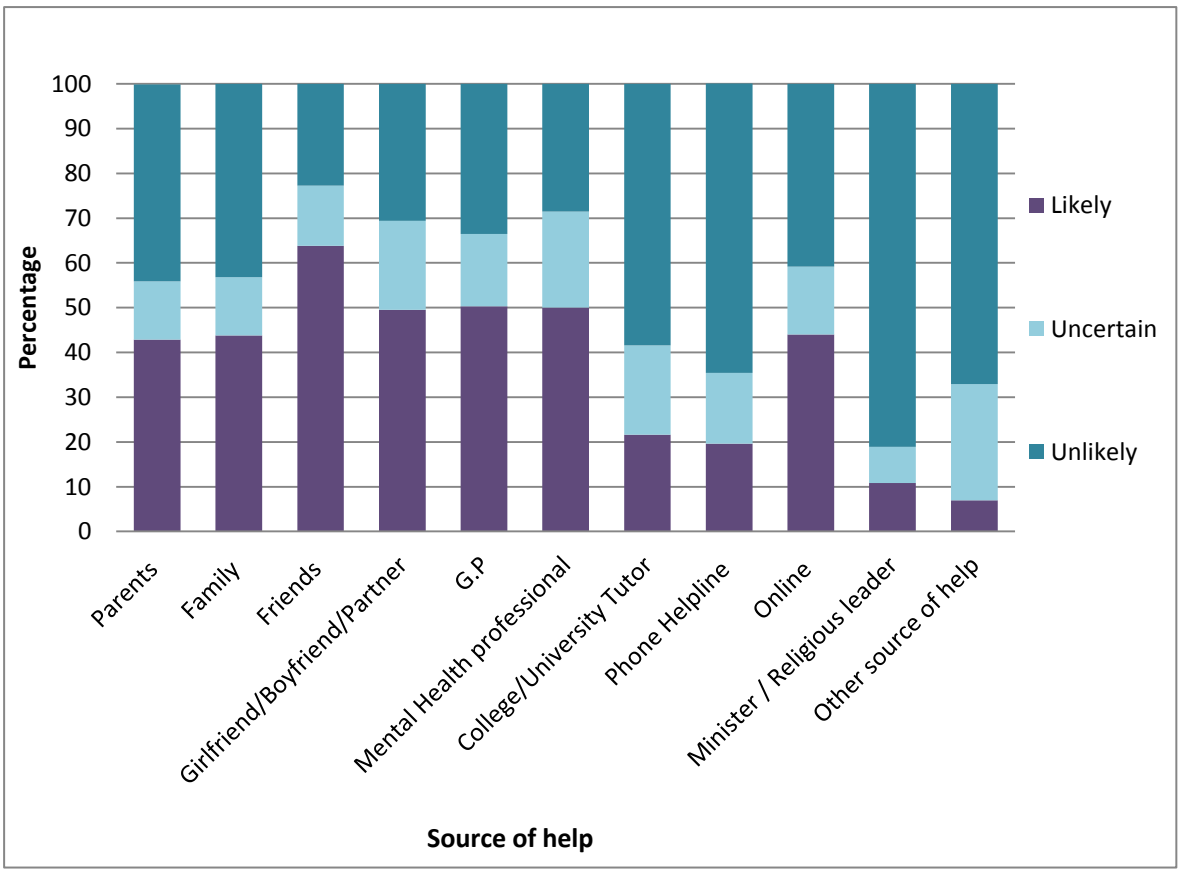

Figure 12. Intention to seek help in the future according to different help sources

Influence of Gender and Intention to Seek Help

Intention to seek help was further analysed across male and female participants using a Chi-Square and Odds Ratio (OR) analysis (table 9). As shown in the table, males and females reported that they were most likely to seek help from their friends (53%, *n* = 31 and 68%, *n* = 86 for males and females respectively). A chi-square analysis showed that there was a significant different between male's and female's intention to seek help from friends (Fisher's Exact, *p* = .039), however there was a non-significant difference found between gender and other help-sources.

Table 9. *Likelihood of seeking help from different help-sources between males and females*

Help Source		Males % (n)	Females % (n)	Total (N)	Fishers Exact Test OR (95 CI)
Parents					
	Likely [1]	29.1 (23)	70.9 (56)	79	P = .312
	Other [2]	33.7 (35)	66.3 (69)	104	0.81 (0.43 -1.53)
Family member					
	Likely	25.9 (21)	74.1 (60)	81	P = .098
	Other	35.9 (37)	64.1(66)	103	0.62 (0.33 -1.18)
Friends					
	Likely	26.5 (31)	73.5(86)	117	P = .039
	Other	40.3 (27)	59.7 (40)	67	0.53 (0.28 -1.01)
Partner					
	Likely	33.3 (30)	67.0 (61)	91	P = .379
	Other	29.8 (28)	70.2 (66)	94	1.16 (0.62 – 2.16)
GP					
	Likely	28.3 (26)	71.7 (66)	92	P = .262
	Other	33.7 (31)	66.3(61)	92	1.29 (0.69 – 2.41)
Mental Health professional					
	Likely	29.3 (27)	70.7 (65)	92	P = .335
	Other	33.3 (31)	66.7 (62)	93	1.20 (0.65 – 2.24)
Tutor					
	Likely	28.2(11)	71.8 (28)	39	P = .846
	Other	31.7 (46)	68.3 (99)	145	0.85 (0.39 – 1.85)
Minister/religious leader					
	Likely	30.0 (6)	70.0 (14)	20	P = 1.00
	Other	31.1 (51)	68.9(113)	164	0.95 (0.35 – 2.61)
Phone Helpline					
	Likely	27.8(10)	72.2 (26)	36	P = .840
	Other	31.3 (46)	68.7 (101)	147	0.84 (0.38 – 1.90)
Online					
	Likely	25.0 (20)	75.0 (60)	80	P =.196
	Other	35.0 (36)	65.0 (67)	103	0.62 (0.32 – 1.19)

[1] Rated likely – very likely

[2] Rated uncertain – very unlikely

Likelihood of Seeking Professional Help In the Future

Participants' intention to seek help from a GP or mental health professional was analysed using a Chi-Square and Odds Ratio (OR) analysis across a number of different socio-demographic variables and measures. The results from the analysis are summarised in table 10.

As shown in table 10, 61% (*n* = 112) of participants indicated that they were likely to seek professional help from a GP or a MHP should they experience a mental health difficulty in the future. Overall, female participants reported a greater likelihood of seeking professional help than male participants (64%% and 54%% for females and males, respectively). However, a Chi-Square analysis revealed that there was a non-significant relationship between gender and intention to seek professional help (Fisher's Exact, *p* = .255).

With the exception of Black and Black British participants, across all ethnic groups, participants reported a greater willingness to seek professional help. For example, 58% (*n* = 60) of White British and 71% (*n* = 22) of Asian or Asian British participants said that they were likely to seek professional help in the future. However, over half of Black or Black British participants indicated that they were uncertain or unlikely to seek professional help (56%, *n* = 10).

Whilst a non-significant relationship was observed between religion and intention to seek professional help (Fisher's Exact, *p* >.05), 41% of participants who were Christian (*n* = 23) and Muslim (n = 20) indicated that they were either uncertain or unlikely to seek professional help if they had a mental health difficulty in the future. Similar patterns were also observed with participants who identified that they had 'no religion'.

A non-significant association was found between highest level of education completed and intention to seek professional help (Fisher's Exact, *p* >.05). With regards to employment status, it was not possible to conduct a Chi-Square analysis as the responses were not mutually exclusive. However, analysis using descriptive statistics revealed that 62% (*n* = 69) of students and almost half of young people working full-time (49%, *n* = 16) reported willingness to seek professional help in the future.

In order to analyse the relationship between self-efficacy and intention to seek help, scores on the GSE were dichotomised into 'high' and 'low' self-efficacy. As recommended by the authors the median point (score of 30) was used as a cut-off. A chi-square analysis showed that there was no significant relationship between participant's self-efficacy scores and whether or not they intended to seek professional help (Fisher's Exact, *p* = .95).

Table 10. *Intention to seek help from GP or Mental Health Professional across different variables*.

Variables		Intention To Seek Help from GP or mental health professional % (n)		Total (N)	Fishers Exact Test	OR (95% CI)
		Likely	Other			
Gender						
	Male	16.8 (31)	14.1 (26)	184	P = .255	1.48 (0.78 -2.79)
	Female	44.0 (81)	25.0 (46)			
	TOTAL	60.9 (112)	39.1 (72)			
Ethnicity						
	White British	58.3 (60)	41.7 (43)	103	P = .448	0.76 (0.42-1.39)
	Black/Black British	44.4 (8)	55.6 (10)	18	P = .140	0.47 (0.18-1.26)
	Asian/Asian British	71.0 (22)	29.0 (9)	31	P = .234	1.69 (0.73-3.92)
	Mixed Ethnicity	72.7 (8)	27.3 (3)	11	P = .533	1.75 (0.45-6.84)
	Other Ethnic background	68.2 (15)	31.8 (7)	22	P = .642	1.42 (0.55-3.68)
Religion						
	No Religion	60.2 (53)	39.8 (35)	88	P = .880	0.93 (0.52 – 1.69)
	Christian	58.9 (33)	41.1 (23)	56	P = .744	0.88 (0.46-1.67)
	Muslim	58.3 (14)	41.7 (10)	24	P = .467	0.88 (0.37 – 2.10)
	Other	76.5 (13)	23.5 (4)	17	P = .201	2.21 (0.69 -7.07)
Relationship Status						
	Single	62.5 (80)	37.5 (48)	128	P = .625	0.83 (0.44 – 1.56)
	Other	57.9 (33)	42.1 (24)	57		
Dependent Children	***Yes***	71.4 (5)	28.6 (2)	7	P = .707	0.62 (0.12-3.27)
Highest level of Education completed						
	GCSEs/A-Level					
	NVQ/BTEC/HND	60.2 (59)	39.8 (39)	98	P = .880	0.94 (0.52-1.71)
	University degree	47.8 (11)	52.2 (12)	23	P = .179	0.55 (0.23-1.31)
	Other Qualification	65.5 (36)	34.5 (19)	55	P = .509	1.32 (0.69 – 2.55)
		75.0 (6)	25.0 (2)	8	P = .485	1.98 (0.39-10.10)
Employment Status						
	Unemployed	40.0 (6)	60.0 (9)	15	-	-
	Student	61.6 (69)	38.4 (43)	112	-	-
	Part-time work	68.8 (33)	31.3 (15)	48	-	-
	Full-time work	48.5 (16)	51.5 (17)	33	-	-
	Unable to work due to sickness/disability	80.0 (12)	20.0 (3)	15	-	-
	Other	63.2 (12)	36.8 (7)	19	-	-
Receipt of Benefits	***Yes***	58.8 (20)	41.2 (14)	34	P = .846	0.89 (0.42 -1.90)
Self-Efficacy	***High***	60.3 (38)	39.7 (25)	63		
	Low	61.5 (75)	38.5 (47)	122	P= .501	0.95 (0.51 -1.78)
Self-Reported History of Mental health difficulty	**Yes**	58.7 (71)	41.3 (50)	121	P = .223	1.34 (0.72 -2.53)
	No	65.6 (42)	43.4 (22)	64		
Self-Reported Current mental health difficulty	**Yes**	58.4 (52)	41.6 (37)	89	P = .287	0.81 (0.45 – 1.46)
	No	63.5 (61)	36.5 (35)	96		
DASS21 (moderate- extremely severe)						
	Stress	64.0 (55)	36.0 (31)	86	P = .305	1.22 (0.67 -2.22)
	Anxiety	63.9 (53)	36.1 (30)	83	P = .274	1.26 (0.69-2.29)
	Depression	56.2 (59)	43.8 (46)	105	P = .063	0.59 (0.32-1.09)

Table Continued						
Sought help for a mental health difficulty	***Yes***	67.5 (56)	32.5 (27)	83	P = .013	0.40 (0.19 – 0.85)
	No	45.5 (20)	54.5 (24)	44		
Previous help from GP or MHP						
	Yes	74.6 (53)	25.4 (18)	71	P = .001	8.83 (2.15-36.25)
	No	25.0 (3)	75.0 (9)	12		
Satisfied with help from GP or MHP	***Yes***	93.8 (30)	6.3 (2)	32	P = .001	10.7 (2.21-51.88)
	Other	58.3 (21)	41.7 (15)	36		
Friends with MH problem Sought help	**Yes**	69.6 (55)	30.4 (24)	14	P = .58	1.09 (0.31 – 3.83)
	No	71.4 (10)	38.6 (4)	79		
Family with MH problem sought help	**Yes**	66.1 (39)	33.9 (20)	59	P = .47	2.05 (0.21-19.59)
	No	80.0 (4)	20.0 (1)	5		
Family Advise help						
	Agree	69.4 (86)	30.6 (38)	124	P = .001	2.99 (1.57 – 5.69)
	Other	43.1 (25)	56.9 (33)	58		
Friends Advise help						
	Agree	67.2 (92)	32.8 (45)	137	P = .004	2.69 (1.34 – 5.39)
	Other	43.2 (19)	56.8 (25)	44		
Instrumental Barrier						
High endorsement		57.4 (27)	42.6 (20)	47	P = .336	0.81 (0.41-1.61)
Low endorsement		62.4 (78)	37.6 (47)	125		
Attitudinal Barrier						
High endorsement		63.0(34)	37.0 (20)	54	P = .414	1.14 (0.59-2.22)
Low endorsement		67.3 (70)	30.2 (47)	117		
Stigma Barrier						
High endorsement		48.9 (22)	51.1(23)	45	P = .046	0.52 (0.26 -1.04)
Low endorsement		64.8 (81)	35.2 (44)	125		

Among participants who reported that they had a current mental health difficulty (*n* = 89), 58% indicated that they were likely to seek professional help in the future (*n* = 52) and 42% said that they were either uncertain or unlikely to seek help (*n* = 37). However intention to seek help was not significantly related to current mental health difficulty (Fisher's Exact, *p* = .287). Between 56% - 64% of participants who scored within the moderate to severe range on the three DASS-21 subscales, indicated a willingness to seek professional help, however this association was again non-significant (Fisher's Exact, *p* > .05).

Intention to seek help was significantly related to previous help-seeking from any source (Fisher's Exact, *p* = .013), and previous help-seeking from a GP or MHP (Fisher's Exact, *p* = .001). Whereby the odds of reporting the likelihood of seeking help in the future was 8 times greater in those who had previously sought professional help (*OR* = 8.83, 95% CI = 2.15 – 36.25). Participants who said they had a positive experience of help-seeking in the past were also significantly more willing to seek help in the future than those who did not have a positive experience (Fisher's Exact, *p = .001, OR = 10.7, 95% CI = 2.15 -51.88).*

Intention to seek professional help was also significantly related to whether or not participant's believed that their friends (Fisher's Exact*, p = .004)* or family (Fisher's Exact*, p = .001)* would advocate help-seeking for a mental health difficulty. Over two thirds of participants reported a willingness to seek help when they perceived their friends or family to advice help-seeking, compared to those who did not. The OR analysis revealed a somewhat larger effect size when participants believed that family recommended help seeking, compared to friends (*OR* = 2.99 and *OR* = 2.69, respectively).

The association between perceived barriers to help seeking, as measured using the BACE, and intention to seek professional help was assessed. A high barrier endorsement was defined as a score above the 75th percentile on each of the BACE subscales. The analysis showed that participants reported a greater intention to seek professional help if they perceived fewer help-seeking barriers. This was particularly evident with scores on the stigma barrier, where 65% of participants who expressed willingness to seek professional help also reported fewer perceived stigma barriers (Fisher's Exact*, p = .046, OR = 0.52, 95% CI = 0.26 -1.04).* However a non-significant relationship was found between intention to seek help and endorsement of attitudinal or instrumental barriers.

Objective 5: Perceived Barriers and Facilitators to Help-Seeking

In the following section participants' perceived barriers and facilitators to mental health help-seeking is presented. Information was gathered using quantitative and qualitative methodological approaches as described below.

Barriers To Seeking Treatment

Participants who reported that they had an emotional or mental health difficulty but who did not seek any help were asked using an open ended question the reasons why they chose not to seek help. Eighty four percent of participants provided qualitative feedback (Appendix 19) detailing reasons they did not seek help (*n* = 38). Thematic analysis was used to code and analyse the responses. Themes that emerged in the data where extracted and the findings are detailed below

Stigmatising Beliefs

Perceived public and self-stigmatising beliefs emerged as a prominent theme in the data. Participants commonly reported on the stigma or discrimination associated with seeking help for a mental health problem. Participants seemed to fear that disclosing or receiving a diagnosis of a mental illness would result in family, friends or professionals responding in a negative manner. One respondent also avoided seeking help, due to their concerns it would impact on their future career prospects.

Fear of public stigma is illustrated in the following responses:

"Being actively labelled with a mental or emotional disability is hard to get rid of once it's official. People might think less of you if they think you might be a little bit crazy."

"There is a negative stigma attached to any mental illness, as soon as you say that you've got one, people judge you and start thinking of you differently. It is something that people are too afraid and shy to talk about …"

Whilst a number of young people had concerns about public stigma and discrimination, in the present study self-stigmatising beliefs also emerged as a barrier among a number of respondents. Some of the young people perceived help-seeking as "*being pathetic*", or expressed feeling "*weak in asking others*".

Perceiving Problem as Not Serious Enough

In the current study, a barrier theme that emerged across many of the responses related to participants believing that their problems were not "*serious enough*" to warrant professional help. A number of participants commented on how they thought that other people had "*more serious problems",* some also drew connections between under-funded services and questioning whether support would be offered because their distress was not "*bad enough*".

"I don't consider my anxiety to be strong enough to justify going to my GP……"

"I don't feel like I'm bad enough to ask for help when there's many more people with much more serious problems then me"

"Because I did not feel I was doing that terribly compared to others and that my problems came from a position of privilege that made my unhappiness meaningless compared to others."

Reliance on Self

A preference for self-reliance, rather than seeking external help for their mental health difficulties also emerged as a major theme in the analysis. Several of the participants indicated that they wanted to resolve their own difficulties because they did not want the "*hassle*"; they were used to coping by putting "*on a brave face*" or coping in other ways. Others commented on not wanting "*to admit I was sick"* or they "*didn't want to talk about it*".

A preference for self-reliance appeared to be influenced by other factors, including how serious they thought the problem was or how much support others could offer. For example one respondent reported *"I felt I could get over it by myself and there was no need to include other people who just tend to confuse the situation".*

Additional comments related to not wanting help because they did not want to stop "*self-harming*" which was their way of coping, or for people to "*monitor what I ate*".

Difficulty Accessing Help

Many participants reported that they did not seek help because they anticipated that help would be unavailable, ineffective or difficult to access. Perceived difficulties in accessing effective help related to a number of factors, including others' limited awareness of mental health: *"Not many people are fully aware and educated on mental illnesses. This causes them to say insensitive things such as: "get over it", "can't you feel happy?".* Others referred to limitations in professional resources, for example *"there's very little they [GP] can do considering how underfunded mental health services are in the NHS".*

A number of participants anticipated that help would be unavailable because others would think "*it's not a real thing", not "serious enough",* or others would not have "time to help". One respondent commented that they did not discuss their concerns with a GP because they thought they would "*be fobbed off with medication".*

The analysis also revealed that difficulties in accessing help were associated with a lack of knowledge about where to access help, or thinking that informal help-sources were unavailable because they were "*part of my problem*". One young person believed that their only means of accessing support was through private services, which they could not afford.

Fear of Negative Outcome

Fear of a negative outcome as a result of seeking help, also emerged as a barrier theme in the written text. Several of the respondents reported that they were fearful that if they spoke about their difficulties it would cause their family or others to "*worry*", become "*upset*", or they themselves would feel like a "*burden*" on others. One participant did not seek help for their self-harming because they did not want "*to disappoint or upset anyone*".

Negative outcomes were also related to the fear that seeking help for a mental health difficulty would worsen their problem; "*Just thinking about having a mental illness can make you feel terrible, so talking about it to another person would make you feel worse."*

Difficulty Identifying or Expressing Concerns

A barrier theme also related to the anticipated difficulty in identifying symptoms, or difficulties with communicating concerns with others. Participants believed that they were unable to, or too afraid to speak about their mental health difficulties, which is illustrated in the following extracts.

"I've tried to go to a mentor to ask for help but have felt unable to and scared of being vulnerable most of the time. I find it hard to talk about my feelings too so I guess that's part of the issue"

"Not understanding and being able to coherently explain my issues, not being physically able to talk about issues due to crying whenever topic comes up…"

"I didn't realise I had a problem…. The only reason this was resolved was I had to go to the doctors because I still wasn't menstruating at 17".

Barriers to Seeking Help In the Future

The Barriers to Access to Care Evaluation (BACE) scale was adapted for the current study in order to quantitatively measure perceived barriers in accessing mental health care in the future. As described in the Method's section, the BACE includes a 12-item 'treatment stigma' subscale and the remaining items can be conceptualised into 'instrumental' and 'attitudinal' barriers. Higher scores on the BACE indicate a greater endorsement of barriers.

The internal consistency of the 12-item 'treatment stigma' subscale was determined using Cronbach's alpha and was shown to have good reliability (a = 0.95) and the overall scale had a Cronbach's alpha of 0.93.

A total of 169 participants completed the BACE. Figure 13 illustrates the distribution of the total score for the BACE across male and female participants. As only 4% of the sample (*n* = 7) had dependent children, 3 barrier items corresponding to parenthood were excluded from the analysis.

The distribution of scores on the BACE was normally distributed across males (*skew* = 0.17) and females (*skew* = -0.18). In order to assess whether or not there was any significant difference between perceived barriers to seeking help among males and females, the mean score were compared using an independent t-test. The results showed that females scored significantly higher on the overall BACE (*M* = 36.5, *SD* = 14.3, *n* = 113) than males (*M* = 30.5, *SD* = 16.7, *n* = 56), where results of a t-test were *t* (167) = -2.46, *p* = .015.

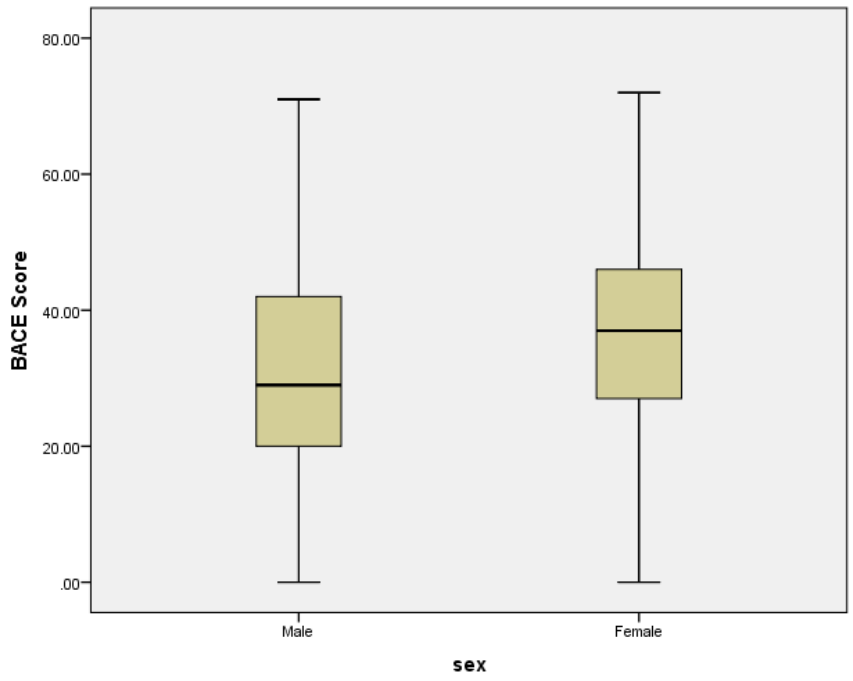

Figure 13. Boxplot of total BACE score across male and female participants.

Stigma Related Barriers

Figure 14 illustrates the distribution of total scores obtained on the 'treatment stigma' subscale across gender. Although the data was normally distributed, as can be seen in the box-plot the data was somewhat negatively skewed for males (*skew* = - 0.10) and a positive skew across females (*skew* = 0.32). A comparison of mean scores showed that females endorsed significantly more stigma barriers (*M* = 15.1, SD = 7.6, n =114) than males (*M* = 12.2, *SD* = 7.9, n = 56), where the results of a t-test were as follows; t (168) = - 2.35, *p* = .02.

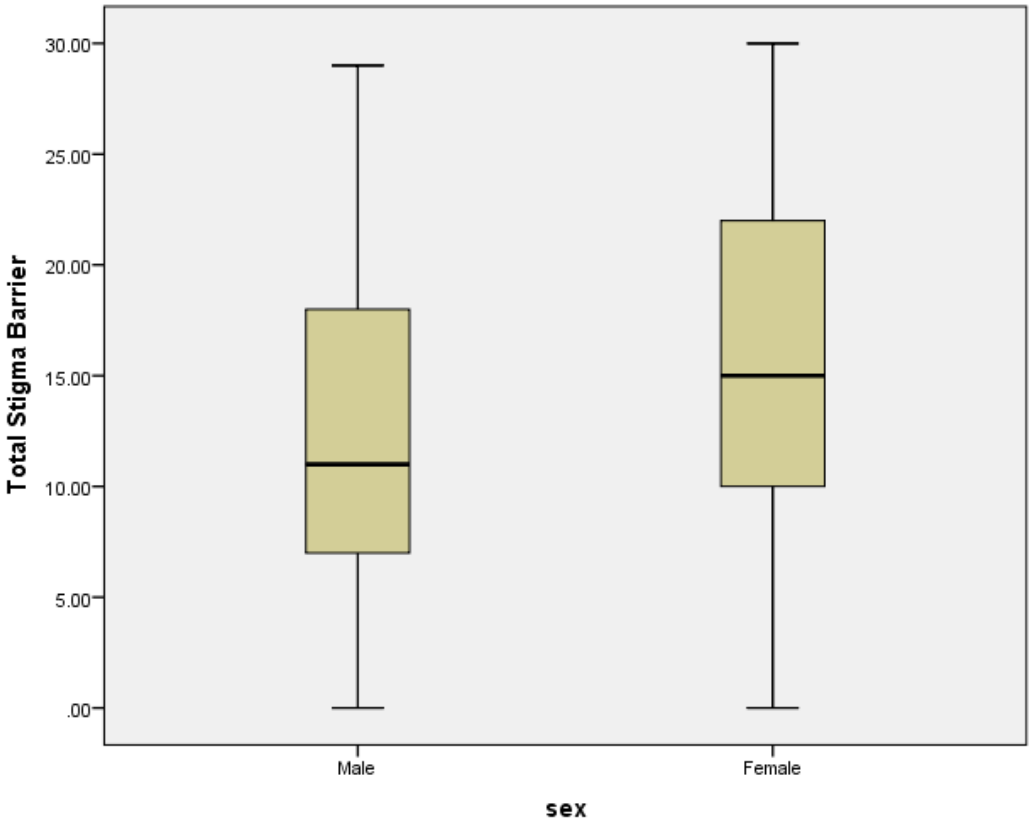

Figure 14. Boxplot of total scores on the treatment stigma subscale across males and females

The percentage of all participates reporting the degree to which each stigma-related barrier would stop, delay or discourage them from seeking professional help was calculated and presented in table 11. The table shows the frequency and mean scores. Each barrier was ranked according to the percentage of participants rating the item as a 'major barrier'.

Table 11 *Percentage, frequencies and mean scores on treatment stigma subscale.*

Stigma Related Barriers	Reporting barrier to any degree % (N)	Reporting as a major barrier %(N)	Total (N)	Mean (SD)
Feeing embarrassed or ashamed	81.4 (144)	31.1 (55)	177	1.70 (1.10)
Concern that it might harm my chances when applying for jobs	77.4 (137)	24.3 (43)	177	1.53 (1.09)
Concern that I might be seen as weak for having a mental health problem	75.1 (133)	22.0 (39)	177	1.45 (1.09)
Concern about what my family might think, say, do or feel	75.7 (134)	22.0 (39)	177	1.42 (1.09)
Not wanting a mental health problem to be on my medical records	71.1 (123)	21.4 (37)	173	1.42 (1.21)
Concern that I might be seen as 'crazy'	66.7 (118)	19.8 (35)	177	1.28 (1.13)
Concern that people I know might find out	73.4 (127)	18.5 (32)	173	1.36 (1.07)
Concern that people might not take me seriously if they found out I was having professional care	77.5 (134)	17.9 (31)	173	1.40 (1.03)
Concern about what people at work might think, say or do	72.8 (126)	15.6 (27)	173	1.34 (1.04)
Concern about what my friends might think, say or do	67.6 (173)	13.9 (24)	173	1.21 (1.05)

As shown in table 11, over two-thirds of participants anticipated that each stigma item would serve as a barrier to some degree if they were to seek help in the future. The most commonly anticipated stigma barrier was 'feeling embarrassed or ashamed'. In the overall sample, 81% (*n* = 144) of participants rated this as barrier to 'any degree' and 31% (*n* = 55) believed that embarrassed or ashamed' would present as a 'major barrier' to seeking professional help. The second most commonly reported stigma barrier was the concern that it might harm their chances of applying for jobs, whereby 77% (*n* = 137) anticipated this as a barrier to any degree and 24% (*n* = 43) considered this as a major barrier. However, concerns about what friends might think, say or do, were endorsed the least, with 14% (*n* = 24) thinking that this would be a major barrier.

Non-Stigma Related Barriers

The remaining items on the BACE correspond to 'non-stigma' related barriers and can be conceptualised into 'instrumental' and 'attitudinal' barriers. The distribution of total scores obtained on items measuring instrumental and attitudinal barriers were calculated and shown in figure 15 and 16 respectively.

Attitudinal Barriers

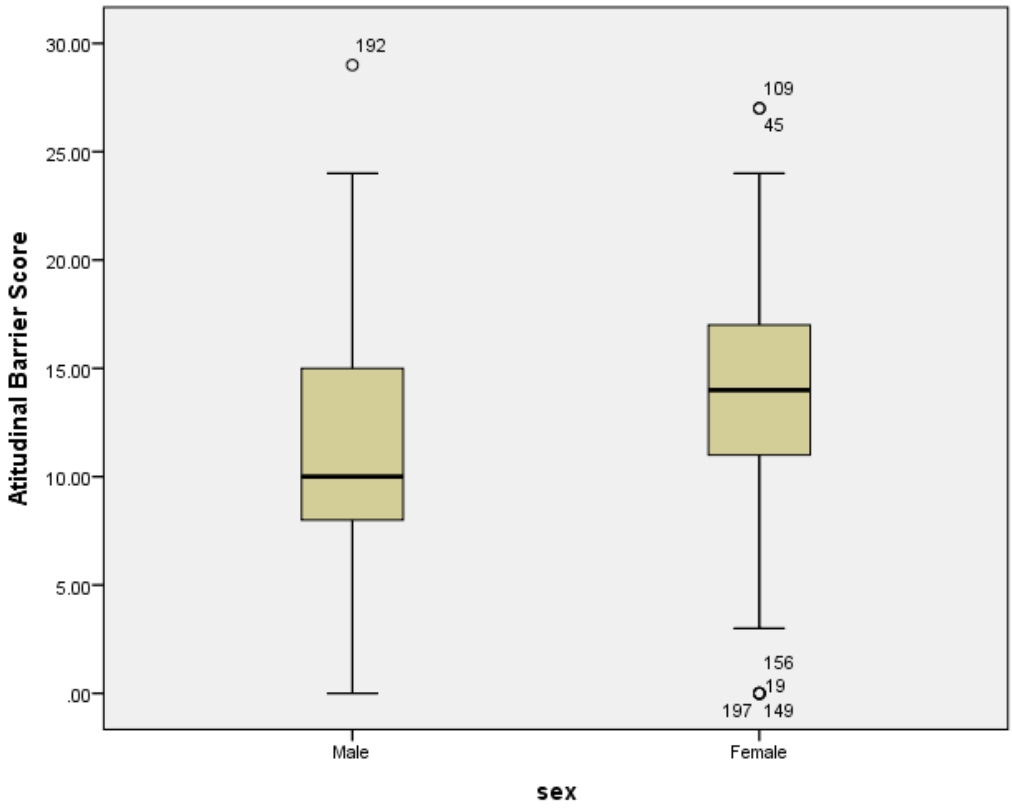

Figure 15. Boxplot of total scores on the items measuring attitudinal barriers within males and females.

A comparison of mean scores showed that male participants reported significantly fewer attitudinal barriers (M = 11.5, SD = 6.1, n = 56) than females (M = 13.6, SD = 5.5, n = 113) where the results from a t-test were; t (169) = - 2.00, p = .047.

The percentage of participates reporting the degree to which each attitudinal barrier would stop, delay or discourage them from seeking professional help was calculated and presented in table 12. The items were again ranked according to the percentage who endorsed the items as a 'major barrier'.

Table 12 Percentage, frequencies and mean score on attitudinal barrier item.

Attitudinal Barriers	Reporting barrier to any degree %(N)	Reporting as a major barrier %(N)	Total N	Mean (SD)
Dislike of talking about my feelings, emotions or thoughts	84.4 (146)	35.8 (62)	173	1.77 (1.10)
Concerns about the treatments available (e.g. medication side effects)	75.9 (132)	27.6 (48)	174	1.53 (1.14)
Wanting to solve the problem on my own	85.3 (151)	24.3 (43)	177	1.68 (1.00)
Thinking that professional care would not help	75.7 (134)	24.3 (43)	177	1.48 (1.11)
Fear of being put in hospital against my will	68.4 (121)	23.2 (41)	177	1.36 (1.54)
Thinking the problem would get better by itself	77.4 (137)	18.1 (32)	177	1.46 (1.03)
Having had previous bad experiences with professional care for mental health	75.9 (132)	16.7 (29)	174	1.01 (1.15)
Thinking I did not have a problem	71.8 (125)	14.4 (25)	174	1.28 (1.03)
Preferring to get help from family or friends	54.1 (93)	9.3 (16)	172	0.86 (0.98)
Preferring to get alternative forms of care	27.1 (48)	4.0 (7)	177	0.40 (0.75)

As shown in table 12, endorsement of attitudinal barriers ranged from 84% to 27%. The most commonly anticipated attitudinal barrier was the dislike of talking about feelings, emotions or thoughts. Whereby 84% (*n* = 146) of participants anticipated that this would serve as a barrier to some degree and 36% (*n* = 62) thought that it would act as a major barrier to them seeking professional help in the future. The second most commonly anticipated barrier was the concern about the treatments available, where 76% (*n* = 132) reported this as a barrier to any degree and 28% (*n* = 48) believed that this would be a major barrier to professional help-seeking. Approximately a quarter of participants reported that wanting to solve their problems on their own and thinking that professionals would not help, were major barriers to them seeking help. The least commonly endorsed barrier among participants was the preference to seek alternative forms of care, where 4% (*n* = 7) rated this as a major barrier.

Instrumental Barriers

Figure 16 illustrates the distribution of total scores obtained on items corresponding to instrumental barriers among males and females in the sample. Although the data was normally distributed, as can be seen in the box-plot the data was somewhat positive skew for both males (*skew* = 0.57) and females (*skew* = 0.19). A comparison of mean scores showed that there was a non-significant difference in the endorsement of instrumental barriers between males (*M* = 6.9, *SD* = 5.0, *n* = 56) and females (*M* = 7.8, *SD* = 4.2, *n* = 113), where *t* (170) = -1.12, *p* = .232.

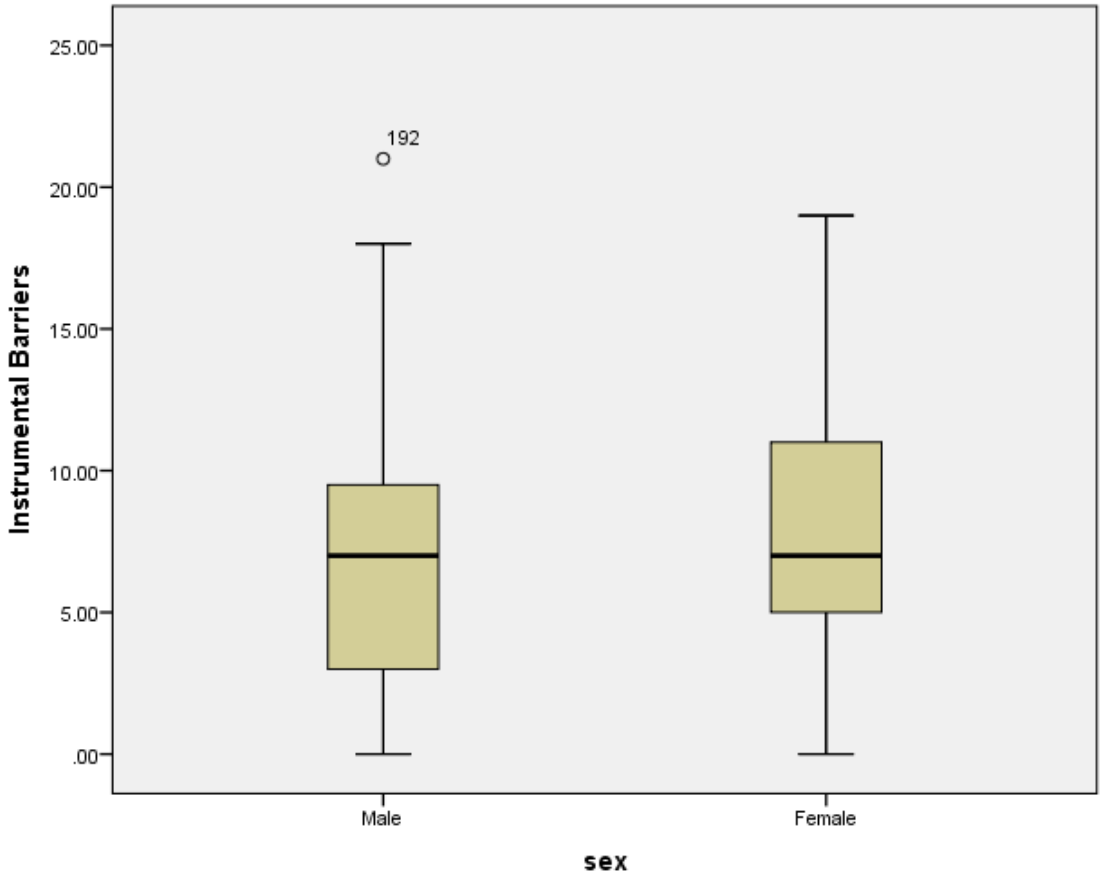

Figure 16. Boxplot of total scores on the items measuring attitudinal barriers within males and females.

The percentage of participates reporting the degree to which each item would serve as an instrumental barrier to them seeking professional help was calculated and presented in table 13. The items were again ranked according to the percentage who endorsed the items as a 'major barrier'.

Table 13*. Percentage, frequencies and mean score on instrumental barrier item.*

Instrumental Barrier	Reporting barrier to any degree % (N)	Reporting as a major barrier %(N)	Total N	Mean (SD)
Not being able to afford the financial costs	66.7 (118)	26.6 (47)	177	1.47 (1.21)
Being too unwell to ask for help	61.3 (106)	16.2 (28)	173	1.11 (1.10)
Difficulty taking time off work	64.7 (112)	14.5 (25)	173	1.20 (1.08)
Unsure where to get professional care	67.8 (120)	13.0 (23)	177	1.20 (1.03)
Problems with transport / travel to appointments	57.1 (101)	12.4 (22)	177	1.06 (1.08)
Having no one who could help me get professional care	63.8 (111)	10.3 (18)	174	1.06 (1.00)
Unavailability of professionals from my own ethnic or cultural group	22.6 (40)	2.3 (4)	177	0.33 (0.69)

As shown in the table above, the most commonly anticipated instrumental barrier was 'not being able to afford the financial costs' involved in seeking professional help. Sixty seven percent (*n* = 118) of participants anticipated that this would serve as a barrier to some degree and 27% (*n* = 47) thought that it would act as a major barrier to them seeking help in the future. The second most commonly anticipated barrier was being too unwell to ask for help, whereby 16% (*n* = 28) anticipated that this would act as a major barrier to seeking professional help. The least commonly endorsed instrumental barrier was the unavailability of professionals from participants' own ethnic or cultural group, where 2% (*n* = 4) rated this as a major barrier.

Factors that Facilitate Help-Seeking

In order to identify which factors may facilitate help-seeking behaviour, participants were asked the following open-ended question '*In the future, if you were to experience an emotional or mental health difficulty, what would make it easier for you to seek professional help*?' Feedback was gathered from 124 participants and the data was analysed using thematic analysis. Dominant facilitator themes that emerged in the text were extracted and are discussed below.

Importance of Availability and Accessibility

Participants' written data revealed that availability and accessibility of services was one of the strongest facilitator themes to emerge. Most of the participants commented on wanting a "*quick response*" from services, having "*drop-in*" services or "*flexible*" appointment times without having to compromise other commitments such as work and study:

"…*somewhere where you don't have to rearrange your day - college/uni is perfect as you don't miss anything or take a day/lesson off but you still get the help you need. It helps you to live life more normally*."

Several of the participants also commented on the importance of having services that were local and "*easily accessible*", or being able to see a professional at their home. Whilst there were differing viewpoints about how they wanted to access services e.g. at home, online, drop in centre, one of the key facilitator themes appeared to be that services were flexible in meeting their needs.

Characteristic of Provider and Services

Many of the participants commented on the characteristic of the provider and the importance of being treated with compassion and respect. It was considered important for the provider to be *"friendly*", for services to be "*less intimidating*" or "*not too formal*". It seemed that the characteristic of the provider influenced how participants perceived their own mental health difficulties: "*comfortable and homey would be better and make it less formal settings. If it feels too patient to doctor it feels like you have a disease."* Participants also commented on the importance of providers being "*understanding*", "*not feeling judged*" and "*being listened to".*

Confidentiality & Reducing Stigma

The importance of confidentiality and reducing stigma also emerged as a facilitator theme in the written text. Many of the participants commented on wanting a service that was "private" or "*anonymous*" and knowing that it would not impact their future career "…*the knowledge that whatever I confide with someone won't affect my career or connections in the future. You can't even expect this if you go to your GP*".

Several of the participants also commented on the importance of reducing stigma and "*normalising*" mental health services as a way to facilitate help-seeking: "*…..rather than somewhere that's obviously mental health based as that alone increases stigma. Make mental health more normalised so it's easier to talk about ".*

Availability of Information and External Support

An additional theme that emerged in the responses related to the availability of information and external support from family and friends. Participants commented that "*knowing where to go*" and having information about local services was an important factor in facilitating help-seeking. Others reported on the importance of raising awareness of mental health issues and knowing when they should seek help: "*Understanding the level of symptoms that would suggest that I need professional help*".

A number of respondents also emphasised on the importance of having additional support from friends or family who could either "*recommend*" or "*encourage*" help-seeking, or support them when attending appointments.

Objective 6: Predicting Help-Seeking Intentions

A binary logistic regression was conducted in order to develop a model to predict participant's intention to seek professional help. The association between intention to seek help and a number of key variables were analysed, the results from the analysis are summarised in table 14.

The model was built in stages, in step one participant's self-reported mental health difficulty and self-efficacy scores were entered into the model, however these variables did not significantly predict intention to seek professional help. DASS-21 scores were also entered, but showed no significant contribution to the mode. When socio-demographic variables, including gender, employment status, education and religion were entered into the model they did not significantly predict the outcome.

In step two, perceived barriers and perceived family and friend's endorsement of help-seeking were entered into the model. Family endorsement emerged as a reliable predictor of seeking help (*Wald* = 6.61, $p < .001$).

In step three, family endorsement and satisfaction with previous professional help was entered in the model. As shown in table 14, family endorsement became non-significant but satisfaction with previous help was found to be a significant predictor of intention to seek help (Wald = 8.76, p <.001). Nagelkerke's R^2 of 0.26 indicates that the two predictor variables entered in step 3 accounts for 25% of the model.

Table 14. *Binary Logistic Regression of predictors on intention to seek professional help.*

IV	**(DV) Intention to Seek Professional Help**			
Step 1	*B*	*Wald*	*OR 95% CI*	R^2
Self-Efficacy	0.12	0.12	1.28 (0.69 – 2.36)	0.005
Current mental health difficulty	0.24	0.61	1.12 (0.59 - 2.14)	
Step 2				
Perceived Barriers	0.26	0.48	1.23 (0.62 – 2.70)	
Family Endorse Help - Seeking	-0.96	6.61**	0.38 (0.19 – 0.80)	0.109
Friends Endorsed Help - Seeking	-0.53	1.79	0.59 (0.27 – 1.28)	
Step 3				
Family Endorse Help-Seeking	-0.33	0.23	0.72 (0.18 – 2.78)	0.255
Satisfied with previous help from MHP	-2.39	8.76**	0.09 (0.02 – 0.45)	

*P <.05 **p <.001

Summary of Key Findings

This study aimed to explore young adult's help-seeking behaviour and to identify the barriers they face in seeking help for psychological distress. The key findings from the study are summarised below.

- One third of participants did not seek any help for an emotional or mental health difficulty and a significant relationship was found between gender, self-efficacy, symptoms of stress and whether or not help was sought.

- Of those who sought help, over four fifths had accessed support from a GP or mental health professional and around half were satisfied with the care they received.

- Friends were endorsed as the most preferred source of help for future help-seeking and one-third reported that they were unlikely to seek help from their GP.

- Intention to seek professional help was significantly associated with: previous help-seeking, satisfaction from services, perceived stigma and perceived family and friend's endorsement of help-seeking. No significant relationship was found between psychological distress and intention to seek help.

- The most common barrier themes were: stigmatising beliefs, perceiving the problem as not serious, a preference for self-reliance, difficulty accessing help or communicating concerns, and a fear of negative outcomes.

- Facilitator themes related to: the availability and accessibility of services, the characteristic of the provider, confidentiality, stigma and availability of information and external support.

CHAPTER 4: DISCUSSION

Principle Findings

Objective 1. Socio-demographic Profile and Prevalence of Distress

The socio-demographic profile indicates that the majority of the participants were female students who were living with a family member. The sample represented an ethnically diverse group of young people, which was comparatively greater than in the general population. For example, data from the 2011 Census showed that 80% of the population in England and Wales are White British (Office for National Statistics, 2011) and in the current study White British participants accounted for only 55% of the sample.

By virtue of completing the online survey, all participants had a good level of literacy and almost a third had completed a university degree. A small proportion of the sample were unemployed or unable to work due to sickness or disability and only 4% had dependent children. Although these socio-demographic findings suggest that the participants were less likely to be economically disadvantaged, a high proportion of the sample were experiencing psychological distress. In light of this information and together with the ethnic diversity of the sample, is it possible that participants experienced social discrimination or exclusion due to their ethnicity and, or their mental health difficulties.

The prevalence of psychological distress was assessed using participant's self-reports and the DASS-21 measure. Approximately two-thirds of the sample said they had experienced an emotional or mental health difficulty in their lifetime and almost half said they were currently experiencing difficulties. This suggests a higher prevalence in the current sample than in the general population where it has been found that 18% of young people aged 16-24 have a common mental health problem (McManus et al; 2009).

In the current study, females were twice as likely to have suffered from anxiety, depression and 6 times more likely to have self-harmed in their life-time than males. This is in line with previous research that has also found a higher prevalence of mental illness among females than males. In the UK it is estimated that 13% or males and 22% of females aged 16-24 experience a common mental health disorder (McManus *et al,* 2009). With rates of self-harm believed to be on the rise; establishing an accurate prevalence rate in the population is a challenge (Hawton, Saunders, & O'Connor, 2012). However, in a UK study Hawton et al; (2002) identified that 13% of adolescents had self-harmed in their life-time and a more recent Australian study estimated the prevalence rate as 8% (Moran et al., 2012). However, the prevalence of self-harm in the current study was higher than estimated in the general population. A possible explanation for this observation is that in the current sample there also

appeared to be a higher prevalence of anxiety and depression, which are known risk factors for self-harm (Hawton et al., 2012).

Although in the current study there was a higher than expected number of participants who had anxiety and depression, as few as 1 in 9 identified problems with alcohol or drug misuse. This finding was unexpected given the ONS recently estimated that between 18% of young people aged 16-24 engage in binge drinking (ONS, 2015a) and the highest prevalence of drug dependency are found in younger males (McManus et al., 2009). Furthermore, mental health problems have been associated with an excessive consumption of alcohol and drug use (Royal College of Psychiatrist, 2010), therefore one would expect to find an elevated prevalence in the current sample. In light of the current research, one hypothesis may be that participants did not perceive their drug or alcohol use as a 'problem' and therefore there was an under-reporting of difficulties.

Psychological distress was also assessed using the DASS-21 and as expected those who self-reported a mental health difficulty were significantly more likely to obtain higher scores on the DASS-21. However, 27% and 25% of participants scoring within the 'severe – extremely severe' range on the anxiety and depression subscale respectively, did not self-report a current emotional or mental health difficulty. This discrepancy between self-reported mental health difficulty and levels of distress indicated by the DASS-21 could be accounted for by a number of factors. Previous studies have suggested that young people may have limited awareness of mental health symptoms (Gulliver et al., 2010); therefore in the current study participants may not have recognised their own symptoms of anxiety or depression. A further explanation is that participants normalised even severe levels of psychological distress as 'normal' distress (Biddle et al., 2007), which could have been mediated by self-stigmatising beliefs about mental health.

It is also a possibility that this finding is an artefact of low specificity on the part of the DASS-21 scale, with the discrepancy between self-perceived mental health difficulty and level of distress as reported on the scale being 'false positives'. Previous studies have however shown that the DASS-21 has high reliability in non-clinical populations, furthermore it also exhibits high convergent validity with other scales measuring anxiety and depression (Henry & Crawford, 2005). Nonetheless, caution must be noted as the DASS-21 was developed to provide a measure of severity within a continuum, rather than providing a diagnostic cut-off. Nonetheless, scores within the 'severe – extremely severe' range were outside of what would be considered a 'statistically normal' range when compared against data from a normative sample (Henry & Crawford, 2005). Therefore the present findings provide good evidence to suggest that approximately a quarter of participants did not disclose any psychological distress.

Overall, the results revealed that there was a higher than expected proportion of participants currently experiencing psychological distress than found in the general population. It is possible that due to the research topic a greater number of young people who had experienced a mental health difficulty were motivated to take part in the study. The anonymity of the survey may have also facilitated self-disclosure among participants who may have otherwise been reluctant to report their difficulties if the study was conducted using face-to-face interviews.

In light of feedback gathered through a consultation process with young adults, the term 'emotional difficulty' was used to measure psychological distress as it was considered to be less stigmatising. However, it is possible that this term was very inclusive and resulted in an over-estimation of mental health difficulty, which would not reach a clinical diagnosis. Nonetheless, for the purpose of this study it was considered important to gather information about participant's own subjective distress, rather than establishing a clinical diagnosis.

Objective 2. Experience of Help-Seeking

Approximately a third of participants who reported that they had an emotional or mental health difficulty said they did not seek any help and males were significantly less likely to have sought help. These findings are consistent with a previous community-based study conducted by Oliver *et al*; (2005) where the authors found that 23% of females and 33% of males (aged 16-24) experiencing psychological distress did not seek help. However, the rates of help-seeking in the present study was greater than that found by Biddle *et al*; (2004), where almost half of females and two-thirds of males did not seek any help in the past. It is possible that the discrepancy in the findings reflect differences in the way in which the sample were recruited and the measures used to assess psychological distress. However, the finding that a significant minority of young people with self-reported mental health difficulties did not seek help is consistent across the current study and these previous studies.

As expected, friends were cited as the most commonly used informal help-source when compared with other informal sources such as a family member or an intimate partner. However, the majority of participants sought help from their GP or mental health professional. No significant differences were found in the pattern of help-seeking between gender, except when seeking help from a mental health professional, where females were three times more likely to have accessed help from a mental health professional than males.

This observed difference in the rate of help-seeking from professionals may be accounted for by a discrepancy in the referral pathways for males and females. Given that GPs predominantly act as a gatekeeper to mental health services, it is possible that females are more likely to be referred by their GP to specialist services, than young males. One hypothesis could be that females communicate their distress differently to males. It would however be important to establish the process in which young people come to access help from a mental health professional and the extent that this is determined by personal or external factors.

Nonetheless, it is an interesting finding that in the current study, participants were more likely to have sought help from their GP or mental health professional than found in previous studies. For example, research conducted both in the UK and internationally, have suggested that young people are more likely to seek help from informal sources such as family or friends, than consult with their GP (Leavey et al., 2011; Mackenzie et al., 2006). A possible explanation for this finding is that over the last decade as the internet has become more accessible, young people have become significantly more knowledgeable about mental health and how to access help from services. Furthermore Rickwood et al (2005) suggested that young people's help-seeking behaviour changes according to their developmental stage. It can be hypothesised that the current findings reflect a pattern of help-seeking that is characteristic of young adults transitioning into adulthood, whereby there is an increased drive to seek help from outside the immediate circle of family or friends.

Satisfaction with Help received from Professionals

The results indicate varying levels of satisfaction with the support received from GPs or mental health professionals, whereby approximately half of participants were satisfied or very satisfied and a third were either dissatisfied or very dissatisfied. Although it was beyond the scope of this study to conduct an in-depth investigation of participants' experiences of help-seeking it was nonetheless important to consider how experiences of help-seeking can shape and even hinder future help-seeking. Based on the qualitative feedback provided by 29 participants, three dominant themes emerged in the data. These themes included the importance of being heard and understood, active and person-centred support and feeling judged.

The qualitative feedback indicated that participant's relationship with professionals was crucial to how they experienced services. For example, many described a power differential in their relationship with professionals when their request for mental health support was unmet. Although there is a lack of research exploring young adult's experience of mental health services, some of these findings are however in line with previous reports exploring

adolescent's experiences of mental health services (Harper, Dickson, & Bramwell, 2013). Freake et al (2007) also conducted a review of the literatre and highlighted the importance of a therapeutic relationship and being listened to by professionals.

The results from the current study emphasised that although some young people may take the necessary steps to seek professional help, their needs are not always met. Further research is therefore required to explore how service providers may serve as a barrier to young people accessing mental health support.

When participants were asked to identify how they would prefer to access professional help, it was interesting to see that 42% stated that they had 'no preference' and approximately a third reported a preference to access support at home, over the internet and through a CMHT. It is possible that participants who indicated that they had no preference, responded in such a way because of a lack of knowledge about the different ways that support can be accessed. The results also highlight that in order to improve access to mental health support, services need to consider how they can deliver support in a flexible way that meets the needs of the individual.

Objective 3.Variables Associated with Help-Seeking

As previously discussed gender was significantly associated with help-seeking, with female's reporting increased help-seeking from mental health professionals. The results also suggest that participants who were Asian, Asian British or Muslim, were significantly less likely to report that they sought help than other participants. These findings are consist with other reports that suggest that BME groups are under-represented in psychological services (Department of Health, 2014). In light of these findings, one hypothesis could be that due to the negative cultural beliefs surrounding mental health (Shefer et al., 2012), participants from Asian or Muslim communities were less likely to seek help.

Regarding the relationship between levels of psychological distress and help seeking, previous studies, including Bebbington et al., (2000) and Biddle et al., (2004) have found that psychological distress predicts help-seeking from a GP; however these findings were not consistently replicated in the current study. Scores on the depression and anxiety subscale, as well as the total DASS-21 did not achieve statistical significance when correlated with help-seeking. However, participants who were currently experiencing symptoms of stress, as indicated by the DASS-21 stress subscale, were more likely to have sought help in the past.

It is important to note that these results do not suggest that participants sought help for stress and did not seek help for depression or anxiety; rather it highlights a significant relationship between levels of stress and whether or not help was sought. Although there is

some evidence to suggest that help seeking varies according the type of mental health problem experienced (Mojtabai et al., 2002), it is difficult to ascertain how levels of stress influenced participant's decision to seek-help. It is however interesting that in the current study psychological distress alone did not serve as a sufficient prompt for participants to seek help. This highlights the complexity of the process and the importance of mediating factors that influence how young people come to decide whether or not they seek help.

In the current study there was a significant, but inverse relationship between self-efficacy and past help-seeking behaviour. Whilst this appears to suggest that participants who rated themselves as being more able to cope with adversity were also less likely to seek help from others, this relationship appears to be mediated by other factors. The results showed that self-efficacy was also inversely related to the stress sub-scale on the DASS21, such that those who sought help also had higher levels of stress and lower self-efficacy. This suggests that those who perceived that they did not have the internal resources to manage their stress, were more likely to seek external support.

Objective 4. Future Help-Seeking Intentions

According to the TPB (Ajzen, 1991) intention to carry out a specific behaviour is a predictor of the actual behaviour. Therefore, in the current study intention to seek help was measured as a predictor of future help-seeking behaviour.

Approximately two-thirds of all participants indicated that they would be likely or very likely to seek help from friends if they experienced an emotional or mental health difficulty in the future. This finding is consistent with previous studies that suggest that young people prefer 'informal' to 'formal' sources of help (Oliver et al., 2005; Rickwood et al., 2005). Taking into account that friends may not always be an effective source of help, especially for a severe mental illness, it was promising to find that professional sources of help were the second most frequently endorsed by participants. Although a third of respondents said they were unlikely to seek professional help, the current results suggest a greater willingness to access professional help than previous studies have reported (Oliver et al., 2005; Wilson et al., 2011; Yap, Reavley, & Jorm, 2013).

The results also revealed that over two thirds of participants were unlikely to seek help using a phone helpline, which is consistent with reports in the literature (see Leavey, Rothi, & Paul, 2011; Sheffield, Fiorenza, & Sofronoff, 2004). Given that the internet was selected by more participants then telephone help-lines as a preferred source of help, this information is important for policy makers and campaigner when designing interventions aimed at improving access to services and mental health wellbeing.

Likelihood of Seeking Professional Help in the Future

The present study also examined how specific variables were related to willingness to seek professional help. The results indicated that socio-demographic characteristics including gender, ethnicity and employment status, had no significant relationship with participants' willingness to seek professional help in the future. These findings do not support theories such as the HBM (Rosenstock, 1974) which specifies the importance of demographic factors in the prediction of engaging in a health related behaviour.

In the current study, the effects of psychological distress on intention to seek professional help were also assessed. Whilst Sheffield et al., (2004) found that DASS-21 scores predicted willingness to seek both formal and informal help, in the current study these findings were not replicated. The results suggested that participants who were experiencing moderate to extremely severe distress, were no more willing to seek help than those who were not experiencing severe distress. This is somewhat concerning, given that those who are experiencing significant distress are often those with the greatest need of professional help.

The results of the current study revealed a significant relationship between intention to seek help and previous help-seeking experiences, particularly when the experience was positive. Participants who were satisfied with previous help-seeking experience were 10 times more likely to indicate that they would seek professional help in the future. Although it is not possible to ascertain precisely how satisfaction from services relates to intention to seek help, one possible explanation for this finding is that those who had a positive experience of seeking help were also more likely to see the benefits of seeking help in the future. This concept is in line with previous studies that have found that perceived benefits of seeking help is a strong predictor of intention to seek help (O'Connor et al., 2014).

Participants' belief that friends and family would endorse help-seeking, also appeared to significantly influence participants' own intention to seek help. These findings are expected given that a high proportion of the sample were living with family members and from a development perspective peer group relationships and affiliation are important for young people. Furthermore, these results are also in-line with the TPB (Ajzen, 1991) which suggests that normative beliefs are important in predicting whether a behaviour will be carried out. These results emphasise the importance of social support and help-seeking for psychological distress.

Furthermore, this study found a significant inverse association between the endorsement of stigma-related barriers and intention to seek professional help, but a non-significant association with non-stigma barriers. These findings indicate that concerns about stigma have a greater impact on young adult's help-seeking intentions than other barriers, these

results are in line with other studies that have found a negative association between help-seeking and stigma. For example, Shefer et al., (2012) reported on the negative influence of stigma from within ethnic communities in London, on help-seeking for mental health problems. Although the interaction between stigmatising beliefs and intention to seek help among young people is unclear, this study provides some preliminary evidence to suggest that stigma is a pertinent factor influencing young adult's help-seeking intentions.

Objective 5. Perceived Barriers & Facilitators to Help-Seeking

Barriers to seeking treatment

In this study a qualitative approach was also utilised in order to gather an in-depth understanding of the factors that may serve as barriers or facilitators to accessing help.

Thirty eight participants provided qualitative feedback for the reasons why they did not seek any informal or formal help for an emotional or mental health difficulty which they experienced in the past. Five key barrier themes emerged in the data, these themes included: stigmatising beliefs, perceiving the problem as not serious enough, reliance on self, difficulty in accessing care and difficulty with identifying or communicating concerns.

A substantial number of participants referred to concerns about public or self-stigmatising beliefs related to mental illness. They seemed fearful that friends, family or the public would respond negatively if they disclosed a mental health difficulty or received a formal diagnosis. For example, several of the young people did not seek help because they thought they would be '*judged*', '*labelled*' or seen as '*crazy*'. These findings are consistent with previous studies and reviews that have identified stigma and discrimination as prominent barriers to mental health help-seeking among young people (Gulliver et al., 2010; Vanheusden et al., 2008). Furthermore, the impact of stigmatising beliefs within society has also been raised at government level, which prompted campaigns such as 'Time to Change' that were aimed at minimising mental health stigma within society (Department of Health, 2011). However, the findings in this study provide some preliminary evidence that despite efforts to reduce public stigma and discrimination, these issues continue to serve as barriers to young people accessing mental health support.

In the current study barriers to help-seeking also related to participants believing that their difficulties were not "*serious enough*" to warrant professional attention. Although it is difficult to ascertain how severe their mental health difficulties were at the time and whether or not professional help would have been advisable, these findings are in line with previous studies (Andrade et al., 2013) as well as theories developed to explain non help-seeking behaviour in young adults (Biddle et al., 2007). Biddle et al., (2007) proposed that 'non-help-seekers'

avoid seeking help through a circular process of normalising and accommodating their distress even when it becomes severe. It is also possible that participants' lack of perceived need for mental health care was related to stigma and fears that may emerge if they did perceive their distress as "*serious*" and consequently sought help.

A dominant theme that also emerged in the study was reliance on self. Taking into account that young adulthood has been described as a period of transition and separation from the family (Arnett, 2000), it is possible that a preference for self-reliance is enhanced during this period in life when young people want to assume increased responsibility for their own mental health concerns. Nonetheless, other studies with adults have also identified that self-reliance is a barrier that prevents or delays help-seeking in adults (Andrade et al., 2013) and therefore, further research would be important to understand the factors that influence the interaction between self-reliance and an avoidance of help-seeking. For example, in the current study there appeared to be an inverse relationship between self-efficacy and help-seeking, therefore one could hypothesise that those who preferred to rely on themselves also perceived that they had the necessary internal resources to manage their distress. Furthermore, given that help-seeking can be conceptualised as a relational process, it also possible that a preference for self-reliance is influenced by a lack of trust towards others, which may have developed from negative early life experiences.

Whilst some of the respondents expressed that they wanted to handle their difficulties on their own, others recognised that they required support, but faced problems in accessing the necessary help. Instrumental barriers included limited availability of social support, concern that others would not take them seriously and doubts about the availability of resources within services. A lack of accessibility of services has previously been identified as a prominent barrier to help-seeking for those living in rural settings (Gulliver et al., 2010). However, in the current study the qualitative feedback highlighted that some of the participants did not seek help as they believed that due to the financial restraints on the NHS help would be unavailable. This highlights the impact of service restraints on young people's reluctance to seek professional help, but it also suggests that participants were unaware of other services that they could have potentially approached, such as third sector charities. Furthermore, these result are also in line with the 'multi-step process' model, which stipulates that sources of help must be available and accessible in order for help-seeking to take place (Rickwood et al., 2005)

Barriers to Seeking Help in the Future

A total of 169 participants completed the BACE scale, which measured the barriers that may hinder professional help-seeking in the future. The results revealed a difference in the endorsement of barriers across gender, where females were significantly more likely to anticipate barriers in accessing mental health care than males. These findings are interesting given that significantly more females in the sample had sought help in the past and there was a non-significant difference found between male and female participants intention to seek future help. This suggests that there are other important factors, other than perceived barriers, which are involved in male's and female's decision to seek help.

The results from the BACE scale revealed that a 'dislike of talking about feelings, emotions, or thoughts' was the most highly endorsed barrier in the study, with 36% reporting it as a major barrier to seeking professional help. As previously discussed, a difficulty in expressing mental health concerns also emerged as a barrier theme in the qualitative feedback. These findings may account for why in the current study over two thirds of the sample indicated that they would be unlikely to seek help using a telephone help-line. These results are also consistent with previous studies on barriers to mental health help-seeking (Gulliver et al., 2010; Rickwood et al., 2005).

The second most prominent barrier that emerged from the BACE was 'feeling embarrassed or ashamed', with 31% of the sample rating this item as a major barrier to help-seeking. These findings may also account for why the majority of the sample also expressed that they had a dislike for talking about their emotions and thoughts, which has been replicated in other research (Ciarrochi, Deane, Wilson, & Rickwood, 2002). Other studies, such as Clement et al., (2012) found that only 20% of their sample reported that feelings of embarrassment and shame were a major barrier for seeking help. This difference in endorsement of barrier may be accounted for by the fact that in their study their sample had utilised mental health services and therefore it is likely that they were more accustomed to verbalising their concerns with professionals. Furthermore, their study was based on a sample of adults aged 18-70, therefore their findings cannot be generalised to young adults.

Interestingly, Clement et al., (2012) found that the most prevalent barrier in their study was the concern that seeking help would harm participants' chances when applying for a job. In the current study, this barrier emerged as the second most highly endorsed stigma barrier. Given the age group of the sample and majority were students, it is understanding that young people would be concerned about the impact of help-seeking on their career prospects. Taking into consideration findings from Clement et al., (2012) together these results further highlight the impact of mental health stigma within society on adults' help-seeking intentions.

One of the most striking findings from the BACE was that the most prominent instrumental barrier was the concern about the financial costs of seeking help. Given that the NHS provides a free service to all, it was unexpected that young people rated this as a prominent barrier. There are several reasons that could account for this finding; it may reflect participants' limited understanding or knowledge about mental health services, such that young people may believe that they are required to pay for a mental health treatment such as psychotherapy. Secondly, it could be that participants believed that due to the cuts in the NHS, their only means of accessing help would be through seeking private treatment which was expressed in the qualitative feedback. Lastly, young people may have concerns that if they attended appointments it would have an impact on their work schedule, which could potentially result in financial problems.

Overall, the finding from the BACE scale provides some valuable information about the factors that could delay or prevent help-seeking among young adults. Although it is not possible to establish the precise degree that these barriers would hinder any future help seeking, it nonetheless provides important information about the concerns that young people have about seeking professional help in the future. Although a longitudinal study is beyond the scope of this study, it would provide a direction for further research in order to identify the extent that these barriers prevented or delayed help-seeking.

Facilitators of Mental Health Help-Seeking

In the current study facilitators to seeking help were also evaluated using a qualitative approach. Written feedback was gathered from 124 participants and 4 facilitator themes emerged from the data which will be discussed below. The major themes related to: availability and accessibility of services, characteristic of the provider, confidentiality, stigma and availability of information and external support.

Many of the participants expressed that in order to promote help-seeking, it is importance that mental health services are easy to access, flexible and services respond quickly to a referral. Participants placed emphasis on the important that health care providers are professional, compassionate and the environment is welcoming and less '*clinical*'. It is interesting that the themes that emerged in the data are in line with the NHS values, which stipulates the importance of compassion, respect and dignity (NHS England, 2014). Furthermore, the themes that emerged in the written feedback are also in line with previous research that explored young people's view of helping professionals (Freake, Barley, & Kent, 2007). These results also provided further evidence to support the importance of establishing a relationship between client and the service provider, which also emerged in the barrier themes.

Participants in the current study also emphasised the importance of confidentiality and reducing the stigma that surrounds mental health, these findings once again provide further evidence about the importance of promoting anti-stigma campaigns in order to reduce stigma and discrimination within society.

Although the results from the BACE indicated that only 13% of the participants thought that uncertainty about where to seek help would present as a major barrier to seeking help, in the written feedback 'availability of information' emerged as a dominant facilitator theme. Participants reported that "*knowing where to go*" and having information about local services was considered an important factor in facilitating help-seeking. Others believed that further education to help young people know when they should seek help was also important. This is in line with previous reports that have highlighted that limited awareness and information acts as a prominent barrier to seeking professional help (Biddle et al., 2006). In line with the HBM (Rosenstock, 1974), it could also be hypothesised that having sufficient information and knowledge about services is closely associated with one's self-efficacy regarding a person's ability to carry out the behaviour (i.e. seek help).

In addition, taking into account the distinct cultural shift between children's and adult services, whereby family involvement is generally less common in adult services, it highlights the importance of making information about services more accessible to young people who may for the first time be seeking help on their own.

Very few studies have explored facilitator themes especially concerning young adults, therefore the current results provide some preliminary insight into what young adults perceive as important factors in facilitating their access to mental health services in the future.

Objective 6. Predicting Help-Seeking Intentions

A regression analysis was carried out in order to develop a model to predict participant's intention to seek professional. Variables that were entered into the model were factors identified as important in the HBM (Rosenstock, 1974), these included: self-efficacy, perceived barriers, socio-demographic variables and although perceived benefits were not directly measured in this study, participant's satisfaction with services was used as a proxy measure. DASS-21 scores and self-reported mental health were also entered into the model as it was expected that those who recognised a current mental health difficulty would have the greatest need and likelihood of seeking help. It was also anticipated that recognition of one's symptoms would serve as a 'queue to action', which is identified in the HMB.

The regression analysis revealed that satisfaction with services was the strongest predictor variable, accounting for 25% of the model. Perceived barriers did not reach any significance

in the model and when satisfaction with services was entered into the model, family endorsement became non-significant. In light of these findings, one hypothesis may be that those who had a previous positive experience of help-seeking were more likely to see the benefits of seeking help and therefore more likely to engage in help-seeking behaviour. O'Connor et al., (2014) also reported that perceived benefits were more important than barriers in predicting intention to seek help among young adults. They also found that perceived severity and susceptibility were not related to intention to seek help, which may account for why in the current study DASS-21 scores and self-reported mental health did not reach significance in the model.

Whilst the HBM has proven an influential model in predicting health-related behaviours, the current findings indicated that there are other factors beyond those identified in the HMB, which appear to be important in predicting help-seeking behaviour among young people. For example, previous studies as well as the qualitative data in this study, highlight that a preference for self-reliance, knowledge about mental health services and emotional competence are all important factors involved in seeking help (Gulliver et al., 2010).

Strengths and Limitations

This study has provided some valuable information that contributes to the understanding of young adults' mental health help-seeking behaviour. To the best of the researchers knowledge, this is the first community based study in the UK that has investigated 18-25 year old's views on what they consider to be important in facilitating help-seeking behaviour and as well as barriers to seeking help. Unlike previously published research in the UK, this study explored both formal and informal help seeking preferences among young adults.

Despite the stigma surrounding mental health, over 172 completed the survey and the study was successful in recruiting participants from minority ethnic groups, who are often under-represented in mental health services. A significant strength of the study was that it used a combination of quantitative and qualitative approaches, which enriched the findings.. Qualitative feedback on barriers to treatment was gathered from 38 participants who previously did not seek help for a mental health difficulty and 124 participants provided written feedback about facilitators to help-seeking.

A further strength of the study was the use of a consultation process to guide the content of the questionnaire. Young people from deprived communities in London provided valuable feedback that was used to ensure the survey was appropriate for the target population.

Although in the current study there was a higher than expected percentage of participants experiencing psychological distress, these young people are nonetheless those who are

most likely to require access to mental health services. Therefore their participation in the study, as well as input from participants from BME groups, provided some essential information about barriers to care and their experience of services. Despite some of the strengths of the study, there are several limitations that need to be considered prior to discussing the clinical implications of the findings.

Study Design & Measures

This study used a cross-sectional survey design and although this methodological approach is consistent with previous research in this area (Biddle et al., 2004; Oliver et al., 2005), there are some limitations to this approach. For example, whilst questions were included to assess historical and prospective behaviour; a cross-sectional design does not permit measure of help-seeking over time. Furthermore, a cross sectional survey design is limited in the extent that it can capture the complexity and dynamic nature of help-seeking behaviour. Although it was not feasible in the current study, a longitudinal study would provide further scope to measure the trajectory of help-seeking.

In this study in order to minimise fatigue, attempts were made to ensure the questions were short and the survey was as least burdensome as possible. However, a limitation of any self-administered questionnaire is that the data can be influenced by bias caused by cognitive burden that is placed upon respondents. Furthermore, whilst survey designs can facilitate the reporting of sensitive information such as details of respondent's mental health difficulties, self-reporting can also be affected by recall bias (Bowling, 2005).

A significant limitation imposed on any study investigating help-seeking for mental health, is the limited availability of a robust and validated measure that can accurately capture this process. Previous studies have assessed help-seeking intentions using a vignette (Wilson et al., 2011), focused on help-seeking attitudes (Mackenzie et al., 2004), or assessed young people's willingness to seek psychological help (Sheffield et al., 2004). In the current study, it was deemed important capture whether participants had accessed help from either professional or non-professional sources, therefore a measure was developed specifically for the study. It is acknowledged that although the questions were developed using previous measures and a consultation process with young people to ensue content validity, a self-developed measure may have compromised the validity or reliability of the findings.

In the current study, help-seeking behaviour was also assessed by measuring participants' intention to seek help from a range of sources. Although this approach is consistent with previous research as well as the TPB model (Ajzen, 1991), it does however pose some limitations to the study. It was beyond the remit of this study to assess whether participants' reported intentions to seek help accurately measured actual help-seeking in the future.

However, in the current study there was evidence to show a relationship between previous help-seeking and intention to seek help, studies have also found that intention to seek help is a predictor of actual help-seeking in the future (Rickwood et al., 2005).

Some limitations were also imposed by using the BACE scale to assess barriers to seeking mental health care. Although there were justifications for using the BACE, for example it includes a comprehensive list of potential barriers, it can be used at any stage in the help-seeking process and the scale was validated using a sample recruited in the UK, its limitation is that further data is needed to assess its validity and reliability in a community sample who have not accessed care (Clement et al., 2012). Furthermore, given that the measure was used to assess anticipated barriers, the ability to draw conclusions on the extent that these barriers hinder or prevent actual help-seeking in the future is limited.

Whilst there was a clear rationale for including the selected variables in this study, the results showed that the study variables only partially predict help-seeking behaviour. Additional variables such as attitudes (Gonzalez, Alegria, & Prihoda, 2005) and desire for autonomy (Wilson & Deane, 2012) have previously been shown to influence help-seeking behaviour. However these variables were excluded from the study in order to reduce the risk of respondent fatigue and drop-out from the study, which could reduce the power of the study.

Sampling method

In the current study, an online, self-report questionnaire was used to collect data. It was anticipated that an electronic survey would yield a higher response rate in the limited time frame of this study and the anonymity of the survey would increase participant's willingness to disclose sensitive information (Bowling, 2005). Despite the benefits of this approach, a key drawback was that it required participants to have access to a computer and basic computer skills, which inevitably introduced an immediate bias to the recruitment of participants.

The study aimed to recruit from a non-clinical population of young adults living in the UK, therefore participants were predominantly recruited from community, educational, organisations and online networks as discussed in the method chapter. Whilst efforts were made to ensure that study was as inclusive as possible, there is nonetheless an inherent sampling bias when using convenience and snowball sampling techniques. For example, advertising the survey in educational establishments would have biased those who were in education.

Although it was not possible to quantify the proportion of participants recruited from the different organisations and websites that were used during recruitment, it is recognised that

advertising the study on mental health forums or through mental health organisations may have resulted in a self-selection bias. For example, those who accessed websites such as MIND and organisations such as Kids Company, may have themselves been experiencing a mental health difficulty and been more likely to take part in the study, than those who had no affiliation with the subject matter. However, given that the study aimed to identify the help-seeking behaviour of young people who are most likely to require mental health services, there were clear justifications for including mental health organisations in the recruitment strategy.

A further limitation of this study is that a large number of people clicked on the survey link but did not take part in the study. Although it was not possible to ascertain the socio-demographics of non-respondents and whether they met the inclusion criteria, there is a possibility that the characteristics of non-respondents differed from respondents. Furthermore, given that males were under-represented in the study and a large proportion of the sample appeared to be of a higher socio-economic status, the generalisability of the findings are limited.

Recommendations

Implications for Clinical Practice, Mental Health Services and Policy

There were several important barriers and facilitators that were raised in this study which have implications for clinical practice and mental health services. The results suggest that in order to increase young people's help-seeking, services must be available, accessible and flexible. Offering flexible appointments outside of working hours and a confidential drop-in service could be beneficial in promoting access to services. It would also be beneficial for services to consider alternative ways that young people can book appointments, such as offering an online or text booking system.

The findings from this study also suggest that many young people struggle to identify symptoms of mental health and they have limited awareness of the services that are available to them. It is therefore important that mental health awareness programs are delivered to young people, policy makers may wish to consider incorporating such programmes into the national curriculum as an essential life skill. Furthermore, knowledge of local services can be improved by ensuring that information about statutory and non-statutory services are available in a wide range of settings such as GP practices, libraries, job centres and educational establishments. Building relationships with local community organisations, such as youth groups, could also facilitate engagement from people who are marginalised from society and at higher risk of developing mental health problems.

The findings from this study reaffirm the importance of establishing a trusting relationship between service providers and young people. In order to improve help seeking it is important that all mental health professional have sufficient supervision and training in basic counselling skills. Whilst the NHS have outlined key values (NHS England, 2014) efforts must to be made to ensure that professionals are adhering to the values and maintaining professional conduct, as the current findings have highlighted that basic professional competencies are not always being met.

Furthermore, given that GPs are often an initial point of contact and act as a gate-keeper to mental health services, it is important to ensure they have sufficient training in mental health assessment. This is particularly important as the results indicate that a prominent barrier to help seeking related to young people's difficulty in communicating emotions or thoughts. As such, in order to improve the detection of psychological distress, it is important that GPs enquire about mental health in their standard practice. Providing information to young people about the availability of local support groups or third sector services may also be of benefit.

The results also revealed that a reason why participants did not access any help for their mental health problems was due to a preference for self-reliance. It is important therefore that young adult's desire for self-reliance is addressed and self-help materials are easily accessible and available. Given that a high percentage of young people have access to the internet and mobile phones, resources could be made readily available through the internet or self-help apps. In order for young people to utilise such resources, it is necessary to advertise such resources in a range of settings and online forums.

In the current study, stigma was also highlighted as a key barrier to seeking help. As such there is a need for policy makers to continue developing anti-stigma and anti-discrimination campaigns concerning mental health. Furthermore, it would also be important for service providers and policy makers to ensure that services were delivered in an environment that is relaxed, friendly and de-stigmatising. Given the stigma attached to the term 'mental health', it may be important to consider how the naming of a service can act as a barrier.

Implications for Future Research

This study aimed to provide further insight into young people's help-seeking behaviour and the factors that might influence their decision to access help; however it has highlighted the need for further research in this area.

As previously discussed, male participants were under-represented in this study and therefore further research is required in order to investigate help-seeking behaviour among males. This is particularly important given that research has shown that males are less likely

to seek help (Biddle et al., 2004; Rickwood et al., 2005) and they may experience different types of barriers compared to females. During the recruitment process it was also observed that young people who expressed mistrust towards services were also very sceptical in taking part in the study. Further research exploring these young people's experiences and preferred means of seeking help would be important. However, it may be necessary to conduct a focus group in a non-clinical environment in order to facilitate their engagement in studies.

A number of limitations were discussed in relation to the BACE (Clement et al., 2012) and measures used to assess help-seeking behaviour. Empirical evidence is required in order to establish the performance of the BACE within a sample of young adults who have not accessed mental health care. Further research is also needed to develop a robust measure of help-seeking from informal and formal sources, as currently there is no well-established instrument that is frequently used.

This study also highlighted the gap in the literature investigating factors that may facilitate help-seeking behaviour. Given that there is evidence to suggest that perceived benefits to help seeking are more influential than perceived barriers (O'Connor et al., 2014), further research in this field would provide important information that could be used to develop interventions aimed at promoting help-seeking for mental health.

As previously noted, GPs often serve as a gate keeper to mental health services and this study highlighted that females are more likely to access help from mental health professionals than males. It would there be important to explore how GPs perceive their role in assessing mental health among young people as such information would provide insight into process that young people are referred into mental health services.

Concluding Comments

This study aimed to further our understanding of the factors that can influence access to mental health services among young adults aged 18-25. Despite some of the limitations to the findings, this is the first known quantitative study to be undertaken in the UK with a community sample of young people within this age group.

The results from this study indicate that a third of young people who experienced psychological distress did not seek any form of help and the findings re-affirm that young males are less likely to access help from mental health professionals than females. Although 86% of those who reported experience of psychological distress actively sought professional help, the study revealed that a significant number of vulnerable young people were dissatisfied with the help that they received from services. Some of young people were left feeling unheard, dismissed and judged by professionals and negative past experiences appeared to have a significant influence of young people's willingness to seek help in the future. These findings suggests that there is a need to improve the quality of care that is delivered in primary-care and specialist mental health services and with the financial stains upon the NHS this is likely to be an going challenge.

The findings from this study also highlight that help-seeking is a dynamic and complex interaction of individual, social and instrumental factors and no single model or theory can accurately capture this process. Nonetheless this study has shed some light onto the influence of stigma, accessibility of services and young people's desire for self-reliance as well as a number of other important factors that appear to influence help-seeking. Further research is recommended in order to disentangle this process and to develop effective strategies to facilitate access to services and promote mental health wellbeing among young people.

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Appendices

Appendix 1: Literature search terms

Databases Searched: PsycARTICLES, PubMed, Google Scholar, Web of Science, Scopus, Science Direct

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Year: 1990 – Present

Search 1: Literature about the prevalence of mental health problems among young adults in the UK

Search Terms Used	Search Field	Population	Location
Prevalence OR Incidence AND Mental Health* OR Mental Distress OR Mental Illness OR Psychological Distress* OR Emotional Distress AND young adults OR Young People OR Adolescents OR Youth	Key Words, Title, Abstract	Young adulthood Humans Adolescents: 13-18 Young adults: 18-29 years	England, Britain, Great Britain, UK, United Kingdom

Search 2: Literature about mental health help-seeking behaviour among young adults

Search Terms Used	Search Field	Population
mental health OR Psychological Distress OR Mental Distress AND Help-seek* OR Service-Use OR Service-Access AND Young people OR Young Adult OR Youth, OR Adolescent*	Title or Abstract Key Words	Humans, Adolescents: 13-18 Young Adult: 19-24

Search 3: Literature about the barriers to mental health help-seeking among young adults

Search Terms Used	Search Field	Population
mental health* OR Psychological Distress OR Mental Distress AND Help-seek* Barriers, OR Help-Seek* Obstacles Or Problem* Accessing Service OR Difficulty Access* service AND Young people OR Young Adult OR Youth, OR Adolescent*	Title or Abstract Key Words	Humans, Adolescents: 13-18 Young Adult: 19-24

Appendix 2 – Recruitment E-mail to potential participants

Are you aged 18-25?

Want to share your views and make a positive difference?

Mental health issues are real & affect 1 in 4 people. We'd like to invite YOU to take part in a short & anonymous online survey aimed at finding out what type of help & support young people want if they're feeling really *down, angry, worried or emotionally stressed*.

We're interested in **everyone's views.** You **don't** need to have had any emotional difficulties to take part. As a thank you for your time you can win a **£30 Amazon voucher.** To find out more visit:

https://herts.eu.qualtrics.com/SE/?SID=SV_cCvQHm0GJt5JBFX

or email Kez at: k.salaheddin@herts.ac.uk

https://twitter.com/kezkez10

Appendix 3 Recruitment poster and flyer

Speak out to improve mental health services

This study has been approved by the University of Hertfordshire Ethics Committee (protocol number **LMS/PG/UH/00298)**

Are you aged 18-25?

Would YOU like to share your views & make a positive difference?

YOU are invited to take part in a short & anonymous *online survey* aimed at finding out:

- What type of help and support young adults want if they're feeling *really down, angry, worried or have other emotional stress.*

We're interested in **everyone's views!** You **don't** need to have experienced any emotional difficulties to take part. Share your thoughts and you can help to improve services & support offered to other people around you.

As a thank you for your time you can enter a prize draw to win a **£30 Amazon** voucher. To find out more visit this link:

http://tinyurl.com/md2lqxz

or email:

k.salaheddin@herts.ac.uk

https://twitter.com/kezkez10

Appendix 4 - Recruitment email to organisations

Dear Sir/Madam

My name is Keziban and I am a Clinical Psychology Doctorate student from the University of Hertfordshire. I would like to kindly ask for your support in the recruitment of participants for a crucial piece of research that I am conducting. My research is aimed at identify the barriers that vulnerable young adults, aged 18-25, face in accessing mental health services. 1 in 4 people have mental health needs, yet less than 30% of young people will seek help when they are suffering.

My research has received ethical approval from the University of Hertfordshire ethics committee (protocol number LMS/PG/UH/00298) and I have set up an online and anonymous survey to gather views and experiences from young adults. I am interested in hearing from ALL young adults aged 18-25, regardless of whether they have experienced any emotional or mental health difficulties. By taking part in this study, your learner's will have an opportunity to contribute towards improving mental health services for vulnerable young adults. Furthermore, it is hoped that the process of taking part in the survey will raise their awareness of mental health issues.

I would be very grateful if the attached message could be e-mailed to learners at xxxxx College, inviting them to take part in this study. Should this is not possible, could this message be posted via your Facebook or Twitter page?

I look forward to hearing from you,

Kind Regards,

Keziban

Appendix 5- Participant welcome page

Appendix 6– Participant Information sheet

PARTICIPANT INFORMATION SHEET

What is the purpose of this study? We'd like to find out where young adults prefer to get help if they're feeling really low, angry, worried or have other emotional stress. To take part you do ***not*** need to have any experience of using mental health services ***or*** have any mental health needs. Taking part in this study is entirely voluntary you can pull out at any time without giving a reason.

What will happen if I agree to take part? You will be asked to complete an online survey, which will take around 15 minutes to do. You'll be asked some background information, whether you have mental health needs and your thoughts about getting help.

How will my taking part in this study be kept confidential? You will **not** be asked to give your name, your answers will be anonymous and treated confidentially. If you enter into the prize draw, your email address will be kept separate from your questionnaire answers.

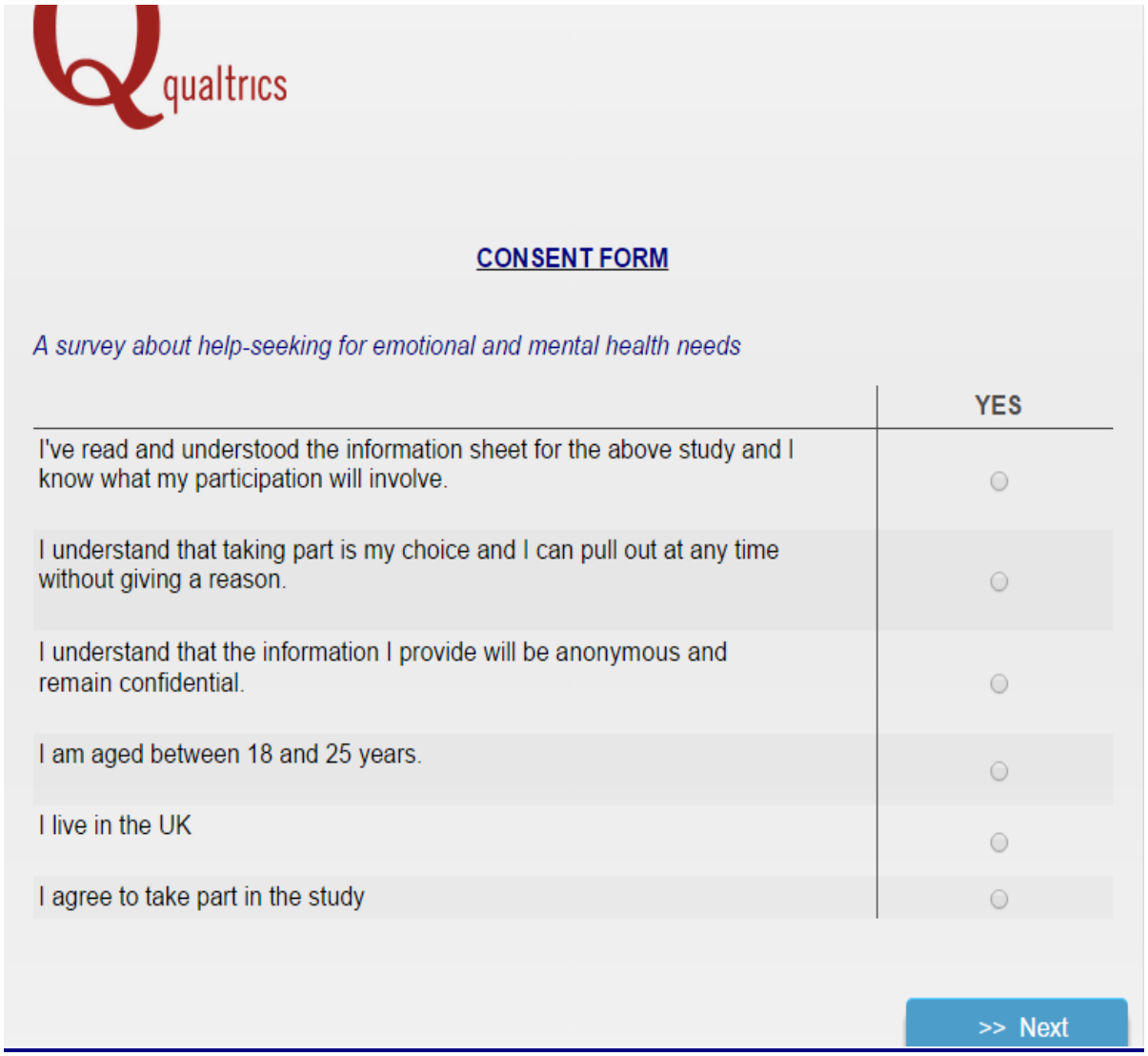
What will happen to the results of the research study? The results of the study will be written up as a thesis for the Doctorate of Clinical Psychology at the University of Hertfordshire. It is planned that the results will be published in a research journal.

Who has reviewed this study? This study has been approved by the University of Hertfordshire Ethics Committee (ethics protocol number LMS/PG/UH/00298).

Who can I contact if I have any questions?
If you would like further information, please contact the researcher Kez Salaheddin at; k.salaheddin@herts.ac.uk.

>> Next

Appendix 7 – Participant consent form



CONSENT FORM

A survey about help-seeking for emotional and mental health needs

	YES
I've read and understood the information sheet for the above study and I know what my participation will involve.	○
I understand that taking part is my choice and I can pull out at any time without giving a reason.	○
I understand that the information I provide will be anonymous and remain confidential.	○
I am aged between 18 and 25 years.	○
I live in the UK	○
I agree to take part in the study	○

>> Next

Appendix 8 – Questionnaire – Demographic information

1. **What is your sex?**
    a. Male
    b. Female
    c. Other (please specify)

2. **What is your age?**

3. **What is your relationship status**?
    - Single
    - In a relationship
    - Married
    - Other (please specify).

4. **Were you born in the United Kingdom?**
    a. Yes/no
    b. (If no) how many years have you lived in the United Kingdom?

5. **How would you describe your ethnicity?**
    - White: British
    - White: Irish
    - White: Other
    - Mixed: White and Black Caribbean
    - Mixed: White and Black African
    - Mixed: White and Asian
    - Mixed: Other
    - Asian / Asian British: Indian
    - Asian / Asian British: Pakistani
    - Asian / Asian British : Bangladeshi
    - Asian / Asian British : Chinese
    - Asian: Other
    - Black or Black British: African
    - Black or Black British : Caribbean
    - Black: Other
    - Other ethnic group (please specify) ……

6. **What is your religion?**
    - No religion
    - Christian
    - Buddhist
    - Hindu
    - Jewish
    - Muslim
    - Sikh
    - Any other religion (please specify) ……..

7. **What is your highest level of education?**

- No qualifications
- GCSEs
- AS or A-level
- NVQ
- BTEC
- HND
- University degree
- Other qualification (please specify)……

8. What is your employment status

- Unemployed
- Student
- Part-time work
- Full-time work
- Volunteer / unpaid work
- Unable to work due to sickness or disability
- Other (please specify) ……

9. Please choose the answer that best describes your living arrangements

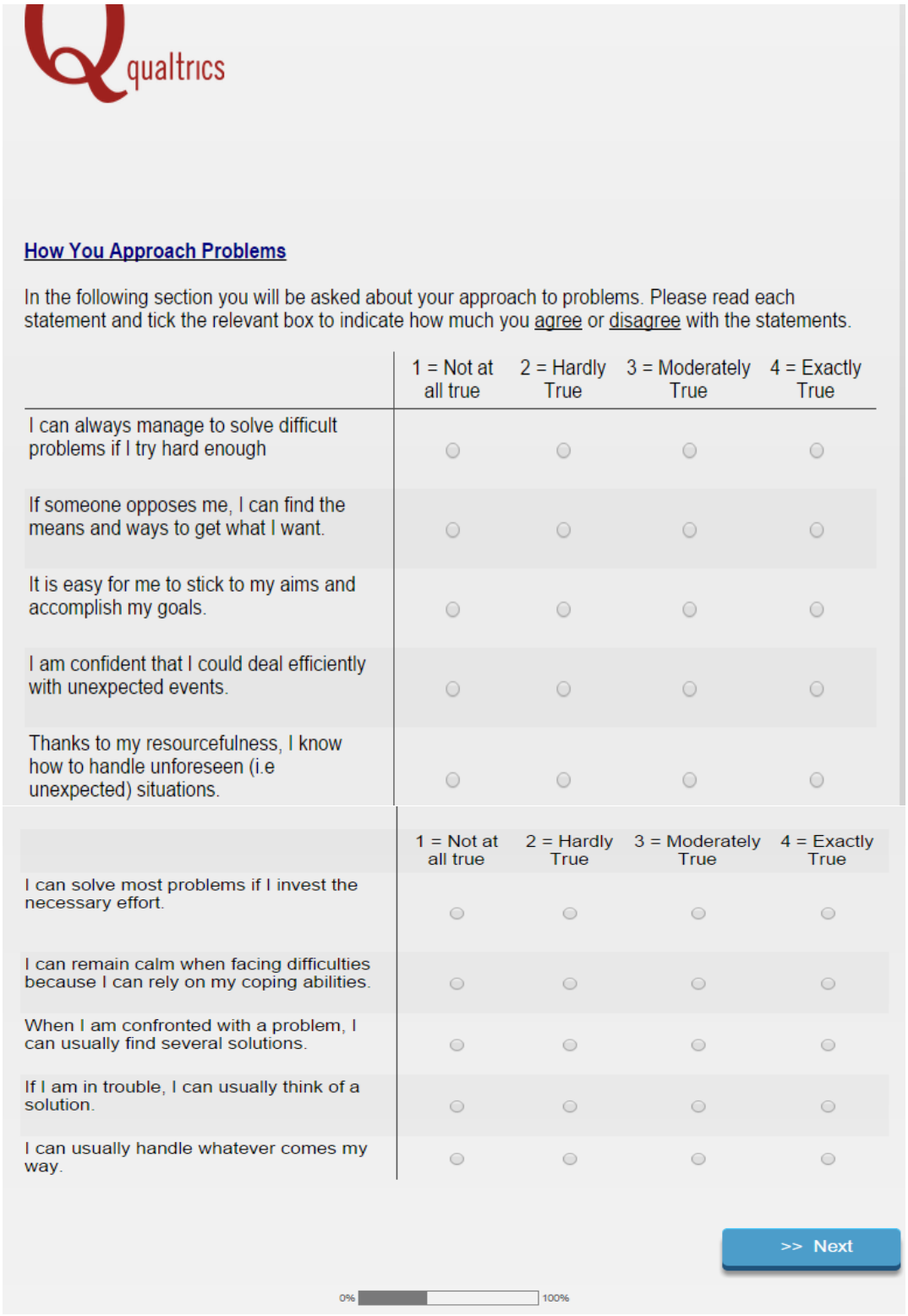
- I live with family
- I live with friends
- I live with partner/girlfriend/boyfriend
- I live alone
- I live in shared accommodation
- I live in student accommodation
- I have no fixed home address
- Other living arrangement……..

10. Do you have any dependent children?

a. Yes
b. No

11. Do you receive any benefits e.g. Income Support/ housing benefits?

a. No
b. Yes (please specify)



How You Approach Problems

In the following section you will be asked about your approach to problems. Please read each statement and tick the relevant box to indicate how much you agree or disagree with the statements.

	1 = Not at all true	2 = Hardly True	3 = Moderately True	4 = Exactly True
I can always manage to solve difficult problems if I try hard enough	○	○	○	○
If someone opposes me, I can find the means and ways to get what I want.	○	○	○	○
It is easy for me to stick to my aims and accomplish my goals.	○	○	○	○
I am confident that I could deal efficiently with unexpected events.	○	○	○	○
Thanks to my resourcefulness, I know how to handle unforeseen (i.e unexpected) situations.	○	○	○	○

	1 = Not at all true	2 = Hardly True	3 = Moderately True	4 = Exactly True
I can solve most problems if I invest the necessary effort.	○	○	○	○
I can remain calm when facing difficulties because I can rely on my coping abilities.	○	○	○	○
When I am confronted with a problem, I can usually find several solutions.	○	○	○	○
If I am in trouble, I can usually think of a solution.	○	○	○	○
I can usually handle whatever comes my way.	○	○	○	○

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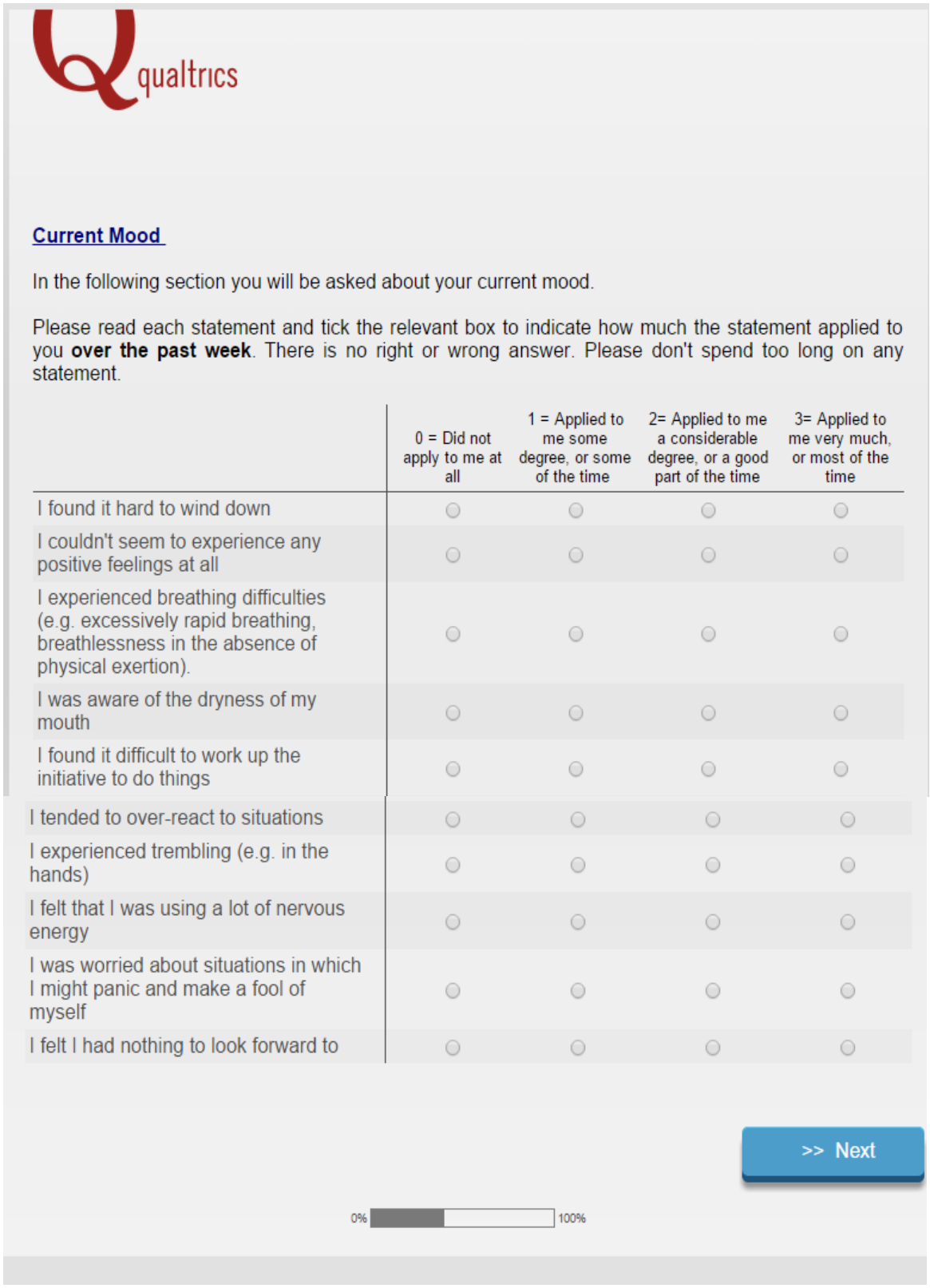

Qualtrics

Current Mood

In the following section you will be asked about your current mood.

Please read each statement and tick the relevant box to indicate how much the statement applied to you **over the past week**. There is no right or wrong answer. Please don't spend too long on any statement.

	0 = Did not apply to me at all	1 = Applied to me some degree, or some of the time	2= Applied to me a considerable degree, or a good part of the time	3= Applied to me very much, or most of the time
I found it hard to wind down	○	○	○	○
I couldn't seem to experience any positive feelings at all	○	○	○	○
I experienced breathing difficulties (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion).	○	○	○	○
I was aware of the dryness of my mouth	○	○	○	○
I found it difficult to work up the initiative to do things	○	○	○	○
I tended to over-react to situations	○	○	○	○
I experienced trembling (e.g. in the hands)	○	○	○	○
I felt that I was using a lot of nervous energy	○	○	○	○
I was worried about situations in which I might panic and make a fool of myself	○	○	○	○
I felt I had nothing to look forward to	○	○	○	○

>> Next

0% 100%

Current Mood - Continued

As before, please read each statement and tick the relevant box to indicate how much the statement applied to you **over the past week**.

Please don't spend too long on any statement.

	0 Did not apply to me at all	1 Applied to me to some degree, or some of the time	2 Applied to me to a considerable degree, or a good part of time	3 Applied to me very much, or most of the time
I found myself getting agitated	○	○	○	○
I found it difficult to relax	○	○	○	○
I felt down-hearted and blue	○	○	○	○
I was intolerant of anything that kept me from getting on with what I was doing	○	○	○	○
I felt I was close to panic	○	○	○	○
I was unable to become enthusiastic about anything	○	○	○	○
I felt that I wasn't worth much as a person	○	○	○	○
I felt that I was rather touchy	○	○	○	○
I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	○	○	○	○
I felt scared without any good reason	○	○	○	○
I felt that life was meaningless	○	○	○	○

Your Mental Health Needs

The following statements ask about your mental health needs and experiences.

Have **you ever** experienced any of the following emotional or mental health difficulties? Please tick the statement(s) that apply to you.

- [ ] I've **never** had an emotional or mental health difficulty
- [ ] Anxiety Disorder
- [ ] Depression
- [ ] Self-Harm
- [ ] Alcohol or substance misuse
- [ ] Eating Disorder
- [ ] OCD (Obsessive Compulsive Disorder)
- [ ] Psychosis
- [ ] Bipolar Disorder
- [ ] Other emotional or mental health difficulty (please specify)

Are you **currently** experiencing any type of emotional or mental health difficulty? This may include difficulties that have not been formally diagnosed by a doctor or mental health professional.

- ○ NO
- ○ YES

qualtrics

Please use the space below to describe the emotional or mental health difficulties that you are experiencing

>> Next

0% 100%


qualtrics
Your Experience Of Getting Help
Have you ever asked for help from other people or agencies (e.g. friends, family, G.P, Samaritans) for your emotional or mental health needs?
YES
NO
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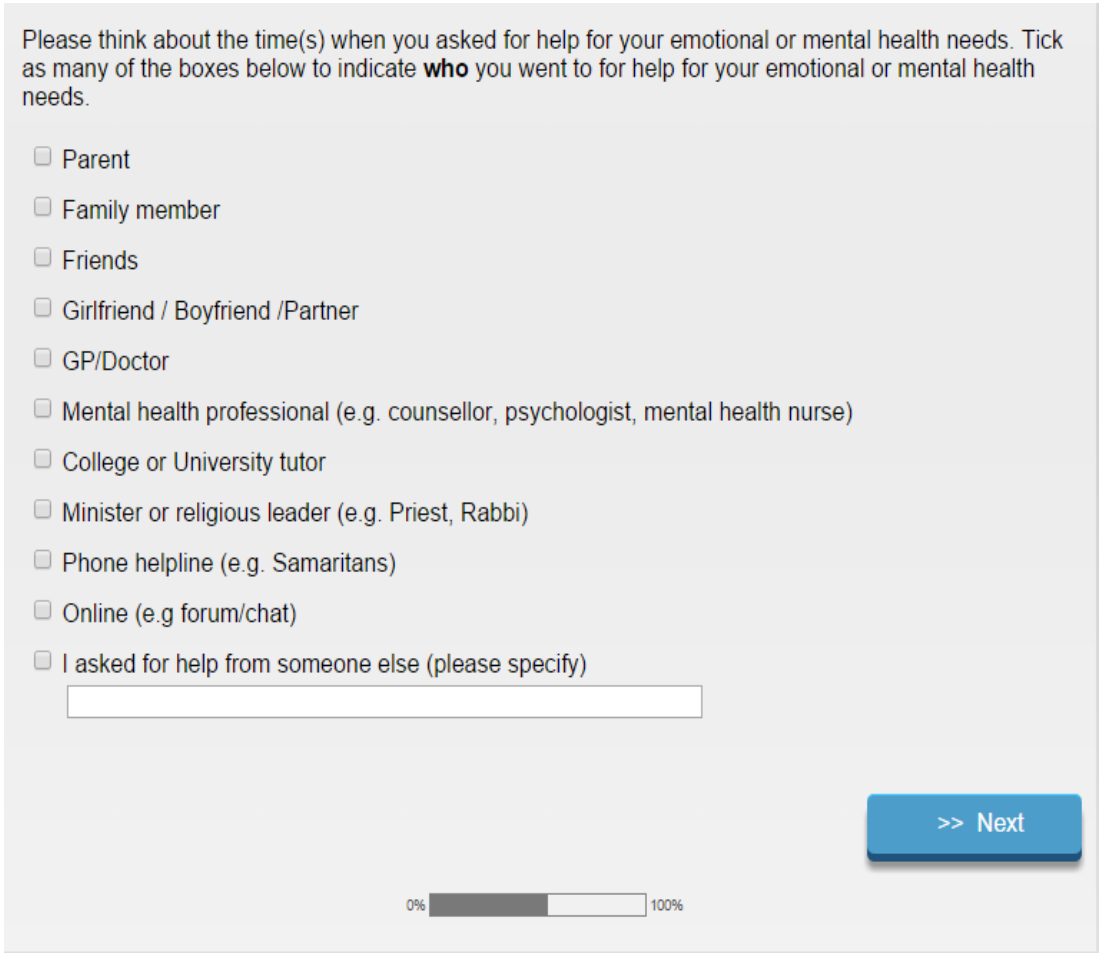
100%


Please think about the time(s) when you asked for help for your emotional or mental health needs. Tick as many of the boxes below to indicate who you went to for help for your emotional or mental health needs.
Parent
Family member
Friends
Girlfriend / Boyfriend /Partner
GP/Doctor
Mental health professional (e.g. counsellor, psychologist, mental health nurse)
College or University tutor
Minister or religious leader (e.g. Priest, Rabbi)
Phone helpline (e.g. Samaritans)
Online (e.g forum/chat)
I asked for help from someone else (please specify)
>> Next
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Please think about the time(s) when you asked for help from the *mental health professional* and/or *GP*. Overall, how satisfied were you with the support that you you received?

Please tick the box that applies to you.

- ○ Very Dissatisfied
- ○ Dissatisfied
- ○ Somewhat Dissatisfied
- ○ Neutral
- ○ Somewhat Satisfied
- ○ Satisfied
- ○ Very Satisfied

If you wish to do so, please provide any further comments about how satisfied you were with the support you received from the mental health professional and/or GP.

There is no right or wrong answer, all feedback is valuable.

Mental Health Needs of People Close to You

Has anyone in **your family** ever had an emotional or mental health difficulty e.g. anxiety, depression?

- ○ Yes
- ○ No
- ○ Unsure

>> Next

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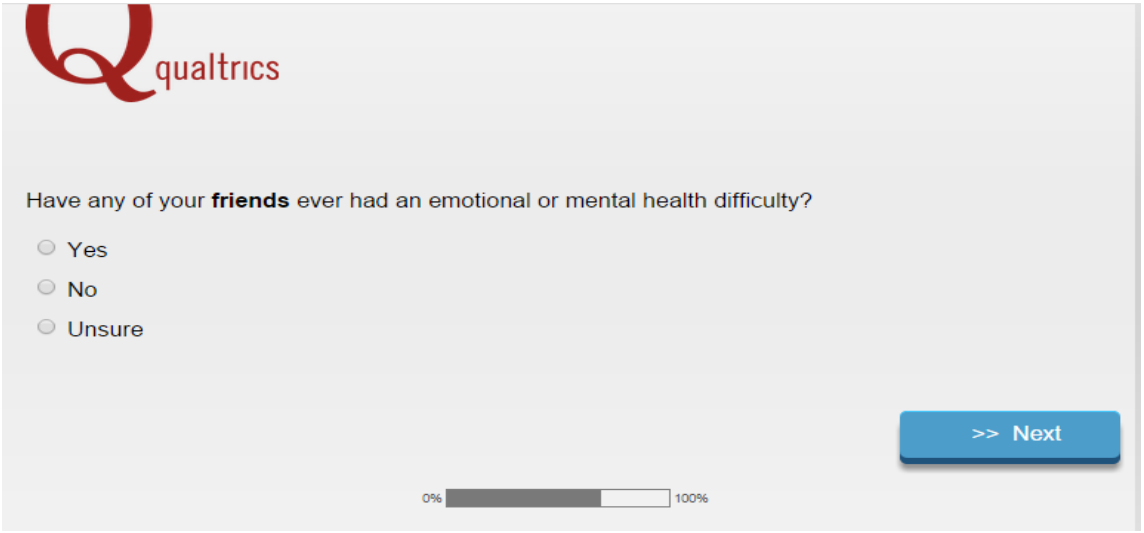
qualtrics
Have any of your **friends** ever had an emotional or mental health difficulty?
Yes
No
Unsure
>> Next
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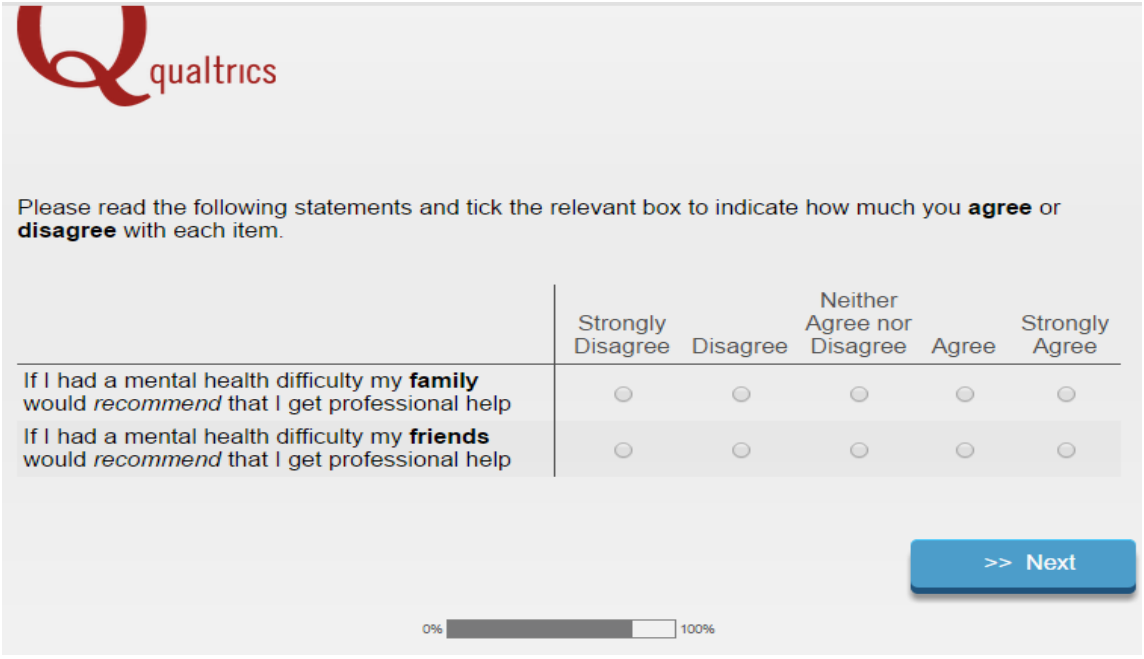
100%


qualtrics
Please read the following statements and tick the relevant box to indicate how much you **agree** or **disagree** with each item.
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree
If I had a mental health difficulty my **family** would *recommend* that I get professional help
If I had a mental health difficulty my **friends** would *recommend* that I get professional help
>> Next
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100%

Getting Help In The Future

The following section will ask about your thoughts on seeking help in the future.

In the future, if you had an emotional or mental health difficulty, how **likely** or **unlikely** are you to ask for help from the following? Please tick all the boxes that apply to you.

	Very Unlikely	Unlikely	Neither unlikely nor likely	Likely	Very Likely
Phone Helpline e.g. Samaritans	○	○	○	○	○
Minister or religious leader (e.g. priest, rabbi)	○	○	○	○	○
Online e.g. Forum/chat	○	○	○	○	○
Family	○	○	○	○	○
Mental health professional (e,g. Counsellor, psychologist, mental health nurse.)	○	○	○	○	○
Parent	○	○	○	○	○
G.P. / Doctor	○	○	○	○	○
Friend	○	○	○	○	○
College or University tutor	○	○	○	○	○
Girlfriend / Boyfriend / Partner	○	○	○	○	○
I would ask for help from another person not listed (please specify)	○	○	○	○	○
I would **NOT** ask for help from anyone	○	○	○	○	○

qualtrics

There are different ways of accessing professional support for an emotional or mental health difficulty. If you were to seek professional support (e.g. from a mental health nurse, G.P, counsellor, psychologist), **where** would *you* prefer to access the support?

Please tick all the boxes that apply to you.

- ☐ I don't mind where I see the mental health professional
- ☐ At a hospital
- ☐ At a community mental health clinic
- ☐ Over the telephone
- ☐ Over the internet
- ☐ At home
- ☐ At college / University / work place
- ☐ Other place not listed (please specify)

In the future, *if* you were to experience an emotional or mental health difficulty, what would make it **easier** for you to seek professional help? All feedback is valuable.

>> Next

Factors Influencing Help-Seeking

If you were to experience an emotional or mental health difficulty, which of these issues would **stop, delay or discourage you** from getting professional help?

By *professional help* we mean help from such staff as a GP (family doctor), community mental health team (e.g. care coordinator, mental health nurse or mental health social worker), psychiatrist, counsellor, psychologist or psychotherapist.

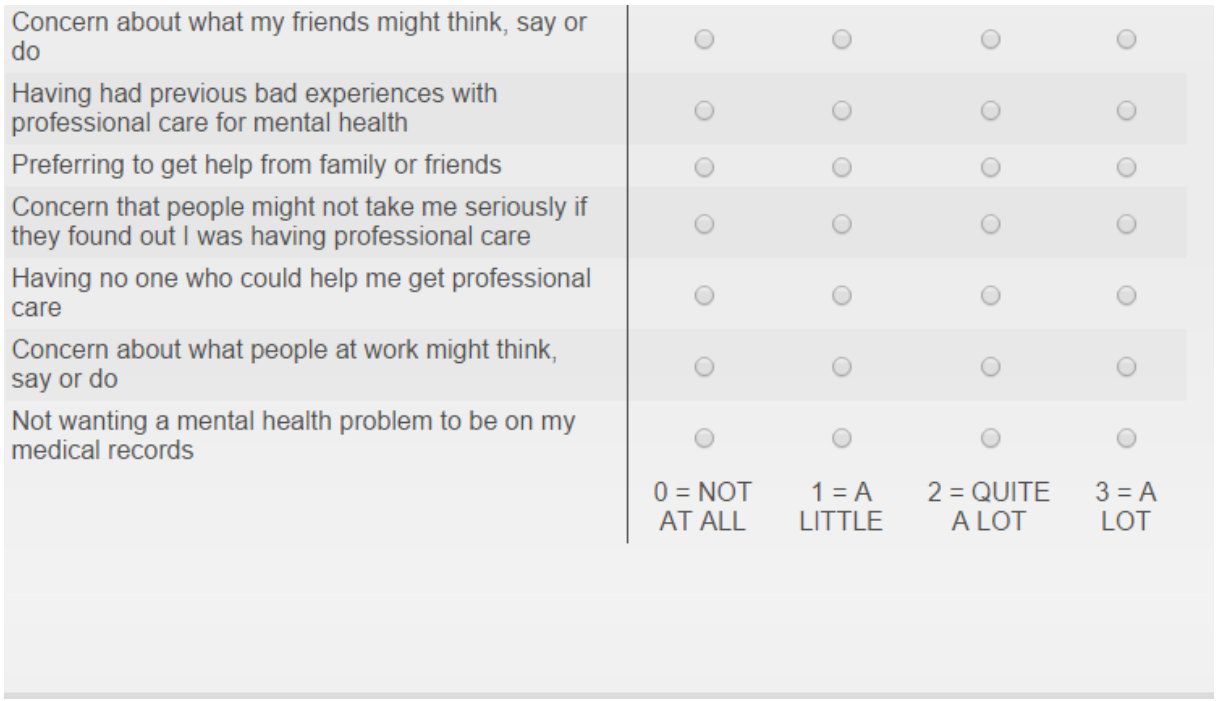
	This would Stop, Delay or Discourage me:			
	0 = NOT AT ALL	1 = A LITTLE	2= QUITE A LOT	3 = A LOT
Preferring to get alternative forms of care (e.g. religious healing or alternative therapy)	○	○	○	○
Being Unsure where to go to get professional care	○	○	○	○
Problems with transport or travelling to appointments	○	○	○	○
Wanting to solve the problem on my own	○	○	○	○

Not being able to afford the financial costs involved	○	○	○	○
Concern that it might harm my chances when applying for jobs.	○	○	○	○
Concern that I might be seen as weak for having a mental health problem	○	○	○	○
Concern that I might be seen as a bad parent	○	○	○	○
Concern about what my family might think, say, do or feel	○	○	○	○
Professionals from my own ethnic or cultural group not being available.	○	○	○	○
Concerns that I might be seen as 'crazy'	○	○	○	○
Fear of being put in hospital against my will	○	○	○	○
Feeling embarrassed or ashamed	○	○	○	○
Thinking the problem would get better itself	○	○	○	○
Thinking that professional care probably would not help	○	○	○	○
	0 = NOT AT ALL	1 = A LITTLE	2= QUITE A LOT	3 = A LOT

Factors Influencing Help-Seeking - *Continued*

As before, if you were to experience an emotional or mental health difficulty, which of these issues would **stop, delay or discourage you** from getting professional help?

	This would Stop, Delay or Discourage me:			
	0 = NOT AT ALL	1 = A LITTLE	2 = QUITE A LOT	3 = A LOT
Concern that people I know might find out	○	○	○	○
Difficulty taking time off work	○	○	○	○
Thinking I do not have a problem	○	○	○	○
Dislike of talking about my feelings, emotions or thoughts	○	○	○	○
Being too unwell to ask for help	○	○	○	○
Concerns about the treatments available (e.g. medication side effects)	○	○	○	○
Concern about what my friends might think, say or do	○	○	○	○



	0 = NOT AT ALL	1 = A LITTLE	2 = QUITE A LOT	3 = A LOT
Concern about what my friends might think, say or do	○	○	○	○
Having had previous bad experiences with professional care for mental health	○	○	○	○
Preferring to get help from family or friends	○	○	○	○
Concern that people might not take me seriously if they found out I was having professional care	○	○	○	○
Having no one who could help me get professional care	○	○	○	○
Concern about what people at work might think, say or do	○	○	○	○
Not wanting a mental health problem to be on my medical records	○	○	○	○

Appendix 13b – Permission to change wording on BACE scale.

Re: BACE v3

sarah.clement@kcl.ac.uk [sarah.clement@kcl.ac.uk]

Sent: 21 August 2014 18:55

To: Salaheddin, Keziban

Cc: Graham Thornicroft [graham.thornicroft@kcl.ac.uk]

Dear Keziban

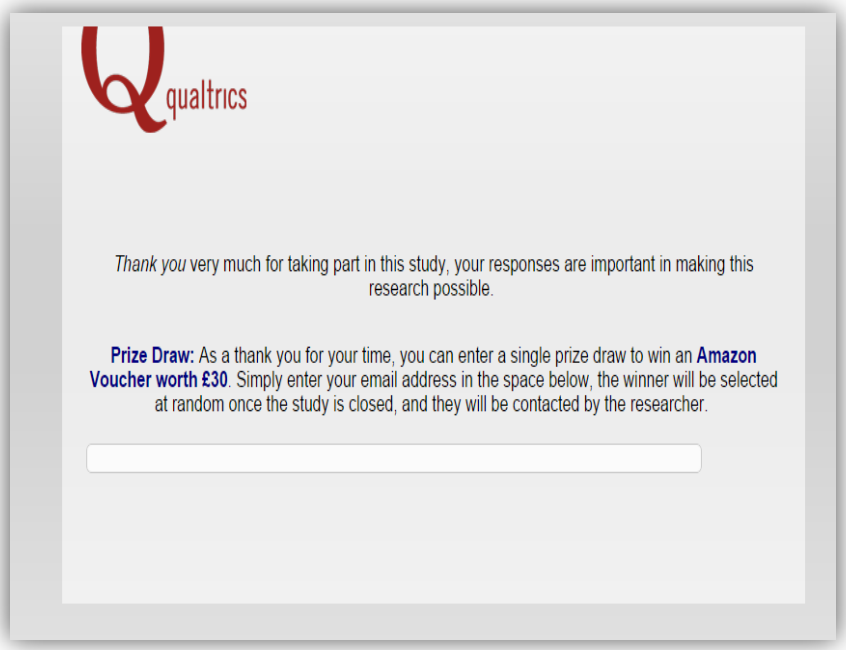
Many thanks for your interest in using the BACE. I have checked with Professor Thornicroft and we are both happy for you to make the wording change you described.

You have our permission to use the BACE. We would appreciate it if you could complete the brief online registratioin question which can be found at www.sapphire.iop.kcl.ac.uk (resources page)

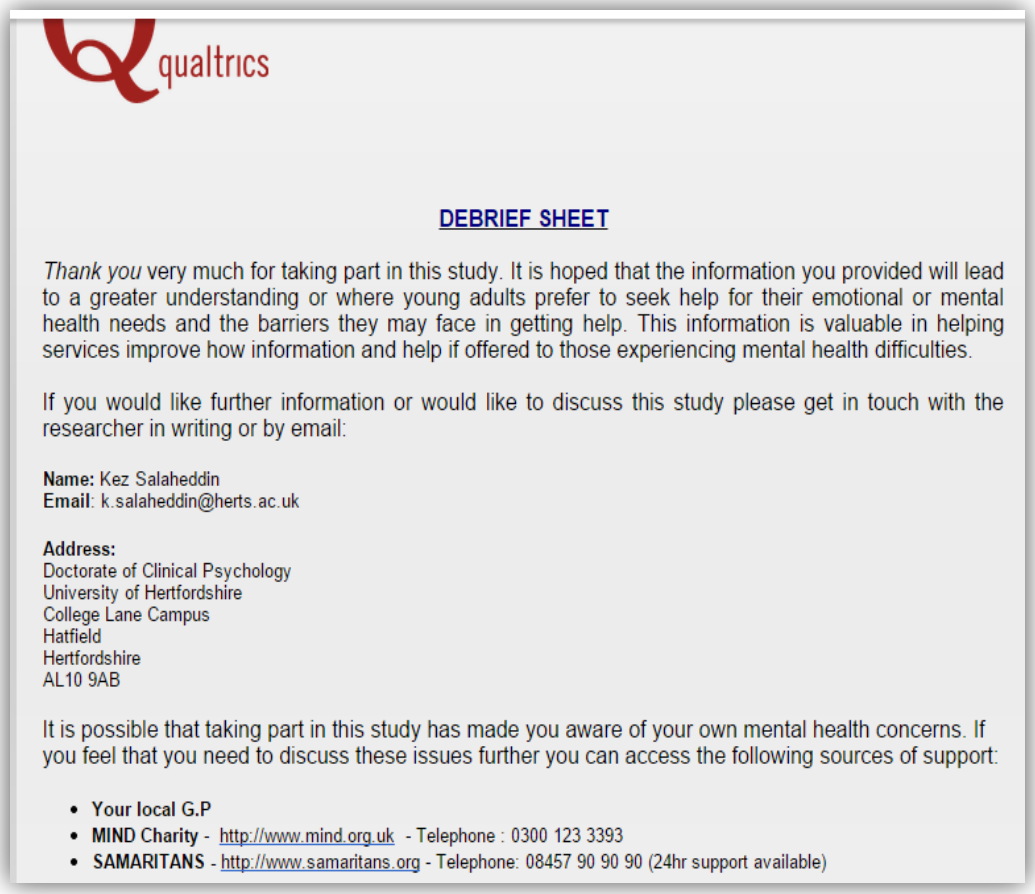
Good luck with your research

Best wishes
Sarah
Sarah Clement PhD

Appendix 14 – Participant Prize Draw



Appendix 15 – Participant Debrief sheet



University of Hertfordshire UH

UNIVERSITY OF HERTFORDSHIRE
HEALTH & HUMAN SCIENCES

ETHICS APPROVAL NOTIFICATION

TO Kezban Salaheddin

CC Dr Barbara Mason

FROM Mr Fraser Heasman, Health and Human Sciences ECDA Vice-Chairman

DATE 12/11/14

Protocol number: **LMS/PG/UH/00298**

Title of study: Identifying young adult's preferences and barriers to help-seeking for mental health difficulties

Your application for ethical approval has been accepted and approved by the ECDA for your school.

This approval is valid:

From: 12/11/14

To: 30/6/14

Please note:

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.

Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Students must include this Approval Notification with their submission.

Appendix 17. Table 15. DASS-21 subscale scores

	DASS 21 Depression	DASS21 Anxiety	DASS21 Stress	Total DASS-21
% (N)	100 (192)	100 (193)	100 (193)	100 (190)
Mean (SD)	8.72 (6.63)	6.47 (5.65)	9.34 (5.60)	14.5 (16.4)
Median	8	5	9	23
Min / Max	0 / 21	0 / 21	0 / 21	0 / 63
Skew	0.33	0.73	0.20	0.33

Appendix 18 – Distribution of scores on DASS-21 subscale

Severity	DASS 21: Depression % (n)	DASS21: Anxiety % (n)	DASS21: Stress % (n)
Normal	33.3 (64)	41.5 (80)	38.9 (75)
Mild	9.9 (19)	12.4 (24)	14.5 (28)
Moderate	18.2 (35)	9.8 (19)	18.7 (36)
Severe	12.0 (23)	5.7 (11)	16.6 (32)
Extremely Severe	26.6 (51)	30.6 (59)	11.4 (22)
Total	N =192	N = 193	N= 193

Appendix 19. Help-seeking across males and females

Source of help Sought	Male % (n)	Female % (n)	Chi Square Fishers Exact Test
Parents	44.4 (8)	50.8 (33)	P = .79 1.29 (0.45 -3.68)
Family Member	27.8 (5)	35.4 (23)	P = .78 1.42 (0.45 – 4.50)
Friends	50.0 (9)	64.6 (42)	P = .29 1.83 (0.64 – 5.24)
Intimate Partner	33.3 (6)	40.0 (26)	P = .79 1.33 (0.45 – 4.0)
GP	66.7 (12)	73.8 (48)	P = .56 1.41 (0.56 – 4.35)
Mental Health Professional	50.0 (9)	76.9 (50)	P = .039 3.33 (1.12 – 9.91)
Tutor	16.7 (3)	36.9(24)	P = .155 2.93 (0.77 – 11.16)
Minister / Religious Leader	0 (0)	9.2 (6)	P = .332 0.77 (0.68 – 0.87)
Phone Helpline	16.7 (3)	38.5 (25)	P = .099 3.12 (0.82 -11.89)
Online	38.9 (7)	60.0 (39)	P = .179 2.34 (0.81 -6.87)

Appendix 20 Qualitative data from written extracts relating to barriers

Raw Data	Initial codes
I believe I can overcome my own problems, all I need is time	Reliance on self Need time
Being judged, people thinking it's not a real thing etc.	Fear of judgement , anticipate negative attitude from others
Don't want to worry my family or be a burden on anyone.	Fear of burdening others or worrying family
Because I did not feel I was doing that terribly compared to others and that my problems came from a position of priveledge that made my unhappiness meaningless compared to others.	Didn't perceive it as a problem Problem not that serious compared to others Self-stigmatising attitude about own problem – shame?
There is a negative stigma attached to any mental illness. As soon as you say that you've got one, people judge you and start thinking of you differently. It is something that people are too afraid and shy to talk about - especially if you have an anxiety disorder. Just thinking about having a mental illness can make you feel terrible, so talking about it to another person would make you feel worse. When opening up to family and friends, they may not fully understand. Not many people are fully aware and educated on mental illnesses. This causes them to say insensitive things such as: "get over it", "can't you feel happy?", "everyone feels down" etc.	Fear of stigma & judgement Difficult, uncomfortable to talk about Worry that talking about the problem will make it worse Fear that others will not understand and respond negatively or insensitively
I feel as though I'm being pathetic, I don't feel like I'm bad enough to ask for help when there's many more people with much more serious problems than me.	Self-stigmatising attitude about seeking help Problem not that serious, others have more serious problems
Because it's not particularly bad. Either way, I've told lots of my friends so I don't really need to 'ask' for help.	Problem not that serious Prefer other sources of help
Do not want anyone to find out	Confidentiality
I don't feel comfortable opening up; my coping strategy is to bury everything inside and 'put a brave face' on it. I would feel vulnerable telling others how I feel; I feel that my outwardly positive attitude is a kind of defence that stops everything from coming flooding out. / I feel it would be better if I could resolve these things on my own.	Used to avoiding Difficulty expressing emotions – feel vulnerable and uncomfortable Preference to rely on self
I don't feel comfortable discussing my issues with my GP, particularly as I feel I would probably be fobbed off with medication	Difficulty expressing concerns Anticipate unhelpful response from professional
Dont think they'd understand how nervous i feel sometimes.	Anticipate lack of understanding

I've tried to go to a mentor to ask for help but have felt unable to and scared of being vulnerable most of the time. I find it hard to talk about my feelings too so I guess that's part of the issue. / / I also find it hard to bring up with my parents as I don't want them to worry about me but also it's just hard to bring up the topic anyway.	Fear of being vulnerable and perceived difficulty of asking for help. Difficulty talking about feelings Fear of worrying family
Due to the stigma & the fact I have to keep strong for the rest of the family as they need me to keep going or else everything will fall apart	Stigma Worry about the effect on family, preference to remain strong – negative perception
Being actively labelled with a mental or emotional disability is hard to get rid of once it's official. / People might think less of you if they think you might be a little bit crazy. / You don't believe they can actually help but they will intervene anyway but not necessarily in a positive.	Fear of being labelled, fear of public stigma/negative attitude Others won't be able to help
Other people need it a lot more than i do and i would be too worried/awkward to.	Others needing help more Too worried or awkward to ask for help
I don't really feel it's severe enough maybe. When Ive briefly approached it with friends before it's been more or less laughed down. I don't feel comfortable to ask for support, and I don't know how helpful treatment would be.	Not serious enough Negative experience in past with friends Perceive that seeking help will be uncomfortable Uncertain how helpful treatment would be
I don't know	Not sure
I hinted at the fact I thought I might have social anxiety to my mum but she dismissed it by saying I just needed to get on with it and all I needed was more practice at socialising. She also said putting labels on people like that are defeatist and unhelpful. So I'm not optimistic about speaking to her or other family members. I don't consider my anxiety to be strong enough to justify going to my gp, besides there's very little they can do considering how underfunded mental health services are in the nhs. I don't think my anxiety is bad enough for medication, even if it was I want to avoid medication, and there's not enough therapy for people with bigger problems than me so I know I wouldn't get any without going private which a) my family can't afford and b) would require more involvement of my family which isn't going to work as I said at the beginning. / / I used to be considerably underweight due to distorted perceptions of a healthy body. I wasnt anorexic or bulimic orbanything, i just wasnt eating enough bevause i had a fear if fatness. It was never noticed and I never got help specifically for it. The only reason this was resolved was I had to go to the doctors because I still wasn't menstruating at 17. My bmi was calculated for this reason and I was told to gain weight and in doing so came to terms with body image etc but I never got treatment form the point of view of my perceptions of weight because it was never noticed and I didn't realise I had a problem.	Not serious enough compared to others Fear negative attitude and stigma from family Don't think provider can offer help Others not recognising the need for help or recognising a problem Not being able to afford private therapy, Didn't realise they had a problem
Didnt want to talk about it	Don't want to talk about problem
I don't have friends and my family we are not close . / I scare sometimes to ask my family some questions.	Limited social support, fear of asking for help
When I was a teenager, I went through a period of disordered eating, including fasting and purging by making myself vomit. I didn't seak help at the time because I had problems with my body image, and while I was aware of the risks, I thought it was	Didn't want to ask for help, don't want to change problem behaviour

worth doing these things in order to loose weight. I kept my problems a secret because I did not want people monitoring what I ate. After a while, my eating became less disordered, and I became more satisfied with my body image- although the initial period lasted a few months when I was 15/16, I have sometimes felt the desire to fast and purge since this time, and also used the 5:2 diet to try and lose weight. / /	
I have tried to work on it myself, and I am worried that it might effect my future career prospects.	Preference on self-reliance Fear negative effect on career prospective
Feel weak in asking others and feel they didn't have the time to help	Self-stigmatising attitude RE help-seeking Others won't have time
I did not feel it was worth it, as I only had a mild form.	Not worth it Not serious enough
Apart from the back pain, I'm functional.	Not serious enough
I am independent and I mostly tend to think that I can deal with my emotion and that I don't need help.	Preference to rely on self, don't perceive need for help
Don't think they would be seen as being serious enough	Others won't perceive it as serious
Not understanding and being able to coherently explain my issues, not being physically able to talk about issues due to crying whenever topic comes up, feeling I don't need professional help, feeling I don't want hassle, avoiding it due to social and other anxiety about getting help, not knowing who to talk to, sometimes wanting to deal with it on my own I knew that if I told someone I would no longer be able to self harm and I became dependent on doing it to relieve myself and the issues I felt I was going through. I didn't want to disappoint or upset anyone I loved and I didn't feel it was serious enough to talk to anyone else when I've seen much more extreme cases.	Difficulty explaining problem and expressing emotions Belief that don't need professional help Preference to rely on self Unsure where to seek help Don't want to upset others Don't want to stop problem behaviour which is a way of coping Not serious enough
I did not want to admit I was sick. Also, was kind of afraid of was people might have thought of me.	Fear of what others think Don't want to admit to self
I don't want to bother or worry people.	Don't want to worry or bother others
my family is part of my problem, they have been through similar things and find it hard to talk about.	Not wanting to burden family
because I was use to keeping things in when I was angry and I was angry all the time	Coped in other ways
It was a very mild case, and resolved itself after a few months.	Problem not serious and resolved itself
i felt i could get over it by myself and there was no need to include other people who just tend to confuse the situation and	Coped on their own

focus and what is going on rather than why. also it was not that serious to demand external help	Not that serious Other make it worse
I never needed help before. When I feel the need for it, I will seek help	Didn't perceive need for help
I don't need help from external sources	Don't perceive need for help
I managed to cope by spending lots of time with my friends and taking my mind off the difficulties I was facing privately (parents divorce and previous domestic violence).	Dealt with it on their own using other coping strategies

Initial Themes	Main Themes
Prefer to rely on self	Reliance on self
Coped in other ways	Problem not serious enough
Didn't think they needed professional help	
Problem not serious	Fear of negative outcome
Seeking help will have a negative outcome on self or others (career, or family)	
Anticipate unhelpful response from professional or help source	
Professionals not being able to offer help Others not perceiving it as a problem	
Asking for help will worsen problem	Difficulty accessing help
Fear of burdening or worrying others	
Fear of stigma and judgement from others	
Self-stigmatising attitude about seeking help	Stigmatising beliefs
	Difficulty identifying or expression feelings/concerns
Fear about confidentiality	
Difficulty asking for help, expressing feelings or concerns	Problems accessing help
Didn't want to change the 'problem' behaviour	
Not being able to afford private help	
Didn't realise they had a problem	
Not knowing where to go	