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Doctoral Thesis

Does Professional Language Affect Help Seeking in Young People? A Randomised
Study.

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Section	Main Text	Appendices (including tables, figures and reference lists)	Total
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Research Paper	7936	12952	20888
Critical Appraisal	2427	1001	3428
Ethics Proposal	4669	863	5532
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Abstract

This thesis comprises of a literature review, a research report and a critical appraisal. The overall focus is on factors that affect whether young people seek help for mental health problems. The systematic review assessed whether mental health literacy interventions delivered to children and young people in education settings improved knowledge, attitudes and help seeking. Seven studies reported significant improvements in knowledge, six reported significant improvements in attitudes and three reported significant improvements in help seeking. Appraisal of quality rated two of the nine studies as moderate and seven papers as weak. The quality and reporting standards limited the generalisability of the majority of the findings and it remains unclear whether mental health literacy interventions delivered in education settings to young people are effective. The research study used a cross sectional, online, experimental design and regression analyses to explore whether the language used by professionals to describe mental health problems affects young people's help seeking intentions. Participants were randomly allocated to conditions and presented with a video clip vignette of either psychiatric language or lay language. The vignette conditions did not directly affect help seeking intentions. Past experience and perceived helpfulness of previous mental health care significantly predicted an increase in help seeking intentions. An interaction effect was also observed where psychiatric language predicted higher help seeking intentions in young people who had past experience of mental health care and lay language predicted higher help seeking intentions in young people who had not. This effect was at a borderline level of statistical significance. Implications for practice and research are discussed and future research to confirm or disprove this interaction is recommended. The critical appraisal extends the discussion

from the research paper with a focus on research methodology, how research is presented and theoretical models.

Declaration

This thesis presents research submitted in October 2016 as partial fulfilment of the requirements for the Lancaster University Doctorate in Clinical Psychology. The work in this thesis is my own except where due reference has been made to other authors.

This thesis has not been submitted for academic award elsewhere.

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Section 1. Literature Review

Do Mental Health Literacy Interventions Delivered in Educational Settings to Children and Young People Improve Knowledge, Attitudes and Help Seeking in Relation to Mental Health? A Systematic Review of Trials Published Since 2010.

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1.1. Abstract

This systematic review assessed whether mental health literacy interventions delivered to children and young people in education settings improve knowledge, attitudes and help seeking. Nine papers were identified from searches of PubMed, PsycINFO, Academic Search Complete, Scopus and Web of Science. Study locations included Nigeria, Canada, Japan, Australia, the USA and Norway. Participants ($N = 3674$) were mixed gender and aged 10 to 24. Seven studies reported significant improvements in knowledge, six reported significant improvements in attitudes and three reported significant improvements in help seeking. Quality appraisal rated two of the studies as moderate and seven studies as weak. Quality and reporting standards limited the generalisability of the majority of findings. It remains unclear whether mental health literacy interventions delivered in education settings to young people are effective. Research is required in this area that is based on theoretical models and reported in line with relevant quality and reporting criteria.

Keywords: Mental health literacy; Intervention; Young People; Help seeking; Attitudes; Knowledge.

Identifying when mental health problems begin and how best to provide early access to treatment is an international public health concern (Kessler et al., 2009). Whiteford and colleagues (2013) identified mental health problems as the leading cause of “years lived with disability” (p. 1575) worldwide and people aged between 10 and 29 years old as the age group that are most affected. Estimates indicate that 10 to 20% of children and young people worldwide experience clinically significant mental health problems (World Health Organisation, 2016). These findings are not surprising given that the most prevalent mental health problems such as anxiety and depression begin in children and young people aged under 25 (De Girolamo, Dagani, Purcell, Cocchi, & McGorry, 2012). Adolescents and young people are also the age group that are least likely to seek help for mental health problems (Gulliver, Griffiths, & Christensen, 2010a; Rickwood, Deane, Wilson, & Ciarrochi, 2005). For younger children, access to help is usually controlled by parents, caregivers and professionals. Research exploring why older adolescents and young people do not seek help when they experience mental health problems has indicated that levels of psychological distress, type of mental health difficulty, stigma and mental health literacy could all be contributing factors (Gulliver et al., 2010a). The reasons however are not yet fully understood.

The model that has been most frequently used as a theoretical base for research in this area is the theory of planned behaviour (Ajzen, 2012). Tools designed to measure help seeking outcomes and a development framework for defining the aspects of help seeking being researched have been based on this theoretical model (Rickwood & Thomas, 2012; Wilson, Deane, Ciarrochi, & Rickwood, 2005). This theory describes behaviour as a decision that we make in accordance with our behavioural intentions; which we form based on our attitudes towards the behaviour, subjective norms and

perceived behavioural control (Ajzen, 2012). Attitudes towards the behaviour refers to the degree to which a person has a positive or negative evaluation of the behaviour in question; subjective norms refer to what others think of the behaviour and perceived social pressure; and perceived behavioural control refers to our perception of how easy or difficult it will be to engage in the behaviour (Ajzen, 2012). This model is a useful way of conceptualising help seeking as it separates out attitudes, intentions and behaviours; and explains that general attitudes are not a reliable indicator of behaviours because of how environmental factors and self-perceptions affect our decisions (Ajzen, 2012).

Wilson and Deane (2012) reported that in a variety of adolescent samples, higher levels of general psychological distress, such as depressive symptoms and suicidal ideation were linked to lower help seeking intentions and an increase in avoidance of help or social withdrawal (help negation) meaning that those who needed help the most were least likely to seek it. Furthermore, people experiencing depression and suicidal ideation, who are most at risk of premature death compared to those experiencing other mental health difficulties, were the least likely to actively seek help (Wilson & Deane, 2010). The association between psychological distress and help negation is not yet understood and has not been fully explained by gender, prior help seeking, quality of previous help seeking experiences, co-occurring mental health conditions, religion and hopelessness (Wilson & Deane, 2012).

Stigma has also been repeatedly indicated as a potential barrier to help seeking (Gulliver et al., 2010a; Rusch et al., 2013; Sheffield, Fiorenza, & Sofronoff, 2004). Stigma is a complex concept, often understood in health help seeking models as an attitudinal factor that can influence a person's assessment of the costs and benefits of

seeking help (Eisenberg, Downs, Golberstein, & Zivin, 2009). Several distinct forms of stigma have been identified. Public stigma refers to collective negative stereotypes and prejudice held by a community or society; perceived public stigma is an individual's perception of public stigma; self stigma is when an individual identifies themselves with a stigmatised group; and personal stigma is an individual's own stereotypes and prejudice (Eisenberg et al., 2009).

Research by Eisenberg and colleagues (2009) exploring associations between personal and perceived public stigma and help seeking found that only personal stigma had a significant independent association with help seeking for mental health. They suggested that interventions aimed at reducing stigma are more likely to improve help seeking for mental health problems if they focus on personally held attitudes rather than perceptions of what others believe (Eisenberg et al., 2009). Similarly, Lally and colleagues (2013) reported a significant association between high levels of personal stigma and a decreased likelihood of future help seeking intentions. Corrigan (2004) suggested that levels of personal stigma could be improved by providing education and personal contact with someone who had experienced mental health difficulties, however there was no indication about whether this translated into improvements in help seeking intentions or behaviours.

An alternative explanation of low help seeking for mental health difficulties was proposed by Jorm and colleagues (1997). They defined "mental health literacy" as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm et al., 1997, p. 182). Jorm and colleagues argued that low levels of mental health literacy could explain the difficulties people have with recognising, talking about and accessing support for mental health difficulties. This

concept has numerous components, which Jorm described as: the ability to recognise specific types of psychological distress; attitudes that facilitate recognition and help seeking; and knowledge and beliefs about risk factors, causes, self-help interventions and professional help available (Jorm, 2000). Early estimates of community mental health literacy levels indicated that “correct recognition rates” of well known mental health difficulties such “depression and schizophrenia” were 39% and 27% percent respectively (Jorm et al., 1997, p. 182). Jorm and colleagues argued that by increasing public mental health literacy, people’s ability to recognise difficulties in themselves and others would increase, stigma would decrease and as a result, willingness to seek help would increase. They therefore made recommendations that raising community mental health literacy levels should be a public health priority (Jorm et al., 1997).

A wide range of interventions have since been developed in various countries aimed at improving public mental health literacy. To measure the effectiveness of mental health literacy interventions, researchers have usually assessed three outcomes. These are the acquisition of knowledge about mental health difficulties, changes in stigmatising attitudes and changes in help seeking intentions or behaviours (Robinson et al., 2013; Wei, Hayden, Kutcher, Zygmunt, & McGrath, 2013). Reviews of intervention studies have so far been unable to draw firm conclusions about their effectiveness (Furnham & Hamid, 2014; Sørensen, 2013; Wei et al., 2013). The reviewers identified issues with the quality of the research papers published; the amount of variation in programmes and research methods used; and inconclusive or contradictory results (Furnham & Hamid, 2014; Sørensen, 2013; Wei et al., 2013).

Two reviews of mental health literacy interventions aimed at children and young people have been conducted so far (Kelly et al., 2007; Wei et al., 2013). One review

provided a brief narrative summary (Kelly et al., 2007), the other was a systematic review of school based interventions and included papers published up to 2010 (Wei et al., 2013). Kelly and colleagues (2007) stated that there was little evidence about what components of intervention programmes were effective in educating young people about mental health. They recommended that “lessons from past interventions . . . are used to guide the development and evaluation of more effective approaches” and suggested that seven components of a “successful campaign” identified in a review of mass media health campaigns could be useful for designing future interventions (Kelly et al., 2007, p.S29). These components included: carrying out preliminary research with the intended audience via focus groups or qualitative research to ensure that messages are tailored appropriately; building the campaign on a proven theoretical base; dividing the audience into relatively homogenous groups; using appropriate media formats to communicate the message; and evaluating the impact on attitudes and behaviours (Kelly et al., 2007).

The systematic review by Wei and colleagues (2013) concluded that there was insufficient substantive evidence to suggest that these interventions were having a positive impact on knowledge, attitudes or behaviours. The reviewers also reported that the overall quality of the evidence from studies evaluating school mental health literacy programs was low (Wei et al., 2013). They recommended that future research should: “address the complexities of the school setting” (p. 118) by using designs such as process evaluations and qualitative research; develop validated measurement tools to ensure the accurate measuring of outcomes; and be based on methodologically sound designs such as well conducted randomised controlled trials to provide the highest level of evidence about interventions that work. They specified that future research needs to

appropriately control for confounders, report on attrition and determine potential biases to observed outcomes (Wei et al., 2013).

Jorm (2012) also acknowledged in a recent discussion paper that although many education based mental health literacy programmes have now been implemented throughout the world, there is limited evidence that they are effective so far as few have been rigorously evaluated. He also recommended that there needs to be more emphasis in future on changing actions rather than beliefs and suggested that mental health first aid programmes may be a more effective intervention (Jorm, 2012). The aim of these mental health first aid programmes is to train members of the public to support someone who is developing a mental health difficulty or experiencing a crisis until professional help is obtained. Since the research papers included in these reviews were published, the concept of mental health literacy has become increasingly known internationally and has become a focus for national policies aimed at improving public mental health (Bagnell & Santor, 2012; Potvin-Boucher, Szumilas, Sheikh, & Kutcher, 2010; Potvin-Boucher & Malone, 2014). This means that government funds will potentially be spent on implementing interventions to improve public mental health literacy. For example, here in the United Kingdom, improving mental health literacy has been recommended as one way that service providers can improve children and young people's mental health and wellbeing (NHS England, 2015; Public Health England, 2015). It would therefore be useful to know whether the recommendations made by Jorm (2012), Kelly and colleagues (2007) and Wei and colleagues (2013) are reflected in recent research.

1.1.1. Objectives

This systematic literature review aims to identify whether research trials published since 2010 assessing education based mental health literacy interventions provide evidence for their effectiveness at increasing mental health literacy in children and young people. Mental health literacy has been measured by research trials in this area as three broad components, these are knowledge, attitudes and help seeking in relation to mental health.

1.2. Method

1.2.1. Inclusion Criteria

A PICO (population, intervention, comparator and outcome) Table was used to develop the inclusion criteria for this systematic review (Boland, Cherry and Dickson, 2014). The population was identified as children and young people in education settings, specifically high schools¹, colleges or universities. The intervention was defined as mental health literacy programmes aimed at increasing knowledge, attitudes and help seeking in relation to mental health. The comparator was defined as a placebo intervention, teaching as usual or no intervention. The outcome was defined as an increase in mental health literacy evidenced by a quantitative questionnaire demonstrating an increase in knowledge, attitudes or help seeking in relation to mental health. See Appendix B for a copy of the PICO Table. Papers were included in this review if they met the following criteria:

- 1) Papers were published in 2010 or later and not included in a previous systematic review;

¹ The study by Bella-Awusah et al., 2014, conducted in Nigeria, specified the participant sample as aged 10-18 years and the setting as secondary school. It may be that the age of transition from primary to secondary education includes children age 10 in that region.

- 2) The intervention was conducted at an educational setting for children or young people (school, college, university);
- 3) The intervention was provided for the children and young people rather than staff members;
- 4) Outcomes measured were at least one of the following: knowledge, attitudes or help seeking in relation to mental health.

The first criterion was defined because papers prior to 2010 have been systematically reviewed; this review aims to identify any improvements or changes in outcomes from research published since that point. Criteria 2 to 4 ensure that the interventions included are appropriate for answering the review question and create some homogeneity.

1.2.2. Exclusion Criteria

Papers were excluded from the review if a full article was not available and contact with the author was not possible. For example, only the abstract was available, the full article was not yet published and no contact details were provided for a corresponding author.

1.2.3. Search Strategy

To identify relevant research papers, searches were conducted between November 2015 and April 2016 using the following databases: PubMed, PsycInfo, Academic Search Complete, Scopus and Web of Science. The search terms used were: “child*” or “adolescent*” or “adolescence or teenage*” or “youth” or “young person*” or “young people*” and “mental health literacy” or “health literacy” and “mental*”. Boolean operators were also used, e.g. AND, OR. The reference lists of relevant reviews and research papers were also searched by hand to identify additional papers.

See Figure 1 for a flow diagram of studies identified and excluded at each stage of the search strategy. Initial searches returned 1072 articles, 867 were removed as they were identified as duplicates or erroneous results. This left 208 articles. The abstracts were screened for eligibility and 177 of these were removed as they did not meet the inclusion criteria. The full text of 28 articles were reviewed, 18 did not meet the inclusion criteria and one met the exclusion criteria. Nine articles remained and were included in the review.

1.2.4. Reporting Standards

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were used to report this literature review (Moher, Liberati, Tetzlaff, Altman, & The, 2009). The Consolidated Standards of Reporting Trials (CONSORT) statement and accompanying extension to cluster randomised trials were used to assist with reading the randomised controlled trial papers (RCTs) and appraising the reporting standards (Campbell, Piaggio, Elbourne, & Altman, 2012; Schulz, Altman, & Moher, 2010). To facilitate a similar level of consideration for the non-randomised trials, the Transparent Reporting of Evaluations with Nonrandomized Designs (TREND) statement was used to serve the same purpose as this tool was designed as a CONSORT equivalent (Des Jarlais, Lyles, & Crepaz, 2004). To indicate the reporting standard in each paper, a percentage score was calculated using the CONSORT and TREND checklists. See Appendix C for the reporting standards scoring Table.

1.2.5. Effectiveness of the Intervention

The Centre for Reviews and Dissemination guidance (2009) recommends that when health education intervention studies are reviewed, the effectiveness of each intervention should be assessed in addition to appraising the quality of studies. A

specific tool designed for this purpose was considered (Van Driel et al., 1997), however, much of the content overlapped with that covered in the TREND statement checklist (Des Jarlais, 2004) and so this tool was not used. Details of the intervention designs, content and methods of delivery used are provided in Appendix D.

1.2.6. Quality of the Studies

The tool chosen for assessing quality in this review was the Effective Public Health Practice Project Quality Assessment Tool (EPHPP; Thomas, Ciliska, Dobbins, & Micucci, 2004). The Cochrane Collaboration Risk of Bias Tool was also considered (Higgins et al., 2011). However, the EPHPP was chosen as it has been evidenced as demonstrating higher levels of inter-rater agreement and its psychometric properties have been more thoroughly validated in comparison with the Cochrane tool (Armijo-Olivo, Stiles, Hagen, Biondo & Cummings, 2012). The overall quality appraisal outcome for each study is presented and discussed in the results section alongside the study characteristics. The EPHPP tool assesses quality based on selection bias, study design, confounders, blinding, data collection, withdrawals and dropouts. A rating of strong, moderate or weak is given to each of the areas and an overall rating is assigned according to how the study was rated in all of the sections. For a full Table summarising the assessments for each section see Appendix E.

1.2.7. Data Extraction

Data were extracted from each article using the headings detailed in Tables 2 to 6. This was carried out independently by the researcher. The reporting, quality appraisal and data extraction tables were cross checked by the research supervisor.

1.3. Results

1.3.1. Study Characteristics

Nine studies were included in this review. The study characteristics are summarised in Table 1. Sampling was largely convenience based. All were pre test post test designs and seven studies also measured changes at follow up (McCluckie et al., 2014; Oijo et al., 2015, Perry et al., 2014; Pinto-Foltz et al., 2014; Reavley et al., 2014, Robinson et al., 2014; Skre et al., 2013). Four studies were cluster RCTs (Milin et al., 2016; Perry et al., 2014; Pinto-Foltz et al., 2014; Reavley et al., 2014), three were non-randomised designs with an intervention and control group (Bella-Awusah et al., 2014; Robinson et al., 2014; Skre et al., 2013) and two measured an intervention group only (McCluckie et al., 2014; Oijo et al., 2015).

Sample sizes ranged between $N = 118$ for a one group, no comparison design (Oijo et al., 2015) to $N = 1070$ for a non-randomised controlled trial with $n = 520$ in the intervention groups and $n = 550$ in the control groups (Skre et al., 2013). Participants receiving the interventions were high school students for eight of the studies and people residing at university campuses for one study. Participants for the eight school based studies were all aged between 10 and 19 years. The university study gave a mean age of 24 years ($SD = 9$). Seven studies were mixed gender, one included only male participants and one included only female participants.

Eight studies delivered the intervention in a school classroom environment (Bella-Awusah et al., 2014; McCluckie et al., 2014, Milin et al., 2016; Oijo et al., 2015; Perry et al., 2014; Pinto-Foltz et al., 2014; Robinson et al., 2014; Skre et al., 2013) with the length of delivery varying between three hours and three full days. Three of these were unique interventions designed by the researchers. The remaining five studies used

pre-existing intervention packages and two of the studies in Canada used the same intervention package. The university based study used a whole of campus intervention that exposed participants to information about mental health using a variety of media for approximately one year (Reavley et al., 2014).

All studies gave at least a brief summary of the intervention content, methods of delivery and duration (see Appendix D). Notably, all studies described the interventions as being delivered using a mix of activities, group discussion and information giving. Some authors also highlighted issues relating to the method of intervention delivery. For example, one study by Bella-Awusah and colleagues (2014) indicated that they used an “education method only” without involving “contact” with someone who had experience of mental health problems (p.213). Contact can refer to either a video clip or real life contact with a person who has experienced mental health problems providing their story (Corrigan et al., 2001); this has been indicated as a method of improving attitudes towards mental health that may be more effective than using education based methods alone (Corrigan et al., 2001). Three of the studies included in this review clearly described using contact as a method of intervention delivery (McCluckie et al., 2014; Milin et al., 2016; Robinson et al., 2009). All three of these interventions indicated improvements in attitudes towards mental health, although this was not notably different to studies that did not report including contact in the programme delivery, stating only that they had used multimodal methods of delivery (Oijo et al., 2015, Perry et al., 2014, Pinto-Foltz et al., 2011).

To measure the effectiveness of interventions at increasing mental health literacy, research outcomes broadly focused on three areas. These were: 1) acquisition of mental health knowledge, 2) improvements in attitudes or levels of stigma towards

mental health and 3) changes in knowledge or intentions about help seeking for mental health difficulties. Some studies only measured one or two of these outcome areas. Eight studies measured both mental health knowledge and stigma or attitudes (Bella-Awusah et al., 2014; McCluckie et al., 2014, Milin et al., 2016; Oijo et al., 2015; Perry et al., 2014; Pinto-Foltz et al., 2011; Robinson et al., 2010; Skre et al. 2013). Help seeking was measured by five studies (Oijo et al., 2015; Perry et al., 2014; Reavley et al., 2014; Robinson et al., 2010; Skre et al., 2013). Statistically significant increases in mental health knowledge following intervention were reported by seven studies (Bella-Awusah et al., 2014; McCluckie et al., 2014, Milin et al., 2016; Oijo et al., 2015; Perry et al., 2014; Pinto-Foltz et al., 2011; Skre et al. 2013). Statistically significant improvements in stigma or attitudes were reported by six studies (McCluckie et al., 2014, Milin et al., 2016; Oijo et al., 2015; Perry et al., 2014; Robinson et al., 2010; Skre et al., 2013). Three studies reported a statistically significant increase in help seeking knowledge or intentions (Oijo et al., 2015; Robinson et al., 2010; Skre et al., 2013). The effect sizes of these changes ranged from trivial to large.

All of the studies were quantitative designs and used psychometric questionnaires to measure outcomes. The tools used varied considerably, with only the two Canadian studies sharing the same outcome measure that was provided with the intervention package (McCluckie et al., 2014, Milin et al., 2016). Four other studies also used surveys specifically designed to measure the intervention packages being delivered (Oijo et al., 2015; Pinto-Foltz et al., 2014; Reavley et al., 2014; Skre et al., 2013). Primary outcome measures for the three remaining studies were reported as modified versions of questionnaires used in previous research, adapted by the researchers to measure the content being delivered (Bella-Awusah et al., 2014;

Robinson et al., 2010; Perry et al., 2014). The questionnaires were named in the research reports as the UK Pinfold Questionnaire (Pinfold et al., 2003), the Mental Health First Aid survey (Kitchener & Jorm, 2002), the Depression Literacy and Stigma scales (Griffiths, Christensen, Jorm, Evans, & Groves, 2004) and the Inventory of Attitudes Towards Seeking Mental Health Services (Corey, Mackenzie, Knox, Gekoski, & Macaulay, 2004). One of the studies used two outcome measures (Perry et al., 2014).

Reporting standards were calculated as percentages based on the number of items included in the reports from the CONSORT and TREND checklists (Campbell et al., 2012; Des Jarlais et al., 2004; Schulz et al., 2010). Of the nine studies included in this review, four reported more than 60% of the information outlined in these checklists (Milin et al., 2016; Perry et al., 2014, Reavley et al., 2014; Skre et al., 2013). See Appendix C for details of the checklist items present for each study. Common information that was missing included:

- how the sample size was determined and stopping rules;
- methods of assignment to group conditions;
- whether blinding took place and if so, details of who was blinded and the strategy used;
- details of deviations from the study protocol;
- comparison between the study population and target population of interest;
- the number of participants included in each analysis and indication of the analysis strategy;
- effect sizes and confidence intervals to indicate precision;

- details of ancillary analyses; and
- consideration of unintended effects of the intervention on participants.

Based on appraisal using the EPHPP quality assessment tool, two studies were rated as moderate quality (Perry et al., 2014; Skre et al., 2013) and seven were rated as weak quality (Bella-Awusah et al., 2014; McCluckie et al., 2014, Milin et al., 2016; Oijo et al., 2015; Pinto-Foltz et al., 2011; Reavley et al., 2014; Robinson et al., 2010). No studies were rated as high quality. The most common areas of concern for the studies rated as weak were selection bias, confounders, blinding and data collection.

1.3.2. Effectiveness at Improving Mental Health Knowledge

Eight studies measured mental health knowledge as a primary outcome. Table 2 details the test statistics and confidence intervals or effect sizes where available, for the seven studies reporting statistically significant improvements (Bella-Awusah et al., 2014; McCluckie et al., 2014, Milin et al., 2016; Oijo et al., 2015; Perry et al., 2014; Pinto-Foltz et al., 2011; Skre et al., 2013). Of these, two were quality assessed as moderate (Perry et al., 2014; Skre et al., 2013), the remaining six were quality assessed as weak. Two papers reported effect sizes (McCluckie et al., 2014, Perry et al., 2014), in five studies effect sizes were not reported. Effect sizes were calculated and interpreted by the reviewer where possible based on guidance from Lenhard and Lenhard (2016). See Appendix F for the effect size calculations used. One study reported no differences in mental health knowledge following intervention (Robinson et al., 2010).

Perry and colleagues (2014) indicated significant improvements in mental health knowledge with a medium effect size ($d = .60$) immediately post test, reducing to a small effect size ($d = .37$) at 6 month follow up. This study reported 64% of the

recommended CONSORT checklist information and was quality assessed as moderate. Skre and colleagues (2013) measured knowledge using symptom profile recognition and open ended questions. Therefore, the data collection method was different to the other studies in this review. They measured outcomes at pre test and 3 month follow up (no immediate post test measure) and indicated a 25% to 30% increase in mean recognition scores. Calculation by the reviewer indicated that this was a medium effect size ($d = .67$). This study reported 67% of the recommended TREND checklist information and was quality assessed as moderate.

The following studies were rated as weak during quality assessment. McCluckie and colleagues (2014) reported an improvement in knowledge scores, with a large effect size ($d = .90$) immediately post intervention and medium effect size ($d = .73$) at 2 month follow up. This study reported 31% of the recommended TREND checklist information. Similarly, Bella-Awusah and colleagues (2014) indicated significant improvements in mental health knowledge post test, maintained at follow up and calculations by the reviewer indicated this was a large effect at both time points. This study reported 48% of the recommended TREND checklist information. Calculations of effect sizes for the results reported by Milin and colleagues (2016) and Pinto-Foltz and colleagues (2011) indicated small effects. It was not possible to calculate an effect size for the findings reported by Oijo and colleagues (2015) based on the information included in the report.

1.3.3. Effectiveness at Improving Attitudes and Stigma

Eight studies measured attitudes or stigma towards mental health (Bella-Awusah et al., 2014; McCluckie et al., 2014, Milin et al., 2016; Oijo et al., 2015; Perry et al., 2014; Pinto-Foltz et al., 2014; Robinson et al., 2010; Skre et al., 2013). Table 3 details

the test statistics, confidence intervals and effect sizes where available, for the six studies that reported significant improvements. Five studies reported significant improvements (McCluckie et al., 2014, Milin et al., 2016; Oijo et al., 2015; Robinson et al., 2010; Skre et al., 2013) and one reported “marginally significant” improvements post intervention (Perry et al., 2014). Of these, two studies were assessed as moderate quality (Perry et al., 2014; Skre et al., 2013) and three reported effect sizes (McCluckie et al., 2014; Perry et al., 2014; Robinson et al., 2010). Two studies reported no differences in attitudes and stigma towards following intervention (Bella-Awusah et al., 2014; Pinto-Foltz et al., 2014).

Perry and colleagues (2014) reported a marginally significant ($p = .08$) decrease in stigma scores at post test with a small effect size ($d = .46$) and a significant decrease at follow up with a medium effect size ($d = .62$). Skre and colleagues (2013) also reported a statistically significant decrease in prejudice belief scores at follow up but did not report an effect size. Calculation by the reviewer indicated a small effect size ($d = .32$). The studies by McCluckie and colleagues (2014), Milin and colleagues (2016) and Robinson and colleagues (2010) were rated as weak during quality assessment. McCluckie reported a significant increase in attitude scores at post test with a small effect size ($d = .25$), maintained at follow up with a trivial effect size ($d = .18$). Robinson and colleagues (2010) measured attitudes and stigma separately and reported a significant increase in attitude scores maintained at follow up with a small effect size ($d = .38$) for the overall mean change and a significant decrease in stigma scores with a trivial effect size ($d = .14$) for the overall mean change. Milin and colleagues (2016) reported a significant increase in attitude scores in the intervention group at post test. Calculation by the reviewer indicated a small effect size ($d = .29$).

One study reported large changes in attitudes towards mental health, maintained at follow up (Oijo et al., 2015), based on participants answers to a question about whether they would help a peer experiencing a mental health problem. Two examples of differing mental health difficulties were given and changes in the percentage of participants selecting the answer “I would talk to someone who would be trusted” (p.577) were used to demonstrate an improvement in this aspect of mental health literacy. It was not possible to calculate the size of effect for these findings based on the information in the report. This study was quality assessed as weak and had reported 38% of the recommended TREND checklist information.

1.3.4. Effectiveness at Improving Help Seeking

Five studies measured help seeking knowledge or intentions. Table 4 details the test statistics, confidence intervals and effect sizes where available, for the three studies that reported significant increases in mental health help seeking knowledge or intentions (Oijo et al., 2015; Robinson et al., 2010; Skre et al., 2013). Of these, one study was quality assessed as moderate (Skre et al., 2013). This study measured spontaneous mention of places to seek help (indicating knowledge of available options) and reported a small interaction effect whereby the number of places mentioned increased following the intervention (Skre et al., 2013). They noted however that no changes occurred for participants who had not indicated any help seeking places at baseline, only those who had indicated some options at baseline showed an increase.

The other two studies were rated as weak during quality assessment. They reported significant changes in help seeking as percentages of participants answering one question about whether they would seek help and both of these reported large changes in the number of participants reporting intentions to seeking help (Oijo et al.,

2015; Robinson et al., 2010). Robinson and colleagues (2010) reported an odds ratio for these changes based on the logistic regression of 3.48 (95% CI = 1.93-6.29, $p < .001$), indicating that the intervention group were 3.48 times more likely to seek help than the comparison group post test. Two studies reported no changes in help seeking following intervention (Perry et al., 2014; Reavley et al., 2014).

1.3.5. Secondary Outcomes

Six studies also included secondary outcome measures or explored interactions between the primary outcome variables (Bella-Awusah et al., 2014; Perry et al., 2014; Reavley et al., 2014; Milin et al., 2016; Skre et al., 2013; Robinson et al., 2010). Significant findings are detailed in Table 5. Skre and colleagues (2013) reported significant interaction effects between age, gender, prejudice beliefs and knowledge about mental health care options. They reported that an increase in prejudice beliefs correlated with not mentioning any options for seeking mental health care (Skre et al., 2013). Milin and colleagues (2016) reported that for each unit increase in mental health knowledge score, students had a correlated increase in positive attitudes towards mental illness of 0.34. Robinson and colleagues (2010) assessed risk of self harm or suicidal ideation as part of the data collection. This information was then used to refer students for further mental health support. Social distance, psychological distress and alcohol misuse were also measured as secondary outcomes, no significant changes were reported for these (Bella-Awusah et al., 2014; Perry et al., 2014; Reavley et al., 2014).

1.4. Discussion

This systematic review of nine intervention studies published since 2010 aimed to identify whether mental health literacy interventions provided in educational settings to children and young people produced significant improvements in the three main

concepts used to measure mental health literacy. These were acquisition of knowledge about mental health conditions, improvement in attitudes or stigma towards mental health and improvement in help seeking knowledge or intentions. The main findings were that seven out of eight studies reported statistically significant improvements in knowledge about mental health difficulties, six out of eight studies reported statistically significant improvements in attitudes and stigma towards mental health and three out of five studies reported statistically significant improvements in help seeking knowledge or intentions. Effect sizes ranged from trivial to large, with larger effects reported for increases in knowledge and smaller effects reported for improvements in attitudes and stigma. The magnitude of improvements in help seeking were only available from one study (Robinson et al. 2010), reported as an odds ratio indicating that the intervention group were 3.48 times more likely to seek help than the comparison group. However, quality assessments indicated that only two of the nine papers were at a moderate quality level (Skre et al., 2013; Perry et al., 2014).

These two papers reported a medium effect on acquisition of mental health knowledge (Skre et al., 2013; Perry et al., 2014). Perry and colleagues (2014) reported a reduction to a small effect at six month follow up. They both reported small effects on attitudes or stigma post intervention, with Perry and colleagues (2014) reporting an increase to a medium effect at follow up. A small increase in spontaneous mentioning of places to seek help was reported by Skre and colleagues (2013), however this increase only occurred for participants who had mentioned some help seeking options at baseline. Perry and colleagues (2014) reported no significant change in attitudes towards help seeking following intervention.

The other seven studies reviewed were quality assessed as weak, limiting the generalisability of their findings (Bella-Awusah et al., 2014; McCluckie et al., 2014, Milin et al., 2016; Oijo et al., 2015; Pinto-Foltz et al., 2011; Robinson et al., 2010). The weak quality ratings for the majority of the papers reviewed were related to selection bias, confounders, blinding and data collection. These areas of the assessment were most commonly rated as weak because information about these aspects of the research was missing from the reports. For five of the studies, 50% or less of the recommended information from the CONSORT and TREND reporting guidance was included in the published research reports (Bella-Awusah et al., 2014; McCluckie et al., 2014, Milin et al., 2016; Oijo et al., 2015; Pinto-Foltz et al., 2011; Robinson et al., 2010; Skre et al., 2013).

These findings are similar to other reviews focused on mental health literacy interventions in respect of the quality of research reporting, the strength and size of the findings; the disparity between the interventions assessed and the outcome measures used (Wei et al., 2013, Furnham & Hamid, 2014). Furthermore, it does not appear that adjustments have been made to the design and evaluation of interventions as yet based on previous review recommendations (Jorm, 2012; Kelly et al., 2007; Wei et al., 2013). Conducting preliminary research with the intended audience to aid the design of interventions, using a proven theoretical base to guide the intervention and research design and using rigorous, well conducted evaluation of the outcomes would have improved the quality of the research papers reviewed.

Only two of the studies reviewed mentioned theoretical models or theories (Pinto-Foltz et al., 2011; Skre et al., 2013). Of these, only Skre and colleagues (2013) stated that the research study or intervention was based on a model or theory. The

intervention assessed by Skre and colleagues (2013) was based on Antonovsky's theory of salutogenesis, meaning that it was focused on health giving or beneficial factors rather than risk reduction or disease prevention (Antonovsky, 1996). Therefore, the intervention was an empowerment based health promotion design (Skre et al., 2013). The authors referred to a meta-analysis of reviews focused on the efficacy of mental health promotion programmes which identified the characteristics of interventions that were more effective (Weare & Nind, 2011). Weare and Nind (2011) stated that the programmes most likely to evidence effective outcomes were those focusing on positive mental health and engaging students in practical tasks and activities. Despite the intervention assessed by Skre and colleagues (2013) being based on a positive mental health approach, the largest area of change in their findings was improvement in knowledge, the effect on attitudes was small and knowledge of help seeking changed only for participants with knowledge of help seeking options at baseline.

All of the authors indicated issues relating to the reliability and validity of the scales being used to measure mental health literacy (Bella-Awusah et al., 2014; McCluckie et al., 2014; Milin et al., 2016; Oijo et al., 2015; Perry et al., 2014; Pinto-Foltz et al., 2014; Reavley et al., 2014; Robinson et al., 2014; Skre et al., 2013). Wei and colleagues (2015) have recently conducted a scoping review to provide information on the mental health literacy measures that have been developed so far and facilitate future research assessing the reliability and validity of the measures available. Once further research has been conducted to identify tools that are reliable and valid for measuring this construct, this may help to improve the accuracy and generalisability of research assessing the efficacy of interventions aimed at improving mental health literacy.

Therefore, it remains unclear whether variations in the intervention designs and methods of delivery reviewed here have impacted on the results due to limitations in the research methods, reporting standards and tools available to measure outcomes. A wider meta-analysis of research reviews found that general mental health interventions with children and young people generally have better outcomes if they teach skills rather than information, start early with young children, continue for a lengthy period of time, focus on positive mental health, engage students in practical tasks and activities, take a whole-system based approach and implement the intended intervention fully and accurately (Weare & Nind, 2011). Research reviews focused on the effectiveness of suicide prevention and stigma reduction have also evidenced that multimodal and multilevel interventions are more effective than single level interventions (Mann et al., 2005; Niederkrotenthaler, Reidenberg, Till, & Gould, 2014). Multilevel means focusing on providing the intervention to several levels of “people or entities” (Gidron, 2013, p.1270). This could include the young people, education staff, parents, peers groups and primary health care providers. Gulliver, Griffiths, & Christensen (2010) suggested that a person’s context and systems influence whether or not they decide to seek help and suggested that social support and encouragement from others aid the help seeking process. As such, a clearer focus in future mental health literacy intervention research on the methods and levels of delivery would help to clarify what types of education based intervention are most effective.

Currently, the evidence remains limited in relation to the effectiveness of mental health literacy interventions at impacting on attitudes, intentions and behaviours, however, recent recommendations suggest that increasing public mental health literacy should be a priority focus for national policies (Jorm, 2012). If interventions such as

these are to be provided to children and young people in schools, colleges and universities, is important that lessons from past campaigns and recent reviews are used in the design of future interventions (Kelly et al., 2007; Niederkrotenthaler et al., 2014; Weare & Nind, 2011). Perhaps alternative designs, or foci for education based interventions that teach skills rather than knowledge such as the mental health first aid programmes described by Jorm (2012) would yield more useful results. It is yet to be established what type of mental health literacy interventions will best achieve the intended outcomes of improving public recognition of, attitudes towards and help seeking for mental health difficulties. Rigorously designed and conducted research assessing interventions that are based on a proven theoretical model are needed to clarify whether these interventions can result in clinically significant changes in mental health literacy.

1.4.1. Limitations

It is possible that some recently published research studies were not identified during the search process. It is also possible that the citation and reporting of the review outcomes were unintentionally biased by the researcher. Although complete cross-checking of data extraction and quality appraisal by two researchers and discussions to establish inter-rater agreement is preferable to account for potential bias, this was not feasible within the scope of the project. To account for this, sections of the original articles, the data extracted and the quality appraisals made by the researcher were cross-checked by a research supervisor from the university.

1.4.2. Clinical Implications

It is currently not clear that mental health literacy interventions achieve useful changes in attitudes towards and help seeking for mental health problems. Furthermore,

a recent report by the Children's Commissioner for England (2016) indicated that if the number of young people seeking help from mental health support services in England increased, service providers would currently be hampered in their capacity to respond. Services in areas of the world that have less resources available are equally, if not more likely, to struggle to respond to a surge in demand. Perhaps then it would be more useful for policy makers and intervention providers to focus on means of using the resources available to improve mental health for young people. For example, teaching skills for maintaining positive mental health (Weare & Nind, 2011) , teaching first aid skills for assisting people experiencing distress or crisis (Jorm, 2012) and starting early with young children (Weare & Nind, 2011).

1.4.3. Conclusions and Recommendations

Although most of the papers reviewed indicated statistically significant findings, issues relating to the quality and reporting of findings mean that the majority of the findings are not generalisable. Therefore, it remains unclear whether mental health literacy interventions delivered in education settings to young people are effective at improving knowledge, attitudes and help seeking in relation to mental health.

Recommendations are made that future research in this area is designed and reported in line with relevant quality assessment and reporting criteria. Drawing on guidance such as the CONSORT and TREND statements and consideration of quality assessment criteria used by appraisal tools such as the Effective Public Health Practice Project tool or the Cochrane Risk of Bias tool when reporting findings would help future reviews to establish whether intervention effects are reliable and generalisable. This would then allow the significance of findings to be considered.

Wei and colleagues (2015) published a review of available mental health literacy measures recently to facilitate future research validating these tools. Policy makers and education providers looking to implement education based mental health literacy interventions as a strategy to improve public mental health require interventions that are effective at achieving the intended outcomes. To provide suitably evidenced interventions that meet the needs of the providers and intended recipients, further research is needed to identify:

- reliable and valid measures of mental health literacy for this population suitable for evidencing intervention effectiveness; and
- what methods and levels of mental health literacy intervention delivery are most effective.

Clear identification of appropriate theoretical models as a base for intervention designs and evaluative research would also help increase the usefulness and quality of findings reported in this area. In spite of the methodological limitations mentioned, the notable level of interest in this topic is reflected in the number of new studies recently published from varied international locations. Increasing our understanding of what intervention methods and designs are most effective for improving children and young peoples' knowledge, attitudes and intended actions in response to mental health problems is an important area of contribution for future research.

1.5. References

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1.6. Tables and Figures

Table 1. Study Characteristics

Study and Location	Sample Size, Age and Gender	Design	Duration, Mode of Delivery and Intervention	Primary Outcome Measures	Mental Health Literacy Outcomes [◊]			Reporting Standard and Quality [#]
					<i>Knowledge</i>	<i>Attitude/ Stigma</i>	<i>Helpseeking</i>	
Bella-Awusah et al. (2014), Nigeria.	<i>N</i> = 154, Age 10-18, Mixed.	Quasi experimental, Pre and post, 1 intervention group (<i>n</i> = 78), 1 control group (<i>n</i> = 76).	3 hours, Classroom, Unique design.	“UK Pinfold Questionnaire” (Pinfold et al., 2003) modified.	↑	–	N/A	48%, Weak.
Mcluckie et al. (2014), Canada.	<i>N</i> = 265, Grade 9*, Mixed.	Single Group, Pre, post, 2 month follow up, 1 intervention group (<i>N</i> = 265).	10-12 hours, Classroom, The guide.	“The guide” knowledge and attitude survey.	↑	↑	N/A	31%, Weak.
Milin et al. (2016), Canada.	<i>N</i> = 519, Mean age 16.5 (SD=0.98)**, Mixed.	Cluster RCT, Pre and post, 17 intervention groups (<i>n</i> = 362), 7 control groups (<i>n</i> = 157).	6 hours, Classroom, The curriculum guide.	“The curriculum guide” knowledge and attitudes survey.	↑	↑	N/A	84%, Weak.
Oijo et al. (2015), Japan.	<i>N</i> = 118, Age 14-15, Mixed.	Single Group, Pre, post, 3 month follow up, 1 intervention group (<i>N</i> = 118).	2 x 50 minutes, Classroom, Unique design.	Own questionnaire.	↑	↑	↑	38%, Weak.
Perry et al. (2014), Australia.	<i>N</i> = 379, Age 13-16, Mixed.	Cluster RCT, Pre, post, 6 month follow up, 5 intervention groups (<i>n</i> = 207), 5 control groups (<i>n</i> = 173).	4-8 weeks, Classroom, Headstrong.	Depression Literacy Scale modified and Depression Stigma Scale (Griffiths et al., 2004), Inventory of Attitudes Towards Seeking Mental Health Services	↑	↑	–	64%, Moderate.

				(Mackenzie et al., 2004).				
Pinto-Foltz et al. (2011), USA.	<i>N</i> = 156, Age 13-17, Female.	Cluster RCT, Pre, post, 4 and 8 week follow up, 2 intervention groups (<i>n</i> = 95), 2 control groups (<i>n</i> = 61).	1 hour, Classroom, In Our Own Voice.	“In Our Own Voice” knowledge measure (Wood & Wahl, 2006), 7-item acceptability scale Attribution questionnaire subscale (Watson, 2004) modified.	↑	–	N/A	48%, Weak.
Reavley et al. (2014), Australia.	<i>N</i> = 767, Mean age 24 (SD = 9)**, Mixed.	Cluster RCT, Pre, post, 1 year follow up, 6 intervention groups (<i>n</i> = 426), 3 control groups (<i>n</i> = 341).	1 year, Campus wide, MindWise.	Own questionnaires.	N/A	N/A	–	86%, Weak.
Robinson et al. (2010), Australia.	<i>N</i> = 246, Age 14-16, Male.	Non-randomised design, Pre, post, 3 month follow up, 1 intervention group (<i>n</i> = 118), 1 control group (<i>n</i> = 128).	2 hours, Classroom, Unique design.	MHFA training questionnaire (Kitchener & Jorm, 2002) modified.	–	↑	↑	50%, Weak.
Skre et al. (2013), Norway.	<i>N</i> = 1070, Age 12-17, Mixed.	Non-randomised cluster controlled trial, Pre, post, 2 month follow up, 1 intervention group (<i>n</i> = 520), 2 control groups (<i>n</i> = 550).	3 days, Classroom, Mental health for everyone.	Own 66-item questionnaire.	↑	↑	↑	67%, Moderate.

Note: *only school year provided. **only mean age and standard deviation (SD) provided. [◇]↑ = statistically significant improvement, – = no change, N/A = not assessed. [#]Reporting standard is the percentage of CONSORT or TREND checklist items reported, calculated using 22 comparable items (Campbell et al., 2012; Des Jarlais et al., 2004; Schulz et al., 2010). The EPHPP tool was used to appraise quality (Armijo-Olivo, Stiles, Hagen, Biondo, & Cummings, 2012).

Table 2. Analyses, test statistics and confidence intervals for intervention effectiveness at improving mental health knowledge

Study and Location	Analyses	Primary Outcome - Knowledge	
		<i>Post Intervention</i>	<i>Follow up</i>
Bella-Awusah et al. (2014), Nigeria.	Linear random intercept models	Significant increase in mean knowledge score in intervention group compared to control group post intervention, adjusted mean difference = 1.25, (95% CI = 0.74-1.76, $p < 0.001$). Effect size not reported. Effect Size d_{ppc2} sensu (Morris, 2008) calculated by reviewer*. Indicated a large effect size (d = 0.81).	Significant increase in mean knowledge scores in intervention group compared to control group at follow up, adjusted mean difference = 1.25, (95% CI = 0.74-1.76, $p < 0.001$). Effect size not reported. Effect Size d_{ppc2} sensu (Morris, 2008) calculated by reviewer*. Indicated a large effect size (d = 0.86).
Mcluckie et al. (2014), Canada.	Paired t-tests. Bonferroni correction.	Significant increase in knowledge scores post intervention compared to baseline, $t(408) = 18.22, p < 0.001$. Large effect size (d = 0.90).	Significant increase in knowledge scores at follow up compared to baseline, $t(264) = 11.92, p < 0.001$. Medium effect size (d = 0.73).
Milin et al. (2016), Canada.	Multilevel model analyses. Bonferroni correction.	Significant time by condition effect on knowledge scores. $F(1, 521.74) = 20.09, p < .001$. Post hoc analyses showed a significant increase in knowledge scores in the intervention group. $F(1, 495.33) = 25.78, p < .001, \beta = .67$, (95% CI = 0.41-0.93). Effect size not reported. Effect Size d_{ppc2} sensu (Morris, 2008) calculated by reviewer*. Indicated a small effect size (d = 0.41).	No follow up measurement.

Oijo et al. (2015), Japan.	Wilcoxon signed rank, McNemar's test.	Significant increase in mean general mental health knowledge score. Post intervention score 5.8 compared to 5.1 at baseline, $p < .001$. Effect size not reported. Significant increase in mean knowledge of treatment score. Mean score 5.7 compared to 4.2 at baseline, $p < .001$. Effect size not reported. Calculation by the reviewer was not possible with the information reported.	Significant increase in mean general mental health knowledge score. Follow up score 5.8 compared to 5.1 at baseline, $p < .001$. Effect size not reported. Significant increase in mean knowledge of treatment score. Mean score 5.1 compared to 4.2 at baseline, $p < .001$. Effect size not reported. Calculation by the reviewer was not possible with the information reported.
Perry et al., (2014), Australia.	Logistic regression, mixed-models repeated measure, analysis of planned contrasts.	Significant increase in intervention group compared to control group. Mean score 2.19 points higher than for control group, $t(492) = 5.33, p < .05$. Significant interaction between group condition and measurement occasion, $F(2,494) = 14.63, p < .05$. Medium effect size ($d = .60$).	Significant increase in intervention group compared to control group. Mean score 1.39 points higher than for control group, $t(494) = 2.87, p < .05$. Significant interaction between group condition and measurement occasion, $F(2,494) = 14.63, p < .05$. Small effect size ($d = .37$).
Pinto-Foltz et al., (2011) USA.	Two multiple regressions.	Non-significant increase in knowledge scores post intervention for both groups, no between group difference.	Significant increase in intervention group score compared to control group at follow up. 1 point difference at 4 week follow up, 0.6 point difference at 8 weeks. Overall model adjusted $R^2 = .48$. $b = 1.85, \beta = .14$, (95% CI = -0.17 - $3.53, p = .03$). (*F and T statistics not reported). Effect size not reported. Effect Size d_{ppc2} sensu (Morris, 2008) calculated by reviewer*. Indicated a small effect size ($d = 0.26$).

Skre et al., (2013), Norway.	Linear mixed model regression using a logit link function, generalized estimating equation.	No immediate post test measurement.	Significant increase in intervention group symptom profile recognition scores at follow up compared to baseline. Intervention group baseline mean score 0.38, follow up mean score 0.64. Mean difference 0.27, (95% CI = 0.24-0.30, $p < .001$). Control group mean difference = 0.00, (95% CI = -0.03-0.03, $p .92$). Effect size not reported. Cohen's d calculated by reviewer*. Indicated a medium effect size ($d = 0.67$).
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Note: *For effect size calculations see Appendix F.

Table 3. Analyses, test statistics and confidence intervals for intervention effectiveness at improving mental health attitudes and stigma

Study and Location	Analyses Used	Primary Outcomes - Attitudes/Stigma	
		<i>Post Intervention</i>	<i>Follow up</i>
Mcluckie et al. (2014), Canada.	Paired t-tests, Bonferroni correction.	Significant increase in attitude scores post test intervention compared to baseline, pre test mean = 34.09 (SD = 5.48), post test mean = 35.34 (SD=5.82), $t(347) = 4.78, p < 0.001$. Small effect size ($d = 0.25$).	Significant increase in attitude scores at follow up compared to baseline, follow up mean = 34.26 (SD = 4.10), $t(233) = 2.73, p < 0.007$. Trivial effect size ($d = 0.18$).
Milin et al. (2016), Canada.	Multilevel model analyses, Bonferroni correction.	Significant time by condition effect on stigma scores, $F(1, 479.96) = 8.86, p < .01$. Post hoc analyses showed a significant increase in intervention group stigma scores compared to baseline, $F(1, 488.95) = 11.33, p < .01, \beta = .51$, (95% CI = .21-.81) and a non-significant decrease in comparison group scores. Effect size not reported. Effect Size d_{ppc2} sensu (Morris, 2008) calculated by reviewer*. Indicated a small effect size ($d = 0.29$).	No follow up measurement.
Oijo et al. (2015), Japan.	Wilcoxon signed rank, McNemar's test.	Significant increase in positive response to "willingness to help peers" question at post intervention compared with baseline, $p = .001$. Percentage who would help peers with mental health problems in depression example increased from 33% at baseline to 74.5% post test. Schizophrenia example increased from 47.9% at baseline to 86.2% post test.	Significant increase in percentage "willing to help peers" maintained at follow up. Depression example 72.3% and schizophrenia example 74.5% . $p = .001$.
Perry et al. (2014), Australia.	Logistic regressions, mixed-models repeated measures.	Marginally significant decrease in mean stigma scores post test compared to baseline, intervention group scores 2.59 points lower than control group	Intervention group scores decreased more than control group at follow up compared to baseline, 3.46 points

		<p>scores. $t(517) = 1.74, p.082.$ Interaction effect, $F(2,520) = 3.86, p<.05.$ Small effect size ($d = .46$).</p>	<p>between groups, $t(522) = 2.67, p<.05.$ Interaction effect, $F(2,520) = 3.86, p<.05.$ Medium effect size ($d = .62$).</p>
<p>Robinson et al. (2010), Australia.</p>	<p>Logistic regression, McNemar's test. Paired t-test.</p>	<p>Significant increase in intervention group mean attitude scores compared to control group post intervention. Baseline mean 3.6 (SD 1.5), post 4.4 (SD 1.5), $p<.001.$ Small effect size for overall mean change ($d = 0.38$).</p> <p>Significant decrease in intervention group mean stigma scores compared to control group post intervention. Baseline mean 8.7 (SD 5.4), post 7.7 (SD 5.4), $p.03.$ Trivial effect size for overall mean change ($d = 0.14$).</p>	<p>Significant increase in intervention group mean attitude scores compared to control group maintained at follow up, mean score 4.1 (SD 1.6). Small effect size for overall mean change ($d = 0.38$).</p> <p>Significant decrease in intervention group mean stigma scores compared to control group maintained at follow up, mean score 7.2 (SD 5.1). Trivial effect size for overall mean change ($d = 0.14$).</p>
<p>Skre et al. (2013), Norway.</p>	<p>Linear mixed model regression using a logit link function, generalized estimating equation.</p>	<p>No immediate post test measurement.</p>	<p>Significant decrease in prejudice belief mean scores post intervention in both intervention and control groups. Intervention group mean difference -0.29 (95% CI = -0.37- -0.22, $p<.0001$). Control group mean difference -0.10. (95% CI = -0.15-0.05, $p.02$). Effect size not reported. Cohen's d calculated by reviewer*. Indicated a small effect size ($d = 0.32$).</p>

Note: *For effect size calculations see Appendix F.

Table 4. Analyses, test statistics and confidence intervals for intervention effectiveness at improving help seeking knowledge or intentions

Study	Analyses Used	Primary Outcomes – Help seeking	
		<i>Post Intervention</i>	<i>Follow up</i>
Oijo et al. (2015), Japan.	Wilcoxon signed rank, McNemar’s test.	Significant increase in indication that would seek help in response to question “what would you do if you had the problem described” post intervention compared with baseline. Percentage who would seek help in the depression example increased from 46.8% at baseline to 87.2% post test. Schizophrenia example increased from 54.3% at baseline to 88.3% post test. <i>p</i> .001.	Significant increase in percentage willing to seek help maintained at follow up. Depression example 74.5% and Schizophrenia example 76.6%, <i>p</i> .001.
Robinson et al. (2010), Australia.	Logistic regression, McNemar’s test, paired t-test.	Significant increase in intervention group general willingness to seek help compared to control group at post test. Intervention group 44.9% at baseline increased to 66.9% post test. Logistic regression group 1 v 2 post test <i>p</i> = .001. Odds ratio group 1 v 2 post test 3.48 (95% CI = 1.93-6.29, <i>p</i> <.001). McNemars test for group 1 pre-post, <i>p</i> = 0.001. Significant increase in intervention group willingness to seek help from professional compared to control group at post test. Logistion regression group 1 v 2 post test <i>p</i> = .01. Odds ratio group 1 v 2 at post test 2.18 (95% CI = 1.16-4.10, <i>p</i> .01),	Significant increase in percentage of intervention group willingness to seek help maintained at follow up (64.4%), McNemars test for group 1 baseline to follow up <i>p</i> = .001. Significant increase in intervention group willingness to seek help from professional maintained at follow up (31.4%), McNemars test for group 1 baseline to follow up <i>p</i> = 0.001.

McNemars test for group 1 pre-post
 $p = 0.001$, intervention group 15.3% at
 baseline increased to 30.5% post test.

Skre et al.
 (2013),
 Norway.

Generalized estimating
 equation.

No immediate post test measurement.

Significant increase in knowledge about
 helpseeking. General estimating equation
 model used for spontaneous mentioning of
 places to seek help in open ended question.
 Measured as a group x time interaction.
 No effect found for those who mentioned
 no places at baseline. Significant effect
 found for time x group interaction for
 mentioning: home, self-help, internet,
 Exp(B) 2.39, 95% (CI = -1.25-4.56,
 $p < .01$); primary health care, Exp(B) 1.75,
 (95% CI = -1.20-2.57, $p < .01$); and
 specialist health care, Exp(B) 0.50, (95%
 CI = 0.36-0.69, $p < .001$).

Table 5. Secondary Outcomes

Study	Analyses Used	Secondary Outcomes
Milin et al. (2016), Canada.	Multilevel model analyses, Bonferroni correction.	Significant interaction between knowledge and attitudes towards mental illness, $F(1, 987.71) = 84.26, p < .001, \beta = 0.34, (95\% \text{ CI} = .27-.41)$.
Robinson et al. (2010), Australia.	Logistic regression, McNemar's test, paired t-test.	71 students (21%) identified as 'at risk' of deliberate self harm or suicidal ideation and referred for further support.
Skre et al. (2013), Norway.	Linear mixed model regression, generalized estimating equation.	Significant interaction between prejudice beliefs and 'no places mentioned' to seek help, $\exp(B) 1.69, p < .001, (95\% \text{ CI} = 1.46-1.96)$.

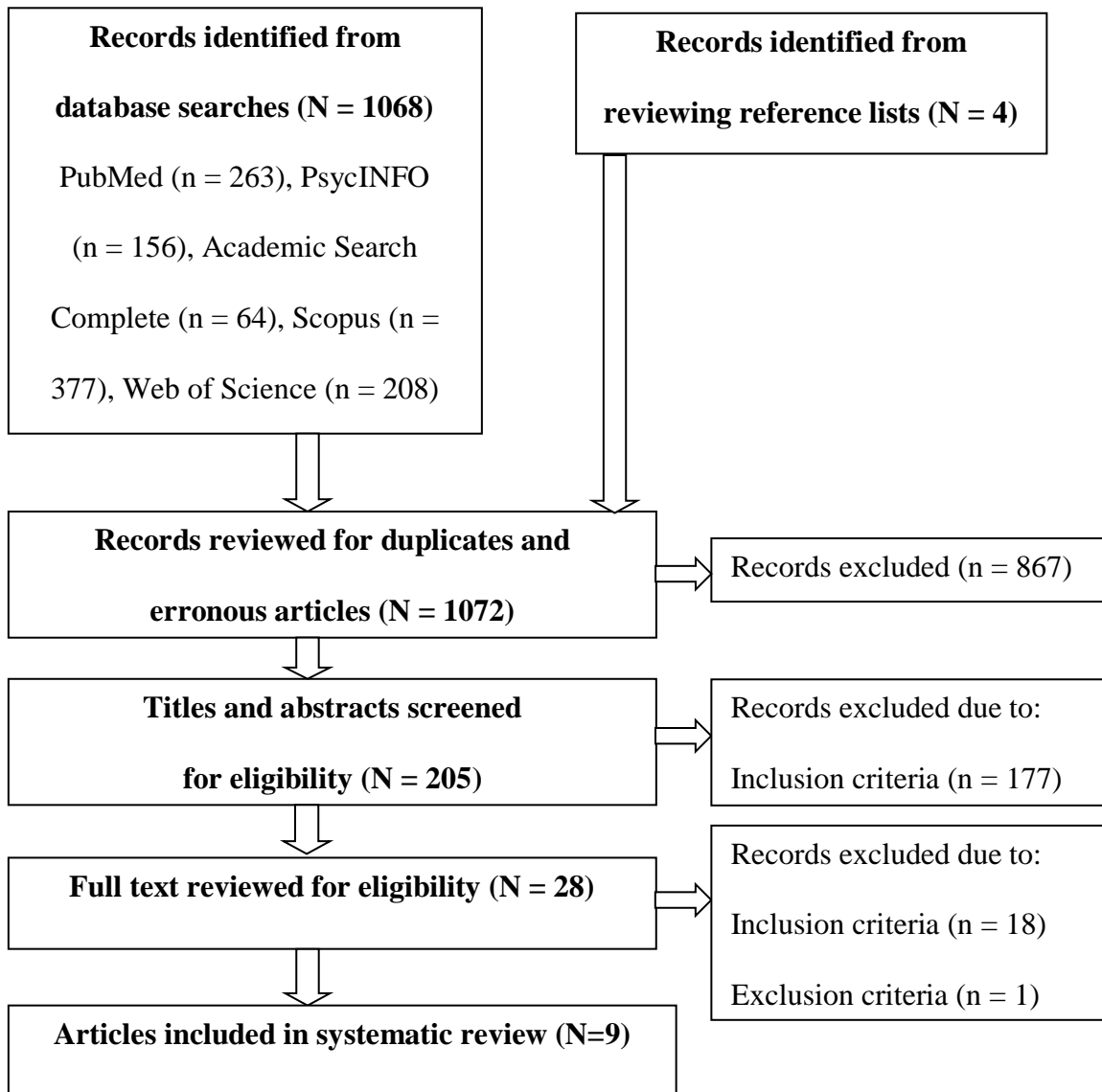


Figure 1. Flow diagram of search strategy

1.7. Appendices

Appendix A. Author information pack**JOURNAL OF ADOLESCENCE****AUTHOR INFORMATION PACK****TABLE OF CONTENTS****p.1 • Description****p.1 • Impact Factor****p.2 • Abstracting and Indexing****p.2 • Editorial Board****p.3 • Guide for Authors**

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GUIDE FOR AUTHORS

Introduction

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Appendix B. PICO Table

Review Question	Do mental health literacy interventions delivered in educational settings to children and young people improve mental health literacy? A systematic review of studies published since 2010.
When	Since 2010
Where	Delivered in educational settings
Population	Children and young people
Intervention	Mental health literacy interventions aimed at improving knowledge, attitudes and help seeking
Comparator	The stated intervention compared with a placebo, teaching as usual or no intervention.
Outcomes	Any quantitative outcome measures focused on aspects of mental health literacy (namely, knowledge, attitudes and help seeking).

Appendix C. Reporting Standards

Study	Checklist Used	Checklist Items Reported	Total Score	Percentage
Bella-Awusah et al. (2014)	TREND	1abc, 2a, 3abcd, 4, 6ab, 8ac, 10a, 11a, 12a, 14ab, 15, 17b, 20abc, 21, 22	10.65/22	48%
Mcluckie et al. (2014)	TREND	1bc, 2a, 3cd, 4, 5, 6abc, 10a, 11ad, 14c, 17b, 20ad	6.74/22	31%
Milin et al. (2016)	CONSORT	1ab, 2ab, 4a, 5, 6ab, 7ab, 8ab, 9, 10, 11a, 12ab, 13ab, 14a, 15, 16, 17ab, 18, 20, 21, 22	18.5/22	84%
Oijo et al. (2015)	TREND	1abc, 2ab, 3c, 4, 5, 6a, 11d, 12a, 17b, 20acd, 21, 22	8.41/22	38%
Perry et al. (2014)	TREND	1ab, 2ab, 3a, 4ab, 5, 6a, 7ab, 8ab, 9, 10, 12ab, 13ab, 17b, 20, 21, 22	14/22	64%
Pinto-Foltz et al. (2011)	CONSORT	2ab, 3a, 4a, 6a, 12ab, 13ab, 14a, 16, 17ab, 18, 20, 21, 22	10.5/22	48%
Reavley et al. (2014)	CONSORT	1ab, 2ab, 3a, 4ab, 5, 6a, 7ab, 8ab, 9, 10, 12ab, 13ab, 14ab, 15, 16, 17ab, 18, 20, 22	19/22	86%
Robinson et al. (2010)	TREND	1c, 2a, 3bc, 4, 5, 6a, 10a, 11ab, 12a, 13, 14b, 16a, 17ab, 18, 19, 20ac, 21	11.07/22	50%
Skre et al. (2013)	TREND	1abc, 2a, 3abcd, 4, 5, 6abc, 8ab, 11cd, 12a, 13, 14abc, 15, 16a, 17ab, 18, 20acd, 21, 22	14.82/22	67%

Appendix D. Intervention Design and Description

Study and Location	Intervention Package, Duration and Format	Content, Delivery and Design.
Bella-Awusah et al. (2014), Nigeria.	Unique design, three hours, one session.	Objectives: to evaluate personal views, begin to differentiate mental health problems from distress, demonstrate limitations of own responsibility, consider ways can support peers, access support and strategies can use to maintain mental health. Taught using small group discussions and feedback, vignettes, presentations and facilitator clarification of misunderstandings and key points. Design based on format used previously in UK based training programme for CAMHS professionals. This was modified by the researchers for the current project.
Mcluckie et al. (2014), Canada.	The guide, 10 to 12 hours, six modules.	Topics include stigma and mental illness, information about specific mental illness, first voice experiences, impact of mental illness on individuals and families, help seeking and the importance of positive mental health. Taught through a mix of didactic instruction, group discussion, group activities, self-directed learning and video presentations. Teacher self-study modules also include providing in-depth understanding of the topics. This curriculum is the same material studied by Milin et al. (2016) and appears to be under continual review and revision. It has been revised since this study was conducted. It is a comprehensive secondary school mental health and illness curriculum reviewed by an expert team of specialists across Canada to ensure the content is classroom appropriate.
Milin et al. (2016), Canada.	The curriculum guide, six hours, six modules.	The modules covered: stigma of mental illness, understanding mental health and mental illness, information on specific mental illnesses, experiences of mental illness, seeking help and finding support and the importance of positive mental health. Each

		<p>module contains a lesson plan with activities and resources. Uses digital stories and a video interview of a youth with mental illness. A teacher self-study guide increases the teachers’ understanding of the topics. This curriculum is the same material studied by Mcluckie and colleagues (2014) and appears to be under continual review and revision. It has been revised since this study was conducted. It is a comprehensive secondary school mental health and illness curriculum reviewed by an expert team of specialists across Canada to ensure the content is classroom appropriate.</p>
<p>Oijo et al. (2015), Japan.</p>	<p>Unique design, one hour 40 minutes, two sessions.</p>	<p>The sessions consisted of: explaining mental illnesses (prevalance, onset, risk factors, treatability, possibility of recovery and symptoms) and frequent misunderstandings; showing typical symptoms of depression and “schizophrenia”; showing pictures of a psychiatric outpatient clinic to demonstrate that it is not unusual or frightening; and sharing ideas of solutions to help peers suffering from mental health problems. Teaching methods included standard instruction using text and a blackboard, showing animations and group discussion. The programme was developed by a collaborating team of psychiatrists, public health nurses and teachers.</p>
<p>Perry et al. (2014) Australia</p>	<p>Headstrong, 10 hours, five modules across four to eight weeks.</p>	<p>The modules are: mood and mental wellbeing (introducing the concept of mental health and wellbeing, values, perceptions, the dynamic nature of mental health and stigma); the low down on mood disorders; reaching out – helping others; helping yourself; and making a difference. Resources included a booklet, slideshow and appendices. The headstrong content is freely available to teachers and is linked to syllabus outcomes, allowing teachers to meet their objectives relating to mental health and self development.</p>

<p>Pinto-Foltz et al. (2011), USA.</p>	<p>In Our Own Voice, one hour, one session.</p>	<p>Delivered in one session, this “knowledge, contact” intervention focuses on five components: first experience of symptoms of mental illness; acceptance; treatment; coping and successes, hopes and dreams. It incorporates narrative storytelling, discussion and a video presentation. This intervention has previously been evidenced as “effective” by three studies with older adolescents and young adults. It has been delivered to over 200,000 people in the USA. Although it’s short and intermediate-terms effects on stigma and mental health literacy had not been evaluated in school aged adolescents.</p>
<p>Reavley et al. (2014), Australia.</p>	<p>MindWise, one year, an ongoing “whole of campus” varied means of exposure based intervention.</p>	<p>Incorporated the following key messages: depression and related disorders are common; there are recognisable signs; early help seeking leads to better outcomes; there are several sources of professional help available; there are useful types of self-help available; and there are helpful first aid actions that staff and peers can take. Other messages included safe alcohol consumption guidance. Messages were delivered via websites, Facebook pages, twitter, factsheets, booklets, emails to students, campus events, posters and mental health first aid training provided by staff at the student counselling service. The interventions were designed with input from student and staff focus groups and student advisory groups.</p>
<p>Robinson et al. (2010), Australia.</p>	<p>Unique design, two hours, one session.</p>	<p>Content included: warm-up, introductions and rules, what is depression, stigma, coping skills, help seeking, summary and conclusions. Teaching methods included providing information directly, using an interactive electronic “keepad” that students could use to give anonymous feedback to an onscreen PowerPoint display, a video of a young person describing personal experiences of depression, two animated help seeking videos, having a sporting ambassador present at the session who</p>

Skre et al. (2013),
Norway.

Mental health for everyone,
duration of sessions not stated,
three days.

shared their own experiences of mental health problems, a communication game and role-play.

The aims of the intervention are to: contribute to the prevention of mental disease; challenge attitudes and prejudices against mental health problems and the mentally ill; contribute to openness and confidence about mental health issues; and impart knowledge about mental health services and availability of help. Three packages are available for grades 8 to 10 (year groups), All schools when first introducing the programme are advised to deliver the 8th grade package as they build upon each other. Therefore, the 8th grade package was delivered to all and assessed in this study. The theme for this package is self-awareness and identity. It includes wellbeing, mental health problems and mental disorders. The package is delivered across three consecutive school days and includes individual tasks, group tasks, plenary (whole group) sessions, illustrated videos and lecture about the most common or well known disorders. The tasks are all intended to gain attention and encourage reflection such as making playlists, bringing in symbolic items, or a catwalk demonstration where the commentator mentions only positive and inner personal qualities of the model. Universal mental health promotion programme available from Norwegian government website. Based on Antonovsky's theory of salutogenesis (Antonovsky, 1996).

Appendix E. Section Ratings for EPHPP Quality Appraisal Tool

Components	Bella-Awusah et al. (2014)	Mcluckie et al. (2014)	Milin et al. (2016)	Oijo et al. (2015)	Perry et al. (2014)	Pinto-Foltz et al. (2011)	Reavley et al. (2014)	Robinson et al. (2010)	Skre et al. (2013)
A. Selection Bias	Moderate	Weak	Moderate	Moderate	Moderate	Weak	Weak	Moderate	Moderate
B. Study Design	Strong	Moderate	Strong	Moderate	Strong	Strong	Strong	Strong	Strong
C. Confounders	Strong	Weak	Weak	Weak	Strong	Strong	Strong	Weak	Strong
D. Blinding	Moderate	Moderate	Moderate	Weak	Moderate	Weak	Weak	Weak	Moderate
E. Data Collection	Weak	Weak	Weak	Weak	Moderate	Moderate	Weak	Weak	Weak
F. Withdrawals	Strong	Moderate	Strong	Strong	Weak	Strong	Weak	Moderate	Strong
Overall Quality	Weak	Weak	Weak	Weak	Moderate	Weak	Weak	Weak	Moderate

Appendix F. Effect Size Calculations

Study	Calculation
Bella-Awusah et al. (2014).	<p>Knowledge post intervention: Mean pre and post test change in intervention group (M1 = 9.7 [2.1] N = 78, M2 = 11.4 [2] N = 78) minus pre and post test change in comparison group (M1 = 9.5 [2.1] N = 76, M2 = 9.5 [2.2] N = 76) divided by pretest pooled standard deviation (2.1).</p> <p>Knowledge follow up: Mean pre and post test change in intervention group (M1 = 9.7 [2.1] N=78, M2 = 11.3 [1.9] N = 70) minus pre and post test change in comparison group (M1 = 9.5 [2.1] N = 76, M2 = 9.3 [2.7] N = 75) divided by pretest pooled standard deviation (2.1).</p>
Milin et al. (2016).	<p>Knowledge post intervention: Mean pre and post test change in intervention group (M1 = 8.12 [2.18] N = 352, M2 = 8.82 [2.41] N = 319) minus pre and post test change in comparison group (M1 = 8.69 [2.14] N = 170, M2 = 8.51 [2.45] N = 159) divided by pretest pooled standard deviation (2.16).</p> <p>Stigma post intervention: Mean pre and post test change in intervention group scores (M1 = 20.39 [2.89] N = 352, M2 = 20.93 [3] N = 319) minus pre and post test change in comparison group (M1 = 20.98 [2.61] N = 170, M2 = 20.70 [2.96] N = 159) divided by pretest pooled standard deviation (2.75).</p>
Pinto-Foltz et al. (2011).	<p>Knowledge follow up: Mean pre and follow up test change in intervention group (M1 = 60.68 [6.71] N = 95, M2 = 62.60 [7.08] N = 93) minus pre and follow up test change in comparison group (M1 = 61.84 [6.44] N = 61, M2 = 62.02 [6.58] N = 55) divided by pretest pooled standard deviation (6.58).</p>
Skre et al. (2013).	<p>Knowledge follow up: Calculated based on F-test statistic ($F = 98.49$) and group sample sizes ($N_1 = 434, N_2 = 455$) due to limited information available in report (Thalheimer & Cook, 2002).</p> <p>Stigma follow up: Calculated based on F-test statistic ($F = 22.86$) and group sample sizes ($N_1 = 434, N_2 = 455$) due to limited information available in report (Thalheimer & Cook, 2002).</p>

Section 2. Research Report

Does the Language Used by Professionals to Describe Mental Health Affect Help Seeking
Intentions in Young People?

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Intended Journal: Journal of Adolescence. See Appendix A for Author Information.

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2.1. Abstract

To explore whether the language used by professionals to describe mental health problems affects young people's help seeking intentions, we used an online cross sectional experimental design and regression analyses. Participants ($N=177$) were randomly allocated to conditions and presented with a video clip vignette of either psychiatric language ($n=90$) based on the DSM-5 (American Psychiatric Association [APA], 2013) or lay language ($n=87$) suggested in published guidance (Division of Clinical Psychology [DCP], 2015). The vignette conditions did not directly affect help seeking intentions. Past experience and perceived helpfulness of previous mental health care significantly predicted an increase in help seeking intentions. There may also be an interaction where psychiatric language predicts higher help seeking intentions in young people who do have past experience of mental health care and lay language predicts higher help seeking intentions in young people who do not. Future research to confirm or disprove this interaction is recommended.

Keywords: language, labelling, diagnosis, help seeking, young people, randomised.

In this study, “language” means “a system of words . . . that are used and understood by a particular group of people” (Merriam-Webster’s Collegiate Dictionary, n.d., Def. 2). Specifically, words used by mental health professionals to describe and understand mental health problems. All language systems are in a continuous process of change over time due to the evolving needs and experiences of the people using them (Aitcheson, 1991). This happens in mental health, just as it does elsewhere and the system in use will differ dependent on the area of mental health, discipline of the professionals and theoretical approach used in a given context (Falvey, Bray, & Hebert, 2005; Koffmann, 2014; Townsend, 2014).

The most appropriate way to understand and describe mental health problems has always been a controversial topic (Porter, 2002). The system of words used in this context, particularly in western areas of the world, is driven by the dominant models used to understand mental health at a given time. Descriptions have gradually evolved from a supernatural occurrence caused by gods and demons, through rationalised understandings of “mental illness” as naturally occurring in the human body, to “incurable madness”, then the science and psychiatry based understandings we see today (Porter, 2002, pp. 10-123).

The widespread use of a biomedical model is reported to have begun with the addition of “mental disorders” in the sixth edition of the International Classification of Diseases (ICD-6) in 1948 followed by the publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I) in 1952 (McLeod, 2014). A biomedical model posits that “symptoms” of “mental illness” have an underlying physiological explanation such as a chemical imbalance, genetic predisposition, virus or bacteria (Morrison & Bennett, 2009). Since then, a medicalised conceptualisation of mental health has become predominant internationally, mainly as a result of researchers and mental health professionals using the ICD and DSM to guide their work (NHS Choices, 2013). The initial model was heavily criticised as being overly reductionist and has since evolved to become a “biopsychosocial” model which

explains “mental illness” as a combination of physical, social, cultural and psychological factors (Engel, 1977; Morrison & Bennett, 2009). A “stress-vulnerability” model introduced during the same year by Zubin and Spring (1977) has also become widely accepted and used. This model was proposed as an explanation for “schizophrenia” and has since been applied to other forms of “mental illness”; it asserts that an individual has unique biological, social-psychological and environmental factors that create vulnerability to stress and trigger episodes of illness (Zubin & Spring, 1977). Although additional factors have been included in more recent dominant models of mental health problems, our current understanding continues to be operationalised through the use of medical language (i.e. illness, symptoms, disorders, treatment) as outlined in diagnostic manuals (Boyle, 2013).

2.1.1. Arguments For and Against Medicalised Language in Mental Health

Debate about whether it is appropriate for mental health to be described in this way has been longstanding (Albee & Joffe, 2004; Johnstone, 2014). In 2010, the president of the APA argued that the use of “common language” by mental health professionals is a weakness, leaving the speciality vulnerable to attack and that “we need to be more medical to be taken seriously” (Schatzberg, 2010, p.1162). Furthermore, some researchers have proposed that the lay use of psychiatric language by individuals to describe their experiences of emotional distress can enable the process of self-recognition and help seeking for appropriate mental health treatments (Thompson, Issakidis, & Hunt, 2008; Wright, Jorm, & Mackinnon, 2012; Yap, Reavley, & Jorm, 2014). Other researchers have argued that the accurate labelling of symptoms using psychiatric terms increases the ability of general practitioners (GPs) to recognise mental health problems and refer people for professional help (Biddle, Donovan, Gunnell, & Sharp, 2006; Haller, Sanci, Sawyer, & Patton, 2009).

In contrast, MacCulloch (2010) suggests that psychiatric labels are used as a “gate keepers” to mental health services (p.152). Based on this idea, the link between lay use of

psychiatric terms and help seeking could be understood as reflecting public perceptions of what labels they can and cannot seek help for, guided by eligibility criteria for services.

Furthermore, Angermeyer and Matschinger (2003) argue that negative public perceptions of some psychiatric terms strongly outweigh any potential benefits. Indeed, researchers who have evidenced findings in favour of the use of psychiatric language also warn that “community education that promotes accurate labelling of psychosis should proceed with caution and address beliefs about dangerousness and unpredictability” (Wright, Jorm, & Mackinnon, 2011, p. 1).

In relation to the accuracy of psychiatric language, the lead editor of the DSM-5 was quoted as stating in an interview that “there is no definition of a ‘mental disorder’... I mean you just can’t define it” (Johnstone, 2014, p. 15). The validity and reliability of psychiatric diagnosis was first refuted by Rosenhan (1973). He discussed the powerful influence that the choice of words used to label emotional distress can have on perceptions, behaviours and attitudes and concluded that approaches to understanding mental health that are “less attached” to psychiatric labels might be more benign and effective (Rosenhan, 1973, p.257). More recently, Boyle (2013) stated that there is still no direct evidence to support the application of a “medical model” to mental health (Chapter 1, para. 2). Similarly, Johnstone (2014) argued that the use of medicalised language to describe emotional distress does not aid scientific decision making as is often implied, but makes a value judgement based on social and cultural standards. She added that many of the terms are pejorative and stated that “whatever your view about the validity” of functional psychiatric language, it is “universally acknowledged that these labels lead to stigma and discrimination” (Johnstone, 2014, p. 55).

Professional mental health organisations have also stated that it is time to change the way we describe and understand mental health problems. In 2013, the director of the National Institute of Mental Health (NIMH) described the DSM as lacking validity (Insel,

2013). More recently, the British Psychological Society's (BPS) DCP released a position statement on the publication of the DSM-5 calling for a paradigm shift in relation to the use of functional psychiatric diagnoses (DCP, 2014). This was followed soon after with professional guidance on "language use" recommending that clinical psychologists "avoid the use of functional psychiatric diagnostic language where possible" and instead use "psychological or ordinary language equivalents" (DCP, 2015, pp. 4-5).

2.1.2. Operationalising the Arguments For and Against Psychiatric Language

The arguments for the use of psychiatric language have been focused on facilitating the process of recognition, help seeking and treatment. Whereas the arguments against have related to attitudes, stigma, discrimination, lack of utility in relation to clinical decision making and lack of scientific validity and reliability. If an alternative way of describing mental health is to be introduced and used on a widespread basis by mental health professionals and services as a replacement for functional psychiatric language, empirical evidence for the benefits of its use is needed. Boyle (2013) suggested that the persistent use of medical language to describe mental health problems, despite strong arguments against doing so, is partially a consequence of how arguments for alternative approaches are presented and researched. She states that new models for understanding mental health are needed and that arguments for alternative approaches need to challenge the assumptions of research based on medically focused models (Boyle, 2013).

Indeed, research advocating the use of psychiatric terms does not dispute the link between the use of some psychiatric terms and stigma (Yap, Reavley & Jorm, 2014). The focus has instead been on the benefits of the accurate labelling of mental "disorders" by laypersons using psychiatric terms (Wright et al., 2012). Researched in this way, statistically significant links have been evidenced between the use of psychiatric terms and increased intentions or willingness to seek help (Wright, Jorm, Harris, & McGorry, 2007; Wright et al.,

2012; Yap, Reavley & Jorm, 2014). The design of this research was influenced by two proposed models of help seeking (Biddle, Donovan, Sharp, & Gunnell, 2007; Vogel, Wester, Larson, & Wade, 2006). One of them, an information-processing model of the decision to seek professional help, proposes that when encoding and interpreting internal and external cues, people have difficulty in making appropriate decisions about whether or not to seek professional help (Vogel et al., 2006). Vogel and colleagues (2006) recommended that educating the public about how to identify symptoms of mental illness could empower them to make informed decisions about their needs. The other model is a dynamic interpretive model of illness behaviour named the cycle of avoidance (Biddle et al., 2007). The social meaning attributed to mental illness and being helped is central to the model and the authors suggest that the cycle of avoidance shows how young adults respond to mental distress by accommodating or denying it rather than look for ways to resolve it, even when the distress experienced becomes severe (Biddle et al., 2007). Biddle and colleagues (2007) argue that lay diagnosis is the crucial first step to seeking help and that delays in seeking help are due to difficulty in recognising severe symptoms, inappropriately normalising them.

Understanding why people with mental health problems experience delays in seeking and receiving appropriate help is important because research worldwide has indicated that two-thirds of people experiencing mental health problems do not receive any professional support or treatment, even where a wealth of resources and services are available (Thornicroft, 2007). Furthermore, the level of unmet need is highest among young people aged 16 to 24 where 65% to 95% of those experiencing mental health problems do not receive professional help (Mauerhofer, Berchtold, Michaud, & Suris, 2009). This is perhaps not surprising as three quarters of all lifetime mental health problems start before the age of 24, with later diagnoses mostly co occurring alongside other conditions (Kessler et al., 2005). This indicates that the age group who experience the first onset of mental health problems are

also undergoing social, emotional, and physical developments that make the identification of problematic experiences difficult (Carr, 2015). Without the right support, mental health problems can lead to long term illness and shortened lifespans (Kessler et al., 2009).

Help seeking, as with most human behaviours, is a complex process. Therefore, research needs to identify the aspects of the help seeking process that are being studied along with the research designs theoretical base. Early research in this area was based on illness behaviour models and the first definition of help seeking was reportedly proposed by Mechanic (1982) as an adaptive coping strategy. More recently, Rickwood and Thomas (2012) conducted a comprehensive review of the mental health help seeking literature and found no commonly used definition of help seeking. They also found that most research does not define the aspect of the help seeking process being studied or refer to a theoretical model (Rickwood & Thomas, 2012). To facilitate improvements in research, Rickwood and Thomas proposed that “in the mental health context, help seeking is an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern” (Rickwood & Thomas, 2012, p. 180). They also identified the most commonly used theoretical model in the study of help seeking as the theory of planned behaviour (Rickwood & Thomas, 2012). This theory proposes that behaviour is a decision, made in accordance with our behavioural intentions; and that our behavioural intentions are formed based on our attitudes towards the behaviour, along with our perceptions of what others think of the behaviour, social pressures, and how easy or difficult engaging in the behaviour will be (Ajzen, 1985). It has long been recognised that general attitudes are not a reliable predictor of behaviours (Ajzen & Fishbein, 1977; LaPiere, 1934). The theory of planned behaviour is a useful way of conceptualising help seeking as it separates out attitudes towards the behaviour, intentions and behaviours; and further to this, incorporates how environmental factors and

self-perceptions can explain why one does not necessarily predict the other in the way we might expect (Ajzen, 1985).

Using the theory of planned behaviour to consider the arguments for and against the use of psychiatric language helps illustrate the differences in research designs and findings. The arguments against the use of psychiatric language have largely focused on attitudes and therefore may not predict an impact on behaviours (Angermeyer & Matschinger, 2003; Johnstone, 2014; Mackenzie, Erickson, Deane, & Wright, 2014). The arguments in favour of psychiatric language are mixed and based on problem recognition, expressions of willingness or intentions to seek help, or identification of appropriate sources of help (Wright et al., 2007; Wright et al., 2012; Yap, Reavley & Jorm, 2014). Much of the research exploring links between psychiatric labels and help seeking has been based within the field of “mental health literacy”(p.182); defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (A. F. Jorm et al., 1997, p. 182). Therefore, a recurrent recommendation has been that increasing community mental health literacy, by teaching people how to recognise and accurately label mental disorders, should increase appropriate help seeking and access to treatments (Wright et al., 2012; Yap, Reavley & Jorm, 2014). However, evidence for the effectiveness of mental health literacy interventions at increasing help seeking intentions and behaviours is limited (Jorm, 2012; Wei et al., 2013).

Furthermore, the same researchers that evidenced a link between mental health literacy and help seeking also found that knowing a close friend or family member who had received professional help for mental health difficulties increased levels of stigma relating to what others may think (Yap, Reavley, & Jorm, 2013). The authors proposed that this may represent vicarious stigma experienced in relation to the friend or family member’s treatment history (Yap, Reavley & Jorm, 2013). Furthermore, Yap, Reavley and Jorm (2013) also found that young people experienced embarrassment in relation to seeking help. They

hypothesised that mental health professionals might be viewed as “specialising in severe mental disorders” leading young people to feel that their problems are not serious enough to seek help (Yap, Reavley & Jorm, 2013, p. 260).

2.1.3. Additional Factors That May Impact on Help Seeking

The factor that is most commonly mentioned as a barrier to help seeking is stigma. Forms of stigma include: “public stigma” meaning collective negative stereotypes and prejudice held by a community or society; “perceived public stigma” refers to an individual’s perception of public stigma; “self-stigma” is when an individual identifies themselves with a stigmatised group; and “personal stigma”, is an individual’s own stereotypes and prejudice (Eisenberg et al., 2009, p. 523). Research exploring the impact of stigma on help seeking has evidenced significant associations between personal stigma and lack of help seeking (Eisenberg et al., 2009; Lally et al., 2012; Schomerus et al., 2009).

Others factors proposed as contributing to help negation are past experiences that are not perceived as helpful by the adolescent and levels of psychological distress (Wilson & Deane, 2012). Martinez-Hernaez, DiGiacomo, Carceller-Maicas, Correa-Urquiza and Martorell-Poveda (2014) also suggested that past experiences of accessing professional services directly led young people to avoid future contact with mental health services, reasons given for this included the use of psychiatric language (Martinez-Hernaez et al., 2014).

Consideration of these additional factors alongside the evidence for the use of psychiatric language indicates that there could be an interaction between past experiences of mental health care and the language used by young people. It is possible that those who have accessed past care and want to directly avoid future contact with health services are likely to avoid the use of psychiatric language (Martinez-Hernaez et al., 2014). Whereas others who have experienced the use of psychiatric terminology as providing access to support services

(MacCulloch, 2010) may be likely to use and prefer psychiatric language to understand and describe their own difficulties (Yap, Reavley & Jorm, 2014).

In summary, recent statements by professional organisations and professional guidance have advised clinical psychologists to avoid the use of functional psychiatric diagnostic language (DCP, 2015; Society for Humanistic Psychology, 2015). These actions indicate that it is useful and timely to focus research on the language that is used by professionals to describe mental health difficulties. Additionally, some researchers have suggested that the language used to describe mental health may influence young people's willingness to seek help (Mackenzie et al., 2014; Martinez-Hernaez et al., 2014; Yap, Reavley & Jorm, 2013). Some have argued that accurate psychiatric labelling facilitates help seeking (e.g. Yap, Reavley & Jorm, 2014), others have argued that the medicalisation of mental health may have led to an avoidance of professional services (e.g. Mackenzie et al., 2014). So far, no research has directly tested the effect that the language used by professionals to describe mental health has on help seeking.

2.1.4. Aim and Research Question

This study aims to compare professional descriptions of mental health problems using psychiatric terms based on the DSM-5 (APA, 2013) with descriptions using alternative lay terminology proposed by the DCP guidelines (DCP, 2015). Language is presented using vignettes to make the research method comparable with studies that have evidenced positive links between psychiatric labels and help seeking (Wright et al., 2007; Wright et al., 2012; Yap, Reavley & Jorm, 2014). The theory of planned behaviour is the theoretical base for this study (Ajzen, 2012). This model has been chosen because it clearly distinguishes between the different aspects of the help seeking process and factors that influence them, allowing for a clear definition of what is being measured (Ajzen, 2012). Furthermore, this is the most

commonly used model in help seeking research, allowing for useful comparison (Rickwood & Thomas, 2012).

Age, personal stigma, levels of psychological distress, experience of past mental health care, perceived helpfulness of past mental health care, and the interaction between past mental health care and language, were also measured due to indications from the research literature that they may be confounding variables. Nationality data and the time period since the onset of mental health problems were also collected to ensure that these factors were balanced across groups and to allow for inclusion and control of these variables in the analyses if required. The research question was: Is there a significant relationship between the language used by professionals to describe mental health and help seeking intentions in young people? A secondary question was: Do any of the additional variables measured here affect the relationship between the language used by professionals to describe mental health and help seeking intentions in young people?

2.2. Method

2.2.1. Participants

This was an online study that included participants who were: 1) aged between 16 and 25; 2) able to read and understand the English language; and 3) self-identified as experiencing mental health problems either currently or in the past. The recruitment period for eligible participants was between November 2015 and January 2016. The number of participants who completed the demographic section of the protocol was 195 (for the predictive power calculation used see Appendix H). From these, 177 continued with the survey and were randomised to comparison and experimental conditions using a Qualtrics block randomization tool (Qualtrics LLC, 2015a). Ninety participants were allocated to the comparison condition (vignette A) and 87 participants were allocated to the experimental

condition (vignette B). See Figure 2 for a breakdown of the number of participants completing each stage of the survey.

Nineteen participants dropped out following randomisation, 10 from the comparison condition and 9 from the experimental condition. Sixteen participants continued until they were presented with the vignette video clip then did not complete the GHSQ. The demographic data for these participants were tabulated to see whether there were significant differences between participants who dropped out at this stage and those who continued with the survey (see Appendix I); no significant differences were observed. Only data from participants who completed the primary outcome measure were considered for inclusion in the analyses.

2.2.2. Design

This was a cross-sectional experimental design, with equal randomisation to two parallel experimental conditions that differed according to the vignette presented. The primary independent variable (IV) was the language used to describe mental health in the vignette conditions. Block randomisation was applied by the survey software using a built in function (Qualtrics LLC, 2015a) meaning that the researcher was blind to which experimental condition participants were assigned to during randomisation and data collection.

2.2.3. Materials

Materials used for this research study were: video recording equipment and editing software, video clip vignettes, Qualtrics online survey software (Qualtrics LLC, 2015a) and psychometric measures.

2.2.3.1. *Vignette video clips*

The comparison Group (Group A) were presented with a vignette video clip giving a brief general description of how mental health problems are understood and described by a mental health professional using psychiatric language based on the DSM-5 (APA, 2013).

The experimental Group (Group B) were presented with a comparable vignette using suggested alternative lay terms from professional language guidance (DCP, 2015). See Appendix J for the vignette scripts. The video clips can be viewed at <https://youtu.be/wZ8J5hVtBUg> and <https://youtu.be/JNQgzmBbMsU>.

The vignette design was guided by research literature (Brauer et al., 2009; Sandhu, Adams, Singleton, Clark-Carter, & Kidd, 2009), input from research team members at the clinical psychology doctorate programme, and feedback from young people who were members of a research advisory group. Four vignette script options were created and reviewed. Vignettes were chosen and adjusted to ensure that they were appropriately targeted to engage the intended audience and equally matched in terms of complexity, length, word order and timing. The vignettes were pilot tested and the sentence structures were adjusted to improve the flow of the script.

The research advisory group suggested presenting the vignettes as a video clip portraying a professional communicating the message to maximise engagement. They also advised that a female character would be preferable and warned that complex terms such as diagnosis and formulation would not be understood by most young people, biasing the outcomes. A review of doctor-client gender dyads by Sandhu and colleagues (2009) supported the decision to use a female actress, finding that overall, consultations with female doctors were experienced more favourably than consultations with male doctors.

2.2.3.2. Primary outcome measure

The primary outcome was future help seeking intentions operationalised using the General Help Seeking Questionnaire (GHSQ) created by Wilson and colleagues (2005). See Appendix K. The scale can be scored as a full scale and can also be separated into individual scale items or subscales (Wilson et al., 2005). For this study, the measure was used as a full scale, consisting of 8 questions, each scored between 1 and 7 on a 7-point Likert style scale. The scoring range is 8-56 with a higher score indicating a higher intention to seek help. Cronbach's alpha for the full scale has previously been reported as .85, with a test retest reliability of .92, assessed over a three-week period (Wilson et al., 2005). The Cronbach's alpha for this study was .66, reflecting a moderate level of internal consistency.

2.2.3.3. Additional measures

To evaluate current mood and anxiety levels the Revised Children's Anxiety and Depression Scale-Short Version (RCADS; Ebesutani et al., 2012) was used. (See Appendix L). Ebesutani and colleagues (2012) tested the use of this scale in a high school sample and reported a Cronbach's alpha of .86 for the anxiety scale and .79 for the depression scale. Anxiety was measured using 15 questions and depression using 10 questions. Each question scored between 0 and 3 on a 4-point Likert style scale. The scoring range is 0-45 on the anxiety scale and 0-30 on the depression scale, with a higher score indicating a higher level of anxiety or depression. For this study the depression and anxiety scales both showed a Cronbach's alpha of .86, reflecting a good level of internal consistency.

Perceived helpfulness of past help seeking within the previous 12 months was measured using a 4-item prior counselling measure that has been used in samples of high school and college students (Wilson et al., 2005; See Appendix M). The questions were: have you ever seen a mental health professional (e.g. counsellor, psychologist, psychiatrist) to get help for personal problems?, how many visits did you have with the health

professional(s)?, do you know what type of health professional(s) you've seen (e.g. counsellor, psychologist, psychiatrist)?, and how helpful was the visit to the mental health professional?). The helpfulness question was rated on a 5-point Likert style scale. The score for this item ranged from 1 to 5, with a higher score indicating more helpful.

Personal stigma was measured using three questions adapted from the Discrimination-Devaluation Scale (Link, 2004), used in similar research (Eisenberg et al., 2009; Lally, O'Conghaile, Quigley, Bainbridge, & McDonald, 2013). In this survey, participants answered agree or disagree to three questions. Each scored as 0 or 1. See Appendix N. The scoring range is 0-3 with a higher score indicating a higher level of personal stigma.

2.2.4. Procedures

Potential participants were contacted online using social networking and media sites, forums, websites and emails to relevant organisations such as student unions, a young people's community radio station and local libraries asking them to distribute information about the study. Details of the study were shared via Twitter, Tumblr, Reddit, Facebook, ClinPsy.org.uk, the clinical psychology doctorates webpage, posters on two university campuses, in a student union office and in libraries. See Appendix O for examples.

Online adverts included a direct link to the survey (Qualtrics LLC, 2015b). To facilitate ease of access, printed posters and information detailed a Twitter account (<http://twitter.com>) used specifically for this research project. A link to the online survey was placed at the top of the Twitter account so that it was clearly visible. The web link and survey were tested prior to general release for ease of use, accessibility and functionality of the survey. Adaptions were made to the survey in response to feedback from the pilot test and minor amendments were requested from ethics. See Section 4.

The final version of the online survey displayed in the following order: 1) introductory page including a downloadable participant information form and a consent form;

2) demographic questions; 3) vignette A or B; 4) orienting paragraph; 5) self-report psychometric measures; 6) debrief information page (see Appendices G to K for copies of the forms and survey pages). Following exposure to the vignettes, the first self-report measure presented was the GHSQ, the dependent variable. The remaining measures (psychological distress, personal stigma and past help seeking) were collected at the end of the survey. This was to ensure that completion of these measures did not bias the relationship between the language used in the vignette conditions and help seeking intention scores. Figure 3 illustrates the data collection sequence.

2.2.5. Data Analysis

Exploratory analyses of the demographic and descriptive data were completed. A regression was conducted to answer the main research question: is there a significant relationship between the language used to describe mental health and help seeking intentions in young people? Based on reviewing the relevant research literature, data for personal stigma, levels of psychological distress, past experiences of mental health care, helpfulness of past mental health care and an interaction between language and past experience of mental health care were also collected and considered for inclusion in the regression model. To evaluate whether the inclusion of these additional variables significantly impacted on the relationship between language and help seeking intentions, a hierarchical multiple regression was conducted. Demographic variables that did not appear balanced across vignette conditions at baseline were also included and controlled for. These were gender and nationality.

The assumptions of a regression analysis were tested for all data prior to entry into the models. An additional hierarchical multiple regression analysis was also conducted that was not planned at the protocol stage of the research to facilitate the inclusion of the predictor variable helpfulness of past mental health care. This variable was not included in the main

analysis as it applied only to a subgroup of the participants who had experienced mental health care previously ($n = 115$).

2.2.6. Ethical Considerations

This was an anonymous online survey, no identifiable participant information was collected. Informed consent was gained from all participants by using a consent form to enter the survey and a participant information sheet that participants were requested to read prior to involvement in the study (See Appendix Q). See Section 4 for further ethical considerations.

2.3. Results

2.3.1. Demographic Data

One hundred and sixty one participants completed the primary outcome measure. Of these, 81 were allocated to the comparison condition (vignette A) and 80 were allocated to the experimental condition (vignette B). Participants were predominantly female in both conditions, with a smaller number of participants identifying as male, transgender or other gender identities such as genderfluid, non binary or demigirl (see Table 6). There was a small difference in gender distribution, with a higher percentage of females in the experimental condition (76.3%) compared to the comparison condition (72.8%). There were also some marginal (1 to 2.5%) differences between male, transgender and other gender identities across conditions. Participants were fairly equally matched in terms of age and the timescale of mental health problem onset. Nationality data were grouped into participants from the UK and Ireland, the rest of the world and nationality unclear. The spread of participants from the UK and Ireland appeared similar again here across conditions, however, the number of participants grouped as from the rest of the world and unclear varied slightly.

As participants were randomised to vignette conditions, any imbalances at baseline are a chance occurrence. However, it is important to consider the size of any imbalances that have occurred and whether they will impact on the results of the statistical analyses. The only differences between vignette conditions that appeared to be more than marginal, were a higher percentage of female participants in the intervention condition and differences in nationality groups across conditions. It could not be established whether the difference in nationality groups was a true difference due to missing and unclear data. Age was included in the multiple regression analysis due to indications from research that it affects help seeking (Mauerhofer et al., 2009). Gender and nationality variables were included in all analyses to

control for the impact of imbalances at baseline. As these were categorical variables with more than two categories, dummy variables were created. The gender variable used in the multiple regression analysis was coded as 1 = female, 0 = male, transgender and other gender identities. The nationality variable used in the analysis was coded as 1 = UK and Ireland, 0 = rest of world and unclear.

2.3.2. Linear Regression

A linear regression analysis, controlling only for potential gender and nationality imbalances at baseline was calculated to test whether the language that participants were exposed to in the vignette conditions significantly explained any variance in help seeking intention scores. No differences were observed between vignette groups ($\beta = -.01$, $t = -.08$, $p = .93$).

2.3.3. Identifying Additional Predictor Variables

To evaluate the impact of other potential predictors of help seeking that had been identified, they were also measured and considered for inclusion in this analysis. These were levels of anxiety and depression (RCADS), personal stigma, past experience of mental health care, perceived helpfulness of previous mental health care and an interaction between past experience of mental health care and language. A comparison of mean scores for all of these variables and for the outcome variable in each vignette condition is shown in Table 7. There were 4.4% more participants in vignette B who had experienced past mental health care than in vignette A. Helpfulness of previous mental health care was only relevant to, and therefore presented to, participants who had previous experience of mental health care ($n = 115$). To account for this, the effect of helpfulness of past mental health care in the smaller subgroup of 115 participants was analysed in a separate regression.

Prior to conducting the regression analyses, tests were conducted to identify any potential outliers and to check that the assumptions of the regression analyses had been met. These analyses are detailed in Appendix H. The data for personal stigma was not normally distributed and attempts to transform the data were not successful. Therefore, this variable was not included in the regression. To answer the research question: “do any of the additional variables measured here affect the relationship between the language used by professionals to describe mental health and help seeking intentions in young people?” a hierarchical multiple regression analysis was performed in three steps. At step one demographic predictor variables were added to the model. These were age, nationality and gender. At step two, predictors indicated by prior research were added to the model. These were RCADS anxiety and depression total scores and past experience of mental health care. At step three, new predictor variables that had not been tested in previous research were added. These were the vignette condition and the interaction variable for previous experience of mental health care and the vignette condition.

2.3.4. Hierarchical Multiple Regression

At step one, age predicted a small amount of variance in help seeking intentions at a borderline significance level ($\beta = 0.15$, $t = 1.91$, 95% CI = -0.01-0.77, $p = .06$). Additional predictors were added to the model at step two and age was no longer significant, only past experience of mental health care explained any variance in help seeking ($\beta = -0.14$, $t = 1.75$, 95% CI = -0.31-5.09, $p = .08$), again this was borderline significant. At step three the language used in the vignette conditions and the interaction between past experience of mental health care and the language conditions were added to the model. The language used in the vignette conditions did not significantly explain any variance independently. At this step, the significance level of the variance explained by past experience of mental health care

improved ($\beta = 0.27$, $t = 2.49$, 95% CI = -0.9-8.20, $p = .01$). This indicated that having past experience of accessing mental health care predicted an increase in help seeking intentions. The interaction between the language used in the vignette condition and previous experience of mental health care also explained some variation in help seeking at a borderline level of significance ($\beta = -0.32$, $t = 1.77$, 95% CI = -10.23-0.56, $p = .08$). Participants who had previously experienced professional mental health care indicated higher help seeking intention scores in the psychiatric language condition (mean GHSQ score = 27.05, SD = 7.92, $N = 58$) than in the alternative language condition (mean GHSQ score = 25.57, SD = 5.59, $N = 60$). Conversely, participants who had not previously experienced professional mental health care indicated higher help seeking intention scores in the alternative language condition (mean GHSQ score = 25.28, SD = 10.48, $N = 18$) than in the psychiatric language condition (mean GHSQ score = 22.18, SD = 7.00, $N = 22$). See Figure 4. The overall regression model at stage three was at a borderline significance level, $F(8, 157) = 1.89$, $p = .07$.

2.3.4.4. Subgroup analysis

A second multiple regression was conducted including helpfulness of previous mental health care for participants who had experienced mental health care previously to see if the inclusion of this predictor affected the model (see Table 9). As the interaction between past mental health care and the language used in the vignette condition explained some variance in the main analysis, an interaction term was created and included in this analysis for helpfulness of previous mental health care and vignette condition. The only predictor to significantly explain any variance in help seeking in this analysis was helpfulness of previous mental health care ($\beta = 0.48$, $t = 3.98$, 95% CI = 1.40-4.18, $p = .001$) showing that helpfulness of previous mental health care significantly explained an increase in help seeking

intentions. The language used in the vignette conditions and interaction term did not significantly explain any variance (see Table 9). Overall, the regression model was significant, $F(8, 114) = 3.22, p < .001$, with helpfulness of previous mental health care explaining 14% of the variance in intentions to seek help, adjusted $R^2 = .14$.

2.4. Discussion

These findings do not indicate that there is a significant direct effect of language on young people's help seeking intentions based on the use of functional diagnostic psychiatric language from the DSM-5 or alternative lay terms based on the guidance released by the DCP (APA, 2013; DCP, 2015). Whether or not participants had experienced past mental health care and perceived helpfulness of previous mental health care significantly predicted an increase in intentions to seek help. An interaction effect whereby the language used in the vignette conditions and past mental health care predicted some variation in help seeking was also observed. Participants who had previously experienced professional mental health care expressed higher intentions to seek help when presented with psychiatric language. Conversely, participants who had not previously experienced professional mental health care expressed higher intentions to seek help when presented with a comparable lay alternative. As this was not significant at $p < .05$, future research focusing on this interaction is recommended. This could test the hypothesis that the language used by professionals to describe mental health problems impacts differently on young people's help seeking intentions dependent on whether or not they have prior experience of mental health care.

If an interaction effect is found to be present, this could provide support for both the arguments for and against the use of psychiatric language and potentially explain the differences in findings. Where young people have previously experienced mental health care, they will have experienced the use of psychiatric terminology to describe their difficulties

and learnt how to recognise, describe and understand their own experiences in this way from professionals involved in their care (Biddle et al., 2007). They will also have gained some awareness that psychiatric terms indicate severity of need and provide access to support services (MacCulloch, 2010). It is likely that these experiences will lead young people who are intending to seek help from mental health professionals again to prefer the use of psychiatric language to understand and describe their own difficulties (Yap, Reavley & Jorm, 2014).

For young people who have not accessed mental health care previously, it is less likely that they will have experienced their own difficulties being described and understood using psychiatric terms. This means they are more likely to prefer descriptions that are familiar (Martinez-Hernaez et al., 2014). Yap, Reavley and Jorm (2013) suggested that the language used to describe mental health impacts on levels of embarrassment in relation to seeking help and lay judgements about how serious mental health difficulties need to be to warrant professional help. It could be that if young people do not understand their difficulties using psychiatric terms, they do not judge their difficulties as serious enough to seek professional help (Haller et al., 2009), which influences the judgements of professionals such as GPs' about whether or not to make referrals to services (Biddle, Donovan, Sharp, & Gunnell, 2007a). This could mean that the use of psychiatric terminology is an unintentional barrier to help seeking for some. Furthermore, young people who have vicariously experienced previously unhelpful mental health care or stigma through the experiences of family or friends, may be less willing to describe their experiences using psychiatric labels and simultaneously less willing to seek help (Yap, Reavley & Jorm, 2014).

2.4.1. Limitations

Potential limitations of this study include the use of vignettes, a focus on intentions rather than behaviour and the internal consistency of the outcome scale used. Although the outcome measure used here had previously been demonstrated as reliably predicting future help seeking behaviour (Wilson et al., 2005), it does not measure future behaviour directly. Also, some researchers question the generalisability of findings from vignette studies as they do not accurately reflect real life experiences (Brauer et al., 2009). Although the design of the vignettes in this study were intended to closely resemble a description of mental health given by a professional, real life experiences of meeting with professionals are very different.

Another factor that was not considered here and that it would be useful to control for was prior exposure to language used in discussions about mental health with family and friends, within the local community and in media reporting. Considering the variety of ways and the timescales during which people are likely to have been exposed to messages about mental health, it is unlikely that exposure to one brief vignette will make a significant change to behaviour. Repeated exposure over a longer period of time would allow a person to assimilate the descriptions into their existing view before any impact on help seeking intentions or behaviours can be accurately assessed. As such, future study designs providing longer, repeated exposure to the language options could provide clearer results. Also, using interactions with actual mental health professionals and measuring actual behaviours would be preferable due to uncertainty regarding the generalisability of findings from vignette use and uncertainty regarding the strength of the relationship between intentions and future behaviours (Rickwood & Thomas, 2012). That said, an experiment of that type would not have been within the scope of this thesis.

Furthermore, although the internal consistency of the General Help seeking Questionnaire has previously been reported as good (Tuliao & Velasquez, 2014; Wilson et al., 2005), in this study, it measured as moderate (Cronbach's alpha = 0.66). This is lower than previously reported and outside of the generally accepted value range of 0.70 to 0.90, indicating that the results found here may not be reliable (Tavakol & Dennick, 2011). This could explain why variables that were expected to predict some variation in help seeking were not significant in the regression model. It also supports the recommendation for future research to confirm or disprove whether the interaction effect found here is significant. Also, as the data for personal stigma was not normally distributed, this variable was not included in the regression model. Including this variable in future research exploring the significance of an interaction effect is recommended.

A further limitation of this study is that data were collected anonymously and online. This means that the validity of the results cannot be guaranteed as it is not possible to ensure that all participants were within the sample requirements and completed the survey honestly. It was also not possible to ascertain reasons that participants dropped out of the survey. Potential explanations could include technical difficulties, interruptions, lack of interest in continuing with the survey or a decision to withdraw. Despite these uncertainties, conducting exploratory cross sectional research online is practical in relation to time and cost to indicate areas for future study. These benefits outweigh the potential weaknesses of this design as follow up research focused on areas of significant interest can then look to replicate results using different data collection methods.

It also became apparent while conducting this study, that academic research overwhelmingly does not include transgender and other gender identities as data categories. The psychometric measure used to score levels of depression and anxiety provides coding

and norms, however this includes only male and female options. Future research providing normed psychometric data on commonly used scales for genders other than male and female is recommended to facilitate accurate research and clinical interpretation of results.

2.4.2. Strengths

The design of this experiment resembled previous research (e.g. Yap, Reavley & Jorm, 2014) that had evidenced links between psychiatric language and help seeking by young people allowing for comparison. This study also aimed to increase how closely the vignettes represented real life experience of professional language use. This was achieved by using an actor in a video-clip portraying a professional. The relevance, content and level of engagement for young people was also considered by involving young people in the project. The theory of planned behaviour, provided a strong theoretical base and a clear definition of the area of study (Rickwood & Thomas, 2012). Additionally, the study successfully exceeded the minimum numbers identified for recruitment and experienced low dropout rates.

2.4.3. Clinical Implications

Delays in recognition of mental health problems and referrals for help by GPs have been linked to how young people describe the problems they are experiencing (Haller et al., 2009). Therefore, referral pathways to services could also be influenced by the factors considered here. MacCulloch (2010) argued that psychiatric labels are used to assess and indicate eligibility for access to mental health services. Consequently, GPs and other professionals may judge whether or not a person's emotional difficulties are severe enough for specialist help based on either: the person either using psychiatric terms when describing their own difficulties; or the person agreeing with a description their difficulties by the professional using psychiatric terms (Biddle et al., 2007; Haller et al., 2009). At a

practitioner and service level in the United Kingdom, the terms used in leaflets and service material are often simplified to ensure that they can be understood by the young people accessing the service as recommended in *You're Welcome* (Department of Health, 2011). Perhaps then, if future research confirms that young people who have not previously accessed services express higher intentions to seek help when an alternative to psychiatric language is used to describe mental health; changing the terminology used by professionals and services as a whole could simplify the process of providing mental health care. Kinderman, Read, Moncrieff and Bentall, (2013) suggest a “‘problem definition’, formulation approach rather than a ‘diagnosis, treatment’ approach” (p.3) as a viable alternative. This may help to open up the pathways to care for some of the majority of young people experiencing mental health problems who do not seek help (Thornicroft, 2007).

2.4.4. Conclusions

The overall findings from this study are that the language used by professionals to describe mental health does not directly affect help seeking intentions. However, past experience of and perceived helpfulness of previous mental health care do significantly predict variation in help seeking intentions. There may also be an interaction effect where psychiatric language predicts higher help seeking intentions in young people with past experience of mental health care and lay language predicts higher help seeking intentions in young people who have no experience of professional mental health care. Future research using a longitudinal design with repeated exposure to the effects of language could provide the opportunity for people to assimilate the information into their existing view and provide more reliable results than the design used here. It would also be useful to explore whether the language used to describe mental health has an effect on embarrassment in relation to help

seeking and on judgements about how serious mental health difficulties need to be to warrant professional help (Yap, Reavley, & Jorm, 2013).

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2.6. Tables and Figures

Table 6. Demographic Information for Participants that Completed the GHSQ

	Completed GHSQ (<i>N</i> = 161)					
	Vignette A			Vignette B		
	Traditional Language			Alternative Language		
	N	Mean or %	SD	N	Mean or %	SD
Age	81	20.19	3.10	80	19.84	3.00
Nationality						
<i>UK and Ireland</i>	27	33.3%		26	32.5%	
<i>Rest of World</i>	43	53.1%		49	61.3%	
<i>Unclear*</i>	11	13.4%		5	6.25%	
Gender						
<i>Female</i>	59	72.8%		61	76.3%	
<i>Male</i>	14	17.2%		12	15.0%	
<i>Transgender</i>	4	5.0%		2	2.5%	
<i>Other**</i>	4	5.0%		5	6.25%	
Mental Health Problem Onset						
<i>Past 12 Months</i>	11	13.6%		10	12.5%	
<i>12-24 Months ago</i>	5	6.2%		5	6.3%	
<i>Over 24 Months</i>	65	80.2%		65	81.2%	

Note.*No response or indication of ethnicity/race only. **People identifying as gender identities not listed. Examples given included genderfluid, non-binary and demigirl.

Table 7. Mean Scores in Each Vignette Condition

	Vignette A			Vignette B		
	Traditional Language			Alternative Language		
	N	Mean or %	SD	N	Mean or %	SD
GHSQ	81	25.89	8.05	80	25.80	7.11
RCADS						
<i>Anxiety</i>	80	21.22	9.04	78	21.49	7.63
<i>Depression</i>	80	17.85	5.76	78	18.77	5.46
Personal Stigma	80	0.09	0.36	78	0.08	0.31
Past Mental Health Care						
<i>Experienced</i>	58	72.5%		60	76.9%	
<i>Not experienced</i>	22	27.5%		18	23.08%	
<i>Helpfulness</i>	57	3.56	1.23	58	3.47	1.10

Table 8. Hierarchical Multiple Regression Analysis (N = 158)

		R ²	Adj. R ²	b	Std. Error	Beta	95% Confidence Interval
Model 1	Constant	.04	.02	16.81	4.12		8.66 - 24.95
	Age			0.38	0.20	0.15*	-0.01 - 0.77
	Nationality ¹			1.21	1.29	0.08	-1.35 - 3.77
	Gender ²			1.11	1.37	0.07	-1.60 - 3.81
Model 2	Constant	.07	.04	19.65	5.19		9.56 - 29.75
	Age			0.27	0.20	0.11	-0.14 - 0.67
	Nationality ¹			1.21	1.35	0.08	-1.45 - 3.87
	Gender ²			0.69	1.38	0.04	-2.04 - 3.40
	RCADS Depression			0.03	0.14	0.02	-0.24 - 0.30
	RCADS Anxiety			-0.12	0.09	-0.14	-0.30 - 0.05
	Previous Mental Health Care			2.39	1.37	-0.14*	-0.31 - 5.09
Model 3	Constant	.09	.04	17.10	5.34		6.54 - 27.66
	Age			0.30	0.21	0.12	-0.10 - 0.71
	Nationality ¹			0.92	1.35	0.06	-1.75 - 3.59
	Gender ²			0.99	1.38	0.06	-1.74 - 3.73
	RCADS Depression			0.05	0.14	0.04	-0.22 - 0.33
	RCADS Anxiety			-0.13	0.09	-0.15	-0.31 - 0.04
	Previous Mental Health Care			4.58	1.84	0.27**	-0.95 - 8.20
	Vignette A or B			3.41	2.35	0.23	-1.23 - 8.06
	Vignette*Mental Health Care			-4.84	2.73	-0.32*	-10.23 - 0.56

Note: ¹UK Ireland = 1, Rest of World/Unclear = 0, ²Female = 1, Male, Transgender or Other = 0. * $p < .10$, ** $p < .05$

Table 9. Subgroup Multiple Regression Analysis (N = 115)

		R ²	Adj. R ²	b	Std. Error	Beta	95% Confidence Interval
Model 1	Constant	.03	.00	21.69	4.52		12.73 - 30.65
	Age			0.22	0.21	0.10	-0.20 - 0.64
	Nationality ¹			1.45	1.45	0.12	-1.10 - 4.63
	Gender ²			1.56	1.56	-0.24	-3.47 - 2.72
Model 2	Constant	.17	.13	15.56	5.77		4.09 - 27.03
	Age			0.11	0.21	0.05	-0.30 - 0.52
	Nationality ¹			1.71	1.40	0.12	-1.07 - 4.48
	Gender ²			-0.21	1.49	-0.01	-3.16 - 2.75
	RCADS Depression			0.06	0.13	0.05	-0.20 - 0.31
	RCADS Anxiety			-0.03	0.90	-0.03	-0.21 - 0.15
	Helpfulness of Previous Care			2.23	0.53	0.38***	1.18 - 3.27
Model 3	Constant	.20	.14	14.30	5.90		2.61 - 25.99
	Age			0.10	0.21	0.05	-0.31 - 0.51
	Nationality ¹			1.90	1.42	0.13	-0.91 - 4.71
	Gender ²			-0.22	1.50	-0.01	-3.19 - 2.74
	RCADS Depression			0.07	0.13	0.06	-0.18 - 0.33
	RCADS Anxiety			-0.04	0.09	-0.04	-0.21 - 0.14
	Helpfulness of Previous Care			2.79	0.70	0.48***	1.40 - 4.18
	Vignette A or B			3.12	3.91	0.23	-4.63 - 10.87
	Vignette*Helpfulness Care			-1.32	1.05	-0.37	-3.40 - 0.77

Note. ¹UK Ireland = 1, Rest of World/Unclear = 0, ²Female = 1, Male, Transgender or Other = 0. *** $p < .001$

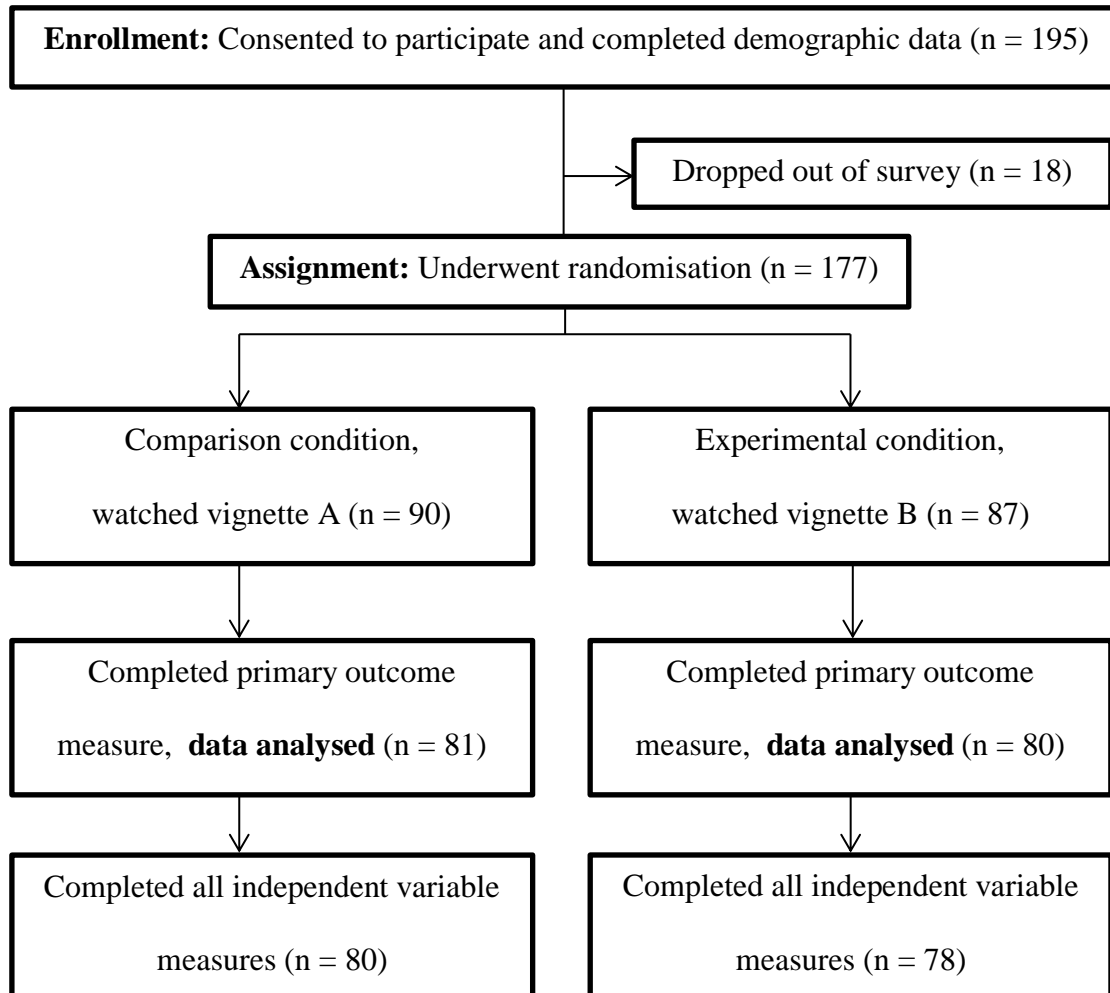


Figure 2. Flow Diagram of Participants Completing Each Stage of the Survey

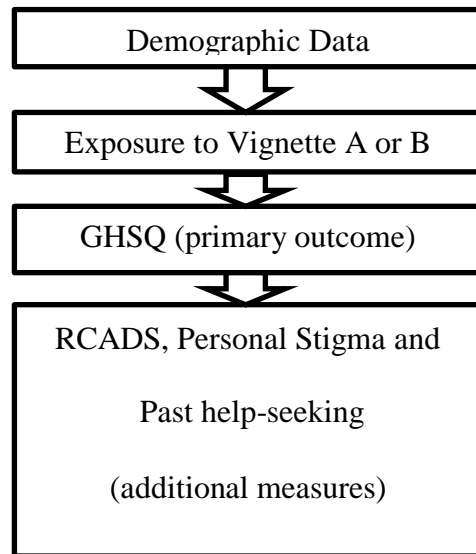


Figure 3. Survey Sequence

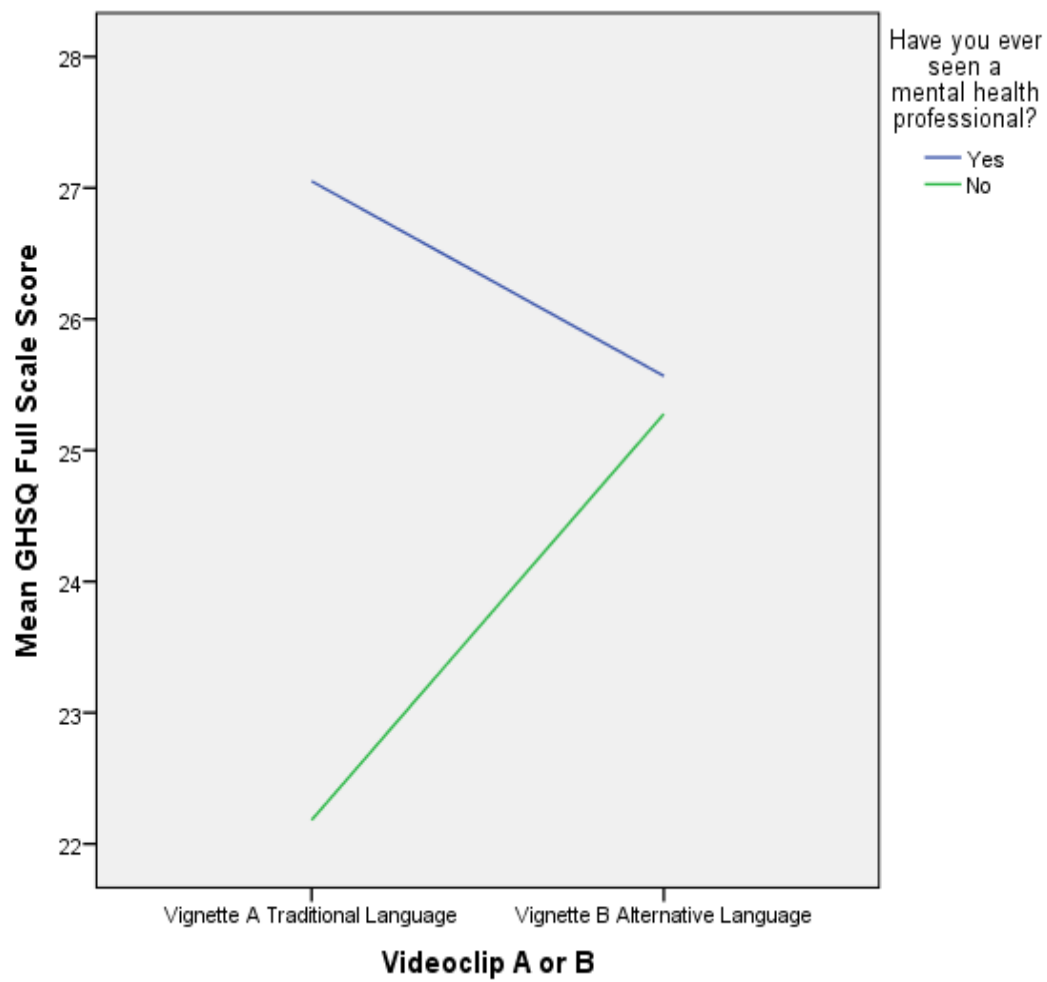


Figure 4. Plot of Interaction Between Previous Experience of Mental Health Care and Vignette Condition

2.7. Appendices

Appendix G. Author information pack

3. JOURNAL OF ADOLESCENCE

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12. ISSN: 0140-1971

13. DESCRIPTION

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86. GUIDE FOR AUTHORS

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Appendix H. Additional Calculations

Predictive Power Calculation.

The minimum sample size for this study was initially 98 participants. This was based on a predictive power calculation using G*power (Faul, Erdfelder, Buchner, & Lang, 2009), aiming to detect a medium effect size; power of 0.80 and $p < 0.05$, with 6 predictor variables. Once data had been collected, 8 predictors were identified for inclusion in the analysis. A further predictive power check was calculated to ensure that the sample size was sufficient to include 8 predictors in the model. The minimum sample required based on this calculation was 109 participants.

Identification of Outliers and Testing Assumptions of Multiple Regression.

Before entering additional predictor variables into the regression model, standard residuals were analysed to identify outliers. One participant was identified as an outlier and removed from the dataset and a repeat analysis confirmed there were no further outliers (std. residual minimum = -2.45; std. residual maximum = 2.37). The data for this participant was reviewed and there was less variation than expected in their responses on the GHSQ and the RCADS. All responses on the GHSQ were either 6 or 7 (on a 7 point scale), indicating a high intention to seek help from all sources and also from no-one. This differed from other participants where a higher score was indicated for only one or two help seeking options. Similarly, this participant used only two scoring options (either 2 or 3 on a 5 point scale) on the RCADS. These patterns suggested that the outlier may be a response bias or data entry error. The regression analysis was conducted with and without the outlier and there were no significant changes, therefore the data was retained. Multicollinearity tests did not indicate any concern and the data met the assumption of independent errors. Histograms, normal P-P plots and scatterplots of standardised residuals indicated that the data entered in to the

regression models contained approximately normally distributed errors and met the assumptions of homogeneity of variance, linearity and non-zero variances.

Appendix I. Demographic Information for Participants that Completed the GHSQ and that Dropped out at the Vignette Stage

	Completed GHSQ (<i>N</i> = 161)						Dropped out at Vignette Stage (<i>N</i> = 16)					
	Vignette A			Vignette B			Vignette A			Vignette B		
	Traditional Language			Alternative Language			Traditional Language			Alternative Language		
	N	Mean or %	SD	N	Mean or %	SD	N	Mean or %	SD	N	Mean or %	SD
Age	81	20.19	3.10	80	19.84	3.00	9	18.56	2.80	7	18.71	3.25
Nationality												
<i>UK and Ireland</i>	27	33.3%		26	32.5%		1	11.1%		3	42.9%	
<i>Rest of World</i>	43	53.1%		49	61.3%		7	77.8%		4	57.1%	
<i>Unclear*</i>	11	13.6%		5	6.25%		1	11.1%		0		
Gender												
<i>Female</i>	59	72.8%		61	76.3%		6	66.7%		6	85.7%	
<i>Male</i>	14	17.2%		12	15.0%		2	22.2%		1	14.3%	
<i>Transgender</i>	4	5.0%		2	2.5%		1	11.1%		0	0%	
<i>Other**</i>	4	5.0%		5	6.25%		0			0		
Mental Health Problem Onset												
<i>Past 12 Months</i>	11	13.6%		10	12.5%		1	11.1%		1	14.3%	
<i>12-24 Months ago</i>	5	6.2%		5	6.3%		0	0%		1	14.3%	
<i>Over 24 Months</i>	65	80.2%		65	81.2%		8	88.9%		5	71.4%	

Note. *No response or indication of ethnicity/race only. **People identifying as gender identities not listed. Examples given included genderfluid, non-binary and demigirl.

Appendix J. Vignette Scripts

Traditional Terminology Script:

As a professional, I describe people with mental health disorders as having a mental illness.

Common mental illnesses include major depressive disorder and general anxiety disorder.

My understanding of illnesses such as these is based on the symptoms and impairments that are reported along with other relevant information. So for example, a person who has major depressive disorder may report symptoms such as depressed mood, insomnia, fatigue and restlessness. (69 words)

Alternative Terminology Script:

As a professional, I describe people with mental health problems as experiencing emotional distress. Common mental health problems include long term depression and anxiety. My understanding of problems such as these is based on the difficulties and emotions that are reported along with other relevant information. So for example, a person experiencing long term depression may report difficulties such as low mood, sleeping problems, reduced energy and feeling uneasy. (69 words)

Appendix K. General Help Seeking Questionnaire (GHSQ)

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

Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de' facto)	1	2	3	4	5	6	7
b. Friend (not related to you)	1	2	3	4	5	6	7
c. Parent	1	2	3	4	5	6	7
d. Other relative/family member	1	2	3	4	5	6	7
e. Mental health professional (e.g. psychologist, social worker, counsellor)	1	2	3	4	5	6	7
f. Phone helpline (e.g. Lifeline)	1	2	3	4	5	6	7
g. Doctor/GP	1	2	3	4	5	6	7
h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain)	1	2	3	4	5	6	7
i. I would not seek help from anyone	1	2	3	4	5	6	7
j. I would seek help from another not listed above (please list in the space provided, e.g., work colleague. If no, leave blank) _____	1	2	3	4	5	6	7

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

Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de' facto)	1	2	3	4	5	6	7
b. Friend (not related to you)	1	2	3	4	5	6	7
c. Parent	1	2	3	4	5	6	7
d. Other relative/family member	1	2	3	4	5	6	7
e. Mental health professional (e.g. psychologist, social worker, counsellor)	1	2	3	4	5	6	7
f. Phone helpline (e.g. Lifeline)	1	2	3	4	5	6	7
g. Doctor/GP	1	2	3	4	5	6	7
h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain)	1	2	3	4	5	6	7
i. I would not seek help from anyone	1	2	3	4	5	6	7
j. I would seek help from another not listed above (please list in the space provided, e.g., work colleague. If no, leave blank) _____	1	2	3	4	5	6	7

Appendix L. Revised Children's Anxiety and Depression Scale (RCADS)

Name: _____

Date: _____

RCADS – Short Version

Please put a circle around the word that shows how often each of these things happen to you. There are no right or wrong answers.

1. I feel sad or empty	Never	Sometimes	Often	Always
2. I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
3. I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
4. Nothing is much fun anymore	Never	Sometimes	Often	Always
5. I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
6. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
7. I worry what other people think of me	Never	Sometimes	Often	Always
8. I have trouble sleeping	Never	Sometimes	Often	Always
9. I feel scared if I have to sleep on my own	Never	Sometimes	Often	Always
10. I have problems with my appetite	Never	Sometimes	Often	Always
11. I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
12. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
13. I have no energy for things	Never	Sometimes	Often	Always
14. I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
15. I cannot think clearly	Never	Sometimes	Often	Always
16. I feel worthless	Never	Sometimes	Often	Always
17. I have to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
18. I think about death	Never	Sometimes	Often	Always
19. I feel like I don't want to move	Never	Sometimes	Often	Always
20. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
21. I am tired a lot	Never	Sometimes	Often	Always
22. I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
23. I have to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
24. I feel restless	Never	Sometimes	Often	Always
25. I worry that something bad will happen to me	Never	Sometimes	Often	Always

Appendix M. Prior Counselling Measure taken from Wilson and colleagues (2005)

“The prior counselling measure comprises four items that have been used in samples of prison inmates (Deane et al., 1999), high school students (Carlton & Deane, 2000), and college students (Deane, Wilson, et al., 2001)” (p.21).

The four items in the current prior counselling measure included:

- “Have you ever seen a mental health professional (e.g., counsellor, psychologist, psychiatrist) to get help for personal problems?” (“Yes” or “No”)
- “How many visits did you have with the health professional(s)?”
- “Do you know what type of health professional(s) you’ve seen (e.g., counsellor, psychologist, psychiatrist)?”
- “How helpful was the visit to the mental health professional?” This evaluation was rated on a 5-point Likert scale ranging from 1 (“extremely unhelpful”) to 5 (“extremely helpful”).

Appendix N. Personal Stigma Measure taken from Eisenberg and colleagues (2009)

Please indicate whether you agree or disagree with the following statements.

1. I would willingly accept someone who has received mental health treatment as a close friend.
2. I would think less of a person who has received mental health treatment.*
3. I believe that someone who has received mental health treatment is just as trustworthy as the average person.

Appendix O. Adverts for sharing survey

Tweet/brief advert

Aged 16-25? Experienced mental health problems? Check out our survey:

[#youngpeople #mental health](https://lancasteruni.qualtrics.com/SE/?SID=SV_5pcyEX4pw045MVL)

More detailed advert wording for sharing on webpages/blogs

We are looking for young people aged 16-25, who have experienced mental health problems, to take part in some research. If this describes you, we want to ask you some questions about help seeking for mental health problems. Interested? Then check out our survey here: Aged 16-25? Experienced mental health problems? Check out our survey:

[#youngpeople #mental health](https://lancasteruni.qualtrics.com/SE/?SID=SV_5pcyEX4pw045MVL)

[or via twitter using @mhsurvey2015]

Email

Hi [Insert name],

[optional: Further to our conversation, here is some further information about my research project.] My name is [name], I am a trainee clinical psychologist, conducting my doctoral thesis at Lancaster University. My research is focused on help seeking for mental health problems amongst young people aged 16-25. If you could help me to recruit participants by sharing the advert below on your [blog/webpage/forum/email distribution list] I would be very grateful. If you want further information about the project, more details are provided on the first page of the survey, this can be accessed without participating by clicking the link in the advert below.

This is the advert that has been approved by the ethics committee at Lancaster University:

We are looking for young people aged 16-25, who have experienced mental health problems, to take part in some research. If this describes you, we want to ask you some questions about help seeking for mental health problems. Interested? Then check out our survey here: Aged 16-25? Experienced mental health problems? Check out our survey:

https://lancasteruni.qualtrics.com/SE/?SID=SV_5pcyEX4pw045MVL [#youngpeople](#)
[#mentalhealth](#)

[or via twitter using @mhsurvey2015]

Thank you very much for your help and please don't hesitate to ask if you have any further questions.

Poster



Aged 16-25?

Experienced Mental Health Problems?

Check out our survey  @MHSurvey

#youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

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@MHSurvey #youngpeople #mentalhealth

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@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

Photo for social media



Aged 16-25?

Experienced Mental Health Problems?

Check out our survey  @MHSurvey

#youngpeople #mentalhealth

Appendix P. Introductory Page and Consent Form

Hi there, thank you for your interest in this research!

We are looking for young people aged 16-25 who have experienced mental health problems. If this describes you, we want to ask you some questions about help seeking for mental health problems. Before you begin, please have a read of our participant information form [hyperlinked] that goes into a bit more detail about the study. If you have any questions before taking part please contact [name] by email at [email address] If you're happy with all of that then please read the statements below, click on each one to indicate that you agree and click the button at the bottom to proceed:

1. I confirm that I have read the participant information sheet [hyperlinked].
2. I confirm that I have had the opportunity to ask questions.
3. I understand that my participation is voluntary and that I am free to withdraw from completing the survey at any time without giving any reason.
4. I understand that the answers I give will be anonymous.
5. I understand that the questions are about my experiences of mental health problems and focusing on this topic could cause me to feel distressed. I understand that there is a list of services I can contact for support given at the end of the survey. Here is a copy for download should you need it: [hyperlink].
6. I understand that the researcher will share and discuss the data from my responses with the project supervisors.
7. I consent to the data from my responses being published, used in reports, conferences and training events.
8. I consent to Lancaster University keeping the survey data for five years after the study has finished, or if it is published, for five years after publication.

[I consent to take part in this study.]

Appendix Q. Participant Information Sheet

Participant Information Sheet

My name is [name]. I am a trainee clinical psychologist at Lancaster University and I am conducting this research project as part of my training. I am being supervised by [supervisor names] lecturers at the University.

The research study is about help seeking for mental health problems amongst young people. Specifically I am interested in finding out whether peoples' decisions about seeking help are affected by things such as previous experiences of mental health services. The results will be submitted as part of my doctoral thesis project at Lancaster University. If possible, I also hope to publish the results in an academic journal.

Can I take part?

You can take part if you are aged between 16-25 and feel that you have experienced mental health problems.

You don't need to have accessed help or received an official diagnosis. Your opinion is all we need, so if you have ever felt like you have struggled with mental health problems you are welcome to take part. Examples might include things like long-term low mood, anxiety, difficult thoughts or experiences other might think are unusual such as seeing or hearing things that other people cannot see or hear.

What will happen if I decide to take part?

Once you have consented to taking part you will be asked to answer a few brief questions about your age, gender, nationality and if you have experienced mental health problems. You will then be shown a brief videoclip and asked some detailed questions about your views and experiences of mental health problems. The survey will last for about 5 minutes. You can exit the survey at any point by clicking the exit button [example] that will be shown on each page.

At the end of the survey, or if you click the exit button, you will be directed to a page that gives information about services to contact for support.

Will taking part affect my care or legal rights?

The study is not linked to any service. Your decision will make no difference to the care you receive from any service or to your legal rights. This study is completely anonymous. This means that you will not be

asked at any point for your name, address, date of birth or other identifying information.

Do I have to take part?

No. Participation is voluntary. You can exit the survey at any point and your decision will make no difference to the care you receive from any service or to your legal rights. This study is completely anonymous.

What will happen to the results of the research?

The information that you give will be combined with answers from other participants. This information will be analysed and the findings will be written up into a research report and submitted to Lancaster University as part of a thesis project for the doctorate in clinical psychology programme. The findings may also be submitted for publication in an academic journal, used in reports, conferences and training events.

A summary of the findings will be made available at [Lancaster website where theses shown or via twitter account used for the project] after the project has been completed.

What are the benefits of taking part?

There will be no direct benefit to you from taking part. However, by contributing to research you will be increasing knowledge about mental health. Also, it is hoped that the findings of this research will be published and contribute to improving future mental health service provision for young people.

Who reviewed the research?

This research project has been reviewed by the Faculty of Health and Medicine Research Ethics Committee (FHMREC) and approved by the University Research Ethics Committee (UREC), Lancaster University.

I want to take part, what do I do now?

If you would like to take part continue with the survey by clicking the button at the bottom of the page that says 'I want to take part' [show example].

Before the survey begins, there is a consent form which asks you to tick next to some statements, agreeing that you understand what the research is about and how your information will be used. If you agree with all of that, then tick the boxes and click to begin the survey.

Who do I contact if I have a complaint or serious concern about this research?

If you have any complaints or concerns and do not want to contact the researcher, you can contact:

Research Director, Doctorate in Clinical Psychology, Division of Health Research, Furness College, Lancaster University, LA1 4YG. Tel: email:

Or

Associate Dean for Research, Faculty of Health and Medicine (Division of Biomedical and Life Sciences), Lancaster University, Lancaster LA1 4YD. Tel: email:.

Appendix R. Demographic Questions

- What is your age?

Options: 16, 17, 18, 19, 20, 21, 22, 23, 24, 25

- What is your gender?

Options: male, female, transgender, other [option to type in alternative]

- What is your nationality?

[open text box]

- Have you experienced a mental health problem?

Options: Yes, no [A help box will be available here giving the following advice –, If you were struggling and felt like you needed some help, tick yes. You don't need to have actually accessed any help, your opinion is all we need. Examples might include things like, long-term low mood, anxiety, difficult thoughts or experiences other might think are unusual such as seeing or hearing things]

- If tick yes, a follow up question will be when did the problem first occur?

Options: In the past 12 month, between 12-24 months ago, over 24 months ago

Appendix S. Orienting Paragraph

Imagine that if you were to seek help for mental health problems in the future, your problems would be understood in the way just described by the professional in the video. Keep this in mind whilst answering the following questions.

Appendix T. Debriefing Page

Thank you for taking part in this research! If you need support, advice, or someone to talk to about mental health problems here are details about some of the services available.

Immediate 24 hours

999

If you experience an acute emergency, you should call 999 and ask for the ambulance service or the police.

This is where there is immediate danger to life or physical injury. For example, an overdose of medication or self-harm is showing signs of its effects, such as slurred speech or sleepiness.

If someone is threatening aggression, holding a weapon, committing or about to commit a serious assault, ask for the police.

111

If you require urgent care but it is not life threatening, you could call [NHS 111](#). For example, if you or someone you know are:

- suffering a relapse with existing mental health problem symptoms
- experiencing a mental health problem for the first time
- injured from, or wanting to, self-harm in a way that clearly does not immediately threaten life
- showing signs of onset of dementia
- experiencing domestic violence or physical, sexual or emotional abuse

However, if you've already been given a Crisis Line number by your GP or local services, you should call them instead.

Mental Health Helplines

If you want to talk to someone right away, the [mental health helpline page](#) has a list of organisations you can call for immediate assistance. They have specially trained volunteers who'll listen to you and help you through the immediate crisis.

These ones are open 24 hours and offer online support through the websites too:

- Samaritans

Confidential support for people experiencing feelings of distress or despair. Available any time, in your own way, and off the record – about whatever’s getting to you.

Phone: 08457 90 90 90 (24-hour helpline)

Website: www.samaritans.org.uk

- ChildLine

ChildLine is a private and confidential service for children and young people up to the age of 19. You can contact a ChildLine counsellor about anything - no problem is too big or too small. You can phone, have a 1-2-1 chat online or send an email.

Phone: 0800 1111 (24-hour helpline upto age 19)

Website: www.childline.org.uk

- Refuge

Advice on dealing with domestic violence.

Phone: 0808 2000 247 (24-hour helpline)

Website: www.refuge.org.uk

In a non-urgent situation

NHS

Mental health services are free on the NHS, you will usually need a [referral from your GP](#) to access them. Some mental health services will allow people to refer themselves. You can search to find out [what mental health services are available in your area](#).

College or University

Your college or university should have services to support your wellbeing. You could talk to your head of year, tutor or visit your college or university website for information on what is available. This usually includes, counselling or student advice services, support networks and drop-in provisions,

Rethink Mental Illness

If any of these options seem confusing and you want some practical advice about mental health services, check out Rethink's website, or they have a daytime advice line. The advice service offers practical help on issues such as the Mental Health Act, community care, welfare benefits, debt, criminal justice and carers rights. They also offer general help about living with mental illness, medication, care and treatment.

Phone: 0300 5000 927 (Mon-Fri, 10am-2pm)

Website: <http://www.rethink.org/living-with-mental-illness/young-people>

Section 3. Critical Appraisal

Is it Time for a Paradigm Shift?

Emma L Williamson

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Division of Health Research, Lancaster University

Word Count: 2427

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Throughout this project the key message that stood out to me was that perhaps progress is halted by the way that alternative arguments are presented (Boyle, 2013). In this thesis I aimed to compare arguments that were based on varied methodologies and epistemologies (Bryman, 1984). Whether or not it is possible to truly compare arguments that are grounded in different philosophies is debated (Yilmaz, 2013). Qualitative research is currently considered to have the greatest value in providing detailed descriptions and understanding of experiences that can guide areas of research interest (Silverman, 2013). Tools have been developed to appraise qualitative research (Greenhalgh, 2010); however, common criticisms of qualitative approaches are that they lack rigour and that it is not appropriate to use concepts such as reliability, validity and generalisability to evaluate them (Noble & Smith, 2015). Quantitative methods, particularly randomised designs are generally considered to be more powerful and at less risk of bias than non-randomised or qualitative designs and therefore are most often the type of research that is used to guide funding, clinical guidance and service provision (Sullivan, 2011).

That said, the use of random allocation in experimental designs only balances for unknown prognostic factors between groups at baseline and does not prevent bias in other aspects of the research such as the way that interventions are delivered, how outcomes are measured and how the results are interpreted (Jadad & Enkin, 2008). To account for this, a variety of quality assessment tools that measure risk of bias have been developed for different quantitative designs and are used by reviewers to consider how well other forms of bias have been considered and controlled for (e.g. Armijo-Olivo, Stiles, Hagen, Biondo & Cummings, 2012). Quality assessments of all types of research design are used to inform the design and provision of health and social care; however, they are currently based on appraisal systems that rank types of research hierarchically dependent on the methods used and quantitative

randomised methodologies are initially allocated a higher ranking than qualitative designs (e.g. National Health and Medical Research Council, 2009; National Institute for Health and Clinical Excellence [NICE], 2014).

This research project was a quantitative, randomised design comparing two groups. This type of design was chosen so that the findings could be considered useful for informing service provision based on the current criteria (NICE, 2014). It was also a vignette based design, similar to previous research in this area of study to facilitate comparison (Yap, Reavley & Jorm, 2014). The findings of this research study did not indicate that the language used by professionals to describe mental health has a direct impact on young people's help seeking intentions. Whether or not the person had accessed mental health care previously significantly predicted some variation in future help seeking intentions. A possible interaction effect between this variable and the professional language the young person was exposed to in the vignette condition was also noted. Participants who had previously experienced professional mental health care indicated higher help seeking intentions in the psychiatric language condition. Conversely, participants who had not previously experienced professional mental health care indicated higher help seeking intentions in the psychological or ordinary language equivalent condition.

The importance of an interaction such as this is if it is replicated, in relation to how it guides future research and clinical practice, could be interpreted in more than one way depending on who is reading the results. One interpretation could be that those who have accessed services have higher help seeking intentions when presented with psychiatric language as they have learnt how to accurately understand and recognise their difficulties so know what action to take when they require help again in the future. A link between the use of psychiatric language and higher help seeking intentions among young people who have

accessed mental health care previously could be explained by MacCulloch's argument that when medicalised labels are assigned, they give reassurance and security by providing a name for the difficulties being experienced, legitimising them and justifying the need for treatment, therapy or support (MacCulloch, 2010). Importantly, he also states that psychiatric terms act as gatekeepers to services, with the provision of a diagnosis being used to judge eligibility and treatment referrals (MacCulloch, 2010). It could be argued that young people who have accessed services previously will have gained an awareness of this, potentially influencing their preference for psychiatric terminology dependent on whether they found services helpful and wish to access them again in the future.

This perspective also forms the basis for providing mental health literacy interventions and education for the public (Jorm, 2012). The premise behind this perspective is that the public do not possess the necessary knowledge to understand and interpret their difficulties accurately and so fail to recognise that they need assistance. Teaching people how to recognise mental illness, what to do immediately to help and where to direct people to access specialist support is recommended as the solution to improve access to mental health care, assist recovery and lower the burden that experiencing mental illness has on individuals and society (Jorm, 2012). However, evidence for the effectiveness of doing this is limited (Wei, Hayden, Kutcher, Zygmunt, & McGrath, 2013) and some argue that the current system for understanding and providing treatment for mental health difficulties does not effectively meet people's needs (Kinderman, Read, Moncrieff, & Bentall, 2013).

Another interpretation of the interaction outlined could be that those who have not accessed care previously will have higher intentions to seek help if alternative lay language is used as this is experienced as less confusing (Martinez-Hernaez, DiGiacomo, Carceller-Maicas, Correa-Urquiza & Martorell-Poveda, 2014), stigmatising (Angermeyer &

Matschinger, 2003) and pejorative (Johnstone, 2014). This interpretation could mean that changing the language used to describe mental health, as proposed by the Division of Clinical Psychology (DCP) may increase the help seeking intentions of some people who have not previously accessed help (DCP, 2015). Furthermore, recent actions taken by the National Institute for Mental Health to no longer use categories from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) as a research framework (Insel, 2013) and the DCP to publish clinical guidance advising against the use of functional psychiatric diagnoses (DCP, 2015) indicate that the move towards identifying an alternative system for conceptualising mental health has already begun. That said, a replacement for the biomedical model of mental health has not yet been identified (Boyle, 2013) and the extent to which the dominant language used by all mental health professionals will change is currently unclear.

The current dominant model has advanced since its introduction and developed to incorporate additional social, cultural and psychological factors (Engel, 1977). Antonovsky (1996) suggests that new generations of medical students and researchers are quick to forget the value that current and past models have added to the field and how they have advanced our understanding. Additionally, some argue that a better alternative does not exist and the value of the current model is in its utility (Mullins-Sweatt & Widiger, 2009). Conversely, Wakefield (2016) proposes that discussions about utility take the focus away from the validity of the system, which should be our ultimate scientific and professional goal in identifying the best model of understanding mental health difficulties. He concludes that rather than stating “if it cannot be perfect, let it be useful”, a more useful alternative aim should be “if diagnostic criteria cannot be perfectly valid, let them be as valid as possible” (Wakefield, 2016, p.34). Jablensky (2016) argues that attaining validity in the

conceptualisation of mental health is an unachievable aim, but that it remains a useful concept for guiding empirical research to improve the clinical utility of “diagnostic concepts and tools”, increase their “phenomenological accuracy” and improvement the provision and planning of mental health care (p.30).

In view of identifying alternative options, (Pickersgill, 2014, p. 524) states that:

an expansion of the sphere of public discourse around this to include voices which are less seldom heard . . . might provide a more practice-orientated and potentially patient-centred basis for normative assertions about the design and delivery of mental health systems. (Pickersgill, 2014, p. 524)

Moves towards opening up public and patient-centred discussions have occurred during the past two decades and the involvement of service users in the planning and provision of professional training courses and health and social care has increased substantially (Branfield & Beresford, 2006). Additionally, networks of people who share common experiences that are considered by society to be “mental illness” or “disorders” have formed, become vocal in proposing alternative ways of understanding and conceptualising their problems and gained strength in their ability to shape service provision and policy (e.g. the Autistic Rights Movement, the Hearing Voices Network and the National Survivor User Network). The number of alternatives or improvements to the current approach that have been proposed is beyond the scope of this essay to consider. Suggestions that are considered feasible by professional clinical psychology organisations in the United Kingdom include identifying the base unit of measurement as specific problems (British Psychological Society [BPS], 2011b) and a formulation based approach (Johnstone, 2014; Kinderman, Read, Moncrieff and Bentall, 2013). Formulation is defined by the DCP (2010) as:

The summation and integration of the knowledge that is acquired by [an]

assessment process that may involve psychological, biological and systemic factors and procedures. The formulation will draw on psychological theory and research to provide a framework for describing a client's problem or needs, how it developed and is being maintained. (pp.5-6)

Suggested alternative approaches to inpatient mental health care that have been trialled internationally and have been evidenced in published studies as achieving positive outcomes include the tidal model (Gordon, Morton, & Brooks, 2005) and a sotheria paradigm (Calton, Ferriter, Huband, & Spandler, 2008). The tidal model is a philosophical and theoretical template for mental health care that emphasises helping people reclaim their personal story of mental distress by using their own language and metaphors to articulate the meaning of their personal experiences (Barker & Buchanan-Barker, 2010). The key focus in a tidal approach is to provide support for people who have experienced “a metaphorical breakdown”, assisting them to recover as far as possible based on their own understanding of the concept of recovery (Barker & Buchanan-Barker, 2010, p.171). The sotheria paradigm is an alternative to hospitalisation for people experiencing what has previously been termed “schizophrenia” and is more commonly referred to currently as “psychosis” by providing a community based crisis house, aiming to find meaning in the person's subjective experience and minimise the use of medication (Calton, Ferriter, Huband, & Spandler, 2008).

Boyle (2013) argued that a predominantly medical model of mental health continues to dominate the provision of mental health care despite the availability of viable alternatives partially due to the way that alternatives are researched and presented. She proposed that until new models that are able to replace the current one are fully formed and effectively articulated, the dominance of a medicalised model of mental health is likely to continue (Boyle, 2013). She points out that although some alternatives appear to have been

acknowledged and incorporated into how services view mental health, they have essentially been assimilated into the dominant system; driven by a biopsychosocial model which continues to prioritise biological understandings of mental illness over other causes as can be seen in descriptions such as disorders and illness that are still overwhelmingly used (Boyle, 2013). Indeed, so teria paradigm and tidal model based trials that have been developed as alternatives to standard inpatient mental health care services are currently provided within a wider system that continues to privilege a biopsychosocial model and limits the ability of professionals to use the approaches fully (e.g. McAndrew, Chambers, Nolan, Thomas, & Watts, 2014; Slade et al., 2010).

In relation to the research and development of viable system wide alternatives, the BPS (2011b) stated that alternatives to diagnostic frameworks exist and should be developed with “as much investment of resource and effort as has been expended on revising DSM-IV” (p.3). The move by the National Institute for Mental Health to identify a new framework for research that is not reliant on diagnostic criteria from the DSM-5 is an important advance towards changing how funds and resources are invested in research, however, the new framework is still based on a medicalised conception of mental health (Insel, 2013). Kinderman, Read, Moncrieff and Bentall (2013) suggested a problem definition, formulation approach as a viable alternative. The use of formulation as an alternative has also been proposed by Johnstone (2014). Although good practice guidelines exist for the use of formulation, it is an under researched area and further evidence for its validity and utility are needed (BPS, 2011a). Coles (2013) argues that by moving beyond current thinking about mental health problems, we can also start to recognise increasing levels of psychological distress as an important indication that the social structures and hierarchies that our societies are currently based upon are damaging for many and therefore are not fit for purpose.

However, Boyle (2013) warns that proposed alternatives to a biomedical model often completely neglect the biological elements of mental distress. For example, physical pain, lethargy, sleeplessness and loss of appetite experienced as a consequence of anxiety or depression (Boyle, 2013). Alternative accounts that do not include bodily experiences are considered incomplete or incorrect, leading to invalidation (Boyle, 2013). Including biology into alternative models without it being privileged as the cause and leading the model to become assimilated into the current overarching biomedical model will be a considerable challenge. Thornicroft & Tansella (2013) conducted a review of mental health system change and proposed a balanced care model for global mental health. This is a practically focused service delivery model rather than a conceptual model and as such the language used takes a medicalised approach to mental health, however, the model proposes a way that services could be restructured to incorporate approaches such as crisis houses into care systems (Thornicroft & Tansella, 2013). Importantly, they also state the importance of considering planning and implementation when proposing new conceptual models (Thornicroft & Tansella, 2013).

Based on the arguments considered here, an important first step to embracing the challenge of introducing an alternative approach to the biomedical model is to systematically review the evidence for proposed alternative models and to consider their validity, clinical utility and feasibility for planning and implementation. A systematic review of evidence for the so teria paradigm has been published (Calton, Ferriter, Huband, & Spandler, 2008). To facilitate progression towards a paradigm shift, similar evidence is also required for other suggested alternatives.

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Section 4. Ethics Section

Applicant: Emma Williamson
Supervisor: Guillermo Perez Algorta
Department: DHR
FHMREC Reference: FHMREC15030

23 November 2015

Dear Emma

Re: Does the language used to describe mental health affect help-seeking intentions in young people.

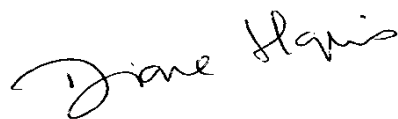
Thank you for submitting your research ethics amendment application for the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The application was recommended for approval by FHMREC, and on behalf of the Chair of the University Research Ethics Committee (UREC), I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact the Diane Hopkins (01542 592838 fhmresearchsupport@lancaster.ac.uk) if you have any queries or require further information.

Yours sincerely,



Diane Hopkins
Research Development Officer

CC Ethics@Lancaster; Professor Roger Pickup (Chair, FHMREC)

Faculty of Health and Medicine Research Ethics Committee (FHMREC) Lancaster University

Application for Amendment to Previously Approved Research

Instructions: Please re-submit your original research ethics approval documents with any amendments highlighted in yellow, attaching this form as a cover sheet. Completed documentation should be submitted as a single PDF by email and a **signed** hard copy of this form to:

Dr Diane Hopkins
Faculty of Health & Medicine
B14, Furness College
Lancaster University
LA1 4YT
d.hopkins@lancaster.ac.uk

1. Name of applicant: Emma Williamson
2. E-mail address and phone number of applicant: e.williamson@lancaster.ac.uk
3. Title of project: Does the language used to describe mental health affect help-seeking intentions in young people
4. Project reference number: RS2015-7
5. Date of original project approval as indicated on the official approval letter: August 2015

**Amendment request**

6. Please outline the requested amendment(s).

Please note that where the amendment relates to a change of researcher, and the new researcher is a student, a full application must be made to FHMREC.

- 1) Including an exit button on each page of the survey as intended is not possible in Qualtrics. As an alternative, a list of services has been included as a downloadable pdf on the consent page and the wording on the consent form and participant information sheet has been adapted accordingly. Please see amended examples attached.
- 2) As the wording of the vignettes has been changed slightly, a brief paragraph will be presented to participants following the video clip to orient participant to the questionnaires. It will say: Imagine that if you were to seek help for mental health problems in the future, your problems would be understood in the way just described by the professional in the video. Keep this in mind whilst answering the following questions.
- 3) The wording at the top of the consent form has been altered slightly to match the format of the Lancaster Qualtrics survey template. Specifically, the Lancaster survey format displays the questions in boxes whereby you click on the question itself rather than a checkbox next to it.

7. Please explain your reason(s) for requesting the above amendment(s):

The survey was pilot tested and some slight changes had to be to the format due to the limitations of the qualtrics survey software being used. Guidance was sought from technical support staff at qualtrics and some of the intended formatting is not possible.

Furthermore, the experimental vignettes were pilot tested and adjusted as per a caveat agreed and detailed in the ethics approval letter. The adjustments made to the vignette scripts made it necessary to introduce an orienting paragraph for participants.

Signatures

Applicant: _____ Date: _____

Project Supervisor: _____ Date: _____
(if applicable)

**Faculty of Health and Medicine Research Ethics Committee (FHMREC)
Lancaster University**

**Application for Ethical Approval for Research involving
direct contact with human participants**

Instructions *[for additional advice on completing this form, hover PC mouse over 'guidance']*

1. Apply to the committee by submitting:
 - a. The University's **Stage 1 Self Assessment (part A only)** and the **Project Questionnaire**. These are available on the Research Support Office website: [LU Ethics](#)
 - b. The completed application **FHMREC form**
 - c. Your full research proposal (background, literature review, methodology/methods, ethical considerations)
 - d. All accompanying research materials such as, but not limited to,
 - 1) Advertising materials (posters, e-mails)
 - 2) Letters/emails of invitation to participate
 - 3) Participant information sheets
 - 4) Consent forms
 - 5) Questionnaires, surveys, demographic sheets
 - 6) Interview schedules, interview question guides, focus group scripts
 - 7) Debriefing sheets, resource lists

Please note that you DO NOT need to submit pre-existing handbooks or measures, which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submit all the materials electronically as a **SINGLE email attachment in PDF format** by the deadline date. **Before converting to PDF ensure all comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.***
3. Submit one collated and signed paper copy of the full application materials in time for the FHMREC meeting. If the applicant is a student, the paper copy of the application form must be signed by the Academic Supervisor.
4. Committee meeting dates and application submission dates are listed on the [FHMREC website](#). Applications must be submitted by the deadline date, to:
5. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application.
6. Attend the committee meeting on the day that the application is considered, if required to do so.

1. Title of Project: Does the language used to describe mental health affect help-seeking intentions in young people

2. Name of applicant/researcher: Emma Louise Williamson

3. Type of study

- Includes *direct* involvement by human subjects.
- Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. Please complete the University Stage 1 Self Assessment part B. This is available on the Research Support Office website: [LU Ethics](#). Submit this, along with all project documentation, to Diane Hopkins.

4. If this is a student project, please indicate what type of project by marking the relevant box: (please note that UG and taught PG projects should complete **FHMREC form UG-tPG**, following the procedures set out on the [FHMREC website](#))

PG Diploma Masters dissertation DClInPsy SRP PhD Thesis PhD Pall. Care
PhD Pub. Health PhD Org. Health & Well Being PhD Mental Health MD
DClInPsy Thesis

Applicant Information

5. **Appointment/position held by applicant and Division within FHM** Trainee Clinical Psychologist. DClInPsy.

6. **Contact information for applicant:**

E-mail: [REDACTED] **Telephone:** [REDACTED] (please give a number on which you can be contacted at short notice)

Address: Clinical Psychology, Doctoral Programme, Division of Health Research, Lancaster University, Bowland Tower East, Lancaster LA1 4YT

7. **Project supervisor(s), if different from applicant:** Dr. Guillermo Perez Algorta, [REDACTED]
[REDACTED]

8. **Appointment held by supervisor(s) and institution(s) where based (if applicable):**

Dr. Guillermo Perez Algorta, Lecturer. Division of Health Research, Clinical Psychology, Doctoral Programme, Lancaster University, Bowland Tower East, Lancaster LA1 4YT

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

9. **Names and appointments of all members of the research team (including degree where applicable)**

[REDACTED]

The Project

NOTE: In addition to completing this form you must submit a detailed research protocol and all supporting materials.

10. **Summary of research protocol in lay terms (indicative maximum length 150 words):**

The language used to describe mental health may influence whether young people seek help when it is needed (Martínez-Hernández et al., 2014; Yap, Reavley & Jorm, 2013a). Some have argued that accurate psychiatric diagnoses enable help-seeking (Jorm et al., 2014). Others have suggested that psychiatric diagnoses are confusing and lead to an avoidance of professional services (Martínez-Hernández et al., 2014). This study aims to investigate whether changing the language used to describe mental health affects help-seeking intentions.

This will be an online experiment, recruiting young people aged 16-25 who have experienced mental health difficulties. Participants will be randomly assigned to two groups. Each group will be shown a vignette describing

mental health difficulties. One will use psychiatric diagnostic language. The other will use psychological and ordinary language equivalents. Following this, help-seeking intentions will be measured using a questionnaire. Other predictors variables will also be measured.

11. Anticipated project dates (month and year only)

Start date: September 2015

End date: August 2016

12. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

The proposed inclusion criteria for the project will be: 1) Aged between 16 and 25; 2) Able to read and understand the English language; 3) Self-identified as experiencing mental health problems.

The 16-25 age range has been specified as research suggests that three-quarters of all lifetime mental health problems start by the age of 24, with later diagnoses mostly co-occurring alongside other conditions (Kessler et al., 2005). To capture this, taking into account that this survey is asking about mental health problems during the past 12 months, setting the upper cut off at 25 seems appropriate. The third criterion has been included as this study is focused on intentions to seek help for mental health problems, and as such, is looking for participants who identify themselves as having experienced mental health problems.

The minimum sample size required will be 98 participants, 49 per experimental group. This predictive power estimate was calculated using G*power (Faul, Erdfelder, Buchner, & Lang, 2009). The calculation was based on: aiming to detect a medium effect size ($f^2=.15$); using a fixed model linear multiple regression; looking for power of 0.80, and $p<0.05$, with 6 predictor variables.

13. How will participants be recruited and from where? Be as specific as possible.

Potential participants will be contacted online via social networking and media sites, forums, websites, online self-help groups, and emails to relevant organisations and professional contacts asking them to distribute information about the study. A variety of advert options will be created so that organisations can assist with recruitment in the ways that are most suited to their resources. Organisations could include colleges, youth clubs and voluntary sector organisations. Examples of how relevant organisations might assist with recruitment could include them tweeting about the project, posting up details on their websites, online pages or forums, sending out group emails or text messages to student distribution lists, or displaying posters and leaflets in communal areas. All online adverts will link directly to the a survey on a Lancaster University website in which the qualtrics software is embedded (Qualtrics, 2015b). Paper copies of posters and leaflets will display a link to the twitter account being used to make the study easily accessible via smartphones and wireless devices.

14. What procedure is proposed for obtaining consent?

This survey will be anonymous and therefore, rather than a 'signed' consent form, an introductory page will provide a link to the participant information sheet and ask participants to **click on each statement check boxes** to demonstrate that they understand what they are agreeing to by participating in the survey. Once all of the **statements have been clicked on boxes are checked**, a button will need to be clicked in order to proceed to the survey.

15. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

Baseline data will be collected about levels of general mental health difficulties, personal stigma, and past mental health service experience. Completing these questionnaires will not cause difficulties where they do not already exist. However, the questionnaires may orient participants to focus on difficulties they have been experiencing and as a result, participants could feel some degree of upset or distress. To account for this, it will be made clear that they are free to withdraw from the study at any point whilst completing the survey and **a list of services that**

can be accessed for support has been included as a downloadable pdf on the consent page. and 'exit' button will be available on all pages of the survey which will link to the debrief page and information about services that can be accessed for support. The debrief information page will also be presented automatically to all participants upon completion of the survey. This will thank the person for their participation and provide information on how and where to seek help or advice relating to mental health. For example: a brief overview of the NHS route via the GP, what to do in a crisis situation (A&E, 999, ChildLine, Samaritans) and links to the NHS online advice pages and other services such as ChildLine or YoungMinds.

16. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

As this is an online, anonymous survey, lone working risks do not apply. A university email account will be used to distribute survey information to relevant organisation. The same university email will be provided as a contact point should participants wish to request further information about the study or ask that their information is withdrawn. Social media sites, websites and forums will also be used distribute details of the survey. Where necessary, and within the acceptable rules of the media site, the researcher will use an account created specifically for the purpose of this project. Where this is not possible, due to the sites regulations, the researcher will instead contact relevant organisations that already have pages on those sites, and ask them to distribute details of the survey on the researchers behalf. For example, organisations such as Lancaster University pages, British Psychological Society groups, young peoples mental health advisory groups, mental health charities and mental health research interest groups. If providing a mobile contact number becomes necessary during the recruitment phase for discussions with relevant organisations a non-personal mobile phone from the course research resources will be used.

17. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

It is not expected that there will be any direct benefit from participating in this study. Some participants may find contributing to research a positive experience as they are helping to increase knowledge relating to mental health. Also, contact details will be provided at the end of the study for mental health support services. Therefore, participation in the project could prompt a person to contact services and seek help. Finally, it is hoped that the findings of this research will be published and contribute to improving future mental health service provision for children and young people.

18. Details of any incentives/payments (including out-of-pocket expenses) made to participants:
None.

19. Briefly describe your data collection and analysis methods, and the rationale for their use. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

Data will be collected online using qualtrics survey software (Qualtrics , 2013). This will be via a Lancaster University website in which qualtrics is embedded. Using this software, participants will be asked to complete closed questions about age and gender, mental health help-seeking, psychometric questionnaires about levels of psychological distress, personal stigma, and help-seeking intentions. This method of data collection has been chosen to facilitate recruiting a large number of young people, without geographic restrictions, a in a short period of time. Having an online location for the survey will mean that it can easily be shared by various means such as social media, email, forum posts, posters in educational settings detailing a link to the survey or text messages.

As this is an anonymous, quantitative survey, the researcher will not collect personal data for any of the participants and individual quotes will not be used. The initial pages will detail the study and include a link to an information sheet. Check boxes and Clicking on statements and a button to indicate consent and agree to proceed will confirm consent to participation. At this point it will be stated that the data provided will be written up in a thesis report and potentially published.

An exploratory data analysis will be conducted to investigate relationships between the independent variables (IVs) and the dependent variable (DV). Those that have borderline significant relationships will be entered into a multiple regression analysis. This option has been chosen as there are a number of IVs being included due to indications within the research literature that they have an effect on the DV and the multiple regression analysis caters well for this type of design (Field, 2013).

20. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

The Young Person’s Mental Health Advisory Group (YPMHAG) were consulted during the design of this project. The researcher attended a group meeting, with approximately 15-20 young people present. Feedback from the meeting was used to guide the design. For example, some of the language used to describe the research was felt to be difficult to understand and suggestions about how to simplify it were given. Additionally, the researcher felt uncertain whether a videoclip, voiceclip or written script would be best for the vignettes. The feeling from attending the group was that a videoclip, portraying a professional communicating the message would be closest to real life and most engaging. Therefore this has been considered during design as the preferred option.

21. What plan is in place for the storage of data (electronic, digital, paper, etc.)? Please ensure that your plans comply with the Data Protection Act 1998.

Data will initially be stored on the Qualtrics secure server as this online survey software is being used to conduct the experiment (Qualtrics LLC, 2015b). At no time will anonymized data be stored on University laptops or personal computers. Once downloaded from Qualtrics, data will be stored on the Lancaster University password protected personal commuter space allocated on H drive, and all data analysis will be conducted via VPN. If for any reason data needs to be transported during the project an encrypted memory stick will be used. Once the project is completed, electronic experimental data will be kept for 5 years by the Lancaster University Doctorate in Clinical Psychology administration office or, if the study is published, for 5 years from the date of publication. After this time it will be destroyed..

22. Will audio or video recording take place? no audio video

If yes, what arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

23. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

The initial data will be seen by members of this projects research team as listed at the beginning of this form. The findings from this research will be reported in my doctoral thesis research paper. Study summaries may also be made available to organisations who assist with the design of the study and recruitment if requested. Results from this research may also be submitted for publication in an academic journal.

24. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

As this is a unique design, a pilot of the study will be tested by members of the research team, colleagues and the YPMHAG before creating the final version. Following this, it is likely that adjustments will need to be made to aspects of the design. It is anticipated this could include: altering the vignettes; changing the psychometric questionnaires for suitable alternatives; adjusting the wording in the adverts, briefing page, consent form or debriefing page; and tweaking the presentation of the study on Qualtrics. If such adjustments are necessary, what further ethical approval will be needed and how do I ensure that this is covered before proceeding?

Signatures: Applicant:

Date:

*Project Supervisor (if applicable):

Date:

*I have reviewed this application, and discussed it with the applicant. I confirm that the project methodology is appropriate. I am happy for this application to proceed to ethical review.

Does the language used to describe mental health affect help-seeking intentions in young people?

Chief Investigator: [REDACTED]

[REDACTED] [REDACTED]
[REDACTED]

Internationally, it has been reported that most people who need support for mental health problems do not seek professional help (Rickwood & Thomas, 2012). Furthermore, the gap between level of need and help-seeking appears to be the greatest amongst the 16-24 year old age group, with levels of unmet need being estimated at between 65 and 95% (Mauerhofer et al., 2009). Recent research focused on help-seeking indicates that the language used to describe mental health may influence whether young people seek help when it is needed (Martínez-Hernández et al., 2014; Yap, Reavley & Jorm, 2013a). Some researchers have argued that accurate psychiatric diagnoses enable help-seeking (Jorm et al., 2014); whereas others have suggested that psychiatric diagnoses are confusing and lead to an avoidance of professional services (Martínez-Hernández et al., 2014).

As help-seeking is a broad and complex concept, research in this area is often focused on other, closely related topics that are believed to influence whether a person seeks help when they need it (Rickwood & Thomas, 2012). One of these, which is often cited as a barrier to help-seeking, is stigma (Gulliver, Griffiths, & Christensen, 2010; Yap, Reavley, & Jorm, 2013b). In particular, significant associations have been evidenced between “personal stigma” and help-seeking (Eisenberg et al., 2009; Lally et al., 2012; Schomerus et al. 2009). This is a dimension of stigma identified as an individual’s stereotypes and prejudices about people experiencing mental health problems (Eisenberg et al., 2009; Lally et al., 2012; Schomerus et al. 2009). A second closely linked topic, believed to be significantly associated with help-seeking, is “mental health literacy” (Gulliver, Griffiths, Christensen, & Brewer, 2012; Martinez-Hernaez, DiGiacomo, Carceller-Maicas, Correa-Urquiza, & Martorell-Poveda, 2014; Yap, Reavley, & Jorm, 2013a). Jorm (2000) introduced the term “Mental Health Literacy” and defined it as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm, 2000, p. 396). Linking these three topics

together, it has been suggested that increasing public awareness and understanding of the terminology used to describe mental health difficulties may be useful in reducing stigma amongst young people (Yap et al., 2013a). This in turn, it is supposed, will lead to an increase in help-seeking (Gulliver et al., 2010; Yap, Reavley, & Jorm, 2014).

Interestingly, findings from the same researchers have indicated that knowing a close friend or family member who had received professional help for mental health difficulties increased rather than decreased a sense of stigma relating to what others may think of them (Yap et al., 2013a). The authors supposed that this may have been linked with vicarious stigma experienced in relation to the friend or family member's treatment history (Yap et al., 2013a). Likewise, other researchers also found that personal contact with an individual with a history of mental health problems was associated with a decrease in future help-seeking intentions (Lally et al., 2013).

Furthermore, some young people interviewed for a qualitative study by Martínez-Hernández et al. (2014) described similar experiences. One young person pointed out that seeking professional support for the problem they had been experiencing introduced an additional burden of stigma (Martinez-Hernaez et al., 2014). Other participants in this study reported that mental health professionals tended to reduce unique problems to “standardized diagnoses and treatments... framed in psychopathological terms” that they did not understand (Martinez-Hernaez et al., 2014, p. 7). This in turn led to miscommunication and an avoidance of mental health services (Martinez-Hernaez et al., 2014). Some suggestions were made by the young people interviewed in this report about how to improve the accessibility of mental health services. One suggestion made was to normalise mental health services by reconceptualising them as a resource for “maintaining mental health”, rather than for treating “mental disorders” (Martinez-Hernaez et al., 2014).

A similar indication that current conceptualisations of mental health in western societies may not be useful in changing help-seeking patterns could also be drawn from Niederkrotenthaler, Reidenberg, Till & Gould (2014). They highlighted that large scale, targeted mental health campaigns to tackle stigma (e.g. “time to change” in the UK), have so far been “largely ineffective” in changing attitudes or help-seeking behaviours (Niederkrotenthaler et al., 2014). The authors do also note however that, as broad awareness raising campaigns can be viewed as a form of social advertising, outcomes could also be linked to the characteristics of the messages being communicated, and indicate a need for additional components within the campaigns to effect change (Niederkrotenthaler et al., 2014). That said, Mackenzie, Erickson, Deane & Wright (2014) also indicate a pattern of contact with mental health problems and services linking to an avoidance of help seeking. They argued that an increase in negative attitudes towards mental health between 1968 and 2008, found as part of their recent meta-analysis, may be an unintended side effect of efforts to “reduce stigma and market biological therapies by medicalising mental health problems” (Mackenzie et al., 2014, p. 99).

Indeed, a medicalised conceptualisation of mental health has become predominant in Western areas of the world primarily as a result of diagnostic manuals such as the Diagnostic and Statistical Manual (DSM-5) or International Classification of Diseases (ICD-10) being used as guides for practice and research (NHS Choices, 2013). How appropriate and useful this conceptualisation is in relation to mental health was a recent focus in the mainstream British media following the release of a position statement by the British Psychological Society’s (BPS) Division of Clinical Psychology (DCP, 2014). The statement was a response to the release of an updated version of the Diagnostic and Statistical Manual of Mental Disorder, fifth edition (DSM-5) and called for a paradigm shift in relation to functional

psychiatric diagnoses (DCP, 2014). A more recent DCP publication proposed that there is a need for professional services to move away from the concept of “treating disease” and towards the concept of “providing skilled help and support to people who are experiencing understandable distress” (BPS and DCP, 2014, p. 102). The DCP have also released professional guidance on language use recommending that clinical psychologists avoid the use of diagnostic language where possible (DCP, 2015).

Similarly, in the lead up to the publication of the DSM-5, the President of the Society for Humanistic Psychology, a division within the American Psychological Association (APA), posted an open letter to the DSM-5 taskforce on a petition website in which they stated “we believe that it is time for psychiatry and psychology collaboratively to explore the possibility of developing an alternative approach to the conceptualization of emotional distress” (Society for Humanistic Psychology, 2015). Since the petition was posted, four other APA divisions are reported to have added their signatures to the open letter, along with the UK Council for Psychotherapy, the Association for Women in Psychology, the Society for Descriptive Psychology, and the Constructivist Psychology Network (Society for Humanistic Psychology, 2015). Separately, an online network has been formed known as the International Critical Psychiatry Network which provides a forum for professionals to share critical thinking and curiosity about the dominant models of psychiatry used internationally (International Critical Psychiatry Network, 2015).

In summary, current debates indicate that it is useful and timely to focus research on the impact of the language that is used to describe mental health difficulties (DCP, 2015; Johnstone, 2014; Society for Humanistic Psychology, 2015). Additionally, there are suggestions within the help-seeking literature that the language and terminology used to describe mental health may influence young people’s willingness to seek help when it is

needed (Martinez-Hernaez et al., 2014; Yap et al., 2013a). Interestingly these suggestions point in different directions. Some have argued that accurate psychiatric labelling facilitates help-seeking (Yap et al., 2013a), others have suggested that standard diagnoses have led to an avoidance of professional services (Martinez-Hernaez et al., 2014).

As help-seeking is a broad and complex process, this study will use the conceptual framework and definition proposed by Rickwood & Thomas (2012). This conceptualisation is based on the theory of planned behaviour (Madden, Ellen, & Ajzen, 1992), as is the case with most research in this field (Rickwood & Thomas, 2012). The theory of planned behaviour is an extension of the earlier theory of reasoned action, adjusted to include perceived behavioural control as an antecedant to behavioural intentions (Ajzen, 1985). The updated theory, on average, explains more of the variation in behavioural intentions (Madden et al., 1992). As such, the theory of planned behaviour proposes that behaviour is a decision, made in accordance with our behavioural intentions; and that our behavioural intentions are formed based on attitudes, subjective norms, and perceived behavioural control (Ajzen, 1985). In line with this conceptual framework and theory, help-seeking is defined as "...an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern." (Rickwood & Thomas, 2012, p. 180). Furthermore, the aspect of the help-seeking process being measured is future behavioural intention (Rickwood & Thomas, 2012).

Aims

This study aims to investigate whether changing the language used to describe mental health affects help-seeking intentions amongst young people.

Research Question

Is there a significant relationship between the language used to describe mental health and help-seeking intentions in young people?

Method**Design**

This is a cross-sectional experimental design, with random assignment to one of two groups that will differ according to vignette, e.g. vignette A or B (Barker, Pistrang, & Elliott, 2003; Marczyk, DeMatteo, & Festinger, 2005). The randomization will be applied by the survey software (Qualtrics LLC, 2015a). During the process of designing the vignettes, guidance will be sought from the research literature (Brauer et al., 2009), research team members from the clinical psychology doctorate programme, and young people from a public involvement advisory group. This is to ensure that, as far as possible, the two vignette designs are equally matched in terms of complexity, length, word order and timing.

Public Involvement

The young people providing consultation for this project are from a research advisory group based within the National Institute for Health Research's Clinical Research Network. The group is called the [REDACTED] [REDACTED] invite researchers to attend to seek advice relating to research studies with this population.

Participants

This is an online study and the inclusion criteria are: 1) Aged between 16 and 25; 2) Able to read and understand the English language; 3) Self-identified as experiencing mental

health problems. The 16-25 age range has been specified as research suggests that three-quarters of all lifetime mental health problems start by the age of 24, with later diagnoses mostly co-occurring alongside other conditions (Kessler et al., 2005). To capture this, taking into account that this survey is asking about mental health problems during the past 12 months, setting the upper cut off at 25 seems appropriate. The third criterion has been included as this study is focused on intentions to seek help for mental health problems, and as such, is looking for participants who identify themselves as having experienced mental health problems.

Sample Size

The minimum sample size required will be 98 participants, 49 per experimental group. This predictive power estimate was calculated using G*power (Faul, Erdfelder, Buchner, & Lang, 2009). The calculation was based on: aiming to detect a medium effect size (using the recommended convention within the G*power software, $f^2=.15$); using a fixed model linear multiple regression; looking for power of 0.80, and $p<0.05$, with 6 predictor variables.

Materials

Materials that may be used during this project are: video recording equipment; video editing software, videoclip vignettes, qualtrics, psychometric measures, a mobile telephone (potentially for initial planning and design discussions; and recruitment discussions with organisations) and an encrypted memory stick. The specific psychometric measures being used are detailed below.

Vignettes

The primary independent variable (IV) of interest is the language used to describe mental health in the two vignette conditions. The comparison group (group A) will be presented with a psychoeducation vignette giving a brief generalised description of **how** mental health disorders ~~and what~~ **are understood and described by** a mental health professional **does** using psychiatric language based on DSM-5 categories. This manual has been chosen as it has been reported as the largest, most widely used diagnostic manual, both clinically and for the purposes of academic research (Johnstone, 2014). The experimental group (group B) will be presented with a comparable psychoeducation vignette using equivalent terms taken from psychological and ordinary language (DCP, 2015; Johnstone, 2014). See Appendix A for proposed vignette script options.

Independent Variable Measures

Other IV's that will be measured at baseline include: demographic data, such as age, nationality, gender and experience of mental health problems; personal stigma, using a 3 item measure adapted from the Discrimination-Devaluation Scale (Link, 2004), tested for internal consistency, and used in similar research (Eisenberg, Downs, Golberstein, & Zivin, 2009; Lally, O'Conghaile, Quigley, Bainbridge, & McDonald, 2013) ; low-mood and anxiety scores, using the Revised Children's Anxiety and Depression Scale-Short Version (Ebesutani et al., 2012); and past help-seeking behaviour within the previous 12 months, using a 4-item prior counselling measure (Wilson, Deane, Ciarrochi, & Rickwood, 2005). See Appendices B-E for examples of these measures.

Dependent Variable Measure

The dependent variable (DV) in this study is future help-seeking intentions and the outcome measure being used is Wilson et al.'s (2005) General Help-seeking Questionnaire (GHSQ). This measure was chosen as significant positive correlations were evidenced with this measure between intention and future help-seeking behaviour within a 3 week time-period (Wilson et al., 2005). Furthermore there is flexibility in the way that the scale is used and scored (Wilson et al., 2005). For the purpose of this study, it will be initially scored as a full scale. It can also be scored as a 3 factor measure (seeking help from professional sources, non-professional sources and no-one); and as individual items identifying specific help sources, one of which is mental health professionals (Wilson et al., 2005). See Appendix F for an example of this outcome measure.

Procedure

Potential participants will be contacted online via social networking and media sites, forums, websites, online self-help groups, and emails to relevant organisations and professional contacts asking them to distribute information about the study. A variety of advert options will be created so that organisations can assist with recruitment in the ways that are most suited to their resources. Organisations could include colleges, youth clubs and voluntary sector organisations. Examples of how relevant organisations might assist with recruitment could include them tweeting about the project, posting up details on their websites, online pages or forums, sending out group emails or text messages to student distribution lists, or displaying posters and leaflets in communal areas. See Appendix G for example advert options.

All online adverts will link directly to the a survey on a Lancaster University website in which the qualtrics software is embedded (Qualtrics LLC, 2015b). The web link and

survey will be pilot tested prior to general release to ensure user acceptability and ease of use. To facilitate ease of access for young people, all hard copy posters and information will state a link to the Twitter account (<http://twitter.com>) being used for this survey, a link to the online survey will be regularly Tweeted from this account throughout the project. The online **link** survey will display in the following order: 1) An introductory page including a link to the participant information sheet and a consent form (see Appendix H); 2) Demographic questions; 3) Vignette A or B; 4) Orienting paragraph; 5) Self-report psychometric measures; 6) debrief information page (see Appendix I).

Following exposure to the vignettes, the participants will be shown a brief orienting paragraph (see Appendix J). Dependent variable data will then be collected first using the GHSQ. The remaining independent variable data, (personal stigma, psychological distress and past help-seeking) will be collected at the end of the survey . This is to ensure that completion of these measures does not bias the relationship between the language used in the vignette conditions and help-seeking intention scores.

Proposed Analysis

An exploratory data analysis will be conducted to investigate relationships between the IV's and DV. Those that have borderline significant relationships will be entered into a multiple regression analysis. This option has been chosen as there are a number of IV's being included due to indications within the research literature that they have an effect on the DV and the multiple regression analysis caters well for this type of design (Field, 2013).

Practical Issues**Data Storage**

Data will initially be stored on the Qualtrics secure server as this online survey software is being used to conduct the experiment (Qualtrics LLC, 2015b). At no time will anonymized data be stored on University laptops or personal computers. Once downloaded from Qualtrics, data will be stored on the Lancaster University password protected personal commuter space allocated on H drive, and all data analysis will be conducted via VPN. If for any reason data needs to be transported during the project an encrypted memory stick will be used. Once the project is completed, electronic experimental data will be kept for 5 years by the Lancaster University Doctorate in Clinical Psychology administration office or, if the study is published, for 5 years from the date of publication. After this time it will be destroyed.

Anonymity

As the participants will be self-selected and accessing the study online, participants will remain anonymous.

Potential Costs

- Travel costs for researcher to attend YPMHAG meetings for consultation with project planning and design.
- Printing of posters and leaflets about project to be displayed in sights to aid recruitment.

Ethical considerations

Baseline data will be collected about levels of general mental health difficulties, personal stigma, and past mental health service experience. Completing these questionnaires

will not cause difficulties where they do not already exist. However, the questionnaires may orient participants to focus on difficulties they have been experiencing. It will be made clear that they are free to withdraw from the study at any point and that a list of services that can be accessed for support and advice will be provided on the debrief page at the end of the survey.

An 'exit' button will be available on all pages of the survey which will link to the debrief page. This debrief page will thank the person for their participation, give contact details for further information about the study, and include information on how and where to seek help or advice relating to mental health from statutory and voluntary sector organisations. For example: a brief overview of the NHS route via the GP, what to do in a crisis situation (I.e. 999, ChildLine, Samaritans) and links to the NHS online advice pages and other support services. The list of support and advice services will also be available as a downloadable file on the consent form so that it is accessible prior to completing the survey. See Appendix I for an example of the debrief information.

Timescale

Data collection is expected take place between September and October 2015. If a minimum number of participants have not been recruited during this time, recruitment strategies will attempt to widen the locations used to advertise the project within the approved options, and the data collection period may be extended up until December 2015. Data analysis and write up will begin once all data has been collected and will be completed by June 2016. Completed results will be shared with organisations who requested a summary of the findings by October 2016.

Appendices

Appendix A - Vignette Scripts

Appendix B – Demographic Questions

Appendix C – Personal Stigma Measure

Appendix D – RCADS

Appendix E – Prior Counselling Measures

Appendix F – GHSQ

Appendix G – Example Adverts

Appendix H – Introduction page, Consent Form and Participant Information Sheet

Appendix I – Debriefing Page

Appendix J – Orienting Paragraph

Appendix A - Vignette Scripts

Vignettes will be presented as a videoclip, spoken by a female actress. This decision is based on a review of doctor-client gender dyads by Sandhu, Adams, Singleton, Clark-Carter, and Kidd (2009). They found that overall, consultations with female doctors are experienced more favourably than consultations with male doctors by both male and female clients. Thus, it is supposed that opting for a female actress will reduce the likelihood of dissatisfaction with the gender of the professional. The background in the video will be plain.

The vignettes scripts are presented below. These are a final version created based on review and refinement following consultation and a pilot study involving research team members and the Young People's Mental Health Advisory Group (YPMHAG).

Option 4

Traditional Terminology Script:

As a professional, I describe people with mental health disorders as having a mental illness. Common mental illnesses include major depressive disorder and general anxiety disorder. My understanding of illnesses such as these is based on the symptoms and impairments that are reported along with other relevant information. So for example, a person who has major depressive disorder may report symptoms such as depressed mood, insomnia, fatigue and restlessness. (69 words)

Alternative Terminology Script:

As a professional, I describe people with mental health problems as experiencing emotional distress. Common mental health problems include long term depression and anxiety. My understanding of problems such as these is based on the difficulties and emotions that are reported along with other relevant information. So for example, a person experiencing long term depression may report difficulties such as low mood, sleeping problems, reduced energy and feeling uneasy. (69 words)

References

Sandhu, H., Adams, A., Singleton, L., Clark-Carter, D., & Kidd, J. (2009). The impact of gender dyads on doctor-patient communication: a systematic review. *Patient Education and Counselling*, 76(3), 348-355. doi: 10.1016/j.pec.2009.07.010

Appendix B – Demographic Questions

- What is your age?

Options: 16, 17, 18, 19, 20, 21, 22, 23, 24, 25

- What is your gender?

Options: male, female, transgender, other [option to type in alternative]

- What is your nationality?

[open text box]

- Have you experienced a mental health problem?

Options: Yes, no [A help box will be available here giving the following advice –, If you were struggling and felt like you needed some help, tick yes. You don't need to have actually accessed any help, your opinion is all we need. Examples might include things like, long-term low mood, anxiety, difficult thoughts or experiences other might think are unusual such as seeing or hearing things]

- If tick yes, a follow up question will be when did the problem first occur?

Options: In the past 12 month, between 12-24 months ago, over 24 months ago

Appendix C – Personal Stigma Measure

Personal Stigma Measure taken from Eisenberg et al. (2009)

“Please indicate whether you agree or disagree with the following statements.

1. I would willingly accept someone who has received mental health treatment as a close friend.
2. I would think less of a person who has received mental health treatment.*
3. I believe that someone who has received mental health treatment is just as trustworthy as the average person.

Note: Answer choices for each item are: 0 = strongly agree, 1 = agree, 2 = somewhat agree, 3 = somewhat disagree, 4 = disagree, 5 = strongly disagree. Items were adapted from the Discrimination-Devaluation scale developed by Bruce Link and colleagues.”

Appendix D – RCADS

Name: _____

Date: _____

RCADS – Short Version

Please put a circle around the word that shows how often each of these things happen to you. There are no right or wrong answers.

1. I feel sad or empty	Never	Sometimes	Often	Always
2. I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
3. I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
4. Nothing is much fun anymore	Never	Sometimes	Often	Always
5. I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
6. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
7. I worry what other people think of me	Never	Sometimes	Often	Always
8. I have trouble sleeping	Never	Sometimes	Often	Always
9. I feel scared if I have to sleep on my own	Never	Sometimes	Often	Always
10. I have problems with my appetite	Never	Sometimes	Often	Always
11. I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
12. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
13. I have no energy for things	Never	Sometimes	Often	Always
14. I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
15. I cannot think clearly	Never	Sometimes	Often	Always
16. I feel worthless	Never	Sometimes	Often	Always
17. I have to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
18. I think about death	Never	Sometimes	Often	Always
19. I feel like I don't want to move	Never	Sometimes	Often	Always
20. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
21. I am tired a lot	Never	Sometimes	Often	Always
22. I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
23. I have to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
24. I feel restless	Never	Sometimes	Often	Always
25. I worry that something bad will happen to me	Never	Sometimes	Often	Always

Appendix E – Prior Counselling Measures

Prior Counselling Measure taken from Wilson et al. 2005

“The prior counselling measure comprises four items that have been used in samples of prison inmates (Deane et al., 1999), high school students (Carlton & Deane, 2000), and college students (Deane, Wilson, et al., 2001).”

The four items in the current prior counselling measure included:

“Have you ever seen a mental health professional (e.g., counsellor, psychologist, psychiatrist) to get help for personal problems?” (“Yes” or “No”)

“How many visits did you have with the health professional(s)?”

“Do you know what type of health professional(s) you’ve seen (e.g., counsellor, psychologist, psychiatrist)?”

“How helpful was the visit to the mental health professional?” This evaluation was rated on a 5-point Likert scale ranging from 1 (“extremely unhelpful”) to 5 (“extremely helpful”)

“The perceived quality of previous mental health care was positively related to intentions to seek help from a mental health professional for personal-emotional problems, $r(55) = .51$, $p < .001$, and suicidal thoughts, $r(54) = .57$, $p < .001$. This indicates a favourable evaluation of prior mental health care related to higher intentions to seek counselling in the future.”

Appendix F – GHSQ

GENERAL HELP-SEEKING QUESTIONNAIRE – Original Version (GHSQ)

Question 1 = Personal or emotional problems

Question 2 = Suicidal ideation

Note: In all questions, items a-j measure **help-seeking intentions**.

Help sources should be modified to match the target population.

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

Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de' facto)	1	2	3	4	5	6	7
b. Friend (not related to you)	1	2	3	4	5	6	7
c. Parent	1	2	3	4	5	6	7
d. Other relative/family member	1	2	3	4	5	6	7
e. Mental health professional (e.g. psychologist, social worker, counsellor)	1	2	3	4	5	6	7
f. Phone helpline (e.g. Lifeline)	1	2	3	4	5	6	7
g. Doctor/GP	1	2	3	4	5	6	7
h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain)	1	2	3	4	5	6	7
i. I would not seek help from anyone	1	2	3	4	5	6	7
j. I would seek help from another not listed above (please list in the space provided, (e.g., work colleague. If no, leave blank)_____	1	2	3	4	5	6	7

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

Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de' facto)	1	2	3	4	5	6	7
b. Friend (not related to you)	1	2	3	4	5	6	7
c. Parent	1	2	3	4	5	6	7
d. Other relative/family member	1	2	3	4	5	6	7
e. Mental health professional (e.g. psychologist, social worker, counsellor)	1	2	3	4	5	6	7
f. Phone helpline (e.g. Lifeline)	1	2	3	4	5	6	7
g. Doctor/GP	1	2	3	4	5	6	7
h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain)	1	2	3	4	5	6	7
i. I would not seek help from anyone	1	2	3	4	5	6	7
j. I would seek help from another not listed above (please list in the space provided, e.g., work colleague. If no, leave blank)_____	1	2	3	4	5	6	7

Appendix G – Example Adverts

Adverts for sharing survey

Tweet/brief advert

Aged 16-25? Experienced mental health problems? Check out our survey:

https://lancasteruni.qualtrics.com/SE?SID=SV_5pcyEX4pw045MVL&Preview=Survey #youngpeople #mentalhealth

More detailed advert wording for sharing on webpages/blogs

We are looking for young people aged 16-25, who have experienced mental health problems, to take part in some research. If this describes you, we want to ask you some questions about help-seeking for mental health problems. Interested? Then check out our survey here:

https://lancasteruni.qualtrics.com/SE?SID=SV_5pcyEX4pw045MVL&Preview=Survey

[or via twitter using @mhsurvey]

Email

Hi [Insert name],

[optional: Further to our conversation, here is some further information about my research project.] My name is [REDACTED] I am a trainee clinical psychologist, conducting my doctoral thesis at Lancaster University.

My research is focused on help-seeking for mental health problems amongst young people aged 16-25. If you could help me to recruit participants by sharing the advert below on your [blog/webpage/forum/email distribution list] I would be very grateful. If you want further information about the project, more details are provided on the first page of the survey, this can be accessed without participating by clicking the link in the advert below.

This is the advert that has been approved by the ethics committee at Lancaster University:

We are looking for young people aged 16-25, who have experienced mental health problems, to take part in some research. If this describes you, we want to ask you some questions about help-seeking for mental health problems. Interested? Then check out our survey here:

https://lancasteruni.qualtrics.com/SE?SID=SV_5pcyEX4pw045MVL&Preview=Survey [or via twitter using @mhsurvey]

Thank you very much for your help and please don't hesitate to ask if you have any further questions.

Kind Regards,

[REDACTED]
Trainee Clinical Psychologist

[email address][designated phone number for project]

Poster



Aged 16-25?

Experienced Mental Health Problems?

Check out our survey  @MHSurvey

#youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

@MHSurvey #youngpeople #mentalhealth

Photo for social media



Aged 16-25?

Experienced Mental Health Problems?

Check out our survey  @MHSurvey

#youngpeople #mentalhealth

Appendix H – Introduction page, Consent Form and Participant Information Sheet

Hi there, thank you for your interest in this research!

We are looking for young people aged 16-25 who have experienced mental health problems. If this describes you, we want to ask you some questions about help-seeking for mental health problems.

Before you begin, please have a read of our participant information form [hyperlinked] that goes into a bit more detail about the study. If you have any questions before taking part please contact [redacted] by email at [redacted]. If you're happy with all of that then please read the statements below, click on each one to indicate that you agree ~~check the boxes below~~ and click the button at the bottom to proceed:

Please check
each statement

1. I confirm that I have read the participant information sheet [hyperlinked].
2. I confirm that I have had the opportunity to ask questions.
3. I understand that my participation is voluntary and that I am free to withdraw from completing the survey at any time without giving any reason.
4. I understand that the answers I give will be anonymous.
5. I understand that the questions are about my experiences of mental health problems and focusing on this topic could cause me to feel distressed. I understand that there is a list of services I can contact for support given at the end of the survey. Here is a copy for download should you need it: [hyperlink].
6. I understand that the researcher will share and discuss the data from my responses with the project supervisors.
7. I consent to the data from my responses being published, used in reports, conferences and training events.
8. I consent to Lancaster University keeping the survey data for five years after the study has finished, or if it is published, for five years after publication.

[By clicking this button to proceed, I consent to take part in this the above study.]

Participant Information Sheet

My name is [REDACTED] I am a trainee clinical psychologist at Lancaster University and I am conducting this research project as part of my training. I am being supervised by [REDACTED] lecturers at the University.

The research study is about help-seeking for mental health problems amongst young people. Specifically I am interested in finding out whether peoples' decisions about seeking help are affected by things such as previous experiences of mental health services. The results will be submitted as part of my doctoral thesis project at Lancaster University. If possible, I also hope to publish the results in an academic journal.

Can I take part?

You can take part if you are aged between 16-25 and feel that you have experienced mental health problems.

You don't need to have accessed help or received an official diagnosis. Your opinion is all we need, so if you have ever felt like you have struggled with mental health problems you are welcome to take part. Examples might include things like long-term low mood, anxiety, difficult thoughts or experiences other might think are unusual such as seeing or hearing things that other people cannot see or hear.

What will happen if I decide to take part?

Once you have consented to taking part you will be asked to answer a few brief questions about your age, gender, nationality and if you have experienced mental health problems. You will then be shown a brief videoclip and asked some detailed questions about your views and experiences of mental health problems. The survey will last for about 5 minutes. You can exit the survey at any point.

At the end of the survey you will be directed to a page that gives information about services to contact for support.

Will taking part affect my care or legal rights?

The study is not linked to any service. Your decision will make no difference to the care you receive from any service or to your legal rights. This study is completely anonymous. This means that you will not be asked at any point for your name, address, date of birth or other identifying information.

Do I have to take part?

No. Participation is voluntary. You can exit the survey at any point and your decision will make no difference to the care you receive from any service or to your legal rights. This study is completely anonymous.

What will happen to the results of the research?

The information that you give will be combined with answers from other participants. This information will be analysed and the findings will be written up into a research report and submitted to Lancaster University as part of a thesis

project for the doctorate in clinical psychology programme. The findings may also be submitted for publication in an academic journal, used in reports, conferences and training events.

A brief summary of the research and findings will be made available at http://www.lancaster.ac.uk/shm/study/doctoral_study/dclinpsy/trainees/research/thesis_abstracts/ after the project has been completed.

What are the benefits of taking part?

There will be no direct benefit to you from taking part. However, by contributing to research you will be increasing knowledge about mental health. Also, it is hoped that the findings of this research will be published and contribute to improving future mental health service provision for young people.

Who reviewed the research?

This research project has been reviewed by the Faculty of Health and Medicine Research Ethics Committee (FHMREC) and approved by the University Research Ethics Committee (UREC), Lancaster University.

I want to take part, what do I do now?

~~If you would like to take part continue with the survey by clicking the button at the bottom of the page that says 'I consent want to take part in this study' [show example].~~

If you would like to take part, read the consent form which asks you to ~~tick next to some~~ **click on some** statements agreeing that you understand what the research is about and how your information will be used. If you agree with all of that, then ~~tick the boxes~~ **click on the statements** and click the button at the bottom of the page to begin the survey.

Who do I contact if I have a complaint or serious concern about this research?

If you have any complaints or concerns and do not want to contact the researcher, you can contact:

Or

Thank you for taking part in this research! If you need support, advice, or someone to talk to about mental health problems here are details about some of the services available.

Immediate 24 hours

999

If you experience an acute emergency, you should call 999 and ask for the ambulance service or the police.

This is where there is immediate danger to life or physical injury. For example, an overdose of medication or self-harm is showing signs of its effects, such as slurred speech or sleepiness.

If someone is threatening aggression, holding a weapon, committing or about to commit a serious assault, ask for the police.

111

If you require urgent care but it is not life threatening, you could call [NHS 111](#). For example, if you or someone you know are:

- suffering a relapse with existing mental health problem symptoms
- experiencing a mental health problem for the first time
- injured from, or wanting to, self-harm in a way that clearly does not immediately threaten life
- showing signs of onset of dementia
- experiencing domestic violence or physical, sexual or emotional abuse

However, if you've already been given a Crisis Line number by your GP or local services, you should call them instead.

Mental Health Helplines

If you want to talk to someone right away, the [mental health helpline page](#) has a list of organisations you can call for immediate assistance. They have specially trained volunteers who'll listen to you and help you through the immediate crisis.

These ones are open 24 hours and offer online support through the websites too:

- [Samaritans](#)

Confidential support for people experiencing feelings of distress or despair. Available any time, in your own way, and off the record – about whatever's getting to you.

Phone: 08457 90 90 90 (24-hour helpline)

Website: www.samaritans.org.uk

- ChildLine

ChildLine is a private and confidential service for children and young people up to the age of 19. You can contact a ChildLine counsellor about anything - no problem is too big or too small. You can phone, have a 1-2-1 chat online or send an email.

Phone: 0800 1111 (24-hour helpline upto age 19)

Website: www.childline.org.uk

- Refuge

Advice on dealing with domestic violence.

Phone: 0808 2000 247 (24-hour helpline)

Website: www.refuge.org.uk

In a non-urgent situation

NHS

Mental health services are free on the NHS, you will usually need a [referral from your GP](#) to access them. Some mental health services will allow people to refer themselves. You can search to find out [what mental health services are available in your area](#).

College or University

Your college or university should have services to support your wellbeing. You could talk to your head of year, tutor or visit your college or university website for information on what is available. This usually includes, counselling or student advice services, support networks and drop-in provisions,

Rethink Mental Illness

If any of these options seem confusing and you want some practical advice about mental health services, check out Rethink's website, or they have a daytime advice line. The advice service offers practical help on issues such as the Mental Health Act, community care, welfare benefits, debt, criminal justice and carers rights. They also offer general help about living with mental illness, medication, care and treatment.

Phone: 0300 5000 927 (Mon-Fri, 10am-2pm)

Website: <http://www.rethink.org/living-with-mental-illness/young-people>

Appendix J – Orienting Paragraph

Imagine that if you were to seek help for mental health problems in the future, your problems would be understood in the way just described by the professional in the video. Keep this in mind whilst answering the following questions.

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November 2009

THE UNIVERSITY OF LANCASTER

PFACT project information and ethics questionnaire

(To be completed by the student together with their supervisor in all cases)

Name of student: _____ Emma Williamson _____

Name of supervisor: _____ Guillermo Perez Algorta _____

Project Title: _____ Does the language used to describe mental health affect help-seeking intentions in young people _____

1. General information

1.1 Have you, if relevant, discussed the project with

- the Data Protection Officer?
 the Freedom of Information Officer?
 N/A

(Please tick as appropriate.)

1.1 Does any of the intellectual property to be used in the research belong to a third party?

Y / N

1.2 Are you involved in any other activities that may result in a conflict of interest with this research?

Y / N

1.3 Will you be working with an NHS Trust?

Y / N

1.4 If yes to 1.3, what steps are you taking to obtain NHS approval?

1.5 If yes to 1.3, who will be named as sponsor of the project?



1.6 What consideration has been given to the health and safety requirements of the research?

___As this study is recruiting online the researcher will not be lone working in the community. Health and safety requirements relevant to this research design have been considered discussed with research supervisors from the course staff team. These are outlined in further detail in the FHMREC application form.

2. Information for insurance or commercial purposes

(Please put N/A where relevant, and provide details where the answer is yes.)

2.1 Will the research involve making a prototype?

Y / N / N/A

2.2 Will the research involve an aircraft or the aircraft industry?

Y / N / N/A

2.3 Will the research involve the nuclear industry?

Y / N / N/A

2.4 Will the research involve the specialist disposal of waste material?

Y / N / N/A

2.5 Do you intend to file a patent application on an invention that may relate in some way to the area of research in this proposal? If YES, contact Gavin Smith, Research and Enterprise Services Division. (ext. 93298)

Y / N / N/A

3. Ethical information

(Please confirm this research grant will be managed by you, the student and supervisor, in an ethically appropriate manner according to:

- (a) the subject matter involved;
- (b) the code of practice of the relevant funding body; and
- (c) the code of ethics and procedures of the university.)

(Please put N/A where relevant)

3.1 Please tick to confirm that you are prepared to accept responsibility on behalf of the institution for your project in relation to the avoidance of plagiarism and fabrication of results.

✓

3.2 Please tick to confirm that you are prepared to accept responsibility on behalf of the institution for your project in relation to the observance of the rules for the exploitation of intellectual property.

✓

3.3 Please tick to confirm that you are prepared to accept responsibility on behalf of the institution for your project in relation to adherence to the university code of ethics.

✓

3.4 Will you give all staff and students involved in the project guidance on the ethical standards expected in the project in accordance with the university code of ethics?

Y / N / N/A

3.5 Will you take steps to ensure that all students and staff involved in the project will not be exposed to inappropriate situations when carrying out fieldwork?

Y / N / N/A

3.6 Is the establishment of a research ethics committee required as part of your collaboration? (This is a requirement for some large-scale European Commission funded projects, for example.)

Y / N / N/A

3.7 Does your research project involve human participants i.e. including all types of interviews, questionnaires, focus groups, records relating to humans, human tissue etc.?

Y / N / N/A

3.7.1 Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law?

Y / N / N/A

3.7.2 Will you take the necessary steps to find out the applicable law?

Y / N / N/A

3.7.3 Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?

Y / N / N/A

3.7.4 Will you take appropriate action to ensure that the position under 3.7.1 – 3.7.3 are fully understood and acted on by staff or students connected with the project in accordance with the university ethics code of practice?

Y / N / N/A

3.13 Does your work involve animals? If yes you should specifically detail this in a submission to the Research Ethics Committee. The term animals shall be taken to include any vertebrate other than man.

3.13.1 Have you carefully considered alternatives to the use of animals in this project? If yes, give details.

Y / N / N/A

3.13.2 Will you use techniques that involve any of the following: any experimental or scientific procedure applied to an animal which may have the effect of causing that animal pain, suffering, distress, or lasting harm? If yes, these must be separately identified.

Y / N / N/A

Signature (student): _____ Date: _____

Signature (supervisor): _____ Date: _____

N.B. Do not submit this form without completing and attaching the Stage 1 self-assessment form.

Stage 1 Self-Assessment Form (Part A) - for Research Students

(To be completed by the student together with the supervisor in all cases; send signed original to Research Support)

Student name and email: Emma Williamson

Supervisor name: Guillermo Perez Algorta Department: DCLinPsy

Title of project: Does the language used to describe mental health affect help-seeking intentions in young people?

Proposed funding source (if applicable): N/A

1. Please confirm that you have read the code of practice, '[Research Ethics at Lancaster: a code of practice](#)' and are willing to abide by it in relation to the current proposal? **Yes**
If no, please provide explanation on separate page
2. Does your research project involve non-human vertebrates, cephalopods or decapod crustaceans? **No** *If yes, have you contacted the Ethical Review Process Committee (ERP) via the University Secretary (Fiona Aiken)? ?*
- 3a. Does your research project involve human participants i.e. including all types of interviews, questionnaires, focus groups, records relating to humans etc? **Yes**
If yes, you must complete Part B unless your project is being reviewed by an ethics committee
- 3b. If the research involves human participants please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data **Yes**
- 3c. If the research involves human participants, are any of the following relevant:
 - No** The involvement of vulnerable participants or groups, such as children, people with a learning disability or cognitive impairment, or persons in a dependent relationship
 - No** The sensitivity of the research topic e.g. the participants' sexual, political or legal behaviour, or their experience of violence, abuse or exploitation
 - No** The gender, ethnicity, language or cultural status of the participants
 - No** Deception, trickery or other procedures that may contravene participants' full and informed consent, without timely and appropriate debriefing, or activities that cause stress, humiliation, anxiety or the infliction of more than minimal pain
 - No** Access to records of personal or other confidential information, including genetic or other biological information, concerning identifiable individuals, without their knowledge or consent
 - No** The use of intrusive interventions, including the administration of drugs, or other treatments, excessive physical exertion, or techniques such as hypnotherapy, without the participants' knowledge or consent
 - No** Any other potential areas of ethical concern? (Please give brief description)

4. Are any of the following potential areas of ethical concern relevant to your research?

No Could the funding source be considered controversial?

No Does the research involve lone working or travel to areas where researchers may be at risk (eg countries that the FCO advises against travelling to)? If yes give details.

No Does the research involve the use of human cells or tissues other than those established in laboratory cultures?

No Does the research involve non-human vertebrates?

If yes, has the University Secretary signified her approval? ?

No Any other potential areas of ethical concern? (Please give brief description)

5. Please select **ONE** appropriate option for this project, take any action indicated below and in all cases **submit the fully signed original self-assessment to RSO.**

- (a) Low risk, no potential concerns identified**
The research does **NOT** involve human participants, response to all parts of Q.4 is 'NO'. No further action required once this signed form has been submitted to RSO
- (b) Project will be reviewed by NHS ethics committee**
Part B/Stage 2 not usually required, liaise with RSO for further information. If Lancaster will be named as sponsor, contact RSO for details of the procedure
- (c) Project will be reviewed by other external ethics committee**
Please contact RSO for details of the information to submit with this form
- (d) Project routed to UREC via internal ethics committee**
SHM and Psychology only. Please follow specific guidance for your School or Department and submit this signed original self-assessment to RSO
- (e) Potential ethical concerns, review by UREC required**
Potential ethical concerns requiring review by UREC, please contact RSO to register your intention to submit a [Stage 2](#) form and to discuss timescales
- (f) Potential ethical concerns but considered low risk, (a)-(e) above not ticked**
Research involves human participants and/or response to one or more parts of Q.4 is 'YES' but ethical risk is considered low. Provide further information by completing [PART B](#) and submitting with this signed original PART A to RSO

Student signature: _____ Date:

Supervisor signature: _____ Date:

Head of Department (or delegated representative) Name: _____

Signature: Date: