2014

University Student Support Systems, Help-Seeking Behaviour And The Management Of Student Psychological Distress

Richard Bostwick

*Edith Cowan University*

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University Student Support Systems, Help-Seeking Behaviour and the Management of Student Psychological Distress

Richard Phillip Bostwick

School of Nursing and Midwifery

A thesis submitted in partial fulfilment of the requirements for the award of Doctor of Philosophy undertaken at Edith Cowan University.

September 2014
Abstract

The issue of student management and retention remains one of the most pertinent considerations for any university. In a climate of increasing awareness of mental and physical health issues, university policy development needs to adapt to ensure all students engage with and utilise support services effectively. It would appear that there are various influences on a student’s university experience, including learning abilities and styles, impact of life events and situations, for example, housing and finance, availability of support services and the ability of an individual to seek out appropriate help. Maslow’s Hierarchy of Needs, in combination with the Health Belief Model can provide a strong foundation for universities to begin to understand why a student may not achieve their potential, or may depart prematurely. This theoretical interaction postulates how needs are determined and prioritised subsequently influences help-seeking behaviour. The application of this interaction assists with developing a picture of students who have ongoing issues, for example: housing, finance, and lack of family support, and how these issues can lead to problems with learning, achievement, and ultimately academic performance. The purpose of this thesis is concerned with seeking to understand how and why students access support services within the university setting, and whether the support services have an impact on the levels of psychological distress. This thesis was conducted in two phases, both collecting data through the use of surveys. Phase one, intended to collect information directly from support services concerning students who were accessing them, however, phase one did not achieve its aim due to lack of responses from support services. Phase two profiled the experience of students who have interacted with support services; this profile assisted in a review of relevant services including how the provision of university support services potentially affects
student’s psychological distress. Results revealed a lack of data for measuring service outcomes, for example measures of psychological distress, which might impact on students’ ability to succeed at university. Recommendations were generated based on the discussion relating to the lack of phase one data and the phase two student profile, these recommendations aiming to enhance the ability of university systems to identify and promote effective help-seeking behaviour, and the efficacy of those systems in reducing psychological distress. The implications of this research include the potential for enhancing operational policies relating to student management and retention within Australian universities.
Declaration

I certify that this thesis does not incorporate, without acknowledgement, any material previously submitted for a degree or diploma in any institution of higher education and that, to the best of my knowledge and belief, it does not contain any material previously published or written by another person except where due reference is made in the text. Nor does it contain any defamatory material.

Name: Richard Phillip Bostwick
Signature: 
Date: 27/11/14
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Finally I would like to thank and pay tribute to my mum Jan, whose true courage, resilience and humour in the face of considerable battles with her own health has been inspiration to me and has given me the drive to complete this piece of research.
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Chapter One

Introduction

Stallman (2008) established that many students, both undergraduate and postgraduate, appear to struggle with adjustment to university life academically and socially. This, in some cases, can inhibit learning resulting in ongoing difficulties with course progression and retention. Anecdotal evidence from an Australian university has noted that many colleagues would approach expert staff members, those with a mental health clinical background, for advice and support on how to deal with the challenges that these students face and present within the classroom adequately. This appears, according to Stallman, not to be unique but common to all universities within Australia. Whilst universities have a legal responsibility to provide support services as outlined in the Higher Education Support Act (Commonwealth of Australia, 2010), little is understood about the impact of university-based support service provisions for students who find adjustment to student life difficult or for those experiencing psychological distress.

1.1. Impact of Negative Experience on University Students

For most university students, their time spent studying is a positive experience; however for a certain percentage of students, their personal lives and emotional wellbeing often interfere with their ability to complete their study successfully (Kovacic, 2012). Whilst some staff may have the skills to deal with the challenges relating to the support of distressed students, it is considered by many that this may over-extend the roles of academics and general staff in areas for which they may be ill-equipped (Murray, Flannery, & Wren, 2008; Stallman, 2008, 2010).

Researchers have identified a range of challenges faced by university students. Within each of these studies it is clear such challenges have a significant
impact on the ability of a student to engage in the university experience (Cvetkovski, Reavley & Jorm, 2012; Stallman & Shochet, 2009). Further, according to Baker and Proctor (2013), such factors can also be seen as causes or contributors to the onset of mental illness. Bradley, Noonan, Nugent and Scales (2008) postulate that unless universities begin to conceptualise and provide targeted support programs and services, student achievement and retention will continue to be compromised. They identify several factors seen to influence university experiences; these include, but are not limited to:

- Housing, including affordability, availability and accessibility (location to the university);
- Finances, including working whilst studying, ability to pay for texts/fees, meeting daily living expenses (food and utilities);
- Relationships difficulties, including the dilution of support systems, acquisition and maintenance of new friendships;
- Isolation for rural students;
- Acculturation and isolation for international students;
- Physical health and disabilities;
- Learning disabilities and other cognitive deficiencies;
- Mental health problems and disorders;
- Access, including available transport, computer and information technology;
- Students from first generation university families;
- Acculturation issues for mature age students who have not studied for long periods of time; and
- Expectations and demands regarding learning and academic achievement.
Working examples of multifactorial variables allow us to understand how both learning and living from a student perspective can influence students’ experience. For example, consider a student who has moved from a rural town to a metropolitan based university to study. They may find themselves without their usual support systems and coping mechanisms; and they may have been living with their parents in stable accommodation without the need to seek employment in order to finance basic living expenses. Upon moving to the metropolitan area they now need to establish secure accommodation for the duration of their period of study. They will need to consider how to finance this accommodation and basic living expenses; this may mean seeking employment in both an unfamiliar environment without the proximal support of family and friends. Further, the need to work flexible or irregular hours may mean a reduced amount of time dedicated to study, especially when compared to a student who continues to live at home with the usual support of family.

Student experiences, like the one described, would be further compounded from the perspective of an international student, who may have to contend with the additional factors relating to English as a second language, acculturation, including religious and behavioural, and physical or mental health problems, depending on past experiences (Romerhausen, 2013). These difficulties and challenges, however, are not typical to either of these student examples. All students from any background may experience significant health issues including mental health problems or disorders, reflecting the fact that university populations are a micro representation of the broader macro community.

Currently a broad range of research studies focus on the contributing factors that can lead to mental health problems, including psychological distress, and mental
illness. The consequences for academic performance will often include a range of issues impacting on the overall health status of the student. For example, the experience of continued failure by a student may contribute to the development of depression or substance misuse disorders (Field, Diego, Pelaez, Deeds, & Delgado, 2012). Further, evidence shows that poor diet quality, smoking and insufficient physical activity are contributors to mental health problems and subsequently all impact on a student’s ability to engage in academia successfully (Jacka, Kremer, Berk, de Silva-Sanigorski, Moodie, Leslie, Pasco, & Swinburn, 2011; Jacka, Mykletun, Berk, Bjelland, & Tell, 2011; Quirk, Williams, O’Neil, Pasco, Jacka, Housden, Berk, & Brennan, 2013).

Staff within universities frequently report that such consequences or difficulties can at times significantly impact on the student’s ability to learn and ultimately succeed. Consequences, according to Smith, Therry, and Whale (2012) can include:

- Poor concentration;
- Low motivation;
- Absenteeism;
- Declining quality of academic work, for example, assignments, exams, assessments;
- Academic misconduct, including cheating and plagiarism;
- Failure to complete course requirements, inclusive of missed deadlines;
- Failure, including academic probation and course exclusions;
- Social withdrawal and isolation from student life;
- Conflict with students and staff;
- Decline in physical health, mental health and general wellbeing; and
• Withdrawal from university.

When discussing these difficulties and challenges with students, Rickwood, Deane, Wilson, and Ciarrochi (2005) found that learning deficits are a consequence of the inability to cope with a combination of academic and personal life stresses. These when combined cause significant psychological distress and become the genesis of the learning deficit; the stresses therefore are centred on this psychological distress, and are attributed predominantly to non-learning factors.

1.2. Purpose of the Study

It is believed that with a greater understanding of these issues, universities may be better informed to design university support systems. The improved or enhanced design of student support services could, in turn:

a. allow students to find improved ways of seeking help;

b. reduce psychological distress within students;

c. improve learning outcomes; and,

d. increase retention rates.

The purpose of this thesis is concerned with seeking to understand how and why students access support services within the university setting, and whether the support services have an impact on the levels of psychological distress. The study has two aspects, the first being to try and establish who accesses support services and the extent to which they access them. The second aspect aims to assess if students, who access support services, report an improvement in their levels of psychological distress and a corresponding shift in the way they might view and seek help in the future.
1.3. Significance of the Study

The significance of this thesis lies in its ability to identify if university student help-seeking behaviour determines use of university support services, and if those services are responsive to their users, ultimately meeting the needs of students. More specifically, what effect do support services provided by universities have on psychological distress, a significant contributing factor to learning outcomes and retention as outlined in the purpose above. In addition, can this information help to influence the way university support systems and services are designed?

A greater understanding of student experiences and the impact they have on mental health problems may assist university administrators to gain an insight into what constitutes effective support of students’ actual versus targeted needs. Possible new measures are being established not only to support distressed students but to improve their overall ability to learn, perform and interact within tertiary education and therefore improve their retention.

Studies previously have focused on quantifying and qualifying help-seeking behaviour and psychological distress within university students (Cvetkovski, Reavley, & Jorm, 2012; Stallman, 2008, 2010; Stallman & Shochet, 2009). Whilst these two issues are important as individual markers, and together are an indicator of how the student may perform and interact within the university environment, they haven't focused on how these measures may lead to the way in which university support systems are designed and configured. Previously, prevalence data has been used to indicate the existence of an issue rather than to assist the development of the form, function and sustainability of support systems.

The point of difference with this thesis is that it initially seeks to understand the demographics of students who access support services by interpreting data
captured across a sample of universities in Australia. This research then aims to ascertain whether a significant change in the psychological distress and help-seeking behaviour of students who access the support services occurs. Studies in the past have concerned themselves with a single measure of these indices taking a snapshot of student psychological distress and help-seeking behaviours across the general population of the university (Cvetkovski, Reavley, & Jorm, 2012; Stallman, 2008, 2010; Stallman & Shochet, 2009). This thesis investigates the impact of support given to students who access student support services, a targeted population within a university. The overall significance of this thesis is to investigate the profile of those who access university support services, and for what purpose; and to ascertain if university support services have a measurable impact on the health and well-being of students. This thesis has the potential to highlight the type of data universities may need to influence support service operation better, and make possible recommendations in order to target the services better to student need.

The factors that may have bearing on, and contribute to the manner a student's overall university experience and academic journey is conceptualised, are explored in more depth in following chapters. For instance, it is important to consider:

- the impact global and national policy and legislation have on shaping universities in Australia and support services within;
- the manner in which university support services are provided at universities;
- the reason student support services engage with the student community and to map student needs;
• any evaluation/annual review/quality improvement policies and processes determining the manner in which university student support services should operate and improve; and,

• how health promotion, and prevention and early intervention are delivered through university student support services, and the identification of exemplars or demonstration models in Australian universities as a way to improve health literacy and mental health first aid actions (Araque, Roldan, & Salguero, 2009; Cvetkovski, Reavley, Jorm, 2012).

This thesis explores the concept of psychological distress, its definition, and the way in which it may impact on a student. Further consideration will be given to the way in which students seek help and the impact stigma may have on the seeking of such help. Health literacy will be viewed in conjunction with the concepts of help-seeking behaviour so as to provide recommendations about the better provision of effective and targeted student support services.

Insights into student attitudes towards their understanding of health literacy and associated health actions will be provided to further comprehend the relationship between psychological distress and help-seeking behaviour. To aid this understanding the theoretical framework explicated in chapter two will integrate two models to provide a basis upon which to review the motivation of students when seeking help, and their prioritisation of health problems. Maslow’s Hierarchy of Needs will assist in the understanding of unmet needs, considered in conjunction with the Health Belief Model, a framework that aims to help understand student behaviour in the context of distress and support. This integrated theoretical framework and subsequent framework equation to be explained in chapter nine will
provide the structure through which the current investigation can consider future support service provision.

**1.4. Research Questions**

In order to implement this research, an investigation of student support services and the help-seeking and psychological distress of students, this research will consider the following research questions:

**Phase 1**

1. What are the current student support services provided by Australian universities?
2. What is the engagement and utilisation experience of a university student accessing support services?
3. What are the basic student demographics accessing each of the identified student support services?

**Phase 2**

1. What is the current student experience as measured by a help-seeking questionnaire?
2. What is the current student experience as measured by the Kessler 10?
3. How much does attendance at university support services affect psychological distress in students?

**1.5. Organisation of the Thesis**

Following this introduction, chapter two considers in detail the manner relevant theoretical frameworks inform, articulate and assist the understanding of student experience, and the manner the research has been constructed and conducted. These conceptual frameworks are used to facilitate the explanation of
data gained relating to the interaction between student need and help-seeking behaviour.

Chapters, three, four and five, will detail the existing research previously conducted on university students, needs, help-seeking behaviour, and experiences of psychological distress. Chapter three will give an overview of university support systems and student support services, including the global and local influences on how services are designed and delivered. It will give a description of the difficulties that are faced by university students, research into this topic being contemporary and providing a comprehensive insight into student university life including the factors that effect learning. Student needs, help-seeking behaviour, perception of student support services, and factors that impede such processes will all be explored.

Chapter four details and reviews the current knowledge base about psychological distress, its definition, measurement, and prevalence, before focusing the review of students in university settings. It will provide insights into the factors provoking psychological distress in university students and their subsequent attempts at coping and help-seeking. This chapter will conclude by presenting an overview of current research aiming to provide details relating to the effectiveness of universities in identifying and managing psychological distress in students.

Chapter five details the recognised attempts at improving health literacy, including mental health, and health promotion for improving students’ understanding of the issues they may face, and how to deal with them effectively. Chapter six will present two nationally recognised programs employed by various Australian universities as a part of a comprehensive program to manage student psychological distress and help-seeking behaviour, which have positive results.
Chapter seven, provides an overview of the implementation of the methods relating to this thesis, details the instruments used to gather the data, gives a detailed step-by-step overview of the procedure relating to the conduct of this thesis, and an overview of how the raw data were organised and analysed. The results and discussion chapters eight and nine will comprise the analysed data obtained during the study and a subsequent discussion of the findings the recommendations, which flow, for university administrators to consider.
Chapter Two

Theoretical Framework

Due to the multiphase nature of this thesis, two theoretical frameworks were found to be relevant to the understanding of content and also method. Maslow’s Hierarchy of Needs (Chapman, 2008) and the Health Belief Model (Janz & Becker, 1984) were chosen to help conceptualise the influences on the pathways, decision-making processes, and help-seeking behaviours undertaken by students when attempting to resolve a range of issues while managing their learning needs.

2.1. Maslow’s’ Hierarchy of Needs

Maslow’s Hierarchy of Needs, a developmental model targeted specifically at human motivation and needs attainment, was selected as a means of explaining the reason students seek assistance for various ‘unmet needs’ (Chapman, 2008). Although this model has not been extensively researched in recent years, it was examined in detail during the 1970s, 1980s and the 1990s as a model to explain education and business service improvement. It is considered an appropriate framework for conceptualising how students’ learning is impacted by unmet ‘lower level’ needs such as shelter and security, given that learning needs are generally thought of, as ‘middle level’.

Maslow’s original theory formulates an individual’s attainment of need in the form of a hierarchy and so presents a framework for understanding why students may disengage with tertiary settings even though they have sought assistance for their learning issues. Maslow’s original theory and subsequent model was developed between 1943 and 1953, and published in 1954. At this time the model comprised of only five levels of needs. This originally designed version remains for many researchers the most widely used Hierarchy of Needs (Chapman, 2008, p.2). These
are: Level 1 Biological and Physiological Needs: basic life needs (e.g. air, food, drink, shelter, warmth, sex and sleep); Level 2 Safety Needs: protection, security, order, law, limits and stability; Level 3 Belongingness and Love Needs: family, affection, relationships and work group; Level 4 Esteem Needs: achievement, status, responsibility, and reputation; and, Level 5 Self-actualisation: personal growth and fulfilment.

This model when updated in the 1970s and 1990s included subsequent levels of Cognitive Needs and Aesthetic Needs, factored in above the Esteem Needs according to Chapman (2008). This adapted hierarchy will be the version upon which this research will focus its conceptualisation and discussion, as it fits best with the experiences of university students (see Figure 2.1).

*Figure 2.1. Adapted representation of Maslow’s Hierarchy of Needs (Chapman, 2008, p.1).*
For the purpose of this research it is vital that the four key assumptions of Maslow’s model are understood (Maslow, 2013, p.18), which are:

(1) Each of us is endowed at birth with a full and, to an important extent, unique compliment of needs that, if allowed expression by our environment, will guide our growth in a healthy direction.

(2) These needs function in a hierarchical manner. The bottom step of Maslow’s five-step pyramid includes physiological needs (for food, water and air). Then come safety needs; next the needs for love and intimacy; then self-esteem needs; and, finally, at the apex of the pyramid, self-actualisation (e.g. intellectual and aesthetic) needs. By hierarchy it is meant that needs lower on the pyramid must generally be satisfied before needs at higher levels are activated. For example, homeless people without food (deprived on level one) will find it difficult to be very concerned about their relationships with others (needs on level three) until they have housing and food.

(3) Needs on the first four levels are called deficiency needs because they drive us to gratify the need, at which point the need lapses in its importance to us until deprivation again motivate us to take action to satisfy the need. Self-actualisation needs (on the fifth and highest level) are called being-needs because, among other unique features, they sustain our interest without our being driven by feelings of deprivation.

(4) The level of self-actualisation, the end-point of the process constitutes the highest level of human experience.

Maslow’s theory has been extensively researched since first published in 1954. Supporters of the theory indicate that recent research appears to support the notion of human needs sought by many on a pathway to greater understanding,
although the original hierarchy is frequently challenged (Tay & Diener, 2011; Villarica, 2011). Adaptations were then made throughout the 1970s and 1990s as the popularity of the theory cycled. Maslow’s hierarchy remains a very popular and frequently referred to individual framework in sociological, educational, business research and university courses, as well as its central theory being implanted into other theories such as Attachment Theory (van Ijzendoorn & Sagi-Schwartz, 2008).

To some extent, Maslow seemed to reconsider the essential aspects of his own theory, but these alterations in thinking never manifested in an alternative version of his theoretical ideas and modelling (Neher, 1991). He believed that “given basic support and nurturing from the environment, our inborn needs are sufficient to foster our psychological growth in a positive health direction” (Maslow, 2013, p. 4). Thus, both Aron (1977) and Neher (1991) believe that Maslow is influenced by human experience making his theory fraught with the problems that stem from the propensity to postulate concrete ideologies.

Few researchers would argue that our lower level needs, hunger and intimacy, are innate, as described in Maslow’s first assumption. But many would propose that in general, the higher needs, intellectual and aesthetic, are as distinctive as Maslow claimed (Neher, 1991; Schott, 1992). Although there is strong evidence for the distinctive nature of some of the higher needs, for example, curiosity as described by Einsenberger (1972), others such as aesthetic drivers are considered influenced by social and cultural experience (Daniels, 1982; Geller, 1982). Aron (1977, p.11) argues that Maslow’s tendency to downgrade the role of the environment in forming the human condition, to his rejection of the behaviourist perspective, has traditionally committed the opposite error of viewing environmental influence as all-important.
When examining the middle level needs it has been contended that in developed societies our biological, physical, and safety needs are often easily met, whereas the next needs’ level, love and for self-esteem, often provide barriers for many people. In similar societies the situation is often the reverse in that community members may go hungry and experience life threatening diseases, but unless these problems are severe these people typically exhibit strong problem-solving skills in lieu of appropriate support systems they can access, either formally or informally (Turnbull, 1972, p. 8).

Authors Aron (1977), Chapman (2001), Neher (1991) and Turnbull (1972) all aver that Maslow’s error has been in his overstating of position in the second assumption. Generally, most researchers agree that need deprivation is ordinarily emotionally and physically damaging. But this does not mean that the opposite situation, ease of need gratification, is emotionally and physically healthy. As is the case with many issues, a sensible position is the most secure one to take when using this part of the theory.

The third assumption of Maslow’s theory is that self-actualisation differs from the lower, basic needs. Maslow’s dissatisfaction with motivation based on unmet needs may have stemmed from his rebuff of the traditional behaviourist theories, which proposed a tension or drive-reduction, that is, disabling unmet needs, especially with respect to basic needs, as the primary initiator of motivation (Neher, 1991). Behaviourists traditionally did not consider higher levels of need such as curiosity and exploration, which parallel the process of tertiary education and attainment of knowledge (Aron, 1977).

However, according to Neher (1991) and Schott (1992) higher level needs are capable of being met, at least in some individuals who specifically attempt to drive
themselves towards such attainment. They state that, because satisfaction implies a prior state of deprivation, these findings call into question Maslow’s assumption that these higher levels operate in the absence of feelings of unmet needs. Essentially, Neher opines, “what appears to be unique about higher-order needs is not the absence of feelings of deprivation, but rather a number of other characteristics, including the purposeful choosing of challenges, and thus deprivations, which can provide almost limitless motivation and satisfaction” (p. 12).

The final assumption of Maslow’s theory, that self-actualisation is the concluding point of need attainment that constitutes the greatest level of human endeavour, has been critically examined by Daniels (1988) and Brennan and Piechowski (1991). These authors found that Maslow himself has admitted that his theory of satisfying lower needs in order to attain self-actualisation is not always possible. Both sets of authors suggest a modification to the basic theory is necessary, and that attainment of the basic needs is not an adequate state for self-actualisation. The difficulty is not the level of self-actualisation is not worth attaining but the requirement of attaining lower level needs first, through their satisfaction, must be altered to reflect human variations and environment conditions. Further, it is reasonable to assume that lower motivations are not always onerous; in fact, they can make their own exceptional contribution to our lives (Brennan & Piechowski, 1991; Daniels, 1988; Schott, 1992).

Even though much of the research discussed has issues with the four main assumptions of his theory, with some modification and reworking experts in the field of Maslow (Aron, 1977; Brennan & Piechowski, 1991; Chapman, 2001; Daniels, 1988; Frick, 1982; Neher, 1991; Schott, 1991) stating his ideas can be forwarded to
a more modern understanding. For example, Neher (1991, p. 15) allows for the following modifications:

1. That we do inherit needs, but among these are needs that Maslow failed to acknowledge as necessary for developing as fully functioning humans. These needs involve the necessity for a great deal of cultural input, more than just what is necessary to gratify our lower needs. In particular, many higher needs require encouragement from the environment for their development. Schott and Chapman add that the search for meaning may belong here although they argue that it could also be part of a process towards self-actualisation, this being inherent in all of us, namely, asking the basic question of human existence.

2. That a type of need hierarchy exists where our basic needs are ordinarily more urgent in their demands than are high-level needs. However, it is not clear that, in the long run, satisfying our lower needs diminishes their urgency, which Maslow felt, was necessary for higher needs to emerge. For many reasons a moderate level of need gratification seems to be more growth enhancing than the high levels of need gratification. In addition, there is probably more linkage between various need levels than Maslow proposed. In particular, the higher needs may not be as autonomous as Maslow’s original theory suggests.

3. That higher level needs seem not to operate apart from a sense of deficiency, as Maslow proposed. However, higher needs certainly are distinctive in that, unlike lower needs, higher motivations such as challenges, and thus deprivations, can be chosen because they are farthest removed from essential survival needs.

4. The level of self-actualisation, as Maslow described it, is unique to humans and is worthy of attainment. A history of having fully met an individual’s basic needs, which is intended to eliminate them as motivations, is required for the attainment of self-
actualisation. In fact, there are many reasons to believe that partial achievements of lower motivations, far from always being a burden, can provide important fulfilments and satisfactions of their own.

2.1.1. Application to education

The field of education has drawn upon Maslow’s model since the 1970s as a way of understanding the motivation of students when engaged in classroom activities. Findley (2002) concluded that in classroom environments, teachers acknowledged students to have difficulty learning if they were hungry; therefore meeting their physical needs was the first priority. This suggests that, as educators begin to understand that such needs other than learning are present in the classroom like security, social, self-esteem, and self-actualisation, and interventions can be more holistically developed and implemented. Findley further discusses the importance of social activities and extended curriculum in helping students to learn social skills and develop a sense of belonging. The increased sense of belonging enhanced students’ self-esteem, further improving their likelihood to seek help and their ability to learn.

Therefore, both Maslow’s original (1954) and updated models (Chapman, 2008) could play an important role in the development of any new university support service that aims to work with individuals in distress, as they provide a basis for identifying the needs and suggesting ways in which these needs can be achieved. The models also provide a basis for understanding what university services have been providing for many years. Additionally, when these models (particularly lower and middle level needs) are applied to current university structures, possible reasons can be found supporting the argument that existing academic staff are ill equipped to
deal with the non-learning needs of students leading to withdrawal and subsequently an increased risk of psychological distress.

2.2. The Health Belief Model

The Health Belief Model was one of the first, and remains one of the most widely used sociological models designed to predict health related behaviour (Janz & Becker, 1984). Rosenstock (cited in Glanz, Lewis, & Rimer, 2002) developed this model in 1966 for studying and promoting the uptake of health services and health action which Janz and Becker (1984) further refined in the 1970s and 1980s with amendments being made up until the late 1980s to accommodate increasing evidence within health research about the roles that knowledge and perceptions play in personal responsibility, including the attribution of priority to actions.

Originally, the Health Belief Model was developed to foresee a person’s reaction to interventions received by unwell patients, but more recently it has been employed to foresee and predict more general health related behaviours that subsequently inform health promotion strategies (Ogden, 2007). The Health Belief Model suggests that an individual’s belief in a health or personal threat, combined with the belief in the effectiveness of the proposed treatment, will predict the likelihood of help-seeking behaviour or action (Rosenstock, Strecher, & Becker, 1988).

An example of the Health Belief Model’s utility could involve an individuals’ view about a particular disease and the behaviour that they engage in when educating them about, or dealing with, that disease. For the purpose of this thesis the following example has been generated.
The original model (see Figure 2.2) included four primary constructs (Janz & Becker, 1984, p. 3):

1. Perceived susceptibility: an individual's assessment of their risk of developing a condition. The greater the risk is of getting a certain medical condition, the more a person will engage in behaviours to decrease the risk. Hence why people are vaccinated or brush their teeth, to prevent disease.

2. Perceived severity: an individual's assessment of the seriousness of the condition, and its potential consequences. For example, getting influenza is a minor matter for most people, involving bed rest for a few days. However, for people who cannot afford to be absent from work, or for people who already have an underlying medical condition, catching influenza could be more serious. Individual differences influence the perceived severity and vary greatly between people.

3. Perceived barriers: an individual's assessment of the influences that facilitate or discourage adoption of the promoted behaviour. Perceived barriers are
about the obstacles in the way of adopting a new behaviour and the consequences of continuing an old behaviour. The perceived barriers are most influential constructs because they determine if someone will adopt a new behaviour or not, depending on if the benefits of the behaviour outweighing the consequences.

4. Perceived benefits: an individual's assessment of the positive consequences of adopting the behaviour. These benefits are opinion based as not everyone adopts the same behaviours. According to this model, individuals only adopt behaviours they think will decrease the chance of getting a disease to which they think they are more susceptible.

*Figure 2.2. Adapted diagram of the Health Belief Model Janz and Becker (1984)*

Constructs of mediating factors were later added to connect the various types of perceptions with predicted health behaviour (Glanz, Lewis, & Rimer, 2002, p12):

- Demographic variables, such as age, gender, ethnicity, occupation;
- Socio-psychological variables such as social economic status, personality, coping strategies;
• Perceived efficacy, an individual's self-assessment of ability to successfully adopt the desired behaviour;
• Cues to action, external influences promoting the desired behaviour including information provided or sought, reminders by powerful others, persuasive communications, and personal experiences;
• Health motivation, whether an individual is driven to stick to a given health goal;
• Perceived control, a measure of level of self-efficacy;
• Perceived threat, whether the danger imposed by not undertaking a certain health action recommended is great; and
• Prediction of the model is the likelihood of the individual concerned to undertake recommended health action, such as preventive and curative health actions.

Glanz, Lewis, and Rimer (2002, p.24) identified and tested the strengths and limitations of the Health Belief Model:

Strengths

• Common sense constructs easy for a range of health professionals to assimilate and apply
• Focusing research attention on modifiable psychological prerequisites of behaviour.
• Making testable predictions: Large threats might be offset by perceived costs; small threats by large benefits etc.

Limitations

• Common sense framework simplifies health-related representational processes.
• Theoretical components broadly defined therefore different modes of operation may not be strictly comparable.

• Lack of specification of a causal ordering.

• Neglects social factors.

• Cannot make testable predictions via counterfactuals.

• May be responsible for ‘blaming the victim’ for his/her illness when factors are beyond the individual's control.

Numerous meta-analyses have been conducted with varying results by reviewing studies to determine the longitudinal effectiveness of the health belief model and its ability to predict behaviour (Carpenter, 2010). Carpenter (2010) reported that “when all the obtained studies were considered together, severity, barriers, and benefits were all related in the predicted direction to the likelihood of performing the target behaviour” (p. 666). He concluded that the Health Belief Model constructs vary in their effectiveness as predictors or behaviour; however, he stated clearly that due to the relatively low number of studies conducted to date, strong conclusions couldn’t be made.
Chapter Three

University Student Support Systems

Chapter three outlines the many influences that affect the way in which a university delivers support services to students. The chapter will first consider the global influences and current thinking around university support services. It then contextualises factors affecting support services delivered within an Australian context, including the Bradley Report (Bradley et al., 2008), which form the central theme for this discussion. In the light of the Bradley report, which reviewed the manner in which tertiary education is provided in Australia, literature is considered which highlights possible implications for the provision of support services to university students. Further consideration is given to the unique aspects of service design for university support systems and the possible impact of current development, including the centralisation of services to improve efficiencies in the manner of delivery. This chapter then seeks to understand current thinking on the nature of support services, in particular the way in which student support services are provided and address the current needs of students. Information regarding the perception of support services and the roles that university staff have in relation to the support of students is also discussed.

Concluding this chapter will be a consideration of salient factors influencing student learning and student life, and their consistent interplay. It is important to understand the nature of stigma and the experience of students new to the tertiary sector, so that full understanding is available on how best to support students. Without the knowledge outlined in this chapter it would be difficult for universities to design support services effectively to meet the needs of their students.
3.1. Australian Universities

According to the Universities Australia (2013) website there are a total of 39 universities throughout Australia. Each university has its own unique profile and caters for a variety of domestic and international students who access courses at varying levels at both undergraduate and postgraduate levels. The consistent themes of Australian universities are to provide and prepare students for future workplace opportunities, ensure skills and knowledge acquired at university translate into economic opportunities, and provide solutions to problems faced by the Australian society on a global and domestic scale.

Recent studies have found that the Australian university system is well placed to meet the challenges of the 21st century (Sheil, 2010). Australian universities are subject to and have a system of continuous monitoring and review as prescribed by the Government of Australia at a Commonwealth level. Figures taken from the Universities Australia (2013) website indicate that the 39 universities that exist in Australia have over one million students with a total staff population of more than 100,000.

Undergraduate and postgraduate students usually attend university for a period of three to six years, dependent on the nature of their degree and choice of completion times, either by part- or full-time study. These students typically come from a multitude of socio-economic backgrounds and cultural and ethnic diversities. Historically, and until very recently, university undergraduate students have come directly from secondary schools; however, recent university and government policy developments now allow for a more open entry to university study (Bradley, Noonan, Nugent, & Scales, 2008). This has subsequently led to changes in the age and social demographics of students attending universities.
3.2. Global influences on University Support Services

Australia, like most countries in the world today, compete in a global market and therefore, by definition, Australian universities compete and are influenced by trends existing within tertiary education sectors around the world. Further, the May 2014 Federal Budget (Commonwealth of Australia, 2014) proposed significant restructuring for the higher education sector in Australia, including extending the demand-driven system of uncapped places to non-university providers and to sub-Bachelor level qualifications. This would allow providers to set their own student fees and herald the introduction of student fees for higher research degrees. It will be therefore useful to understand the global context of university support systems and how they are viewed.

The World Declaration on Higher Education (United Nations, 2002), first presented and published in Paris at the first World Conference on Higher Education, was aimed at guiding universities through the various educational and support challenges of the 21st century. Significant aspects of this document targeted the need to develop student affairs, known as student support services. It presented findings in the form of a potential template for universities to consider when preparing for future changes in higher education including universities in Australia.

Until the early part of the 19th century, according to the World Declaration on Higher Education (United Nations, 2002), the concept of student support services was relatively new to academic and general staff who were rarely expected to manage non-educational tasks for students. This situation occurred in the context of a higher education model and system that did not centralise its focus on the whole student, both inside and outside of the classroom, with access to an education being limited to those who had the financial means to afford it.
In response to changing social policy and views, the types and numbers of students grew and academics who previously managed support by default began calling for more assistance. Thus commenced the aetiology of student support services, with these staff members now in charge of and responsible for not only accommodation and basic needs such as food and finances, but also medical and mental health care. According to the World Declaration on Higher Education (United Nations, 2002), the addition of student support services and programs within the higher education institution sector was not enthusiastically adopted or supported. The expansion of the student population continued to have a detrimental impact on relationships and, more importantly, on learning outcomes for students well into the late 1990s.

During the 1990s, the focus of student support services moved towards an improvement of student outcomes, that is, learning and retention, with administrators working closely with academics and general staff to this end. Opposition toward change ended and the first steps were made in the direction of a greater understanding of students in general (Smith, Therry, & Whale, 2012; United Nations, 2002). It could be argued that this improvement was instrumental in the development towards an inclusive system that promoted positive well-being and university experience, ultimately improving results for students and resource management.

More recently Araque, Roldan, and Salguero (2009) stated, “there is an unprecedented demand for, and a great diversification in, higher education, as well as an increased awareness of its vital importance for socio-cultural and economic development” (p. 5). It is therefore vital to ensure a range of support services exist to provide a mix of services for a diverse student population that makes increasing demands.
Banrey (2008) discusses and explores the importance of sharing knowledge relating to educational practice and developing international partnerships encapsulated within a continual consideration of current technologies, and how this can offer alternative opportunities to close the gap between first world and third world countries. Special focus was on access to and provision of resources for higher education. Banrey further states, “they (first world countries) can also help in reducing the increasing socio-economic stratification and differences in educational opportunity within countries at all levels of wealth and development” (p. 43). This being the case and Australia becomes part of the solution to issues discussed by Banrey, then Australian universities and their support services must carefully consider the ways in which support is to be provided for an emerging international student population base.

Continuing this exploration within the higher education sector, Choudhry, Gujjar, and Hafeez (2008) suggest that, as societies become increasingly reliant on knowledge accessed using information technology available due to social and economic advances, higher education institutions will grow in importance in relation to the development of cultural, socio-economic and environmental sustainability of individuals and their communities. Institutions providing higher education will be confronted with the challenge of change and “must take the lead in moving society from mere economic considerations to the deeper dimensions of the greater good for all. In doing this, they must address social needs and promote solidarity and equity, academic and scientific rigour, originality and impartiality” (p. 23).

The intent of higher education institutions to evolve with social, economic, political, legislative and technological changes that will ensure education itself will be enhanced in both quality and relevance. International strategic directions, as outlined
in the World Declaration on Higher Education, dictate the strong involvement of all aspects of a single society including government at local, state, territory and federal levels, universities, and all relevant stakeholders. Bradley, Noonan, Nugent, and Scales (2008) and the United Nations (2002) emphasise that students must be placed at the centre of policy focus so as to promote lifelong learning that is not only relevant but also integrated into the broader knowledge of current society. These documents further emphasise the need for students to be considered as equal, contributing and fundamental partners in the development of education processes since they are the primary stakeholders in their education, thus having the right to engage themselves within the context of their relevant educational experiences, institutions and communities.

Access to quality higher education should be made available to all individuals regardless of their background or personal characteristics. It therefore becomes vital that the design and implementation of student support services consider the need to provide effective access to higher education and learning, enhance student retention and graduation rates, develop skills relevant to international contexts, and provide nations with new human resource capital (Bradley, Noonan, Nugent, & Scales, 2008; McGaha & Fitzpatrick, 2005).

Belloc, Maruotti, and Petrella (2010) add to the argument that support services centred on student need are pivotal to the healthy functioning of a university, stating:

“As a fundamental premise of providing pertinent and appropriate high impact, student centred services and programs on an ongoing basis, it is imperative that the individuals charged with these tasks acquire the necessary knowledge and skills to carry them out in an effective
manner. It may seem obvious that the most important knowledge required of staff working in the area of student affairs and services should be a thorough knowledge of the student with whom they work, however, this is not consistent practice” (p. 7).

Since students are central to the function of higher education institutions, administrators should be required to have a thorough knowledge of characteristics, such as their demographics; cultural and ethnic diversity; student expectations, experience and satisfaction; their physical and psychological development; and behaviour. This should be a crucial element in promoting and maintaining the development and implementation of programs necessary to promote student enrichment and growth (Choudhry et al., 2008).

Essentially, staff employed at the various student support services will need to be well educated about student experiences of university life, psychological and physical development, and educational attainment. The World Declaration on Higher Education (United Nations, 2002) reviews existing data, suggesting that all staff will need to, “develop a comprehensive and accurate socio-cultural picture of their student population, identifying inadequate or missing information elements so that they can initiate appropriate action and inform campus administrators, faculty, student leaders, and government officials of the nature of the student body” (p. 45).

Although research into the area of student support services provides staff with an overview of student needs and wants, it is recognised that more extensive research must be conducted using instruments and methods typified by scientific rigour and validity. This information could then be used to enhance a broader understanding of student experiences in higher education. The implementation of appropriately designed research should encourage a greater understanding of a
university student population, their needs and experiences (Bewick, Gill, Mulhern, Barkham, & Hill, 2008).

From targeted research the development of a consistent framework will assist administrators to make sense of the needs and experiences of diverse student populations, both as individuals and as members of particular subgroups. Administrators may choose to use or modify existing frameworks relating to student learning, development and success, or generate their own aimed at a specific context or cohort. It is essential that framework configuration and policy be aligned with contemporary knowledge and experiences of university students (United Nations, 2002).

3.3. Local Influences on Australian University Support Systems

The Higher Education Support Act (Commonwealth of Australia, 2003) influences the way in which support is delivered to students who are enrolled in an accredited ‘Higher Education Provider’ course. This Act, as amended by the Higher Education Legislation Amendment (Student Support Services and Amenities) Act 2011 (Australian Government, 2011), prescribes a framework that all universities must use to develop and implement programs to support students. The Act enables universities to levy students at the indexed, capped rate of $250 per annum. The subsequent funds are estimated to total 50,498 million dollars over the period 2010-2014 for the development and enhancement of student support services and programs. These funding arrangements are however fluid in the context of political influences and therefore may change within Australian Government budget arrangements.

The national infrastructure of Australian universities, under this system, ensures that campuses only spend amounts received as student support services
and amenities fees on the following selection of services which are relevant to the current study:

- providing food or drink to students on a campus of the higher education provider;
- supporting a sporting or other recreational activity by students;
- caring for children of students;
- providing legal services to students;
- promoting the health or welfare of students;
- helping students secure accommodation;
- helping students obtain employment or advice on careers;
- helping students with their financial affairs;
- providing libraries and reading rooms for students;
- helping students develop skills for study, by means other than undertaking courses of study in which they are enrolled;
- advocating students’ interests in matters arising under the higher education providers rules;
- giving students information to help them in their orientation; and
- helping meet the specific needs of overseas students relating to their welfare, accommodation and employment.

(Commonwealth of Australia, 2010, p. 6)

The services provided within this legislation, as with budgetary fluctuations, may change in the context of current government education policy. However, for the purpose of this current study, the existing legislation (Commonwealth of Australia, 2010) will be referred to as extant at the time of data collection.
Although there is a legislative requirement to provide support services to students engaged by universities, the question remains whether or not the historical influence of the separation between teaching roles and support services continues to impact on students’ experiences at university. Therefore, if there is an influence, then universities need to be cognisant of the separation when developing and implementing services or programs designed to encourage appropriate help-seeking behaviour. This would then potentially match student need to services more effectively, reducing psychological distress.

An example of how separation may occur in practice has been demonstrated by the attitudes of university staff towards students with learning disabilities. Murray and Flannery (2008) administered a survey to staff that focused on their experience of working with students with learning disabilities. Results indicated that staff in general had positive attitudes towards these students and were willing to accommodate them. However, the main concern of staff was the need for increased training and professional development with regard to the understanding of students’ learning disabilities and their ability to provide support. This suggests that university staff, regardless of academic or general position, would benefit from training. The provision of training may promote a unified understanding of supporting students, and being able to identify the needs of particular student groups in order to provide consistency.

3.4. Challenges Faced by Australian University Support Services

University students are faced by many challenges that impact on their ability to engage with and succeed in university study (Stallman, 2011). For the purpose of this discussion several have been chosen to demonstrate this impact, for example,
provision of tertiary education in rural settings; the experience of mature aged students; and welfare of students from an international background.

Birrell and Edwards (2009) examined the Bradley Report’s rationale for its stance that there is no need for expansion of the university sector and concluding that, in order to meet the educational needs of the Australian population, there will need to be an increase in university campuses. This will include an expansion of universities to outer regions of the metropolitan areas and also rural locations. As this expansion occurs, universities will need to consider and re-conceptualise the type of support students will need, including services traditionally not offered in such areas. Based on the premise that universities have moved towards centralised services it could be argued this could disenfranchise students who study on smaller satellite campuses. The concept of centralised services will be discussed later in this thesis.

Putnam and Gill (2011) further scrutinised the Bradley Report reviewing the challenges outlined regarding how Australian universities could provide enhanced support services. The issue of socio-economic status of university students and an attempt to ascertain a definition for this term was the primary focus of this commentary. The authors analysed university culture and practice pertaining to non-traditional students, for example mature aged, international, or alternative entry students, looking at cultural transformation in particular within the context of recruitment from a broader community. The authors conclude universities need to have a better understanding of socio-economic status and its impact on education in order to gauge the complex needs of students from such a population. Specific findings from the Bradley Report (Bradley et al., 2008) have given scant detail about the preparedness of universities to expand into this unknown population. Therefore,
if it is not known who these students are, how can universities provide targeted services effectively?

Stone (2008) examined one particular student group, common to most university settings: mature aged students. This study found that the majority of mature aged students came from a lower socio economic status or who were first generation participants, that is, those students who were the first in their family to enrol in university education. Stone considered the importance of access to higher education and also assisting students from a range of backgrounds to engage in higher education effectively. His research further suggested that disadvantaged people are under-represented at university; therefore entry and pathway opportunities need to be created. However, universities will need to provide the correct type and amount of services to this population, which has also been identified as having higher negative health needs.

Whiteman et al. (2013) further supports this idea that if you have a group of students from similar backgrounds, for example, lower socio-economic status, students from rural areas, and international students, even though the support may not be provided or accessed in the early stages of university engagement, the need for targeted support may grow over time. As this need becomes more pronounced and begins to interfere with the students’ ability to learn, the need to provide targeted support groups becomes more important. The authors suggest peer support groups as being one possible and integral part to the support services facilitated throughout the university.

Brand (2006) had previously investigated proactive approaches to student support specifically in the context of counselling within the university. Brand deconstructs the notion that there is a greater cost to the university community,
including students, for not providing appropriate counselling services in times of economic hardship, increased times of mental health problems, illness and distress. He argued that providing counselling services proactively, that is, using an early intervention approach, would have a valuable impact on student well-being and retention. Therefore universities should consider providing essential psychological support services in order to increase retention significantly.

3.5. University Support Service Design

In order to provide optimal support services for students, future developments undertaken by universities must consider their design. Yeo and Marquardt (2011) explored service redesign and improvement, discussing three key aspects of service standards: customer orientation, course design and delivery, and support services. Findings revealed the way in which students are perceived as customers versus products, has a direct impact on the type of learning pedagogy developed for both classroom teaching and online endeavours. Implications for teaching practice were discussed and identified a series of points for future discussion:

- students need to be viewed beyond that of conventional roles and engaged to improve overall success;
- courses need to have strong industry links and related content that requires academics to actively engage the students in interactive materials; and,
- the provision of support services requires universities to change their current models of service provision to allow for wider and more innovative ways to provide comprehensive services (p. 34).

The issues which students identify as needing help, include counselling for psychological distress, general health care needs, and learning difficulties; these need to be understood within the university environment. Hurst (1996) considered
the management of individuals’ specific health care and clinical needs arguing that individuals benefit from an integrated and seamless attention to the focus of care and care pathways. He argued that an integrated approach would therefore benefit individuals or anyone interacting with the service.

3.6. Student Support Services and Student Needs

Reavley, McCann, and Jorm (2012) explored the relationships between psychological distress and actions such as first aid behaviours, experienced by students at an Australian university. As with previous studies focusing on specific student groups and their support needs, this study concluded the need to investigate further the impact that either a lack of services or lack of access to existing services have on a student. The authors focused their study on the barriers and enablers for students who use counselling services, concluding that the high level of help-seeking behaviour from university students was initially targeted towards friends and peers; and that first aid behaviours can provide significant support further pointing to the need for effective peer-to-peer support programs to enhance statutory services provided by the university.

Aubin et al. (2012) concluded that if a university provides services to target learning and not lower level needs, like housing or peer support, then the existing services will be ill equipped to manage student distress if that distress is not being caused solely by learning. In effect, the existing service has not been designed to meet student need, and as such, the product has no usefulness to the student. This may provide, in part, an explanation as to why, although services provided are deemed necessary, they have lower levels of engagement and access by students.

Throughout the literature constant reflection and analysis of ‘need’ in the context of the student experience whilst at university is apparent. As described in
chapter one, Maslow presents the opportunity to understand how need may be constructed, especially for those in tertiary settings. Need is a common element experienced by students as well as the general population, the utilisation of Maslow’s Hierarchy of Needs enables the understanding the influence need has on student experience.

Schropp (2008) reviewed senior nursing students, who completed a demographic questionnaire that included academic success, self-actualisation, and satisfaction, the perceived importance of education needs. Findings revealed there to be a positive correlation between the identified educational needs and levels of satisfaction. They also showed the importance of educational needs as the best predictor of academic achievement and the level of satisfaction with the experience of education was the best predictor for self-actualisation. These results are a sign that university support services must ensure they understand the educational needs of all students in order to promote self-actualisation. For example, a counselling service cannot examine the psychological distress of the student without exploring how this condition interacts with educational experience and learning, that is, when distressed the ability to engage and learn is lowered.

Freitas and Leonard (2011) examined a similar student cohort and identified factors that contributed to success amongst university student nurses. The principal aim of this study was to focus on the relationship between met and unmet needs and the attributes of student success, with emphasis on whether unmet lower order needs impede higher order needs being met. The authors identified the most important factors as being the inability of students to cope with both university demands and those of personal life. This affirms that academic staff must identify student issues early so as to ensure the students’ success in later studies; it is an
imperative step in the process of supporting students. The study reveals the manner of implementation; for example, develop pathways of services that students can access to have issues managed effectively. Freitas and Leonard also conclude that universities have the responsibility to develop the learning of students and investigate how other factors impact on their success. Academic and general staff may provide valuable insights into student behaviour, with early detection leading to a reduction in unwanted behaviours and being an integral part of student retention and subsequent course completion.

Moyet (2003) commented on the effectiveness of service designs, and influenced by Maslow’s theory, reviewed the impact that design has on subsequent access and uptake of such a service. Moyet considered the focus on the effectiveness of the care given to an individual must be intensified and the relationship needs satisfaction has with the productivity of staff providing the service given closer attention. In essence this study found that for full effectiveness the service required staff is employed to manage need at the lower level of food, finance, shelter, whilst concurrently employing staff to provide services aimed at middle to higher level need. In the context of a university, the provision of services to assist an individual to find accommodation would work concurrently and more effectively when the university also provided a counselling service to manage the emotional needs.

Moyet (2003) also found it to be important to meet staff needs in order to increase job satisfaction and retention. If both staff and individual needs are being met then the service provided will be both beneficial to the individual and enhancing of staff motivation. McDonnell (2010) contributes to Moyet’s discussion by adding that, by offering individuals control over their lower order needs, that is, involving
university staff and students in service design would enhance their confidence in dealing with such higher order needs as emotional distress. Therefore, consideration should be given to consultation with university students and staff in design of support service provision.

With the knowledge that need is an important driver of student behaviour, the notion of the Health Belief Model ideally links student need with subsequent behaviours students may or may not choose to employ to address that need. Mikhail (1981) evaluated the Health Belief Model from the perspective that any model evaluation should be based on the purpose of the theory. There are clear indications that the Health Belief Model provides one approach to understanding health related behaviours (Jukkala, Deupree, & Graham, 2009). Sahin, Ertepinar, and Teksoz (2012) attempt to link attitudes, values and behaviours, for example, how a university campus can be organised to sustain student behaviour change. Their findings affirm that the university structure should be equipped to meet the external needs of students in order to improve the sustainability of university structures to support needs external to the learning component to university life.

One specific aspect of any service structure is the need for clear and comprehensive guidelines relating to service operation. Thus Blozik, Bussche, Gurtner, Schafer, and Scherer (2013) stress the importance of having guidelines for improving healthcare, emphasising the necessity of having clear guidelines as a checklist to ensure consistency of management and to avoid presenting issues in decline due to the intervention provision.

3.7. Perceptions of Support Services

Nichols (2009) utilised comparative statistics and analyses to examine levels of retention for first time students engaging in distance education, comparing them
with national benchmark figures. Their study focused attention on the difference between students who were engaging in specific course retention interventions and those who were not. Their investigations found that, although students often did not perceive well the addition to normal course material of support interventions, their retention outcomes improved significantly. Nichols suggested educational institutions need to examine the reasons more closely for why students are leaving courses, student perceptions of courses and support services, and investigate the fundamental experience of first-time students and their needs to ensure academic success.

Tones, Fraser, Elder, and White (2009) also studied perceptions of support services and barriers to learning, including subsequent success, within a mature-aged cohort of university students. Their findings revealed that support for transition to tertiary studies for mature-aged students is vital in ensuring overall success, especially if these individuals come from lower socio-economic backgrounds. Given that many universities have a growing number of mature-aged students enrolling in courses, the authors proposed immediate closer focus on the supports provided, how students feel about them, and recommendations for their improvement. This study discovered mature-aged students over the age of 45 were more likely to report a lack of availability, lack of time and lack of awareness as barriers to using support services.

Lee (2010) continued to examine issues predicting success, especially from a cultural perspective, comparing two distinct cultural group’s views on online service quality, learning acceptance, and student satisfaction. Although conceding various limitations on gathering data for these student groups, results pointed to cultural differences impacting on their perception of services and, as a consequence, their
engaging with support services subsequently appeared to influence the students’ academic progress. Lee observed that future research must examine cultural variables within university settings as possible agents of change and success for learning, especially that of online learning.

Specific student cohorts have been examined in order to determine areas, including perception and use of support services, within particular subjects that could be improved or re-examined in order to promote increased student learning outcomes. Amenkhienan and Kogan (2004) focused on engineering students and their perception of how support services impacted upon their academic study and achievement. The study reported three distinct influential factors: individual effort and involvement; peer interaction; and faculty contact (p. 543). Students’ personal involvement and effort, when coupled with positive relationships with peers and staff, was found to greatly enhance academic achievement. More specific areas offered for consideration included: working with students to improve their overall study and homework practices; tutorial services and extra-curricula support; specific cultural support groups for international students; integration of the help-seeking process into orientation practices to initiate the seeking of help for all students; and adding time to the promotion of all the types of student support services available throughout a campus.

Roberts and Dunworth (2010) reviewed the perspectives of international students concerning the provision of various university support services. Their findings were similar those of Amenkhienan and Kogan (2004) regarding engineering students in their study, namely most international students are aware of some of the services provided by universities, but they are not aware of all that is available. Further, Roberts and Dunworth found that while both the students and the
services shared common understandings of each other and their needs, there were areas in which interpretation and comprehension interrupted the ability to seek help. The investigation found students to be more likely to perceive their difficulties in a more narrow and prioritised framework, based on sociocultural needs, whereas staff were more likely to conceptualise the student’s problems from a more holistic framework of understandings.

Recently Wilson and Gore (2013) continued this examination of perceptions on support services by focusing on ‘connectedness’ implying that students found to be more likely to complete their degree showed higher levels of being connected to the university. The research initially focused on making the connection between parental attachment styles as a predictor for peer attachment. For example, student avoidant attachment style towards peers predicted a negative view of academic staff and associated study. This negative view of attachment to academic staff predicted similar perceptions and attachments towards the wider university community, and in particular support services. Wilson and Gore nominated a series of implications for universities including provision of programs that increase a feeling of connectedness towards university peers and staff, and particular programs promoting attachment.

3.8. Roles of University Staff

Since the 1970s a change of focus on the university environment and the need to include a greater emphasis on the provision of student support has occurred and subsequently its impact on the role of academics (Bashley & Shepard, 1977; Entrekin & Everett, 1981). Laws and Fiedler (2012) reviewed and updated the ongoing challenge of universities to engage academic staff in pastoral care activities and the impact that this change had. They revealed five themes influencing an academic staff member’s reluctance to work with distressed students: (1) staff felt
disrupted when distressed students sought assistance in an unplanned way especially those who exhibited behavioural problems or sought emotional support; (2) staff found the provision of emotional support was stressful; (3) staff felt under-skilled for the pastoral care management of students; (4) staff believed processes and procedures were inconsistent and needing updating; and (5) staff was aware of the discord between academic staff and support services when it came to managing ‘at-risk’ students. The authors suggested universities provide more professional development for academic staff and orientation programs to improve the way in which staff define and promote themselves. Additionally, support programs and services need to be reviewed for inclusion of mental health professionals in order to support students and staff. This review suggested that further research and examination is needed into the efficacy of university funding and resourcing of programs targeting students’ behavioural and emotional needs, with the inclusion of extra staff.

Schulz (2013) focused his research on the impact these changes in staff roles have had on the overall level of satisfaction in academic staff. Role conflict, role ambiguity and the changing organisational climate were central allowing Schultz to articulate how a market climate has impacted on academics’ job satisfaction. He distinguished between different types of university cultural climates that produced lower levels of role stress and higher levels of job satisfaction; these were: the Clan, the Hierarchy, and the Adhocracy climate types. He compared these with the more competitive and economically driven types. Schultz found that although there has been a need for university administration and management styles to adapt to the global markets, the Clan type emphasising connectedness, as compared to the
Hierarchy and the Adhocracy types, still continue to play a large role in overall increased staff satisfaction.

Previously, Szekeres (2004) investigated the impact of the marketisation of universities and the accompanying reorganisation of the administration processes within universities. It had become apparent that, as universities became more engaged in a market competition, the need for more efficient and well trained administrators increased. However, a dichotomy is apparent of academic and general staff that often ends in conflictual disagreements about how to improve and run universities. Szekeres maintains that improvement in the overall connectedness and attachments between university administrators and academics will need to focus on how to work effectively together in order to provide a comprehensive and balanced set of programs for students.

Cox, Herrick, and Keating (2012) specifically examined the impact of the need to integrate policy and administration practices effectively and also ‘space’ as a means of improving staff’s positive identity and connection to the university environment. This study found that by improving staff connectedness through improving environmental spaces, it is possible to increase overall support to students. Cox and co-authors hypothesised university space and environment play a role in student disengagement, attendance and retention, that is, an understanding of how staff interact and react in the actual university environment, provides a degree of insight into how students’ engagement is shaped by social and academic practices.

Ramsden (2006) summarised the future challenges for modern universities in the face of major economic, social, and cultural changes. He opined changes to include: an expansion of entry into university leading to significantly higher numbers
of students with a wider variety of learning abilities and needs; the introduction of internet and social media’s influence in information dissemination; reduced public funding; increased emphasis on academic skills; and an increase in levels of accountability at all levels of the university. Concurrent with these changes, teaching and learning practices have come under ever increasing scrutiny, especially the need to provide interactive classrooms that are equally virtual and structural. Ramsden emphasised the key to successful university transitions as being leadership, particularly in relation to morale, productivity and change management.

3.9. Factors Impacting Student Learning

Goldfinch and Hughes (2007) contended students generally came to university confident about the skills that they possessed; however, their study found those who withdrew within the first year had less confidence than those who remained. It alluded to the fact that the most significant factors leading to success were the ability to manage time, work in teams, and have confidence in written communication skills. The research examined the disparity between early confidence levels and ‘actual’ academic skills finding that those students who were essentially falsely or overconfident were more likely to fail and therefore withdraw. This is not the only study that has focussed on the criticality of surviving first year. Indeed many Australian universities have targeted programs to address the fact that students are more likely to drop out in their first year at university than at any other time, and at a rate roughly double that which occurs in second year (James, Krause, & Jennings, 2010).

Mills, Heyworth, Rosenwax, Carr, and Rosenberg (2008) considered a group of students who were enrolled in an undergraduate bachelor degree when they examined the factors commonly associated with success in the first year. They found
that high academic success was correlated positively with a high entry score, being female, and non-indigenous. Significantly, attendance at a government secondary school, the payment of university fees upfront, and completion of an English literature subject in secondary school further increased the likelihood of success. This further compounds the need to target populations of students entering university without these inherent predictors of academic success. Further to these findings regarding first year students, the authors’ research noted ongoing success into second year to be closely related to the participation of students in a mentorship scheme and the mark attained at the end of the year.

Olani (2008) also considered contributing factors to first year success. His study noted high academic achievement prior to university entry to indicate a higher success level in the first year. He noted psychological variables within his research cohort and particularly prior high academic achievement levels in the presence of such negative psychological variables as poor problem solving skills, did not promote academic success in the first year.

Subsequent to the first year experience Hachey, Conway and Wladis (2013) reviewed the changing environment of universities and colleges into the 21st century especially the concept of education being provided through an online medium rather than face-to-face teaching. The study alluded to the fact that universities are tending to focus most of their attention on building the capacity of online courses rather than in building bricks and mortar with increasing capacity in on-campus endeavours. In the survey conducted with universities they found at least 61% of students took some kind of online course. The issue confronted then was how universities were addressing attrition rates of students undertaking such a mode of study. They contended attrition rates for online courses were significantly higher than those of
their face-to-face counterparts. One concept they questioned in order to address some of these concerns in attrition was that universities routinely collected a wealth of information automatically; however in a meta analysis of the utility of this information they found it was either poorly or rarely interrogated to understand possible attrition rates of either online or face-to-face teaching modes.

Variables impacting on a student’s ability to engage in a tertiary learning environment, other than teaching modes, were present in Sheard’s (2009) study. He conducted a two-year study in which the correlation between demographics, including age, and hardiness, a cognitive and emotional variable was examined. Sheard applied these two parameters to gauge their effect on academic success and performance. His findings showed that students who were mature in age and female outperformed their counterparts. Therefore the collection and use of data regarding student s’ hardiness may assist universities to design targeted interventions for vulnerable groups.

Finally, Fenollar, Roman, and Cuestas (2007) considered students attending university, examining the parameters of achievement goals, self-efficacy, and class size on their effect on academic performance. These authors concluded that the role of study strategies, university structure inclusive of class size, and self-efficacy had the strongest indirect effect on performance.

3.10. The Effect of Stigma on University Students’ Wellbeing

Hussain, Guppy, Roberston, and Temple (2013) reviewed the perspective that university students are immune to ill health, including physical and mental health, due to coming predominantly from privileged positions in society. The premiss that students (or persons) from middle to upper class areas do not experience ill health however is not accurate. Universities are more than ever a
micro representation of the broader community with additional factors that impact on the health of all students, irrespective of their socio-economic status. It is well researched that a sizeable proportion of students experience such physical health difficulties, such as fatigue and headaches, as well as increasing rates of mental health problems, like depression and anxiety. More recent indicators of mental health show that university populations and such problems are now higher when compared as a percentage of the general population. These authors emphasise the importance of further investigation into university student perspectives on help-seeking and support services.

Hussain et al. (2013) also recorded the most common physical health concerns reported by students, including fatigue, headaches, and allergies; whereas the most common mental health concerns were anxiety, coping difficulties and depression. This study found that the most common sources of support sought were medical doctors or friends (82% and 78% respectively). However, when more qualitative reviews were undertaken with students, clear indicators of reluctance to seek help, other than the two identified areas, appeared related to stigma, privacy of disclosed information, and anonymity in the seeking of support. The authors clearly identified the need for university administrators to review and manage barriers relating to stigma in a manner that improves levels of access and help-seeking. They contend consideration must be given to the types of customised programs required to manage stigma related to help-seeking behaviours, but depending on the specific profile of each university.

One specific and targeted approach would be to deal with self-stigma, defined as a reduction in an individual’s self-esteem, confidence and perceived social acceptability (Hussain et al., 2013). Self-stigma occurs when a person internalises
the external worldview of a particular health circumstance and applies such to their own understandings of self. Tucker, Hammar, Vogel, Bitman, Wade, and Maier (2013) further separated self-stigma as it relates to mental illness from help-seeking self-stigma. Their study dwelt on the importance of understanding both concepts in order to appreciate fully the influence of stigma on service provision and recovery. The implications for university support services relies on their ability to define, identify and understand the difference between the two stigma types, and target student health promotion to encourage a more positive view of mental illness and of help-seeking practices.

Targeted programs consider further the individual variables that impact upon levels of perceived stigma. For example, Golberstein, Eisenberg, and Gollust (2008) found that perceived stigma was “higher amongst males, older students, international students, students with lower socioeconomic status backgrounds, and students with current mental health problems” (p. 392). Their study found that negative associations between the stigma of mental illness and help-seeking practices were most prominent among the young aged university student cohorts. Therefore targeted health promotions may of necessity concentrate on the younger cohort within universities also exploring the reason for older cohorts not perceiving mental illness and help-seeking in the same way.

Several studies emphasise the necessity for targeted approaches to the younger university cohorts (Lally, O’Conghaile, Quigley, Bainbridge, & McDonald, 2013; Reavley, McCann, & Jorm, 2012). Primarily they indicate the urgency of understanding and supporting the younger male university student when inculcating appropriate levels of mental health literacy, especially this cohort is most likely to experience difficulties and be the least likely to access services.
More specifically, amongst the younger cohort at large, emphasis on cultural variables plays an important role in both help-seeking behaviour and the openness of some younger students, especially internationals. Tang, Reilly, and Dickson (2012) found that students from a Chinese background were less likely to seek help, but if they did they tended towards more closed discussion practices when compared to their western student counterparts and even though their overall attitudes towards illness were not significantly different. Further, the findings relating to interpersonal openness imply difficulties for students from some cultural backgrounds, in this case, Chinese, to disclose personal information. In addition to interpersonal openness, intuitive attitudes of self-reliance also appear to have an impact on help-seeking behaviours. Such studies clearly identify the need to be more aware of the complexity of the stigma issues and how they relate to the individuals students and the wider university community.

As the rates and prevalence of mental health problems and illnesses increase in the various university cohorts, the institutions will be charged with providing a responsive and targeted support process to them. Many Australian universities have provided a series of services already to deal effectively with those who present with mental health issues; however these services continually battle with stigma and the perceived beliefs held by some students about accessing support. Quinn, Wilson, MacIntyre, and Tinklin (2009) found the overall attitude of university students to be a reluctance to access services, and to disclose any feelings of distress, symptoms or history of mental health problems. Study findings revealed that students, who did access support services, found them useful; however the challenge remains as to the engagement of those students not attending. One significant factor found was
that those experiencing mental illness had impacts both on their ability to achieve academic success their ability to find course related employment.

These outcomes highlight the misperception among some students about how information disclosed is managed within the higher education support processes. Further clarification about what constitutes a mental health problem, where to go for help, and principles of confidentiality, leads to the necessity for implementing educative procedures relating to the necessary interaction between the service and academic faculties. Quinn et al., (2009) attested to the simple reassurance embedded in a typical health promotion campaign as providing a strong basis for an increase in service access for those students who need it. Further, they urge university policy to reflect a clearer process of supporting students, coupled with a more comprehensive program of staff training, in order to improve support provision to students.

One identified way in reducing misperceptions and stigma amongst students would be to implement nationally recognised training programs like Mental Health First Aid (MHFA). O’Reilly, Bell, Kelly, and Chen (2011) reviewed the effectiveness of the MHFA program for reducing mental health stigma amongst university students and misperceptions about the availability and use of support services. Their study utilised a non-randomised control design with all third year university students in a pharmacy course, inviting them to participate in a full MHFA course. Of the 60 students who participated it was noted that on a distributed mental health literacy survey, there was a decrease in negative attitudes related to high levels of stigma, improved understanding of mental illness and improved confidence in the use and recommendation of appropriate support services. These authors concluded training
can reduce misperceptions and stigma; therefore further investigation amongst other cohorts of university students and staff is warranted.

The enhancement of positive attitudes toward counselling services, directly and indirectly targeting stigma, may not be the province solely of large-scale university implemented programs. Aegisdottir, O’Heron, Hartong, Haynes, and Linville (2011) infer the actual counselling practices warranted review. For example, introducing and discussing issues of fear and stigma, myths surrounding counselling, and the interaction between such university services and academic functions, could significantly reduce drop-out rates of students from counselling. Their study found that by altering an initial aspect of intake or initial interview with a counsellor, reduced concerns about image, reduced overall attitudes towards mental illness stigma, and negative views of attending counselling.

Martin (2010) added further emphasis by contending that, unless the tertiary institutions begin to examine more closely the reluctance of students to access appropriate help, then the mental health difficulties already indicated would continue to worsen. Martin’s study contributes to the growing body of knowledge relating to the impact of students’ perceptions about access to mental health support services, particularly stigma associated with being labelled as mentally ill. It has offered a range of measures perceived as important in tackling the impact of stigma and the empowerment of students to seek help. In particular, Martin implies the need for a holistic approach to the provision of services in addition to such prevention and promotion strategies as wellness promotion and illness promotion. Further the author declared these programs not be provided separate to curriculum delivery, but should be integrated, thereby uniting academia and pastoral care. Finally, he has clearly indicated that unless students feel empowered and confident about the support
systems being provided, and the broader university system in which they are being delivered, they would continue not to disclose fully even if they managed to access an appropriate service.

The research literature on teaching and learning pedagogy recognises that young people particularly experience difficulties in accessing services requiring transport to and from face-to-face appointments. Subsequently, internet and online support options and programs have been considered by universities, for example, offering online support, advice and guidance (Horgan & Sweeney, 2010). They remind that social and environmental factors plus perceptions of stigma and self-worth play an inordinate part in this access problem. One way forward would be the provision of web-based support sites and services; however, according to Horgan and Sweeney this is yet to be fully examined for usage and effectiveness in relation to students in higher education.

Horgan and Sweeney (2010) found that 72.4% of the student participants opened the internet multiple times a day for various information seeking activities. An additional 30.8% were found to have focused their searching on mental health information, with the majority of topics concerned with searches corresponding with depression. The interesting aspect of this study was that, although 68% of participants indicated they would utilise web-based mental health services, 79.4% of students intimated they would prefer face-to-face contact and support. As stated earlier in Horgan and Sweeney’s study, this area requires closer examination before universities begin to invest significant time and resources into the provision of alternative online programs for students experiencing mental health problems.

Results relating to the stigma of attending services, especially mental health and counselling services, need to be considered alongside general help-seeking
research. Although there are a range of promotion, prevention and intervention services already being employed by institutions, little is still known about the impact within the university setting (Yamaguchi, Wu, Biswas, Yate, Aoki, Barley, & Thornicroft, 2013). In recent years there has been a marked increase in university students seeking medical assistance and acceptance of medication as a form of intervention (Stone & Merlo, 2011). This trend is wide and community based, being reflected within the university setting; however upon closer examination of the university population two distinct users of psychiatric medications are apparent, those who use prescribed and non-prescribed medications. According to Stone and Merlo the rates of non-medically prescribed use of psychiatric medication amongst university students is higher than medically prescribed use. Therefore they suggest that any promotion campaign needs to consider education about the appropriate use of psychiatric medication and the consequences of its misuse.

3.11. The Experience of First Year University Students

A multi-year study (1994-2009), by the Centre for the Study of Higher Education at the University of Melbourne (2010), across nine Australian universities, provided an insight into the higher education sector in Australia, and in particular the salient factors that could influence both the social and learning experiences of first-year students attending university. This study looked at the changes in student attitudes and study approaches in order to assess whether or not educational outcomes change over time with the implementation of focused first-year support. Results from 2422 student responses indicated that students were finding the transition to university less difficult in 2009 when compared to the 1994 cohort as a result of engaging in quality transition programs provided by the universities. The trends identified throughout the various studies are suggested by the authors as a
point of focus for universities, to understand students better, with a view to improving overall educational outcomes, attitudes and study behaviours.

Schrader and Brown (2008) reviewed and evaluated the first year experience programs implemented over the past few years within various university settings. First year experience programs, developed in response to dramatic reductions in student retention, have been implemented as a way of identifying ‘at-risk’ students and promoting to them the variety of support programs available. First year programs also emphasise connectedness and positive attachment to peers and staff (Wilson & Gore, 2013) as a way to open up students to positive help-seeking practices. In essence Schrader and Brown found that overall, the first year experience programs are capable of increasing the knowledge, skills and help-seeking behaviours of students; that there was a positive impact on attitudes towards staff and support services especially for females who scored slightly higher than males on attitude scales; and, that further study is required into such programs due to the highly complex nature of intersecting first year students, university environments, and the provision of student support services.

Brownlee, Walker, Lennox, Exley, and Pearce (2009) examined more closely the relationship between personal knowledge and understanding of students, and effective teaching and learning practices. This study found a pattern that strongly suggested a relationship existing between the core beliefs of a student about ‘knowing or knowledge’ and core beliefs relating to learning. This also appeared to differ between students who saw learning as a rote learning process versus a critical thinking process. Therefore consideration of different learning styles and expectations must be explored. Brownlee et al. emphasised there to be an increasing need to explore, understand and work with students’ core belief systems
and the interaction of these with their ability to comprehend university study. This must include a stronger focus on personal reflective practices early in the university experience, thus allowing students then to explore and adapt other ways of viewing the acquisition of knowledge through learning.

Chesbrough (2011) also reviewed the motivation of students and their levels of service involvement on a college campus. His research identified clear differences in motivation between the genders in that women are more likely to be motivated by internal factors, whereas men are more likely to be motivated by external factors. Such a difference would need to be examined more closely in relation to how these levels of motivation inherently influence a student’s choice to access appropriate services when faced with difficulties. For example, if men are more likely to be motivated by external factors, these would need to be clearly identified if and when support services are promoted or offered to male students and provided in order to increase the rates of help-seeking behaviour.

Understanding the transition from high school environments to tertiary environments is key to providing effective supports within first year experience programs. It is clear this transition is difficult for many students, few being equipped to manage the behavioural, emotional and social changes that are inherent. Brinkworth, McCann, Matthews, and Nordstrom (2009) compared students attending a first year experience program and students attending a traditional orientation week. Expectations of students and staff were the central focus, aiming to have an understanding of the decision-making processes relating to course selection in particular. Specifically they found that although students knew university was going to be different from high school, they had limited understanding about how it was different. Students identified academic success to be not solely based on academic
ability, but rather dependent on a students’ ability to adapt quickly and effectively to a learning environment that expects greater degrees of autonomy and individual responsibility.

It would seem that if this transition were not managed effectively or targeted through specific first-year experience programs then the impact could lead to lower academic success and course withdrawal. Jamelske (2009) found that, although impact on academic success was significant on retention rates, improvement only occurred for those students who were classified as performing below average in their studies and were females. This study further suggested that whilst first year experience programs were effective in improving the attitudes and awareness of students, further work is needed to target specifically the other factors relating to the learning success, like ability or disability. Jacobs and Archie (2008) strongly suggest that as universities review existing first year experience they consider the program’s ability to encourage and promote community connectedness among students. They further suggest future research into first year experience needs to identify more of the factors that can positively influence a students’ ability to develop appropriate university attachment.

Given the issues that surround the design and structure of Australian universities and our understanding of how students interact within, the intention of chapter four was to consider the concept of psychological distress. Initial information was given to the definition of psychological distress in the context to this thesis, in particular psychological distress as it pertains to the student population. Consideration of current ways and means by which it is measured and its prevalence within university populations were discussed. Peer reviewed articles were presented in relation to the relevant factors that influence the psychological distress of an
individual. The impacts of current coping strategies of students who exist in varying states of psychological distress were also noted. The final component of chapter four relates to pertinent aspects of the literature, the effectiveness of universities to manage psychological distress, and the impact that comorbidities have on the ability of these institutions to manage their effect.
Chapter Four

Psychological Distress in University Students

The relevance of information given within this chapter outlines the importance psychological distress plays in the life of a university student in Australia. Without this information it may be difficult for universities to provide support to their students. The impact of psychological distress and consideration of relevant support service design in the absence of information; appears crucial to the successful journey of a student through the tertiary education system.

4.1. Psychological Distress

Psychological distress and its severity are often considered the cornerstone to identification and support provision. If distress is left untreated, consequences for students are often severe, leading to significant impacts on learning, academic success and retention. Psychological distress is an area targeted to some extent within general health and counselling services within universities; however, in the main, there is an obvious lack of integration of any response to such issues with the academic areas. It should be noted psychological distress appears at all levels and in all areas of student experience, including classroom environments. Ignoring its identification in non-health related areas can lead to unwarranted distress within the tertiary student population, thus impacting significantly on the ability of non-health related student support services to support student needs adequately (Reavley, McCann, & Jorm, 2012). The following outlines the issue of psychological distress and identifies salient tools to measure its impact.

4.2. Defining Psychological Distress

The difficulty in defining psychological distress as a separate and discrete concept is ongoing. Ridner (2004, p 536) states “psychological distress is frequently
discussed in nursing, medical, psychological, and social science literature ... as a concept of maladaptive psychological functioning in the face of stressful life events”.

Ridner further identifies psychological distress as a fluid state of experience, essentially an individual reacting to external and/or internal events according to their abilities to manage stress. His findings demonstrate the cost of psychological distress to occur on a positive to negative continuum, that is, the higher the level of psychological distress the higher the subsequent cost to the individual and subsequently the broader community (negative due to the consequences) compared to lower psychological levels of distress being attributed to lower costs to the community (positive due to the motivational effect).

As a general rule psychological distress is defined as a negative psychological outcome when a person faced with adversity does not have the coping strategies to manage (Ridner, 2004). Negative emotional reactions like anxiety and depression are all common outcomes of psychological distress considered to interfere with a person’s ability to perform daily living activities. A person’s experience of psychological distress may be acute is acknowledged, its onset is immediate in reaction to an adverse event, or pervasive due to repeated exposure to the stressful event. Psychological distress is generally seen as a precursor to the development of a range of psychological disorders, especially anxiety and depression, and depending on the maladaptive coping strategies employed as alcohol or illicit substance misuse, may even lead to psychosis (APA, 2013; Muir-Cochrane, 2009). For the purpose of this study Ridner’s definition of psychological distress will be utilised.
4.3. Measuring Psychological Distress

In order to measure the concept of psychological distress, Kessler (1979) designed a 10-item questionnaire focusing on criteria related to the key aspects of anxiety and depressive symptoms over a period of one month. These are pertinent health issues that have been attributed to an effect on an individual’s level of distress. The Kessler 10 questionnaire has significant positive attributes, the main being that it is self-reporting in nature and therefore strives to collect relevant information from the individual experiencing of psychological distress. Though self-report measures employed in social science research have inherent problems in regard to reliability, that is, re-test, and validity such as content, the personal perspective of an individual’s knowledge will allow for a greater understanding of university experience.

One of Kessler’s (1979) earlier studies related to stress, social status and psychological distress. The usefulness of this study led to the early development of his distress rating scale, the Kessler assessment tool. This work focused on the concepts of status and stress, examining how participants from diverse backgrounds experienced these concepts. The population to be observed in this current study is both diverse and encompasses individuals from various status groups, levels of health, and cultural backgrounds.

The Kessler Psychological Distress Scale (Kessler 10) is a tool developed in 1992 by Professor Kessler for application in population research (see Appendix A). According to Andrews and Slade (2001) the Kessler 10 has been extensively utilised in the United States as well as in Australia, where it was included in the Australian Survey of Mental Health and Wellbeing and the Australian National Health Survey. The tool has had widespread use in Australia as a national outcome measure for all
public mental health services. Research has shown a correlation between high scores on the Kessler 10 and the diagnosis of anxiety and depressive disorders (Andrews & Slade, 2001).

Validity and reliability analyses suggest (Andrews and Slade, 2001) the Kessler 10 to be an appropriate screening tool aiding in the identification of anxiety and depression in the general population; it has been used in the monitoring of treatment outcomes. As a result, the Kessler 10 is highly regarded as a concise gauge of psychological distress and as a means of monitoring individual change following treatment for mental health conditions like anxiety and depression.

The Kessler 10 scale is based on a set of 10 questions that elicits information about negative emotions experienced by an individual in a preceding four-week period. Each item has been constructed using a ‘Likert Scale’ format, which allows allowing for a rating of each item from ‘none of the time’ (1) to ‘all of the time’ (5). The overall score is summed to provide a profile of experience out of a possible 50: lower scores indicate low levels of distress grading to higher scores indicating high levels of distress (Kessler, 1992, p. 4).

The Kessler 10 assessment tool has been reviewed for its effectiveness to screen and identify anxiety and depressive experiences. Hides, Lubman, Devlin, Cotton, Aitken, Gibbie, and Hellard (2007), Spies, Stein, Roos, Faure, Mostert, Seedat, and Vythilingum (2009) and Stallman, McDermott, Beckmann, Wilson, and Adam (2010) all assessed the reliability and validity of the tool across sets of diverse populations. Findings in all studies suggest sensitivity in identifying a number of determinants of distress, including anxious and depressive symptoms. More specifically they all demonstrated the ability of the Kessler 10 to have internal consistency, concurrent validity, and reliability.
4.4. Prevalence of Psychological Distress in University Students

The prevalence of psychological distress in university students has been comprehensively established in the current research literature. Koochaki et al. (2009) employing the Kessler 10 measured levels of self report stress in a sample of 222 medical students. They reported no significant statistical difference between stress levels for students in the pre-clinical and clinical phases or different years in which they studied. Results showed that married students had lower scores than single students, but no gender differences were found; however, the study did indicate a correlation between mild to moderate stress and physical health problems. Coincidental findings showed students who selected their course themselves had lower stress levels than those encouraged to take courses chosen by their families.

Kilkkinene et al. (2007) designed a study to elicit the prevalence of psychological distress with a specific focus on levels of risk as determined by gender and age. The Kessler 10 survey was widely distributed and 1563 people aged 25-74 responded. This study found the prevalence for psychological distress to be similar for both genders (31%) with more than 60% reporting moderate levels of distress. The prevalence of depression and anxiety was less than 10%. The age range experiencing the highest levels of all three was the 45-54 year olds. Also found no consistent gender differences were present in any of the three clinical indicators; however given the highest age group represents mature aged, this data may be of some note when designing support services for mature aged students.

Verger et al. (2009) identified the comprehensive nature of psychological distress can be undertaken by the use of performance indicators, but little is known about the role and contribution of stressors on this student condition. They assessed the prevalence of psychological distress employing the Kessler 10, including the
associations with stressors, and the significance of gender. A random sample of students aged 18-24 was surveyed. Results disclosed that, although psychological distress was related to university based stressors, this study did not identify any external variables possibly contributing to such levels of distress as socio-economic factors.

Although the link between socio-economic factors and psychological distress has not been strongly established, gender does appear to influence the levels experienced by university students. Bernhardsdottir and Vilhjalmsson (2013) focused their study specifically on female students attending university. Rates of depression and anxiety were found to be 22% and 21% respectively, similar to that of women in the general population requiring treatment. Less than one third of the study cohort had received appropriate professional help. Clinical levels found in this population revealed there to be a need to focus university support services on prevention and early identification measures, possibly with a focus directed towards female students. This would parallel current health promotion initiatives within the greater population such as Beyond Blue, the national depression campaign.

Beyond gender and socioeconomic factors, various issues have been investigated in lieu of developing appropriate support systems and programs. For example, research has centred on the importance of recognising the impact that transition from senior schooling to tertiary education has on first year university students. Topham and Moller (2011) found that nearly 25% of first year students reported subclinical levels of psychological distress and moderate to very severe social anxiety. Psychological distress appeared to have been associated with low self-esteem and social anxiety, often found within the first year university students.
In contrast to studies focusing on the distress levels of students at the beginning of their course, or the variability between different years of enrolment, some studies have paid attention to the developing levels of distress throughout their degree and at the conclusion or final stages of study. Stallman and Shochet (2009) and Andrews and Chong (2011) stressed the importance of recognising and supporting the university student population. Data used in the later study came from information at a university medical service it indicated students to be experiencing significantly higher rates of psychological distress than the general population. Half of the sample (n=1168) was reported to be experiencing elevated levels of psychological distress; the more severe of these students had not sought assistance beyond the medical service. It was found that if these levels of distress were not effectively managed at the beginning of the semester, then distress could reach interfering levels, often including the development of depression, anxiety and stress related disorders. This is also evidenced in a previous study by Shiels, Gabbay, and Exley (2008) who found that students attending a university-based medical service were experiencing depression and anxiety at rates of 10% and 47% respectively. The percentage discrepancy between these two highly comorbid disorders in this study suggest a need for further investigation of this population.

Studies such as the above further emphasised the need for universities to ensure the availability of appropriate and effective clinical pathways, and to engage in preventative programs to reduce overall distress levels in students. Since 2008, a number of Australian universities have instigated some changes, particularly in the realm of prevention, for example, university-based health and wellness programs and mental health first aid training for staff (Andrews & Chong, 2011; Stallman & Shochet, 2009). However, it is necessary for these programs’ effectiveness to be
assessed a measure of psychological distress such as the Kessler 10 to ascertain whether the implementation of these programs effect actual change in the reduction of psychological distress.

4.5. Psychological Distress in University Students and the General Population

Reviewing the research related to the prevalence and impact of psychological distress in university students reveals the necessity of establishing whether these rates are present at higher levels than in the general population. If this is the case, then other factors influencing the onset and development of psychological distress, specific to the university setting, would need to be investigated.

Cvetkovski, Reavley, and Jorm (2012) examined the difference between a variety of higher education and vocational study students in relation to experiences of psychological distress. They also examined the association of various socioeconomic factors associated with psychological distress. Utilising Kessler 10 data from the various household surveys that had been conducted nationally they obtained results indicating there to be a higher prevalence of moderate distress among tertiary students when compared to non-students of the same age in the general population; however, high levels of distress were not significant between these two groups.

The implications discussed by Cvetkovski et al. (2012) contend that, although research does not always show a correlation between socio-economic factors and psychological distress of university students, socio-economic factors do have an impact in the general population, that is, the higher the level of socio-economic factors the higher the level of psychological distress. As the Australian university sector continues it process of enabling persons from lower socio-economic
backgrounds to enter tertiary education through alternative pathways, this suggests the need to investigate further the change in university demographics, and the impact such factors might have on the levels of overall psychological distress. For example Cvetkovski et al. (2012) state, “financial factors increase the risk of high distress and are likely to take on more importance as the participation rate of socio-economically disadvantaged students increases” (p. 457).

The importance of recognising the difference between university student populations and similar elements in the general population rates of prevalence has not been extensively covered in the literature; this imbalance would need to be addressed in order to modify existing university practices effectively. Stallman (2010) reiterates there to be a need for more epidemiological data to allow for effective comparisons between university student populations and elements of the general population. Stallman found in a total of 6479 university students across two universities the socio-demographic description was consistent with the general population. Results showed the prevalence for mental health problems was 19.2% with 67% having mental health problems or subclinical symptoms. These rates are significantly higher than the general population. Importantly, Stallman found psychological distress to be associated with disability and lower academic achievement, with predictors of distress including: full-time study, financial stress, being aged between 18 and 34 years, being female, and in a subsequent year of their undergraduate degree.

Nerdrum, Rustoen, and Ronnestad (2006) in a Norwegian study investigated the difference between university populations and the general population with a specific focus on psychological distress. Their results informed that 21% of students reported clinically significant psychological distress symptoms. Variables associated
with these high levels included, gender, marital status, and family’s level of education. Apparently, Norwegian students experienced a lower level of psychological distress than found in similar studies around the world.

The implications for universities have been stated in several studies (Leahy et al., 2010; Stallman, 2008). Results revealed there to be significantly more students with psychological distress when compared to the general population; however, results were consistent in that over 60% of students had not sought assistance for their distress. Increased levels of distress were also associated with increased psychiatric disability among students. It has been recommended that the benefit of co-locating a specialist mental health service within the university would endorse a whole of university approach to mental health care, with general practitioners, psychiatrists and clinical psychologists working collaboratively to improve the accessibility of care for students. This would appear an increasing imperative with current research continuing point out that the high distress levels among tertiary students may be more widely spread than first thought. Low levels of treatment rates suggest that the current or traditional models of intervention may be inadequate to deal with the complex needs of university students.

4.6. Factors that Influence Psychological Distress

One of the continuing difficulties in the provision of effective services, beyond merely identifying the prevalence of psychological distress and the associated mental and physical health consequences, is the identification of the factors that can lead to the development of such conditions. Quinn et al. (2009) states, “against the backdrop of a massive expansion in higher education, the number of students in higher education experiencing mental health problems is increasing, which poses a significant challenge to higher education institutions in terms of how they best
respond to students with mental health needs” (p. 405). They discuss the implications and the factors influencing students’ ability to ascertain the most issues related to their willingness to access a service, support or appropriate help.

Quinn et al. (2009) found students to exhibit often a general reluctance to access support and to discuss their mental health problems, largely due to the fear and anxiety about being stigmatised. The study points out that students who did seek help from university counselling services reported positive experiences, valued the time they spent there, and felt the benefit from the support given. This indicates it is necessary to develop partnerships between university support services and local mental health services in order to encourage students to seek help and be able to find effective, targeted and responsive clinical pathways. Further, the authors advise universities to take a more systematic approach to promotion, prevention and intervention in mental health and illness to ensure students can have increased confidence of engaging in an environment wherein they feel safe when talking about their problems.

Studies focusing on the prevalence on the psychological distress and mental illness of university students have allowed researchers to understand the necessity of addressing the issue of low access when it comes to seeking appropriate support services. Research has established that university students are an at-risk population for mental health problems, beginning with the transition to university from senior schooling through to the ability of students to succeed at their studies. Demands on students are a central focus in many studies because they infer increased psychological distress levels.

Wynaden, Wichmann, and Murray (2013) provide an overview of the facilitators and barriers university students meet, especially those associated with
psychological distress. An examination of a large sample of students, each having accessed a web-based survey to provide descriptions of a range of symptoms, behaviours and disorders causing them to have problems with their university studies, found the most common forms of distress, including mental health problems, to be depression, anxiety and stress-related concerns. More than 50% of the sample had not sought professional help, even though they were able to identify a problem clearly. These authors contend universities to have a strong role to play in the provision of appropriate, accessible and affordable primary health care options as a way to intervene early with these students, and to identify and assist them to identify and manage the demands of tertiary study.

In addition to factors relating to willingness to access university-based psychological distress services, a further barrier has been identified that focuses on the relationship between the problem-coping style of students, experience of personal difficulty and psychological distress, and the actual use of support services in the academic setting (Julal, 2013; Siu & Chang, 2011). Students with a more reflective style of problem coping, including decision-making and negotiation, were found to be more likely to use student support services. As expected, the students with less effective problem-coping styles experienced psychological distress at higher levels. This tells that, when designing or providing support services, consideration must be given to a student’s ability to problem-solve and therefore manage distress effectively.

Although studies focusing on the impact of socio economic factors on levels of psychological distress seem to suggest further study is required, one specific factor influencing levels of psychological distress is isolation. In many studies (Cvetkovski, Reavley, and Jorm, 2012; Hunely, 2010) the effects of isolation have
been investigated specifically in relation to students who are studying abroad and/or classified as international students. Psychological distress, loneliness and the impact these two have on academic functioning have been central to the studies. Results clearly indicate attention needs to be placed on this particular cohort of students, there being a significant relationship between students experiencing more psychological distress, more loneliness and their ability to perform academically.

4.7. The Impact of Comorbidities on Psychological Distress

In the context of this study, comorbidity becomes an important concept to explore and understand due to the levels of prevalence of more than one interacting disorder or issue, and the impact of such on a student’s ability to learn. Hamdan-Mansour, Halabi, and Dawani, (2009) explored the prevalence of substance misuse, depressive symptoms, and hostile behaviour within a group of university students. The findings indicated a significant degree of depressive symptoms within this population (75%). These symptoms were positively correlated with incidences of alcohol use and hostile behaviours. This possibly indicates the reasons for students without mental health issues often being cautious with, if not suspicious of other students with mental health concerns. The issues relating to stigma may play a part in the process of student mentor support given that, when faced with a student having mental health concerns, mentors may react negatively.

Similarly, Price, McLeod, Gleich, and Hand (2006) in a two-phase study sought to identify the prevalence of major depressive disorder in first-year university students. They also investigated the comorbid presentation of major anxiety disorders within this population. The findings indicated that 70% of men and 14% of women met the criteria for major depressive disorder. This figure is consistent with the general population with regard to the reporting of such symptoms and disorders.
Conclusions from this study point to the most salient responses being those targeted towards prevention initiatives. In particular identification of risk factors such as family of origin issues, relationship difficulties, or poor self-esteem would be paramount. The authors also conclude that responses reducing the effect of stigma as viewed by the greater population towards mental health issues may assist greatly in the prevention of mental health disorders. Price and co-authors postulate the university setting being a premium environment to challenge and change the mentality of those dealing with mental health issues.

Bitsika and Sharpley (2012) sampled Australian university students specifically and found they were more likely to have comorbid anxiety and depression (32%). This figure is four times the comparative prevalence rates of either anxiety or depression as a sole diagnostic group. The study explained the comorbidities of anxiety and depression tend to be more serious in presentation and exist in large populations among students within universities. One conclusion made was support services, especially counselling, might wish to consider the inclusion of screening and identification of both disorders as core business.

In addition to high prevalence disorders like depression and anxiety, Hodgins and Racicot (2013) examined the correlation between undergraduate students’ drinking patterns of behaviour and gambling. They found there to be a link between the two behaviours that they described in the context of a problem syndrome model. A generalised link between the two in the context of students using both as a mechanism of coping was described; however, this finding could be generalised to larger populations. The significant matter signified was the imperative to target treatment options for those students who identified drinking and or gambling as a
significant issue, there by indicating that support in other realms of student life may need attention in order to provide the most opportune learning environment.

Previously, Ross, and Tisdall (1994) had identified substance misuse disorders, specifically those relating to alcohol within a population of students. They sampled those who attended support services. Initially the study found alcohol use/misuse was generally less than that of larger student populations. Those who reported substance misuse associated the behaviour with the presentations of anxiety, panic, and other mental health disorders. Those surveyed in this study also implied that the disorder identified might have preceded the use of substances indicating their misuse may be a significant coping strategy used by this research cohort.

4.8. Coping Strategies Reported by University Students

Julal (2013) surveyed undergraduate students enrolled at university, examining the associations with problem-focused coping, experience of personal difficulty and psychological distress. This research sought to ascertain how and why students accessed support services provided within the university environment. Findings show students who experienced personal difficulties and had an ability to be reflective of the way in which they solved problems and coped, were more likely to access and use university support services. Those students who experienced personal difficulties and who were less able to be reflective and problem-solve tended to be more reactive and their uptake of student support services was less than the initial group. This second group also reported greater levels of psychological distress than the first, therefore reinforcing the need for students to be equipped for problem solving of various aspects of university life.
Penland, Masten, Zelhart, Fournet, and Callahan (2000) attempted to correlate between the two types of possible selves, both positive and negative, and of depression and coping skills within a student population. The authors explained that ‘positive possible selves’ were those schema or beliefs that enabled an individual to envisage positive outcomes to a life event or circumstance; ‘negative possible selves’ are the converse. They found students who rated highly on inventories for depression reported significantly higher negative self; therefore coping strategies tended to include high levels of avoidance. Their findings also affirmed that those students who had the presence of ‘positive possible selves’, especially in regard to cognitive schemas or beliefs, might inherently have a mediator for depression that increased coping skills.

4.9. Effectiveness of University Support Services to Manage Psychological Distress

Given the high prevalence of psychological distress experienced by university students coupled with the increasing entry of students from low socioeconomic status or disadvantaged backgrounds into tertiary settings, universities are faced with the need to evaluate what they currently provide, what they are expected to provide, and how effective these services are in reaching these ‘at risk’ students. Attitudes towards seeking professional help continue to be one of the most important aspects when understanding the choices to access or not to access university support services. As found by Chang (2007), high levels of depression are associated with low levels of help-seeking and negative attitudes towards university services.

In particular, universities need to recognise the competing demands faced by students in their everyday lives. Hammer, Grigsby and Woods (1998) intimate that
the reported perceived effectiveness of university support services, and general satisfaction with the experience of university study on conflicting demands of work, family, and school, have a direct impact on decisions to seek and access services. Hammer et al. investigated 375 university students across both undergraduate and postgraduate courses, finding students who felt that universities provided effective support were less likely to indicate work-study-personal conflict. Those lower in satisfaction with their university experience of services reported higher levels of work-study-personal conflict. This study also affirms the necessity for assisting students to achieve a better balance between the demands of work, family and university study. The authors’ discussion offers several possible university-based strategies including: restricting class schedules to accommodate working students; providing workshops; and teaching students how to negotiate their work and study demands. From a university economic perspective, the study also associated the higher levels of satisfaction with high levels of retention.

Regehr, Glancy, and Pitts (2013) more recently found that a high number of university students are experiencing depression and anxiety but only a small number received assistance. They conducted a systematic meta-analysis to examine the effectiveness of universities to target students experiencing depression and anxiety. Their study involved 1431 students across 24 studies and found a variety of interventions including cognitive, behavioural and mindfulness were associated with lower level of identified depression and anxiety. These results promote the need for universities to provide preventative programs to address student distress and thus reduce anxiety and depression. Day, McGrath, and Wojtowicz (2013) add that web-based programs are an effective way to target both anxiety and depression. These above studies suggest the provision of flexible, online based, student directed
programs could positively alter psychological distress in a high percentage of university students.

As indicated in the research on psychological distress and service access, young people, especially males, were the least likely to access services in either the general population or the university subset. Rickwood et al. (2005) conducted an extensive investigation of this issue, surveying over 2700 young people to determine what they saw as the primary issues relating to lack of access. Issues identified included: adaptiveness of help-seeking; appropriateness of different sources of help; and the relationship of help-seeking with other forms of coping. The study revealed there to be a continued need to explore further issues relating to the manner organisations like universities measure help-seeking, conceptualise help-seeking, analyse and provide support for help-seeking across the students’ lifespan, and the factors that facilitate effective help-seeking behaviour among students.

Universities will also need to consider geographical matters related to the location of their courses offered and the current availability of services within the local communities. Calloway, Kelly, and Ward-Smith (2012) reviewed the attitudes and perceived barriers students may have towards help-seeking, specifically those attending a rural-based university campus. Their research was similar to that conducted by Rickwood et al. (2005), being particularly important as a large number of universities within Australia have rural or satellite campuses. These facilities may not be entirely based in rural areas where access to appropriate and professional support deemed the norm for metropolitan universities might be absent. Calloway et al. found the stressors pointed out by students were physical, psychological, academic and financial, and the source of barriers they experienced when help-seeking were centred on confidentiality, stigma, treatment concerns, and a lack of
awareness of the services available and at their disposal. The authors further suggest that, while the geography of the campus can be changed, it is important to target the common denominators of students’ distress.

One of the main factors influencing psychological distress is the impact of students who study overseas for example international students. Ryan and Twibell (2000) conducted research on cross-cultural students who are overseas nationals. These students described having to adapt to a new culture, sometimes very diverse from their own and having to learn and perform in an alien academic environment. Pre-departure support and preparation was found to be a significant factor in reducing overall stress and distress, including studying the culture of the host country, and learning about their university of choice, including maps and locations of essential services. Students would also need to self-evaluate, ensuring flexibility to adapt and adjust to a new cultures’ way of thinking, values and acting.

In addition to these suggestions Vivekananda, Telley, and Trethowan (2011) examined students attending a university counselling service. They found that international students, non-English speaking background students, students with a disability, and male students were all identified as ‘at-risk’ cohorts. They disclose there to be a relationship between an experience of distress for a student in one of these cohorts and academic performance.

It is evident that a clearly identified need exists to investigate more closely the prevalence of psychological distress, the factors that influence its development, including the university setting, and the specific cohort effects. Further, studies should be implemented to investigate more closely the reasons for students accessing or not existing university support services, and what universities must do to improve levels of access. Research conclusions clearly indicate (Constantine,
Wiltoin, & Caldwell, 2003; Lockard et al., 2012) significant reductions in psychological and academic distress scores for the students attending the counselling services and/or other university support services. Students not attending a support service showed no change in their distress levels, thereby causing concern, given the evidence showing levels of distress will continue to rise and impact on students if left unattended.
Chapter Five

Help-seeking Behaviour of University Students

The information provided in this chapter outlines the importance help-seeking behaviour has for a university student who would or would not access appropriate support for issues relating to psychological distress. To consider supporting service design in the absence of information relating to the help-seeking behaviours of students, combined with the understanding from the previous chapter regarding psychological distress, would be remiss without a context.

5.1. The Importance of Health Literacy for University Students

Health literacy can be examined from both physical and psychological constructs. Francis, Pirkis, Dunt, Blood, and Davis (2002) reviewed the available literature, determining mental health literacy media campaigns designed to reach the general public can achieve the positive outcomes of improved literacy. Results indicate that these health promotion strategies are most effective when deployed across several different types of media, paper, social, television, poster, or targeted broad based community interventions. However, these authors declare the impact of such campaigns to be limited, especially since mass media campaigns relating to health literacy are rarely utilised by government agencies.

Furnham, Cook, Martin, and Batey (2011) undertook a study with university students to assess levels of mental health literacy. They found students with the highest levels of mental health literacy tended to be those with high levels of emotional intelligence, were female, and had studied health related subjects. These results add to the growing body of knowledge suggesting recognition of mental health disorders and symptoms have a greater bearing on students accessing and
being directed to help, rather than an individual understanding the mental illness itself.

From a more general perspective, Ickes and Cottrell (2010) examined university students in the context of general health issues, assessing their physical health literacy levels. The study concluded that most university students had a good understanding of physical health literacy thus allowing them to seek appropriate health care if needed. However, the results also suggested students who scored lower on the numeracy components of the scale had lower levels of total physical health literacy, thereby intimating health information to be targeted to students who understand health information messages contrasting comprehension, literacy and numeracy as promoted by various media.

Previously, Jukkala, Deupree, and Graham (2009) had investigated health care providers and students attending a university-sponsored presentation on physical health literacy. These participants were studied to assess the impact of limited physical health literacy on both the health care system and the individual or patient. The findings indicated that, while participants proved knowledgeable with regard to the impact of physical health literacy on patients, they were less knowledgeable regarding its impact on the health care system. By translating this into service provision within a university context, it would appear the impact of health literacy on both the individual and the system must be developed in order to improve overall health outcomes and help-seeking behaviour, such as, the reduction of the unnecessary and inappropriate use of health care services thereby possibly releasing service capacity in the university systems.

Smith and Shochet (2011) researched the impact of mental health literacy on help-seeking behaviour in a cohort of first-year psychology students. This study
concluded that high levels of mental health literacy were associated with students who had a greater intention to seek help from appropriate health professionals and services. They recommended further investigation was warranted in order to address lower levels of help-seeking behaviour within certain populations, declaring individual universities must conduct reviews with their student populations in order to ascertain vulnerable groups.

5.2. Help-Seeking Behaviour

Help-seeking behaviour has historically been described in the context of health; however, the concept would be useful to understand how and why students access a variety of systems and their services during undergraduate studies. The concept has been generally employed in the identification of individuals meeting the criteria for acute presentations, rather than those who may benefit from earlier interventions. That is, trying to understand the reasons why, where and how students seek help may possibly prevent further distress. Examples of such behaviours show the implications to be serious: withdrawal from courses; onset of major mental illness and suicide; and non-suicidal self-injury. The following introduces the concept of help-seeking behaviour and provides a working definition for the purposes of this current study.

5.3. Conceptualising Help-Seeking Models

Barker (2007) reviewed the literature on adolescents’ social support and help-seeking behaviour, making several recommendations. He distilled help-seeking into three paradigms firstly help-seeking for specific needs by identifying health needs in the context of the health care system, including the role of pharmacists and traditional healers. The second paradigm, help-seeking for normative developmental needs, refers to help-seeking in relation to completion of school, vocational
organisational training, and employment. In this group Barker focused on its relevance to specific groups, the main being adolescents and young people. The third paradigm in his study discussed help-seeking behaviour as it centred on individuals who had experienced personal stress or problems. Help-seeking behaviour was found to have occurred in situations such as a crisis within families that included, but was not exclusive to, family violence and abuse, relationship difficulties, financial hardship, homelessness, and issues associated with health, both chronic and acute in nature.

Conceptualisation of the three paradigms of Barker (2007) was influenced by the work of Costello, Pickens, and Fenton (2001) who concentrated on the idea of social support. Barker suggested that, as with help-seeking behaviour, there appeared to be wide ranging views on both definition and parameters of the subject area. This comment was made specifically in the context of adolescent health and development. Costello et al. (2001) offered an explanation of social support which they divided into three paradigms, the first being ‘instrumental support’ wherein this was deemed to be in the form of direct support to an individual such areas as training, finance, and health. The second level of social support centred on the provision of information to an individual or group. This was related to the process of referral or information for assistance exemplified as health related need. The third paradigm concerned what Costello et al. (2001) called ‘affiliative support’, defined as support given by a group of individuals who have mutual interests.

5.4. Influences on Help-Seeking Behaviour

Murray (2005) studied young people’s help-seeking behaviour, finding that any policy direction implemented by an organisation whose aim is to support young people and their help-seeking aspirations must investigate diverse models of service
provision. In predominantly adult paradigms, Murray postulated traditional models of service provision to have relevance still to young people. However, he noted the limits to this approach, these being the need to incorporate the legitimisation of a young person’s problem and their experience of prior help-seeking pathways. More specifically, Murray recorded, “its fundamental appeal is that it conceptualises help-seeking as dynamic rather than linear, static and individualised … incorporates the past as well as the present, help givers as well as help seekers, and problems are legitimised rather than given” (p.1). His work highlights the importance of incorporating the experiences of young adults, both past and present, to shape future policy and service provision.

Nicholas, Oliver, Lee, and O’Brien (2004) studied the impact of modern technology on help-seeking behaviour in adolescents and young people. They examined 243 adolescents of mixed gender from government schools in the state of Victoria, Australia. Their study focused on the relevance of the internet on how an adolescent might seek assistance for a variety of issues therein, the study referring to these issues as ‘tough times’. The results revealed the study cohort to be in favour of using the internet as a means of support during these ‘tough times’. The authors noted the absence of significant difference between males and females, either when visiting the internet for help or having the intention to do so.

O’Neil, Lancee, and Freeman (1984) focused on the help-seeking behaviour of students at university, investigating the comparison between students who attended a university clinic and the general population to predict the single most important factor influencing students to seek help for depression. The investigation, using the Beck Depression Inventory, identified the severity of symptom presentation as the most salient issue rather than any one symptom itself. The authors
commented that students who sought help were more likely to come from a cohort of older students living away from family and traditional support groups. The presence of a ‘confidant’ was identified as a significant barrier to help-seeking behaviour, O’Neil et al. stating “the presence of a confidant may be preventative but does not necessarily decrease the need for professional help … decisions to seek help may be influenced by four factors: the severity of the problem; the individual propensity to seek help; the ability of alternative resources; and the accessibility of psychiatric services” (p. 3).

Gender differences remain one of the most debated aspects of help-seeking behaviours (Kessler, Brown, & Broman, 1981; Oliver, Pearson, & Coe, 2005). Galdas, Cheater, and Marshall (2005) reviewed the literature regarding men and health help-seeking behaviour, noting studies were not specific when identifying factors influencing particular help-seeking behaviours between genders. However, the review emphasised the finding that males are far less likely to seek help than females when they become ill; they do not seek help until an acute crisis occurs. This is important in light of the growing body of research demanding early intervention approaches as being both cost effective from an individual trauma/distress perspective as well as increased costs to society.

Additional influences on how a student may or not seek assistance were further investigated in a medical student cohort. Thistlethwaite, Quirk, and Evans (2010) undertook a qualitative, observational study to examine the influence of medical students’ perceptions in relation to student/doctor interactions. This study found medical students to reflect on their issues related to their seeking specific medical assistance, and the impact of this reflection on their decision-making processes. Studies such as the above have implications for help-seeking behaviours
when examining the impact on specific areas of study and student groups, and their willingness to access specific support services.

Other studies have extended the understanding of help-seeking behaviour, in that, rather than examining individual influences like age, gender, student cohort effects, factors such as stage of illness or crisis presentation, were just as likely to effect outcomes of help-seeking behaviour. Cornally and McCarthy (2011) centred their study on more specific help-seeking behaviours, examining the reasons for individuals often seeking assistance for health related issues only when they become chronic or acute. The concept of help-seeking behaviour is often interchanged with the actuality of such behaviour. According to Cornally and McCarty’s research, the process of help and health-seeking has several different components: problem focused; intentional in its action; and having interpersonal interaction. Therefore, based on the authors’ understanding of help and health seeking behaviour, which accorded with the health setting, it would seem reasonable for these three key concepts to be generalised to any population seeking help for an issue related to their individual needs.

5.5. Measuring Help-seeking Behaviour

Even recognising the influence of above factors on help-seeking behaviour, an ongoing complication remains: the ability of researchers to design and validate tools effectively and consistently so they accommodate the variability within student populations. Wilson, Deane, and Ciarrochi (2005) measured the intentions of students from a New South Wales public high school, grades 7 to 12 in their study. Their intention was to ascertain whether the General Help-Seeking Questionnaire was flexible enough in its parameters to measure a student population. The fundamentals of their study intended trying to understand whether help-seeking
behaviours could be adjusted in order to increase possible engagement with support services, such as counselling. The authors researched a sample of 218 students, finding the General Help-Seeking Questionnaire (GH-SQ) to be satisfactory in terms of both reliability and validity.

General help-seeking tools use a format that can be modified according to the specific purpose and need of a study or sample. Within this format, sources of assistance and types of problems can be altered to meet sample demographics and study parameters (Wilson, Deane, Ciarrochi, & Rickwood, 2005). Based on recommendations by Ajzen (2002), the GH-SQ utilises the following problem search within which targeted types of problems can be swapped: “If you were having [problem-type], how likely is it that you would seek help from the following people?” (p. 2). The GH-SQ is formatted and scored using a Likert Scale. Questionnaires required participants to reply to each type of problem by rating their help-seeking behaviour on a 7-point Likert Scale ranging from 1 (extremely unlikely) to 7 (extremely likely) for each help source option. Higher scores indicate higher help-seeking behaviours. Further, help-seeking behaviours can be reviewed individually by combining scores for different types of problems. Likewise, given that help-seeking behaviours are a function of both the particular issues in question and the sources of help, information for individual help sources may also be of interest (p.3).

General help-seeking questionnaires have been utilised in several studies (Ciarrochi et al., 2002; Ciarrochi & Deane, 2001; Deane, Ciarrochi, Wilson, & Rickwood, 2001, 2005) demonstrating positive associations with aspects of emotional competence. Preliminary evidence suggests such questionnaires to offer promise as a flexible measure of help-seeking behaviours. Its construct validity is
supported if current help-seeking intentions are related to future help-seeking behaviour.

Reavley et al. (2012) enhanced the ability of researchers to establish the help-seeking behaviours of university students by adapting the content area from the GH-SQ specifically for use with Australian university students. The Mental Health Literacy (Higher Education) Wave One Questionnaire (see Appendix B) allowed for a comprehensive review of Australian university students focusing on the recognition of depression, anxiety, help-seeking behaviours, attitudes towards interventions and services, and stigmatising attitudes.

5.6. Relationship between Psychological Distress and Help-seeking of University Students

Hunt and Eisenberg (2010) when studying help-seeking behaviour among college students with mental health problems identified an abundance of data across tertiary education institutions with regard to prevalence. They note these data are predominantly descriptive in nature identifying real time behaviour rather than the evaluation of current approaches to the support of students with psychological distress. They comment upon the lack of research encompassing evaluation of current service provision as significantly hampering the identification of improvements to services and the development of future prevention, identification and treatment programs. The authors imply that it may be beneficial for tertiary education institutions to take heed of effective interventions in generalised youth populations in order to shape future service provision.

It would appear that Hunt and Eisenberg (2010) have opened up discussion regarding research to progress the link between student support services and the prevalence of mental health problems, psychological distress and help-seeking
behaviour. It is clear that although there is an understanding of individual influences on help-seeking behaviour, and even an effective measure, universities continue to struggle to provide effective integration of learning and support for students, possibly due to the under-recognition of the influence of psychological distress on decision making processes, like that of help-seeking behaviour.

Marton and Choo (2012) reviewed the manner help-seeking behaviour was assessed through the use of an electronic medium. They questioned whether there was some way to determine the influence on student behaviour by information imparted through electronic means. This information recommends the necessity to scrutinise the various ways in which help-seeking behaviour and information seeking as integrated with the Health Belief Model, is understood. In order to implement such an intervention successfully a coordinated approach across faculties, schools and support services is important so that the information obtained is provided in a uniform manner, without duplication, in a manner understandable by various student groups. A more systemic review of models regarding information dissemination and how they are required for university students must occur. It may be also useful to understand how theoretical models apply to the application of knowledge acquisition.

Czyz et al. (2013) further contributes to this discussion through the identification of the barriers to help-seeking behaviour of students who had elevated risk of suicide. Their study sought to describe barriers students identified for not seeking professional help. They examined 165 students as a part of a web-based treatment linkage intervention for the period of a year during 2010-2011. A questionnaire was utilised seeking responses through an electronic medium from students concerning the reasons for not seeking professional help. The most prominent reason for not seeking help was found to be that the student did not
perceive a need for treatment. Other reasons included the lack of time students had within their busy schedule and the choice preferred to self manage issues. The study concluded that interventions for students should primarily be targeted at the barriers for not accessing services; this could include the increase of web-based resources and interventions (King, 1982).

Health literacy and help-seeking behaviour having now been discussed, chapter six seeks to explore the relevant research regarding several strategies used within communities to promote and prevent detrimental health outcomes, and to provide strategies that build capacity within communities that may be experiencing particular issues. In this study, university students are the targets; they experience levels of psychological distress and the impact it may have on levels of achievement. In chapter six these are shown as health promotion and prevention activities specific to universities and associated health education as possible ways in which the university community may build internal capacity.
Chapter Six

Health Promotion, Prevention and Intervention Activities at Universities

The importance of this chapter and its relevant literature to the university setting may be crucial in understanding possible ways in which a university and its community might support students and thus provide an environment in which learning is optimised. Building stronger communities has not only beneficial impact for universities but also the larger community functioning as a whole.

An increasing pressing need to address the mental health needs of university students is apparent, approximately one quarter of all students having a diagnosis of mental illness (Silvestri & Bonis, 2006). Therefore changes in the health literacy of students is essential particularly as Silvestri and Bonis’ (2006) study found students routinely reporting lower health and quality of life scores than their working counterparts. Thus there is a need for universities to review and implement health promotion strategies targeting the range of physical and mental illness experienced by students.

The manner of achieving this is still under review and requires close examination for effectiveness in delivery structures, content, and student and staff perceptions. A variety of programs is possible: an in-house (or university) type (Ambegaonkar & Caswell, 2011; Dix, Slee, Lawson, & Keeves, 2012); an individually focused, target or tailored approach towards improving caring of self (Stark, Hoekstra, Hazel, & Barton, 2012); an inclusion of holistic approaches focusing on the physical, medical and social (Nguyen-Michel, Unger, Hamilton, & Spruijt, 2005); a web-based and outreach method to improve at-risk students’ attendance at appropriately identified supports and services (Haas, Koestner, Rosenberg, Moore, Garlow, Sedway, Nicholas, Hendin, Mann, & Nemeroff, 2008); or a whole university-
wide health promotion campaign (Ying & Lindsey, 2013). Whatever the program, specific thought is required in relation to a university’s: specific demographic distribution and diversity; community supports; willingness for integration and collaboration; and ability to provide appropriate support and training to all university staff.

6.1. The Importance of Targeting Health Education at Universities

Reavley, McCann, and Jorm (2012) investigated the mental health literacy of university students between the age of 18 and 24 years. This population was chosen because approximately 50% of this total cohort was involved in some form of tertiary education. An understanding of the knowledge relevant to psychological distress and actions needed to deal with mental health problems would benefit this group and the wider community. Students were interviewed using scales to ascertain their current levels of psychological distress and their ability to understand actions to be taken if psychological symptoms were present. The findings showed a significant proportion of students (27%) reported some level of psychological distress in particular depressive symptoms. The most significant course of action taken by students to deal with such issues was the use of close friends, physical activity and talking to family. The researchers noted that over 72% of students with a problem had sought professional advice and help mainly from counselling services or a general practitioner. The study conclusion recommended the necessity of a further investigation into possible barriers and enablers to the use or otherwise of student support services. An addendum noted the high level of help-seeking from friends was worthy of further investigation thereby ensuring that effective first aid education for those providing support was current and accurate.
More specifically Commons-Treloar and Lewis (2008) investigated targeted clinical education for health service providers such as clinicians for patients who presented with deliberate self-harm related diagnosed with Borderline Personality Disorder. This group consistently proves to be difficult in acceptance of consistent treatment options even from qualified health professionals. This is especially so when this cohort experiences increased stigma and negative attitudes. The authors found expert clinicians with specific education about Borderline Personality Disorder dramatically improved clinical outcomes and significantly reduced stigma and negative attitudes. The assumption can be made that in the university setting; staff will have appropriate responses to students with this specific disorder or associated behaviours, with the provision of appropriate education and training.

The research of Rosenthal, Russell, and Thomson (2008) considered the case of international students' health and wellbeing while studying at an overseas university. In measures of physical, mental health, and wellbeing, they found a few international students experienced studying in an overseas country which was detrimental to their health and well-being; thus, those who encountered such difficulties or were at-risk needed targeted interventions to ensure the access to, and availability of necessary support services. A major outcome of this study revealed students not to be identifying physical health issues as a major factor in their ability to achieve academically. The authors affirm international students to require targeted health education so ensuring their early identification of physical health concerns, then access to appropriate interventions or services.

6.2. The Importance of Mental Health Literacy in Universities

The consistent theme within university settings is the lower the level of mental health literacy the lower the levels of engagement with appropriate assistance. The
consequence being reduced academic achievement and lower levels of student retention. The ability of individuals to recognise their problem is key to their seeking appropriately identified assistance. Secondary, but still important is for students to conclude that they require help.

The general community is reported to have significant difficulties in the recognition of specific disorders and the different types of psychological distress; this is reflected in university settings (Jorm, 2000). Research over the past decade has attempted to focus on the different attitudes expressed by the public, coupled with the influence of a significant body of inaccurate and misleading information about mental illness. Jorm identifies the public's mental health literacy, including that of university students, as a problem. He contends improved health promotion activities will continue to be hindered if the public do not accept certain facts as the truth. DeWalt, Berkman, Sheridan, Lohr, and Pignone (2004) attest lower levels of health and mental health literacy is associated with poorer health outcomes to be well established. With what is known about the influence of poor physical and mental health on academic achievement and success, it is imperative that tertiary institutions begin to make this a primary focus.

Age distinctions and the levels of literacy within different university age cohorts, must be considered when developing programs to improve mental health literacy (Farrer, Leach, Griffiths, Christensen, & Jorm, 2008), that is, age appropriate messages about the experiences of mental illness should be widely known to ensure university students concerned about their mental health can achieve improved outcomes.

The impact of university location, either rural or urban campus locations, is an important consideration. The literature relating to the differences between these
types of communities is credible and transferable to the university settings means institutions of learning will accept the issue of mental health literacy being nuanced. The research of Griffiths, Christensen, and Jorm, (2009) emphasises rural locations typically have lower levels of mental health literacy and experience mental health problems and illnesses at rates likely to be higher than their urban counterparts. Communication strategies appears to be key in the early delivery of mental health literacy messages, in that, appropriate education about the support services available to persons suffering from illnesses such as depression appears to have a significant impact on rural community members’ ability to seek help if necessary.

Gender continues to be a key indicator of poor health literacy levels and subsequent poor health and mental health outcomes. For example, Cotton, Wright, Harris, Jorm, and McGorry (2006) studied the effects of gender on mental health literacy in young people. They found a clear difference between males and females, with males being more likely to have lower recognition of symptoms of mental illness and to perceive alcohol use as an appropriate way to deal with mental health problems.

An example of how mental health literacy is being addressed within the Australian population is the utilisation of the Mental Health First Aid program. It is a targeted initiative developed by the Australian National University aiming to provide information to the general public about psychological distress and mental health issues so this population understands better and is able to identify appropriate avenues for support (Kitchener & Jorm, 2006).

6.3. The Use of the Act Belong Commit Program

The impact of the Act-Belong-Commit (ABC) program has been well established in recent years (Anwar-McHenry, Donovan, Jalleh, & Laws, 2013). The
primary focus of this program is to encourage people in the community to identify
and engage actively in a chosen community program designed to improve their
mental health. The program targets mental health through improved engagement
and collaborative community partnerships, increased health promotion and active
participation in these programs. Although health concerns, including physical health
issues such as obesity and diabetes, are not the primary focus of this program, they
are often a consequence of increased participation in ABC’s activities (Anwar-

Conceived as a community-based health promotion strategy and campaign
ABC aims to re-engage people in active behaviours that are known to improve and
sustain mental health (Donovan, James, Jalleh, & Sidebottom, 2006). Through the
use of three simple messages for community members to act, to belong, and to
commit, and a commitment from community organisations to actively promote
activities to increase attendance, participation, membership and volunteerism, this
program has shown significant results (Donovan & Anwar-McHenry, 2014; Donovan
et al., 2006).

Evaluations have been conducted with both the community participants and
the community services/organisations (Anwar-McHenry et al., 2012; Jalleh,
Donovan, James, & Ambridge, 2007). To date one university in Australia, Southern
Cross University in New South Wales and Queensland, has implemented the ABC
program as a broad-based health promotion activity for its students. At this time
however evaluation data regarding effectiveness specifically within a university
setting has yet to be conducted.

According to an evaluation done by Anwar-McHenry et al. (2012) since its
implementation the ABC campaign has reached approximately 75% of the intended
population (p.189). The reach was achieved through television ads, radio ads, or print. Within the 75% reached, 25% reported changing the way they perceived the concepts of mental health and illness, with 20% reporting behaviour change. In addition these authors reported the campaign to be deemed effective in assisting people to be more positive about mental health issues including stigma (p.190).

The impact on community organisations of the ABC program was assessed when community organisations participating in the program were surveyed. This two year period of assessment indicated that collaboration in the ABC program has impacted positively on staff expertise about the way such initiatives can improve the mental health and wellbeing of a community and also influence their willingness to collaborate in future events (Jalleh et al., 2013). The key message to be learned from this investigation is that all sectors of the community working together are necessary to promote mental health and wellbeing at the local community level.

6.4. The Use of the Jigsaw or Headspace Program

The Jigsaw program, located in Geelong Victoria, and the Headspace program, located throughout Australia, have both been developed to provide alternative mental health services for youth who traditionally are not able to access mainstream mental health. Central to the philosophy of both programs is a ‘community of youth services’, whereby services collaboratively pool resources and time to provide clinical and non-clinical support efficiently to young people, inclusive of substantial health promotion, prevention and intervention (Illback, Bates, Hodges, Galligan, Smith, Sanders, & Dooley, 2010; McGorry, Tanti, Stokes, Hickie, Carnell, Littlefield, & Moran, 2007).

Tertiary institutions’ ability to provide effective support services to students, especially those of a younger cohort, must consider programs like Jigsaw and
Headspace; these have been evaluated and demonstrated to provide improvements in both access and clinical outcomes in the youth mental health area (Illback et al., 2010; McGorry et al., 2007). Callaly, von Treuer, van Hamond, and Windle (2011) discussed the critical considerations for all services when undertaking the formation and maintenance of collaborative support systems both internally and externally. Callaly et al., have documented partnerships and coordinated care to be the process which best maximises clinical outcomes through the enhancement of expertise and improvements in access, and also reductions in service duplication.

Callaly et al., (2011) strongly encourage organisations to develop key partnerships and ensure staff in tertiary institutions, and to play a key role in these actions. This involvement will create consistency, empowerment, and appropriate ownership of any intervention provided to students; academic staff playing a vital and frontline role. This process, however, must not be seen as simple, the bringing together of services from different quadrants of the university and externally requires that common goals and objectives need to be negotiated. The authors suggest that the goodwill of people is not enough, stating most collaboration will fail due to the intricate nature of organisational behaviours and agendas.

Further to the development of internal and external partnerships and collaborations, consideration must be given to the coordination of care being delivered to the students identified to be at-risk. The current evidence (Scott, Hermens, Glozier, Naismith, Gustella, & Hickie, 2012) points to interventions requiring a primary health approach, including the range of psycho-social factors that impact on a student’s ability to engage with and learn at university. Therefore consideration must be given to the development of collaborative primary health practices within university settings that encompass strong and key identified external
health service provisions from the wider community at the local level. This would include the Jigsaw and Headspace programs and possibly assessment tools used (see Appendix C). For example, the University of Canberra has implemented a Headspace program on its Canberra campus.

Chapters two to six have examined the available literature relevant to the global nature of this thesis and explored two integrated theoretical frameworks. Chapter seven will outline the methodology developed to answer the research questions stated in chapter one. The coming research method chapter includes the choice of participants, procedures, data collection and analysis undertaken.
Chapter Seven

Method

7.1. Research Design

The research design for this thesis was quasi-experimental as there was no control group due to a range of ethical considerations, including the withholding of interventions and/or support from potentially distressed university students. Quasi-experiments offer a desirable alternative when traditional experiments cannot be conducted (Campbell & Stanley, 1966; Shadish, Cook, & Campbell, 2002). The nature of this thesis concerns service provision to distressed students, a traditional control group was not possible as withholding support from a distressed individual was not deemed appropriate; therefore a ‘true experimental’ process was not recommended (Shaughnessy, Zechmeister, & Zechmeister, 2009). However, quasi-experiments can lack the level of control found in traditional experimental designs, most notably the lack random assignment. This research overcame the latter by conducting the study across eight university sites, benchmarked as similar in nature, employing, for example, student demographics and key performance indicators. Higher participation numbers were targeted to increase internal validity, known to be low in non-randomised studies.

This thesis further utilised a mixed method approach to data collection and analysis, the instruments incorporating descriptive and quantitative methodologies. The descriptive aspect of this research design depended on the use of thematic and demographic analysis. The quantitative aspect focused on pre-test and post-test variation utilising an ‘Interrupted Time-Series design’ thereby increasing validity of the measure (variance) being analysed. This design allowed for an examination of such observations as measures of psychological distress, both before and after a
student has accessed an intervention or support service. Evidence for an intervention effect occurs when there are discontinuities or sudden change in the time-series data at the time the intervention was implemented and recorded (Shadish, Cook, & Campbell, 2002).

Phase two of the study comprised a paired-group pre-test and post-test design (Shaughnessy et al., 2009, p. 208). It employed both descriptive and quantitative techniques to collect and analyse the individual student data, the aim being to provide a profile of student experience, history and intervention effectiveness.

The major difficulties with internal validity in the interrupted time-series design are effects relating to history, and changes in instrumentation and measures happening at the same time as the intervention. To reduce these effects, a concurrent quantitative measure was taken at both time intervals in order to determine the presence of such ‘historical influences’. Further, in an attempt to address the second major threat, as a part of the benchmarking phase, a profile of support services and interventions was conducted. Although such factors as changes in interventions cannot be accommodated for in this thesis, variations will be discussed and compared.

7.2. Participants

For the purpose of this thesis ‘participants’ has been defined as those involved in the actual process of data collection. This means there are two types of participants: (1) the eight universities involved in the phase one data collection cycle; and (2) the university students in phase two from which specific demographic, psychological distress and help-seeking behaviour measures were taken.
7.2.1. Participant group one – Universities

The ‘Institutional Performance Portfolio: Technical Document’ (2013), was perused to determine which universities were comparable with Edith Cowan University. This document defines its purpose as facilitating strategic and performance benchmarking at the whole of university level with a peer group of ‘like’ institutions. Eight universities were selected based on this document; they participated in recent benchmarking exercises, including Edith Cowan University. This allowed for a range of study sites to be selected from across the country (see Appendix D). The Institutional Performance Portfolio: Technical Document is a benchmarking tool under the auspices of, and funded by the Australian Government’s Department of Education; it comprises 14 criteria used to compare performance across institutions (Department of Education, 2013).

The benchmarking prior to this research was conducted according to the following criteria that allowed for a comparison list of universities (Australian Government, 2013):

- similar number of domestic student enrolments;
- similar numbers of international students;
- high proportions of domestic mature age students;
- fewer than 5% of domestic students are enrolled in Higher Degrees by Research;
- similar proportion of domestic postgraduate enrolments;
- similar numbers of total staff;
- similar proportion of teaching only staff within academic staff;
- similar proportion of research only staff within academic staff;
- high proportion of Australian Government financial assistance as a
percentage of total revenue;

- similar proportion of fees and charges as a % of total revenue;
- similar proportion of employee costs as a % of total revenue;
- offer similar broad fields of education for domestic student;
- have more than 3 campuses in Australia; and,
- similar age.

The above benchmarking process and technical document found the following institutions to be comparable institutions to benchmark (Australian Government, 2013, p. 62). The descriptions of the eight universities have been taken directly from the Australia’s Universities website listing.

### Participant University 1 - Charles Sturt University (CSU)

Established in 1989 as a multi-campus institution, CSU includes campuses in Albury-Wodonga, Bathurst, Canberra, Dubbo, Goulburn, Ontario in Canada, Orange, Parramatta, Port Macquarie and Wagga Wagga; CSU Study Centres in Sydney and Melbourne; and the Australian Graduate School of Policing and Security at Manly. As a national university for the professions, CSU prides itself on providing practical, hands-on courses that ensure students graduate with the skills required to step into employment opportunities. The University offers state-of-the-art facilities on its campuses, from an online newsroom and fully equipped multimedia and television production area, to dental, podiatry and veterinary science clinics. CSU graduates have the skills and practical experience to prepare them for careers in regional or metropolitan communities in Australia and internationally.

*Source: Australia Universities website* [https://www.universitiesaustralia.edu.au](https://www.universitiesaustralia.edu.au)
Participant University 2 - Deakin University

Deakin University, one of Australia’s largest universities, is a public not-for-profit university combining research and teaching strongly focused on strengthening the communities it serves. Deakin has just over 42,000 students – approximately one fifth are international students from more than 100 countries, while almost one third choose to have a wholly off-campus experience. Deakin has four campuses, one in Melbourne, two in Geelong and one in Warrnambool. Additionally, the university has a prestigious multipurpose facility in Melbourne’s CBD, a network of learning centres stretching across regional Victoria, and international offices in India, China and Indonesia. Deakin’s four faculties: Arts and Education, Business and Law, Health, and Science, Engineering and Built Environment, offer undergraduate and postgraduate programs across a wide range of discipline areas. Through an acclaimed community-based delivery model, Deakin’s Institute of Koorie Education also offers courses for Aboriginal and Torres Strait islander students in partnership with the four faculties. Deakin is a sector leader for student satisfaction, currently third in Australia and first in Victoria.

Source: Australia Universities website [https://www.universitiesaustralia.edu.au](https://www.universitiesaustralia.edu.au)
Participant University 3 – Edith Cowan University (ECU)

Edith Cowan University (ECU) is a large multi-campus institution serving communities in Western Australia and a significant cohort of international students. Awarded university status in 1991, in just its 21st year ECU was named in the Times Higher Education 100 under 50 list, a global ranking of the best universities under the age of 50. ECU has more than 23,500 students at both undergraduate and postgraduate levels. Approximately 4,000 of these are international students originating from approximately 80 countries. More than 250 courses are offered through four faculties. ECU works closely with private and public sector organisations, locally and overseas, in designing its study programs. For the past four years the Good Universities Guide has awarded ECU five stars – the highest star rating – for its teaching quality and graduate satisfaction. The University has two metropolitan campuses in Mount Lawley and Joondalup and also serves Western Australia’s South West region from a campus in Bunbury, 200 km south of Perth. The Perth Graduate School of Business at the Mount Lawley Campus provides quality, market-driven business education focused on the needs of postgraduate students and employers.

Source: Australia Universities website https://www.universitiesaustralia.edu.au
Participant University 4 - Griffith University

Griffith University is one of Australia’s most innovative tertiary institutions and an influential contributor to education and research in the Asia-Pacific region. Located across five campuses in the Brisbane-Gold Coast corridor of South-East Queensland, Griffith ranks in the top five per cent of universities worldwide, according to a range of prestigious indices. As Australia’s ninth largest higher education provider, Griffith is both a student-centred teaching institution and a research-intensive university at the cutting edge of enquiry. Griffith features prominently year-on-year in Australia’s national teaching awards and citations. Its more than 43,000 students from 131 countries are attracted by 300 undergraduate, postgraduate and research degrees in a comprehensive range. Campuses at Southbank, Nathan, Mt Gravatt, Logan and the Gold Coast, swathed in sub-tropical sunshine, feature many state-of-the art facilities that reflect the university’s innovation and future focus. Griffith was the first University in Australia to offer Asian studies and was a leader in environmental science. It is now home to a major medical, health and knowledge precinct at its Gold Coast campus; a state-of-the art, self-powering environmental teaching and research facility in Brisbane; and world-class music and creative arts facilities at the Queensland Conservatorium and Queensland College of Art at South Bank – each a part of Queensland’s heritage.

Source: Australia Universities website https://www.universitiesaustralia.edu.au
Participant University 5 - La Trobe University

The University was established in 1964 and now offers nearly 350 undergraduate and postgraduate courses and accommodates 34,492 enrolled students, including 9,008 international students. La Trobe was recently ranked among the top 50 universities in the world under the age of 50 (QS World University Rankings 2012) and the university is one of Australia’s leaders in research. La Trobe is third in Victoria for research and ranks as Australia’s best university for research in Microbiology and equal best in Biochemistry and Cell Biology, and Veterinary Science. Nine of La Trobe’s fields of research rated ‘well above’ world standard and a further seven rated ‘above’ world standard.

Source: Australia Universities website https://www.universitiesaustralia.edu.au
The University of South Australia (UniSA) is a modern and innovative institution that was established in 1991, having been built on more than 150 years of research, teaching and learning excellence. Its global reputation continues to grow, as exemplified by the 2012 QS World University Rankings in which it was again ranked among the top three per cent of more than 10,000 universities worldwide. UniSA also increased its standing in The Times Higher Education rankings, and was ranked 23rd in the world (and number three in Australia) in the QS rankings of the top 50 universities aged under 50. With almost 35,000 students – more than 10,000 of which are international students – it is South Australia’s biggest university, and offers more than 400 degree programs in business, education, arts, social sciences, health sciences, information technology, engineering and the environment. It ranks in the top one third of Australian universities for research income, and in the Excellence in Research for Australia 2012 evaluation more than 86 per cent of its assessed research was deemed to be of world-class standard or above.

Source: Australia Universities website [https://www.universitiesaustralia.edu.au](https://www.universitiesaustralia.edu.au)
Participant University 7 - Victoria University

Victoria University is a diverse, multi-sector university based in Melbourne, Victoria and one of Australia’s largest universities. Victoria University has one of the greatest international student mixes at any Australian tertiary institution. Operating in the western part of Melbourne’s CBD and a spine of campuses through the West of Melbourne, centred on Footscray and St Albans, with smaller campuses and partnerships in other parts of the west, south-west and north-west. The university operates on a trans-national basis with partners in Asia (e.g. China, India and Malaysia), America and Europe. They have more than 50,000 enrolled students, including over 12,000 international students studying onshore and offshore, more than 4,500 staff and nine locations - three in Melbourne’s CBD and six across the western region. Victoria University is proud of its leadership role in the west of Melbourne. We service a very diverse student cohort, with a wide range of countries, cultures, socio-economic and educational backgrounds represented.

Source: Australia Universities website https://www.universitiesaustralia.edu.au
Participant University 8 - University of Western Sydney

The University of Western Sydney (UWS) is a large, research-led metropolitan university operating over multiple teaching campuses in Greater Western Sydney, one of the fastest growing, economically significant and most dynamic regions in Australia. Established in 1989, UWS can trace its history back to 1891 when its oldest predecessor, the Hawkesbury Agricultural College, enrolled its first students. Today the University has over 40,000 students, and 2,500 staff. Its diverse local and international population creates vibrant, intellectual environments, and enriches the student experience. UWS is enterprising and forward-looking, embracing diversity and a commitment to excellence, access and opportunity. Over half of its students are the first in their families to attend university, and the University has the largest number of students from lower socio-economic backgrounds in Australia. UWS has built a reputation as a highly adaptable and responsive university, borne out in its consistently high student satisfaction ratings, and praise from the Australian Universities Quality Agency.

Source: Australia Universities website [https://www.universitiesaustralia.edu.au](https://www.universitiesaustralia.edu.au)

These seven sites, plus Edith Cowan University (N=8), were involved in both phases of this thesis. Phase one involved university support services completing a survey that profiled what is available and the basic student demographic, i.e., how many students access the services; what is the primary issue for which they are seeking assistance; what quality measures are being collected; and what types of interventions are being employed.
7.2.2. Participant group two – University students

For the purpose of this thesis a student was determined as any person who is currently enrolled at university for the purpose of study. This may include persons engaged in employment within the university currently studying. Phase two data were collected from only two universities (Edith Cowan University and Deakin University) of the original eight in order to strengthen the validity and reliability of the final result in the absence of a control group. Deakin University was selected based on relative student population and distribution of campuses across regional and metropolitan venues, essentially a comparable university to Edith Cowan University.

Phase two targeted students when entering selected support services at the participating universities (N=201) and when exiting (N=125), employing an electronically based survey. The students comprised a representation from different faculties across the two universities, including regional and metropolitan campuses.

7.3. Instruments

7.3.1. Phase one

For the purpose of phase one, a previously developed survey and accompanying introduction letter (see Appendix E) was used and delivered by email and post. Questions elicited information from the eight participating universities about the types of services, including demographic information, they have available to support students. This instrument was extracted from the demographics subsection of a large university support services survey developed by Reavley et al. (2011). No modifications were made and the use of the survey was consistent with its intended purpose; no pilot study was conducted. The survey collected information about the types of services each university provided asking for specific information about student demographics, who accessed the service, hours of operation and
services provided, method of services delivery, length of time for engagement, and type of degree being studied by the student. The aim of this survey was to profile the support services in each of the participating universities; it was offered either by email or by hard copy sent postally. This survey was chosen for use because it been utilised previously testing its content with the same population of Australian university students in similar research studies (Reavley, 2010; Reavley et al., 2011)

7.3.2. Phase two

For the purpose of phase two, Reavley’s (2010) PR623 Mental Health Literacy (Higher Education) Wave One Questionnaire v11, without the AUDIT tool embedded, was used in combination with an introduction letter and the Kessler 10 to capture information relating to both university student help-seeking behaviour and psychological distress (see Appendix F). The AUDIT alcohol assessment tool was removed as it had no bearing on the research aims of this thesis because it was too specific in nature.

The current study’s survey tool was selected based on its previous use in two separate studies with the same population of Australian university students. Reavley (2010) and Reavley et al. (2011) developed, adapted and combined a range of tools serving to provide an appropriate analysis of mental health literacy and help-seeking behaviours in higher education students; it became the Wave One Questionnaire. The first study conducted a survey on how information was elicited about students to access their understanding of various mental health conditions within selected scenarios, help-seeking intentions, beliefs and stigmas relating to interventions. The second study employed this survey and the Kessler 10 to investigate levels of psychological distress among university students and the associated actions to assist individuals with mental health conditions.
7.3.3. Phases one and two

In order to increase the overall number of respondents it was decided to offer both surveys in electronic forms, email for phase one and an electronic survey platform ‘Qualtrics’ for phase two. The Qualtrics survey program was employed to design both surveys and also the distribution method for the survey in phase two. The program allowed for the phase two survey to be easily accessed by URL link distributed to the student support services for this phase and to the students by an email message in post-test conditions. When they cut and pasted the URL into an internet search line, students and services were able to access and complete the designated survey. In addition, easy access of the Qualtric program was chosen for its download compatibility with both Excel and SPSS statistical packages to be used for data analysis in phase two. The program was also compatible with university information technology systems in which both support services and students would use it. The ability to send reminders to all participants to complete the post-test survey was a convenient option within the Qualtric program allowing for increased time efficiency.

Research informs that the use of this particular survey tool not only improves efficiency but also improves response rates to surveys. The Qualtric survey program was found to provide an opportunity to determine possible solutions to typical challenges researchers faced when designing and distributing electronic surveys. This program allowed for the personalisation of the survey, providing access for all collaborators to review and revise the content. Ease of distribution was further enhanced by the ability of the survey to be taken from a range of electronic devices, including smart phones (Luo, 2013).
Organising, formatting, and editing both surveys within the Qualtric program ensured all questions to be presented clearly and precisely so allowing for timely completion either by hand, as in phase one, or on any particular electronic device as in phase two. Luo (2013) further found the use of the Qualtric program to improve productivity and efficiency, and could be distributed twice as quickly as other electronic survey programs. Automating the process for sending respondents reminders to complete post-test questions saved approximately 80% of survey time. The ability of the program to provide appropriate coding features, report and analysis functions, further improved the time required for completion.

7.4. Procedure

Ethics approval for this thesis was required from the eight participating universities including full approval from the Human Research Ethics Committee (HREC) at Edith Cowan University. The research proposal application was made initially to the HREC whereby, upon receipt of final approval (see Appendix G), additional applications were made to the other seven universities involved in this thesis. The process varied across the different universities depending on the policy and procedural nuances for each ethics committee requirement. For example, some universities required only the HREC approval letter from the principal university (Edith Cowan University) while others required a complete application to be submitted to their ethics committee. This thesis did not commence until all sites had approved the proposal.

7.4.1. Phase one

Upon completion of all ethics approvals, surveys were forwarded to all support services located at each of the eight universities. The survey was emailed to all possible respondents. In addition, phone calls were made to each support service
manager or coordinator to promote the study and negotiate the implementation of phase two. Follow-up phone calls were made to these officials one month after initial contact and receipt of the phase one survey. Prior communication with designated and appropriate persons was intended to ensure these surveys had their optimum impact and response.

The phase one survey was widely distributed throughout the eight universities identified to be involved with this research component. Table 7.1 below lists the various services contacted and sent the phase one survey. The full matrix of phase one inclusive of specific service details and contacts has been included as Appendix H.

Table 7.1

<table>
<thead>
<tr>
<th>Service</th>
<th>SS1</th>
<th>SS2</th>
<th>SS3</th>
<th>SS4</th>
<th>SS5</th>
<th>SS6</th>
<th>SS7</th>
<th>SS8</th>
<th>SS9</th>
<th>SS10</th>
<th>Annual Report 2013</th>
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<tbody>
<tr>
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</tr>
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<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<td>✔</td>
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<td></td>
</tr>
<tr>
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<td>✔</td>
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</tr>
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<tr>
<td>Housing</td>
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<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>

Edith Cowan University

Deakin University

University of SA

Griffith University

Victoria University

Charles Sturt University

University of West Sydney

La Trobe University

NB: Not all services are provided directly through campus facilities; NA indicates no service available on campus.
7.4.2. Phase two part one - Pilot study

Prior to the commencement of its distribution, the phase two survey was distributed to 50 students across two faculties (both external to the candidate’s home faculty) from a range of schools at Edith Cowan University. The purpose of this pilot study was to ensure the survey was understandable and comprehensive in order to facilitate the research questions being asked. The pilot study was also used to check the timing of the survey and its useability in an electronic medium (Qualtric program). On completion of the pilot study, the survey was deemed to be appropriate and therefore no changes or alterations were necessary. It should be noted that this pilot study did not collect data and therefore no results have been included in this thesis.

7.4.3. Phase two part two - Survey distribution

Upon completion of the Qualtric survey by inputting the various aspects of the help-seeking questionnaire and the Kessler 10, distribution points were determined through discussion and negotiation with the Directors of student support services and their individual managers or coordinators. It was determined that a combination of information letters and the URL giving access to the survey could be distributed directly through the various student support services with additional advertising of the study by global emails to students.

Prior to the survey being sent each support service was visited at both Deakin University and Edith Cowan University in order to inform staff of the nature of the study and the manner of approaching students to determine their intention to participate in the study. All support services at both universities were given equal amounts of information and time spent. Packs containing letters asking students to consider participating in the study were then sent to university support services at Deakin University and Edith Cowan University.
The principal form of the survey was implemented electronically as a survey in two parts. (1) The assessment of current student experiences of help-seeking behaviour and support services using a help-seeking questionnaire inclusive of the use of vignettes, named John/Jenny, these fictitious characters provide the participants scenarios upon which to base their responses to a raft of questions. These vignettes were previously used and tested on a similar university student population by Reavley et al. (2011). (2) The assessment of whether or not current systems of support affected measures of psychological distress, utilising data from the administration of the Kessler 10. Both these assessments were transmitted by electronic media in pre and post-test conditions across a period of six months of a complete university semester. Due to the nature of this assessment, the Kessler 10 was accompanied by an appropriate information letter offering assistance should this tool cause any level of student distress.

Accessing the undergraduate students at the two selected universities was achieved using an established website to distribute an electronic form of the Qualtric survey for the phase two questionnaire. Phase two study participants were recruited by a third party, namely student support service personnel from both Deakin and Edith Cowan universities. No contact was made by the candidate directly to an individual participant. Prior to students completing the survey, student service managers or coordinators were contacted seeking support for the distribution of the information letter and instructions.

Phase two questionnaires were provided through an electronic medium access through a computer site and login, with students accessing support services being given an introductory instruction letter, inclusive of login details, seeking their participation in this thesis. If they chose to participate they accessed the survey by
an access code. It was expected students need only provide details of an email address through which automatic contact would be made after six months to repeat the survey in post test conditions.

The above two parts of the electronic survey were implemented and the relevant student measures were taken at time 1 (February 2013) and time 2 (July 2013) as required by the pre and post-test design. In order for the surveys to be collated and correlated, each was designated a unique number, the student participants being required to provide an email address only. No further identifying information was required.

7.5. Data Analysis

7.5.1. Phase one

No formal statistical analysis was required for this phase of the study; benchmarking and survey data being reviewed according to the key performance indicators set down by the 'Institutional Performance Portfolio' document (Department of Education 2013) and reported in a descriptive format. The profiling exercise identified support services existing at each university, including details of staff, services, and access and exiting procedures. This was undertaken by accessing existing data at the eight participating universities in the benchmarking process. Additional data were sought from these universities and manually reviewed from the distribution of survey materials to quantify and qualify student support services provided. Follow up phone calls to service providers after the distribution of phase one survey material ascertained the quantity and nature of data provided.

7.5.2. Phase two

Upon completion of the phase two distribution of the help-seeking questionnaire a descriptive analysis was conducted to determine the consistent
ideas and concerns raised by the student group. The data was reviewed quantitatively, the outcomes of the collection process being presented in the following chapter. These data provide information that addresses the current study’s aims and research questions. The pre and post analysis of the measures of psychological distress was gathered by implementing the Kessler 10 survey. The data obtained from this rating were tested for significance by conducting a within-subjects t-test, a procedure used to compare two means from a single sample group over two separate intervals of time. In using this test of significance, the assumption was made that the dependent variable was continuous, measured at the interval or ratio scale level, and the two levels of the independent variable differ either qualitatively or quantitatively. To further improve the power of this significance test, a second comparable set of means was added in order to conduct a matched-sample t-test.

The raw downloaded data from the Qualtrics program into an Excel spreadsheet gave descriptors of the variables in the first two lines. The second line was relabelled as the variable names after reference to the actual survey instrument and the first line removed ready for importing. The raw data were then organised and saved into files for exporting into the SPSS program, the two datasets in excel format were then organised and labelled Phase_2_Post test 5_9_13 (N=118) and Phase_2_Pretest 5_9_13 (N=201).

The raw data were then imported into SPSS from both the pre test and post-test surveys. In the pre test data a specific variable was coded, EmailAddress in order to create the opportunity for paired identification in pre and post-test conditions. Frequencies were then run on variables to check for null variables, or
non-useful variables, with incomplete and duplicated variables deleted. The variable labels were then added and variable values based on the questionnaire.

An ID variable was then created in order to link the pre test and post test cases congruent with the email address information. Duplicates were then identified using the email address. If the email address was the same and there were 2 cases of that email address, one each in the pre test and post-test, then assigned the same ID to that case. This process was completed manually. If there was no duplicate, a new ID number was assigned.

The next step required the addition of a flag variable to indicate whether or not that email address had completed more than one pre or post-test survey. There were 62 pre test cases with no email address; however all of the post-tests had an email address. Two cases with 2 pre tests, 38 cases with 2 post-tests, and 3 cases with 3 post tests were presented. Subsequently removed the first case of any duplicate, based on the date of survey completion. After the process of removing duplicates 199 pre-tests and 74 post-tests remained. A new variable was created, ‘paired’, to indicate whether the case was paired or not with 0=unpaired and 1=paired. The next process included the descriptive analysis on all variables. Descriptive analyses were run first on paired data only then on the remainder of the questionnaire for paired data. These were saved as separate output files according to questionnaire section headings.

The next process in data analysis required the creation of a Kessler 10 score by summing the ten items of the Kessler scale. A Kessler category variable was created to categorise, according to Kessler 10 tool, the ‘likelihood of having a mental disorder’. A paired samples file was then created wherein only the pairs were included. Data were subsequently aggregated so that each person was on one line,
deleting the flag variable, response ID, IP address, DearParticipant, Finished, Emailaddress, and ScenarioRecognition.
Chapter Eight

Results

This chapter outlines the results obtained from the descriptive and quantitative analyses for phases one and two of the research. The data are presented in a range of formats, including pie graphs and tables, outlining the outcomes of each of the conducted tests. Data includes the breakdown of phases one and two surveys.

8.1. Phase One Results

The phase one survey was widely distributed throughout the eight universities identified as suitable to be involved with this phase of the research. The full matrix of phase one inclusive of specific service details and contacts has been included as Appendix H. The response rate for the phase one survey was poor with only four student support services, out of the 64 surveyed, providing information by completing the surveys. The information that was provided in the four responses did not provide enough data to adequately reflect the profiles of the universities concerned and therefore the inclusion of this data would not have benefited the discourse of this thesis. The difficulties encountered at this stage will be discussed further in chapter nine, including limitations to this thesis.

8.2. Phase Two Results

For the purpose of this chapter each of the responses (pre and post) was broken down into individual parts. The results will be displayed for student respondents who had sought support from services provided at their university campus and then completed the surveys at both time intervals (pre and post). In detail the results discussed include student demographics, attitudes towards and actions taken relating to help-seeking behaviour, recognition of mental health
problems, beliefs about interventions, stigmatising attitudes and social distance, exposure to mental disorders, first aid actions, perceptions of university support, and measures of psychological distress (Kessler 10).

8.2.1. Student demographics

A total of 326 responses were received across the pre and post-test conditions (n=201 pre and n=125 post). The majority of them came from Edith Cowan University students (90.5%) when compared to students from Deakin University (9.5%). The age ranges of the participants varied between 18 to 64 years old. The vast majority of students were in the age range 18 to 24 years (33.78%), the second and third most popular age groups being 35 to 44 years (21.62%) and 25 to 34 years (17.57%) respectively. The distribution of ages appears to be consistent with what is expected for most Australian universities. The majority of students were within the school leaver age range with a temporary drop in numbers between the time these leavers graduate and go to work, and the time they return to complete postgraduate study. Consistent with the gender trends in higher education, the vast majority of participants were female representing 87.84% of the cohort. Most of the participants were Australian; thus unfortunately the lack of international respondents will not allow for a greater understanding of their interaction with university support systems (see Table 8.1 for a summary of the student demographics).
Table 8.1

Summary of the Student Demographics

<table>
<thead>
<tr>
<th>University</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECU</td>
<td>90</td>
</tr>
<tr>
<td>Deakin</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>12.16</td>
</tr>
<tr>
<td>Female</td>
<td>87.84</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>10.81</td>
</tr>
<tr>
<td>18-24</td>
<td>33.78</td>
</tr>
<tr>
<td>25-34</td>
<td>17.57</td>
</tr>
<tr>
<td>35-44</td>
<td>21.62</td>
</tr>
<tr>
<td>45-54</td>
<td>13.51</td>
</tr>
<tr>
<td>55-64</td>
<td>2.70</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Citizenship</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Citizen</td>
<td>93</td>
</tr>
<tr>
<td>Australian Resident</td>
<td>1</td>
</tr>
<tr>
<td>Not Australian</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Country of Birth</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>70.3</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>10.8</td>
</tr>
<tr>
<td>New Zealand</td>
<td>2.7</td>
</tr>
<tr>
<td>China</td>
<td>1.4</td>
</tr>
<tr>
<td>United States of America</td>
<td>5.4</td>
</tr>
<tr>
<td>Other</td>
<td>8.1</td>
</tr>
</tbody>
</table>

When reviewing the household configuration, however, it would appear the vast majority of students identify themselves within the ‘single’ categories, while the second largest group comprised others identifying themselves as a ‘couple’ or ‘family’ (see Figure 8.1).
Overall the response rate for students and staff came primarily from students (97.3%) with only a minor representation from university staff (2.7%) who were currently studying (see Figure 8.2). The majority of respondents were studying a bachelor degree (87.8%) with the remainder studying some form of postgraduate qualification (see Figure 8.3). The majority of respondents were studying full time (75.7%), this being reflected in the ‘looking for work’ responses indicating the same number of respondents were not looking for work (75.7%) (see Figures 8.4 and 8.6). The consistency across the responses continues to be reflected in the levels of work being done by respondents, where only 4.1% identified as working full time, 43.2% were not working with the remaining 52.7% working in either part time or casual positions (see Figure 8.5).
Figure 8.2. Student and staff demographics

Figure 8.3. Level of qualification being studied.
Figure 8.4. Study mode – full time or part time

Figure 8.5. Employment status
8.2.2. Help-seeking behaviour - Recognition of mental health problems

The following sets of data relate to the questions asked of respondents to elicit perceptions on help-seeking behaviours. They were first asked to review a series of vignettes upon which they then based their responses. The questions have been included with the results as indicated throughout the following pages.

Question 1 - If you had a problem right now like John/Jenny, would you go for help?

From the responses the majority of respondents indicated they would seek help in both the pre and post test conditions. A slight increase was found between the two with pre test responses for ‘yes’ being 67.1% and post-test responses for ‘yes’ being 70.6%. Responses for the ‘no’ remained nominal between the two test conditions. The slight variation in the ‘don’t know’ may be attributed to the rise in the post-test ‘yes’ responses.

Figure 8.6. Students looking for work
Figure 8.7. Would a student seek help?

Question 2 - If you had a problem right now like John/Jenny, where would you go for help?

The mean number of sources of help respondents would access pre test was 3.23 (SD=2.07, min=0, max=7) and post-test was 3.11 (SD=2.12, min=0, max=9). This difference was not statistically significant – t=0.465, df=73, p=0.643. Although the mean difference between the two test conditions was not significant, descriptive differences can be found. In the pre test the four highest indicated sources in order of decreasing frequency were friend, GP, partner, and university counsellor; however, in post-test conditions the four highest indicated sources were GP, friend, partner, and psychologist. Other points of change also indicate that in the post-test conditions, increases in the psychiatrist, psychologist, counsellor, mental health nurse, and EAP counsellor occurred. This increase in frequency appears for sources who can be described as health professionals (see Figure 8.8). Apparently
respondents would access five primary sources ('who could I talk to'): friends (59%), parents (52%), university counsellor (52%), online sources (45%) and partner (43.8%). Sources like ‘lecturer/teacher’ and ‘supervisor’ were less likely to be the indicated source of contact claiming 21.9% and 23% of responses respectively (see Figure 8.9).

*Figure 8.8. Where would a student go for help?*
Question 3 - If you had a problem like John/Jenny who would you feel able to talk to about it?

![Bar chart showing respondents' choices for whom to talk to.](image)

*Figure 8.9. Who would the respondent talk to/access information?*

### 8.2.3. Beliefs about interventions

Consistent with the previous figures and results, the respondents indicated and the figures show that the majority of health professionals were most likely to be helpful rather than harmful in both pre and post test conditions. The exception to which health professional’s advice was sought appeared to be ‘drug and alcohol service’. Less than 18% of respondents indicated their services as being helpful; however there was a noticeable percentage rise in the post-test condition to 30%. As with the previous results, the ‘lecturer/teacher’ category rated low in both pre and post test conditions when compared to the health professionals. Although respondents did indicate several of the sources to be seen as harmful (less than 3%), the ‘online friend’ and ‘internet’ sources were also seen as potentially harmful
by nearly 20% of them (see Figure 8.10). They clearly pointed out that they did not feel dealing with problems ‘on their own’ would be helpful, the vast majority of them indicating its harmful affect in both pre and post test conditions - 47% and 39% respectively (see Figure 8.11). The responses ‘harmful’ was reduced and to ‘helpful’ post-test was increased.

**Question 4** - Which people would be helpful or harmful to John/Jenny?

*Figure 8.10. Which people would be helpful or harmful?*

**Question 5** - Would it be helpful if John/Jenny tried to deal with their problem on their own?
Question 6 - Which medicines would be helpful/harmful to John/Jenny?

Nearly half of the respondents indicated that vitamins would be helpful (51.4%), followed by antidepressants (41.4%), anti-anxiety (27.1%), and St John’s Wort (18.8%) (see Figure 8.12). Although these all attracted some level of harmful responses, ‘sleeping pills’ and ‘antipsychotics’ were seen as the most harmful by respondents (38.6% and 35.7% respectively). This is consistent with the results for the ‘other interventions’ in that the ‘psychiatric ward’ and ‘drugs’ along with smoking and alcohol were seen are the most harmful types of interventions (see Figures 8.12 and 8.13). The positive responses, especially that of vitamins, are consistent with the results for the ‘other interventions’ in that the highest indicated were the ‘physical exercise’ (85%), ‘relaxation’ (82%), ‘meditation’ (74%), and ‘massages’ (55%).

Further positive health related activities were also indicated as highly helpful; counselling (82%), getting up early (67%), mental health service (55%), CBT (52%),
support group (44%), acupuncture (32%), reductions in smoking (79%), alcohol (86%), and drugs (78%) (see Figure 8.13).

Figure 8.12. Medications that would be helpful or harmful.
Question 7 - Other interventions, which may be helpful/harmful? (see Figure 8.13)

![Interventions that would be helpful/harmful](image)

**Figure 8.13. Interventions that would be helpful/harmful**

### 8.2.4. Stigmatising attitudes and social distance

Respondents tended towards having low levels of stigmatised attitudes towards the help-seeking behaviour in the vignettes in both the pre and post-test conditions (see Figure 8.14). For example, when asked to respond to ‘could make themselves better’ 50% disagreed, inclusive of strongly disagree, and only 26.4% agreed. The ‘sign of a personal weakness’ was clearly indicated as a strong response, 83.8% pointing out they did not agree with this statement compared to 3% who did. This was further observed in the ‘not a real medical illness’ response with a total of 80.9% implying they disagreed. The responses for ‘dangerous’, ‘wouldn’t tell anyone’, and ‘best to avoid them’ were relatively consistent with 73.6%, 67.7% and 81.2% (respectively) who disagreed. The ‘makes them unpredictable’ item however received much lower rates for disagreement (47.1%) with an additional 20.6% of
respondents signifying the ‘neither’ response and 19.1% agreeing. Very little change occurred in the post-test responses (see Figure 8.15).

Figure 8.14. Agreements with statements – pre-test

Figure 8.15. Agreement with statements – post-test
Question 8 - How do you feel about spending time with John/Jenny?

The majority of respondents attested in the positive, that is ‘Yes Definitely’ and ‘Yes Probably’ totalled for each of the social conditions across both the appropriate pre and post test conditions in the questionnaire: go out with (75% and 79.7%), work on project with (66.2% and 67.2%), invite to your house (79.4% and 75%), go to their house (70.6% and 74.6%), and develop a close friendship with (61.8% and 63.5%). The responses showing a closer social or personal contact (got out with, invite to your house and develop a close friendship with) were the items that tended to have negative responses versus the work related contact (work on a project) (see Figure 8.16).

Figure 8.16. Spending time with John/Jenny.
8.2.5. Exposure to mental disorders

Responses for question 9 of the survey ‘have you experienced similar problems’ proposed that in pre test conditions 80.9% of them had experienced a similar issue as the read vignette. In the post-test conditions however only 70.3% indicated they had experienced a similar problem (see Figures 8.17 and 8.18).

![Graphs showing percentage of respondents experiencing similar problems in pre and post test conditions.]

*Figures 8.17 and 8.18. Have you experienced a similar problem? (pre and post test)*

The question ‘what did you think the problem was’ had 80.9% of respondents to indicate they had similar issues in the previous twelve months, having had multiple problems with depression (55.4%), anxiety (55.4%), stress (54.1%), low self esteem (39.2%), and psych/mental/emotional (31.1%). The post-test conditions were relatively the same with stress and depression being recorded as higher (56.8% and 60.8% respectively) (see Figure 8.19).
For both pre and post-test conditions over three quarters of respondents (75% and 77%) revealed that they actioned an intervention to deal with the problem outlined in the previous questions (see Figures 8.20 and 8.21). The avenues of assistance continue to be consistent with results from Figures 8.11 and 8.13, with the GP rating the highest (39.2%), with close friend (40.5%) and family member (32.4%) rating next. Psychologists and university counsellors (23% and 25.7%) and the psychiatrist and lecturer (14.9%14.9%) were preferred sequentially. As with previous results a change to the positive for the identified health professionals (psychologists, counsellor and GP) was evident in the post-test conditions (see Figure 8.22).
Figures 8.20 and 8.21. Did you do anything to deal with the problem? – pre and post-test.

Figure 8.22. Where did the respondent seek help?
Respondents affirmed that in pre and post-test conditions (58.7% and 66.7%) they did try to deal with the problem on their own (see Figures 8.23 and 8.24). Self-management is indicated in Figure 8.25 where the medication most used was vitamins (38.8%), followed by medications requiring health professional assessment, such as antidepressants (32.4%), anti-anxiety (23%), sleeping pills (14.9%), St John’s Wort (6.8%), and anti-psychotics (4.1%). Continuing the self-management pattern, the highest reported interventions to deal with the similar problem were ‘more physical activity’, ‘counselling’, and ‘internet information’, followed by ‘meditation’, ‘getting up early’, ‘massages’, ‘relaxation training’ and ‘CBT’. Using alcohol was testified as an intervention used by only 20% of respondents, a further 20% indicating that they had ‘cut down on alcohol’ (see Figure 8.26). Respondents continued to identify positive health and help-seeking behaviours, the intervention found to be the most helpful (see Figure 8.27), was physical activity (52.7%). In decreasing order the following were also claimed to be effective interventions: GP (24.3%), close family friend (23%), anti-depressants (21.6%), close friend (20.3%), university counsellor (18.9%), meditation (18.9%), psychologist (14.9%) and counselling (14.9%). Lecturer/teacher was thought to be an effective helpful means by 4.1%. 
Figures 8.23 and 8.24. Did you try to deal with the problem on your own?

Figure 8.25. What medications did the respondents take?
Figure 8.26. Did you do any of these things to deal with your problem?
Figure 8.27. Out of all the things you did to seek help which ones helped you the most?

8.2.6. Mental health first aid actions

The respondents were asked to think about a family member or close friend who may have experienced a similar problem as shown in the vignettes. Results indicate that over half of the respondents consistently preferred yes (58.8% and 56.3%) in both pre and post-test conditions (see figures 8.28 and 8.29). Of these
40% were in the category family/friends who had experienced more than one problem (see Figure 8.30). In terms of providing assistance pre and post indications of 63% and 57% showed some form of assistance by their family member or friend (see Figures 8.36 and 8.37). However, there appears to be a dramatic change of opinion for the ‘don’t know’ response from pre test (1.4%) to post-test (35.7%).

*Figures 8.28 and 8.29.* Has anyone in your family had a problem similar to John/Jenny?
Figure 8.30. How many experienced a problem?

Figures 8.31 and 8.32. Did you do anything to help this person?
8.2.7. Perceptions of university support

The following results pertain to the level of perceived support those respondents feel to have come from three sources: university teaching staff, university counselling and other university students. Figure 8.33 reveals 43.3% (pre) and 45.2% (post) of respondents agreed that university teaching staff provided effective support (‘very well’ and ‘well’). This compares to 59.7% (pre) and 59.7% (post) of them indicating effective support from university counselling and 31.3% (pre) and 29.5% (post) indicating effective support from students. Large ‘don’t know’ responses were recorded against this question relative to university teaching staff (29.9% and 30.6%), university counselling (32.8% and 29%), and other university students (37.3% and 34.4%).

![Figure 8.33. How well do these people support those with mental health problems?](image)

Further measures relating to how respondents perceive the support being provided to others with mental health problems (students and staff) have been
collected. These responses should be viewed in the context of 97.3% of respondents being students, with only 2.7% being staff members. The majority of respondents (58.2%) intimated the university provided effective support to students with mental health problems. This percentage was lower (23.9%) for the perceived effective support being provided to staff (see Figure 8.34).

![Figure 8.34. How well does the university support those with mental health problems?](image)

### 8.2.8. Measures of psychological distress - Kessler 10

The data retrieved from the completed Kessler 10 (N=74) were analysed using a paired t-test to determine whether the level of psychological distress was statistically significant between the pre and post-test conditions. The individual results from the Kessler 10 are depicted in Figure 8.35. The results from the t-test were not significant (t=1.238, df=55, p=0.221) (see Tables 8.2, 8.3 and 8.4).
Table 8.2

Results of paired data (74 people)

<table>
<thead>
<tr>
<th></th>
<th>Pre test</th>
<th>Post test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>25.88</td>
<td>25.80</td>
</tr>
<tr>
<td>SD</td>
<td>9.56</td>
<td>10.42</td>
</tr>
<tr>
<td>Median</td>
<td>26</td>
<td>27</td>
</tr>
<tr>
<td>Minimum</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Maximum</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Missing</td>
<td>6</td>
<td>13</td>
</tr>
</tbody>
</table>

Table 8.3

Results for paired t-test (56 people)

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<thead>
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</thead>
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<tr>
<td>Mean</td>
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<td>25.89</td>
</tr>
<tr>
<td>SD</td>
<td>9.43</td>
<td>10.62</td>
</tr>
<tr>
<td>Median</td>
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<td></td>
</tr>
<tr>
<td>Minimum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>18</td>
<td>18</td>
</tr>
</tbody>
</table>

Figure 8.35. Kessler 10 results (N=74) – pre and post.
Table 8.4

*Kessler 10 categories*

<table>
<thead>
<tr>
<th></th>
<th>Pre test</th>
<th>Post test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Likely to be well</td>
<td>22</td>
<td>29.7</td>
</tr>
<tr>
<td>Likely to have a mild disorder</td>
<td>10</td>
<td>13.5</td>
</tr>
<tr>
<td>Likely to have a moderate disorder</td>
<td>12</td>
<td>16.2</td>
</tr>
<tr>
<td>Likely to have a severe disorder</td>
<td>24</td>
<td>32.4</td>
</tr>
<tr>
<td>Missing</td>
<td>6</td>
<td>8.1</td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
<td>100</td>
</tr>
</tbody>
</table>

The final chapter of this thesis, chapter nine, will discuss a detailed overview of the study results and outline the limitations of this thesis. Thus each aspect of the results, including phase one’s unexpected low response rate and phase two’s individual elements, will be discussed. This chapter will also interpret the data so as to provide a series of recommendations for universities to review and improve their coordination of student support services.
Chapter Nine

Discussion, Limitations, Recommendations and Implications

It is clear from the research that university students experience a range of difficulties both related to university study and their personal life. How much these two factors interact with each other and subsequently impact on the student’s ability to learn/achieve academic success has been the subject of much debate (Reavley et al., 2010; Smith & Shochet, 2011; Stallman et al., 2008, 2011). This thesis asked, in addition to previous research, questions relating to the provision of support services, do students have their needs effectively identified and subsequently access the appropriate services to meet these needs?

This chapter discusses the results of the research. In order for sequential analysis and understanding of the findings, this chapter will comprise the following structure: discussion of phases one and two individually; limitations of the study; recommendations and implications of the research. The chapter concludes with a reconceptualisation, based on the recommendations of the manner in which universities can utilise data corresponding to support services, student demographics and outcomes to identify student need best and thus monitor, plan, and develop sustainable support systems.

9.1. Discussion - Phase One

The phase one discussion examines the results answering the designated research questions (see chapter one). Those pertaining to phase one of this thesis are:

1. What are the current student support services provided by Australian universities?
2. What is the engagement and utilisation experience of a university student accessing support services?

3. What are the basic student demographics accessing each of the identified student support services?

Phase one reviewed eight Australian universities that had been benchmarked against each other, focusing in part on the provision of support services in line with national legislative requirements. The review required university support services to provide details of students, including demographics, who had accessed their services and the types of services they received. This aspect of the current study aimed to profile the support being provided and who was accessing these services.

Upon completion of phase one, and as reflected in the results, the survey response rate was found to be very low to the point where no specific data were able to be collected in order to provide the proposed overview for the research questions. When reviewing this response rate a number of reasons have been discussed for the services not being able to provide the requested data or unwilling to.

In the first instance it was discovered that, when phase one commenced, there was no central data repository where a single request could be made for information that pertains specifically to all support services. This situation was unlike that extant in other large organisations providing support services. Secondly, there appears to be no organisational requirement for student support services to collect and generate reports of comprehensive data sets beyond basic demographics, or to report this data to a central body. These issues subsequently meant that the collection of the research data required from each of the identified and individual services could not be completed.
When the survey was chosen it was envisaged, on the information available, that most of the responses needed would have been obtainable from the identified support services. It was not anticipated that the specific and unique information from these services could not have been elicited by the research survey. However, not even basic information about student demographics could be provided. The reasons for this warrant further exploration and explanation. It is suggested that a lack of time for extraction of information from existing data bases to provide the requested data was a cause. Perhaps the data collection systems themselves were deficient, or the sheer load of surveys and reporting that service centres manage within higher education in Australia were to be faulted. But anecdotal evidence from follow-up phone contacts with services suggest lack of responses is due to a combination data collection deficiencies by the services themselves and the high demands of workload.

Different support services appear to collect data that is particular to their own service; however, it is unclear how or if these data are used for evaluation purposes. It is also unclear whether or not this information is analysed and subsequently employed at either the local service level or at the broader university level for planning purposes. These issues will be further addressed in the later stages of this chapter in the form of suggested recommendations and models designed to inform an improved, comprehensive data collection process.

This lack of centralised data collection, analysis and management could mean a wealth of data relating to student demographics, student experiences, help-seeking behaviours, and support outcomes is either not being collected or, if collected, not being utilised by central or local administrations to inform student support service management.
Feedback from service managers indicated they were unaware of the manner in which they should generate reports from data collected for each particular service. The reasons for this were outside of the scope of the current research questions and aims; however, some interesting enquiries about how universities regulate and monitor student support operations are provoked. If the anecdotal information is correct and service managers and coordinators are not adequately supported with data bases and data management processes, the support services are potentially being underutilised, thereby impacting on the ability for university administration to make evidence-based decisions regarding form, function and sustainability of support services. Accurate data is clearly an integral part of decision making (Hoadley, Jorgensen, Masters, Tuma, & Wulff, 2010; Niles, 2010) with current service modelling, especially that within health, drawing, upon data to ensure that support services using limited resources are being designed and operated in the most efficient and effective manner.

Another possible explanation could be the request for data itself not being a priority for the managers of the individually targeted services. This may be due to such an activity not being a part of their core business. Alternatively, it may have been as a result of this request coming from a researcher and not from central university administration. Essentially, due to the individual nature of each university and their unique reporting structures, variations were present as to who was required to interrogate existing data and subsequently produce reports.

One final consideration was that the use of electronic surveys might have impacted on response rates; thus on reflection results may have varied if survey interviews were conducted face-to-face. One contributing factor could have been the restriction of finances necessary to purchase interviewer time for face-to-face
interviews. This particular method for surveying and data collection was beyond the scope and aims of this current study.

9.1.1. Purpose and use of existing university data

A review of the Institutional Performance Portfolio, a published set of data universities produce annually, reveals a substantial quantity of information relating to student demographics and satisfaction within a particular university and its service to students. This data appears generally to relate to teaching associated activities, that is, student satisfaction pertaining to teaching quality and course satisfaction. However, there are no sets of data relating to the specific outcomes and/or effectiveness of support services provided.

Moreover, current outcome measures are in a format specific to the satisfaction of students in relation to teaching and learning only. It would appear that satisfaction surveys are not a useful measure of service provision, effectiveness and outcomes alone. It may be prudent to investigate other ways in which effectiveness data can be collected in conjunction with satisfaction. If services were to garner effectiveness measures beyond student satisfaction this could enhance decision-making processes for other facets of university business, such as support services, the focus of this thesis. An example of an alternative outcome measure, the Kessler 10, as outlined in phase two of this thesis, could be useful for some support services, i.e. counselling, to utilise in determining effectiveness and outcomes.

Available information suggests there to be trends towards collecting data in universities concerning two main areas. The first is the collection of student demographics, such as age, gender, and ethnicity. These can be seen as distinct data sets formed as a part of the ‘Institutional Performance Portfolio’ developed by the Australian Government Department of Education in conjunction with Universities
Australia. The second information type, also collected, is concerned with the measurement of student satisfaction; this is also reflected in key performance indicators collected as a part of the Portfolio. This may disclose the usefulness of these two measures in ascertaining the performance of some aspects of university business. The effectiveness of student support services provided within the university setting is directly related to the focus of this thesis.

The demographic information may certainly be a useful measure to ascertain who is accessing the service provisions of a university, at present this measurement is not refined enough for measuring the utilisation of support services. Currently, these measurements are collected at the university-wide level as a necessary part of a global reporting function; there does not appear to be any ability to extract this data at a support provision level. Due to the lack of specificity of data being collected from support service providers, there appears to be no ability to measure the service provided to a student who comes with a specific need, for example, financial difficulty, homelessness, mental health issues, to have concerns met.

It could therefore be postulated that a specific set of outcome measures need to be developed specifically to ascertain the effectiveness of student support services. Such a set of measures could help to indicate whether or not the student left the service satisfied, and also record that some tangible outcome has been achieved. This concept and further development of related measures will be discussed further in a later section of this chapter parallel with an explication of models and possible future services development. Such measurements may allow universities to not only view the effectiveness of their internal support systems, but also emphasise areas of specific need.
9.2. Discussion- Phase Two

The phase two discussion examines the data related to the designated research questions (see chapter one). These questions are:

4. What is the current student experience as measured by a help-seeking questionnaire?

5. What is the current student experience as measured by the Kessler 10?

6. How much does attendance at university support services affect psychological distress in students?

In addition to a clearer understanding of what universities provide, the types of students who access them, and how this fits with national legislation, the interaction between students and these services was examined with a specific focus on whether or not universities are having an influence on levels of psychological distress. As previously discussed (see chapters four and five), there is an established interaction between how a student experiences distress and the ability to learn; however, what is not clear is the manner of their being identified then provided with appropriate referral pathways. Separate to university processes that provide support pathways, the student appears to be influenced by the manner of identification of needs (see Maslow’s Hierarchy of Needs), the attribution of priority to the required intervention (see the Health Belief Model), and the ability of a student to access a support service as it is related to their ability to identify and prioritise needs.

The composition of this section of the chapter will follow the format previously used to articulate the results for phase two of this investigation. The subheadings therefore are replicated for the results and the discussions, which follow.
9.2.1. Student demographics

When reviewing the current results of this thesis, the age distribution of respondents indicates that the highest percentage of them are from the younger age domains (18 to 24), with the middle domains (25 to 44) are represented at a lower rate. As expected, the majority of respondents are from undergraduate courses, studying full-time and either not working or working part-time. The research sample comprised females predominantly; they represent higher percentage of students in universities today, so this over-representation must be considered when analysing or discussing the data of this current study. In addition, further consideration of the future development of support services outlines the need for service planners to be cognisant of specific cohorts. It is clear that from literature (Furnham et al., 2011; Reavley, 2010), specifically relating to health and mental health, and help-seeking behaviour between the genders, that females are more likely to be able to understand and respond to the needs of other persons and themselves when compared with males. Further research is required to examine how males at universities are overcoming the management of psychological distress, identification of needs, and help-seeking behaviour. This was difficult to determine due to the research cohort having an under-representation of this gender. Additional research and investigation into males and their help-seeking behaviour within university settings would provide specific understanding on how to engage with and provide services for male students.

Knowing that an over-representation of female students in the cohort raises dilemmas. It is known that females are more likely to access appropriate health services when compared with males (Galdas et al., 2005), but does this apply to accessing university services in general? Data achieved from this thesis, reveals
females to be more likely to access support services: therefore the design or evaluation of services must address the engaging of males in discussion, design and implementation.

In addition to gender, the research literature indicates that finances are also a clear factor in the levels of stress and distress of students at universities (Falahati & Paim, 2012). Students need to have financial support from family, a scholarship, or satisfying work to fund the various aspects of university engagement. Therefore there is delineation between the time that a student can allocate for studying and class attendance and when comparing a student who does not need to work.

According to this thesis, 43% of respondents to the phase two survey indicated that they were not working and 4.1% working fulltime. Does this mean that these students have financial supports from other sources such as, family, partners, or scholarships? Or is it simply a case that students who did not have work commitments in addition to university study did not have time to reply to this survey or, due to being off campus more frequently, did not know about the survey. Further investigation is warranted therefore to understand the manner of funding adopted for participation at university, and what, if any, is the impact of a student’s financial status and could the latter impact on the level of psychological distress? It would also be prudent to ensure that as we develop further support services we are able to capture all students by taking into consideration that many students are not on campus during regular business hours. This includes the manner in which researchers advertise, attract, and reach research participants.

Undergraduate students clearly make up the majority of university students; the results from this thesis are consistent with this. The majority were undergraduate students, within their first three years of study, female and not working.
Consideration has to be given to the impact on the types of services that must be provided for any particular cohort of students. Whenever an organisation conceptualises the provision of needs of students and the accompanying legislation, it generally ensures services match the majority cohort. For students experiencing difficulties this could be problematic, as generally they do not fit into the majority cohort. Often they are working to support themselves, living away from family and/or community supports, or living far from the campus at which they are studying.

Service design at universities needs to consider the fact that many students access the campus after hours for late lectures and tutorials, or to study at the library. As with the broader community, most services function with a typical operational structure, for example, opening hours are from 9am to 5pm, thus being closed when a certain cohort students are on campus.

Efforts to support students have already begun in many Australian universities, for example, the ‘first year experience’ program (Mills, Heyworth, Rosenwax, Carr, & Rosenberg, 2008). Such programs offer a range of services within the university context to ensure that first year students attend. The preceding discussion reinforces the need for student support services to define their population clearly by collecting relevant and real time data in the form of key performance indicators, advice supported by the results achieved in phase one of this thesis.

If comprehensive information is collected, then not only the majority of students will be identified and their needs serviced, but specific minority cohorts may also be understood and services redesigned or modified to meet their needs. As indicated in the phase one discussion, services being required for discrete populations or issues may not be delivered within the university setting, but could be brokered from the broader community. Without accurate information to indicate
service needs of discrete populations employing key performance indicators, these students may never have their needs met or only partially met from internal support services. This result may not be the intent or be due to the quality of internal support services being provided, but rather that services in the wider community offer specific assistance or programs that may be more appealing or appropriate.

Results relating to student demographics specifically 'students looking for work', require us to consider whether a correlation exists between the percentages of students studying fulltime and those looking for work. This possibility becomes important when consideration is given to the offering and promoting of services to students studying at university. For example, if a student is working fulltime and studying part time their availability to access services may be more limited when compared to a student who is not working.

In addition further consideration must be given to the manner in which students look for work, and whether the university provides any support, especially for those students who are not familiar with the opportunities existing in their current area of residence. This may be especially true of students who are new to the locale or those who have moved to a university from a rural setting, and/or international students. Rural and international students may experience more difficulties finding work than local students who may be more familiar with employment opportunities. Further investigation needs to consider whether this could be a factor contributing to the levels of distress of certain university students.

In order to facilitate investigation into this phenomenon, specific data must be collected to inform about possible correlations between work and study, particularly students who access support services. Simple indicators of working status may be collected by support services to highlight the profile of student working patterns. It
may be useful to have an understanding of how these differ across support services in order to target needs.

9.2.2. Help-seeking behaviour - Recognition of mental health problems

The results of this thesis indicate that 70% of participants are willing to seek help including both self-management and professional assistance. This may imply that, given the right environment and the right availability to access services, a coordinated approach to service provision within a university environment would be successful. This is most likely because this is a more educated cohort and as a result has better help-seeking behaviours.

It is noteworthy that, although 70% of study cohort would be willing to seek help, there is no indication or results obtained that specifically measure how many of this percentage are actually seeking help. This highlights the need for more comprehensive and specific support service data to provide university administrators with information relating to actual student help-seeking and thus where to target programs or services.

Given the opportunity and the availability based on this sample, students appear to have positive perceptions relating to help-seeking behaviour. When designing and marketing services, consideration needs to be given to the ‘health belief model’ which ensures university administrators are armed with relevant information concerning the seeking of help and how this may facilitate a student presentation to a support service. Other concerns raised by the model include questioning whether more consideration should be given to marketing access and pathways to these services both internally and externally; and does promotion need to ensure students to have the required knowledge for prioritising health problems,
and the seeking of clear support pathways before initiating action towards help-seeking.

9.2.3. Beliefs about interventions

Consistent with the literature on where people are most likely to access help (Harryba, Guilfoyle & Knight, 2012), this research cohort identified family and friend, partners and their general practitioner as appropriate sources of assistance. This finding will need to be taken into consideration when designing student services; for example, mentoring and peer approaches may need to be considered as a priority program within a support service matrix. This tactic should increase the likelihood of students accessing help, including professional services, as a consequence of information and knowledge gained from peer/mentoring options.

This aspect of the results will be essential to review and expand further when thinking about how university services for students are designed and delivered. Clearly university administration/support services will need to be cognisant of what students identify as their primary sources of support and target these sources as potential pathways into their own services. That is, if students seek assistance firstly from friends, then mentoring programs will need to be specifically developed to identify an array of student issues and assist to direct them into the appropriate services.

This investigation suggests that students consider health professionals as generally helpful in both the pre test and post test conditions; however, whether this translates to actual help-seeking or health seeking behaviour is problematic. Even with a level of willingness, if effective and clearly defined pathways are not available to students then they will simply not know what action to take. The results suggest that the will is present, students having a positive view of most health professionals.
Further testing should be conducted to ensure students are aware of how and from whom to seek help.

In this context the importance of ensuring appropriate training for academic and general staff becomes necessary. In the pre test academics, as a source of help, were indicated to be less likely to be approached as avenues of help when compared with other sources of need resolution; however the likelihood of accessing an academic dramatically increased post-test. This could be an indication that by simply making students aware they can approach academic and general staff for appropriate support and referral would increase the likelihood of this avenue being utilised.

In addition to the academic staff being identified as a less likely source of support, drug and alcohol services were also not accepted as frequent source of assistance. It is possible that the stigma and shame relating to the accessing of such services comes into play. Students' insight into the problems associated with drug or alcohol abuse, seeing themselves as a weak or negative stereotype when compared to student peers. The consequence could be that affected university students do not access traditional health services for drug and alcohol treatment. As with various other aspects of help-seeking found by this thesis, it may simply be the case that students require additional health education and promotion about issues relating to drug and alcohol abuse, where to seek help comfortably, and the guarantee of confidentiality.

Students seeking information and assistance are indicated by this thesis cohort to seek online assistance minimally. Several prior studies have informed that students prefer the face-to-face approach and as they find on-line services isolating and generally not meeting their needs (Hachey et al., 2013). Universities need to
ensure that they understand the level of confidence students have regarding online sources and how they utilise such sites. Does this mean that the research relating to the implementation of online supports may in fact not work given that students prefer face-to-face contacts? The issue of the provision of online services needs to be left open as an option when considering the current findings, which infer students may not always be able to access face-to-face services due to work, part-time study, and other external commitments which restrict their access to services operating within normal business hours.

Of particular note was the fact that in both pre and post test conditions only online sources of information and e-based help were identified as harmful. In the current cultural climate, where social media and online services are a predominant source of interaction, mostly for the younger students, this result is surprising. Some literature suggests students still wish to seek face-to-face sources of help (Hachey et al., 2013), and that they potentially understand the inherent dangers of online information sources, namely their lack of reliability coupled with the predatory nature of some individuals and services. This result may be an indication to universities and their support services to investigate this matter further the benefits (or not) of developing online resources or support programs with their own student populations.

Interestingly, the respondents attested that it would be harmful for the persons in the vignettes to deal with the issues on their own. This may be an indicator of positive help-seeking and health behaviour in that the study’s respondents have a strong level of health literacy and capacity to identify ways in which these issues are best managed. This would allow universities to develop support services to promote and reinforce the existing behaviours of students further. However, further investigation would ascertain exactly what knowledge
students have relating to help-seeking or health seeking behaviours and whether or not they can translate this into actual behaviour in accessing health services.

It would not be prudent to assume that results and findings similar to those outlined in this thesis would automatically indicate help-seeking behaviour, given the nature of the health belief model and the manner in which a student may attribute priority to particular issues. This matter should be individually targeted through a coordinated care approach. However, if students are not seeing university support services as effective, or as too complicated to navigate in an already limited time frame, then thought will not be translated into actual help-seeking behaviour.

The post-test results for the question relating to whether or not a student considers self-management as helpful or harmful showed a slight reduction in the perception of being harmful. Possibly the student experience when seeking assistance from a university support service was the cause of this result. The difference was not significant; however, more detailed investigation is warranted of student views on several matters: what universities provide as support; what they think about service coordination; and how effective they believe these services will be in assisting them to manage their issues. Effectiveness measures would need to be introduced to ensure that we can quantify and qualify the value of the services that we are providing, the measures that will provide more detail than the current satisfaction levels, and the measures currently sought by the university administration.

Respondents in the evaluated research cohort signalled that self-management was an avenue that should be explored prior to accessing professional health services, even though in another aspect of this thesis they indicated it would be harmful for the persons in the vignettes to do the opposite. This warrants further
investigation to ascertain whether this is a negative help or health seeking behaviour issue; or whether the respondents were educated in ways in which to manage their health issues outside seeking professional help. Primarily respondents showed across several domains of this survey that the use of self-management, for example, vitamins, exercise, massage, meditation, before accessing medical (prescribed medication) or health professional support (counselling) was the first avenue taken. The disparity between what students reported they would initiate themselves and what they thought would be beneficial for others creates an interesting dilemma. The question arises: How would a university support service not only promote positive help and health seeking behaviour in students, without overriding the obvious indicator that students seek to resolve the issues themselves?

The results regarding self-management and alternatives to professional help allow a greater insight into the health promoting and help-seeking behaviours of university students. Respondents exhibited strong responses to health promoting activities like exercise, meditation and relaxation, all skills essential in the management of stress and distress. However, these students did indicate a negative response to more psychiatric interventions like medication and hospitalisation. This presents a challenge for the promotion of mental health services and interventions. Students in this cohort, like the general population, may hold negative stereotypes of what mental health does and what happens when someone becomes unwell.

The negative attitudes of students towards certain health services are possibly caused by incorrect information about effective health treatment measures like the use of psychiatric medication and anti-depressants, this needing to be explored further. The available services appear to be seen by most students as worthwhile; however other medications such as anti-psychotics are seen as harmful.
The reason may be due to the comprehensive health promotion activity carried out over the past decade for depression when compared to the more limited health promotion activities relating to psychosis. Universities must promote psychiatric services, including mental illness and appropriate treatment, in similar fashion to the attention paid to more prevalent disorders such as depression. Depression occurrences are significantly higher than psychosis; thus it is not surprising universities invest their time and finances in the direction of the more common disorders revealed by students.

It is essential for all university support services, both medical and psychological, to ensure these are linked with recreation and social services providing adjunctive support to students who would benefit from exercise, dietary improvements, and meditation. Such university services would need to ensure a balanced approach to health improvements and support pathways by designing the relevant matrices of equal and linked opportunities for students to receive medical and psychiatric options, counselling or general supports, and recreational and social support. Essentially a holistic program should be provided.

To understand the actual behaviour of students when assessing health threats would be an important piece of additional research to increase the understanding of how students view university support services, attribute priority to various health difficulties, understand from whom to seek assistance, and foretell how universities could use this information to distribute resources into promotion, prevention and intervention activities.

9.2.4. Stigmatising attitudes and social distance

Results from this thesis suggest that students perceive mental health services and interventions as positive; students in the research cohort do not envisage
persons with mental illnesses as being dangerous, which is not case for the general population. The widely held belief that people with mental illness are dangerous has been carefully targeted by health promotion activities and campaigns, especially those persons with a diagnosed psychotic illness (Rusch, Corrigan, Heekeren et al., 2014).

The extent to which this remains an issue in the process of help-seeking is not clear, but warrants further investigation to minimise the widespread fear of approaching or interacting with people with mental health issues, for example, within a mentoring programs or academics within classrooms, leads to the lack of motivation to support such students, thus the tendency to refer on unnecessarily leaving the student to their own devices believing that pastoral care is not a part of their role.

The results derived in this research show that even though participants’ thought persons with a mental illness were unpredictable, most would be willing to study or work with them. The sub-text reveals however that the respondents would tend to be more hesitant to initiate contact in more intimate, social settings. This observation supports the necessity of ensuring a coordinated approach between health and counselling services, and the recreational and social services to ensure that those students experiencing mental health problems or illnesses receive the widest spread of services. It would also be beneficial if promotion campaigns ensured that myths regarding mental illness are challenged with meaningful and accurate information, and affirm that health promotion is a key component of any support service intent.
9.2.5. Exposure to mental disorders

When the respondents were asked whether they had similar issues to the persons in the vignettes in the past 12 months, the overwhelming majority (80.9%) in the pre test answered positively; however the post test figure, though still high, reduced by nearly 10% (70.3%). This may have been due to the time periods pre and post being 12 months apart. Further possible influences could simply be due to the respondents being better able to label, define or identify issues. Essentially the students’ understanding of mental health had improved enabling a reassessment of priorities related to their exposure to the vignette at the time of the survey; that is, proxy learning of what might be a mental health problem.

The most recent evidence relating to the prevalence of depression and anxiety amongst university students (Bitsika et al., 2012; Hamdan-Mansour et al., 2009) supported the current results that indicated these were the most common issues confronted. Further examination would be warranted to understand how these two disorders interact within the university environment, independently and as comorbid conditions, especially at such times of the academic calendar as examination and assessment periods.

Although there is extensive literature on the prevalence and impact of depression and anxiety disorders, exact knowledge about how these present within the university environment and subsequently impact on tertiary education outcomes, such as retention, is yet to be fully explored (Bitsika et al., 2012; Hamdan-Mansour et al., 2009). Current data collection in university settings are insufficient to determine extent of the prevalence and its impact on an individual university. Further, due to this lack of information and the lack of effectiveness measures, impact was unable to be determined. The question therefore remains, how can
programs be designed and implemented that are targeted effectively to identify students with depression and anxiety disorders in the absence of data.

Positive information was received from more than three quarters of respondents who indicated they had commenced an intervention after identifying their need for a particular assistance. The general willingness of students to access services places universities in an advantageous position in that if they are able to determine effective pathways the majority of students would access support; however measures to ensure evaluation and understanding of effectiveness must be implemented.

In addition to the previous discussion about self-management the opinions declaring a high level of positive and healthy strategies sought by students, other results have also shown students would use alcohol as a way to cope with mental health problems. Indications are that 20% of study participants would use alcohol to self-medicate and self-manage their own issues, and that 20% of respondents are trying to cut down on alcohol use. The study parameters meant the researcher could not determine the extent to which this is the same group. If it is the same group, this suggests they consider their use of alcohol unhealthy and needing to be reduced. Members of the study cohort may indeed have a high level of health knowledge, motivation, and possible attribution of priority when dealing with what is perceived as an unhealthy behaviour. This level of participant knowledge, if accurate, may highlight the importance of ensuring that services understand and utilise the health belief model and Maslow’s hierarchy of needs to underpin planning and design of support services.
9.2.6. Mental health first aid actions

The results relating to the willingness of respondents to provide assistance to others is encouraging with possible first aid actions being taken or proposed to be taken by university students. This reveals the majority of students are willing to assist others and could provide universities with an evidence-based platform from which to launch initiatives like Mental Health First Aid, comprehensive peer mentoring, or Act Belong Commit. The presence of mental health literacy or at the very least a willingness to become involved in the support process of others is suggested.

Data pertaining to the ‘don’t know’ response for ‘did you do anything to help this person’ increased dramatically from 26.1% to 35.7%. Possibly the respondents were unsure, lacking the knowledge of interventions available, and making a value judgment regarding these. Further exploration should be implemented related to value judgement formulation in this regard and how it operates as an influence on first aid actions.

9.2.7. Perceptions of university support

There appears to be an indication that whilst university students are willing to access help, the identification of help being the university counselling service is low. Perhaps the service should be more widely promoted; it would thereby be less of a stigma when attending counselling. Possibly students simply do not understand counselling is a confidential service having no impact on their classroom grades. Additional positives are it is free and therefore affordable, and can be accessed across multiple campuses. Another explanation may be that due to heavy demands on counselling services students automatically discount this initiative as a viable option. If indeed perception and reality intersect, due to the demand on services
universities are not able to provide sufficiently, prudent partnerships should be made with external service providers. Without data to support demand and acuity for such services it would be difficult to predict which services should enter into partnerships. The concept of acuity in terms of psychological distress will be discussed in relation to results regarding the Kessler 10 later in this chapter.

It would be also beneficial to examine how staff, both academic and general, promote the use of services to students, or even if they promote services at all. Given the amount of time that students spend in classroom and with the various schools and associated staff such as clinical supervisors, this time could become a source of positive health promotion a small amount of information being delivered gradually and consistently thereby having a significant impact on improving individuals’ help-seeking behaviour and associated health literacy.

Consistent throughout this thesis has been the identification of academic staff as being one of the least likely sources of help. This study indicates academic staff as being less desirable sources of help compared to the other listed sources. This phenomenon needs to be investigated further, including the reasons for this circumstance, especially given the fact that academics have the greatest level of contact with students who may need assistance. When reviewing the service provision model in the university, the abilities and acceptance of academics should be the primary focus. At the outset they should be given additional training in the management of students with mental health, general health or social issues and awareness raising. Any interaction of a staff member with a student should not conflict with their role or with the role of a support service designated to address a specific student issue. At most universities all staff attend an induction when they
first commence; however beyond this initial attendance, workshops that relate to the issues being discussed are offered and attended on a voluntary basis.

The potential message to students that a range of support options is, available and that academics can be one such source must be considered. Students therefore: (a) need to understand that support does not just mean counselling, and, (b) accept that fear of negative responses from staff is unfounded. Such a positive development would have desirable consequences for small campuses where student support services are not available or are limited. It would also reinforce the notion that the first point of contact should be the point of access.

9.2.8. Measures of psychological distress - Kessler 10

The Kessler 10 profile contends that students are experiencing a range of psychological distress with the highest experiences indicated on the items for ‘tired out’ ‘nervous’ ‘restless’ ‘depressed’ ‘hopeless’ and ‘everything an effort’. This profile suggests that students experience levels of psychological distress whilst attending university, possibly indicating the presence of problems like burnout or acute stress. If so, what does this instrument propose regarding the experience of students, especially the results pointing to moderate to high degrees of psychological distress? Respondents’ final Kessler 10 scores reveal they are likely to have a disorder from mild (13.5%), moderate (16.2%) to severe (32.4%) levels of distress. Evidence of this nature provides a rationale emphasising the importance of conducting further investigations into the prevalence of psychological distress in university populations, and the need to review support services provision, and how effective they are in managing and reducing psychological distress. Thus the use of outcomes measures to identify prevalence and severity are validated, and the usefulness of understanding the effectiveness of particular interventions.
There was no variance in the two means pre and post for the Kessler 10 responses, suggesting that, between the two time series assessed, the level of distress did not change. It is important to consider why this may have been the case. Is it because the university services are not equipped to cope with this level of acuity, or a lack of options for referrals to external services if internal services are not able to respond? Or is it because these students are not being identified and/or directed to the most appropriate services to meet their levels of acuity through considered and coordinated clinical pathways. As the phase one discussion has indicated, universities do not collect data that could assist in the determination of the actual prevalence and acuity of psychological distress, and effectiveness of current support services to provide interventions to reduce such levels of distress.

These results are generalised across the general university population and not specific to any particular support service as this was not within the scope of the current study. However, it would be useful to measure levels of psychological distress in different support services in order to ascertain whether levels of frequency and acuity differ according to the types of needs students present. Collection of such data would allow a university to understand the levels and frequency of distress experienced by students accessing services. Maslow’s description of lower order needs such as finance or housing, as opposed to higher order needs such as education support require attention. The employment of such a measure should allow university planners to target specific student needs.

Such measurements, which include an indicator of the level of severity, may assist the understanding of the type of support services that must be provided internally as outlined in the discussion concerning ‘perceptions of university support’.
The need to consider future links with external support agencies/services is necessary.

9.3. Limitations of the Study

Three main limitations were identified requiring consideration when a review of the results and implications of this thesis. Each is listed below along with an explanation of how these issues were mitigated within the methodology.

9.3.1. Phase one of this thesis lacked the results expected with only four out of the 64 support services providing any data relating to the questions asked. Attempts were made by the researcher on two occasions to elicit this information. On the first occasion email was utilised with a follow-up phone call. Both of these attempts are outlined in the method section of this thesis. This limitation emerged during the study’s live phase and was not predicted, because this survey had been employed previously with similar student populations. Appropriate results were achieved then, so the expectation was that the current use of the instrument would elicit the same results from student support services.

9.3.2. The response rates for the participants for phase two of the study was significantly higher from Edith Cowan University than Deakin University. The cause of this difference in response rates remains unknown, even when efforts were made in construction of the study method to mitigate any potential bias at the principal investigator’s home university. The latter was achieved by utilising third parties to promote and distribute survey materials, those third parties being the Student Support Services Centre staff, who employed separately from the researcher’s immediate work area. In addition, in order to ensure no favour was given to any particular support service at any one university, the principal investigator visited the support services on all participating university sites on the
same number of occasions and afforded equal amounts of time to educate and promote the study with those service providers. This entailed travel to Deakin University and Edith Cowan University, a diary of visits and length of meetings being kept throughout the study to establish parity, and as a reference point because the study was conducted over four years.

**9.3.3. The response rate in phase two was lower than anticipated in the pre and post-test situations.** Measures were undertaken as explained in the above response to 9.2.2 to promote and distribute the survey through student support services at all participating university sites. Further promotion would have led to the distribution and collection period being outside the six-month (one semester) period as specified in method of this thesis.

**9.4. Recommendations**

This section will integrate the discussion analysis from phases one and two of this thesis into a set of recommendations that should be considered when progressing the idea of reforming student support services within a university setting. It is purposely divided into three distinct aspects thereby reflecting facets of service delivery and service design. These three aspects are: ‘function’, ‘form’, and ‘sustainability’; recommendations have been separated accordingly.

**9.4.1. Function**

In the context of this set of recommendations the aspect of function is concerned with the way in which support services are provided to students within a university setting.
9.4.1.1. Support service coordination

**Recommendation 1**

There needs to be some consideration of student support through service coordination between internal and external support services. This is particularly relevant to current global and local financial pressures as organisations such as universities seek ways in which they can be more efficient and effective with the resources they have. Partnerships with external support services may enhance the economies of scale needed to provide successful outcomes with limited resources. In order to evaluate the development of internal-external partnerships it would be useful to consider key performance indicators as one measurement tool.

**Recommendation 2**

Discussion needs to occur in regard to the coordination of student support services, especially within universities with offerings spanning several campuses inclusive of rural locations, and how support to these campuses may differ from support required for metropolitan campuses.
9.4.1.2. Support service operating hours

**Recommendation 3**

It would be prudent to review university support services operating hours as currently they are designed using a normal business week structure, that is, Monday to Friday, 9am to 5pm operating hours). Consideration of the students, who cannot access during this time due to work or family commitments, must be made. This would help to provide greater equity of access to support services for all students at university regardless of their family, personal or work commitments.

9.4.1.3. Gender issues

**Recommendation 4**

It is a recommendation from this thesis that further research is conducted to understand better the specific gender-related issues that may influence female and male university students' perspectives on health (including mental health), their experience of psychological distress, and their help-seeking behaviour. This could be contemplated as part of an orientation process of students to their first year at university. For example, this not only establishes the criticality of health and wellbeing from the initial stages of student engagement with the university, but also allows the university to gain an understanding of its students and their needs from day one.
9.4.1.4. Student study modes

**Recommendations 5**

When developing student support services in particular during the consultation phase with consumers (i.e., students) specific questions must be asked regarding the needs of students who study in full-time or part-time modalities. This enables an exploration of the different needs for these two student cohorts (see Recommendation 3).

9.4.2. Form

In the context of this set of recommendations the aspect of form is concerned with the way in which support services are afforded a framework and mechanisms by which they can be administered, measured, evaluated and planned.

9.4.2.1. Support service design

**Recommendation 6**

Students should be an integral part of any future support service design and consultation process. The study indicates students are willing to seek help; therefore a more insightful understanding of how and why they seek help may enhance access.
Recommendation 7
During the design and evaluation processes that need to be embedded within university support services further exploration needs to concentrate on student attitudes towards counselling and academic staff. This could increase a student’s likelihood of seeking support from these groups. This must include the examination of the advice that academic staff will give to students regarding where to go for help.

9.4.2.2. Service design matrix

Recommendation 8
In order to simplify and provide consistency in advice and information given to students, the development of a matrix or template for staff to identify the issues and a clear referral pathway is needed. Maslow’s Hierarchy of Needs can provide the conceptual framework for the development of such a template; the aim being to facilitate the effective identification of need and associated service provision in order of priority. Through the use of the different levels of needs, staff can assist a student identify what level requires the highest priority, and then attribute appropriate intervention.

Recommendation 9
Any training, formulation of policy, and matrices developed need to sit centrally within the university to facilitate continuous monitoring, evaluation, and management to prevent drift that may occur if this process was to be managed within individual faculties or schools.
### 9.4.2.3. Referral pathways

**Recommendation 10**

A university must develop appropriate referral pathways for mental health treatment options in the event students require assistance for more acute mental health issues as well as a more generalised focus on promotion and prevention with such activities as sports and social clubs, spiritual/religious groups, or self-help groups.

**Recommendation 11**

The development of targeted pathways according to student need should be developed with the aid of the use of information gathered to identify specific need, that is, the collection of key performance indicators identifying unmet needs.

### 9.4.2.4. Measurement of psychological distress

**Recommendation 12**

There needs to be continuation of the Kessler 10 component of the current study to examine the levels of psychological distress and the use of data to inform service response to students. In addition to the employment of this tool, the development of more specific survey methods to identify precursors to and coping mechanisms for student distress, that is, specifically what causes students to become distressed and how do they deal individually with such distress.
9.4.3. Sustainability

In the context of this set of recommendations the aspect of sustainability is concerned with the way in which support services enhance and perpetuate existing service provision.

9.4.3.1. Education and training

**Recommendation 13**

Reviews must be implemented to consider the efficacy of online support services and student attitudes towards the usefulness of such. The reviews could take into account the findings of evaluations of large-scale online support programs such as The Desk (Beyond Blue).

**Recommendation 14**

Consideration needs to be given to the particular types of student support services, especially dialogue about the pros and cons of on-line support versus the current predominance of face-to-face approaches, and examination of a possible blend of the two.

**Recommendation 15**

A comprehensive training and education package must be developed for all university staff, both academic and general, to make them aware of the various types of student support services available, and the means by which students can access: different types of services, opening hours and referral pathways. Inclusive of student need identification in order to match students to support services with the knowledge they have gained on the utility of these facilities.
Recommendation 16
Specific education needs to be provided in the area of mental health interventions in light of negatively held views and beliefs found within the student population to address and modify these beliefs.

Recommendation 17
Continuous development and implementation of awareness campaigns and workshops targeting both students and staff regarding people living with mental illness are required.

Recommendation 18
Ensure the sustainability and consistency of approaches within the university to address student need, which has been developed in light of previous recommendations. Regular and ongoing education and update sessions will need to be provided to address the uptake of health and mental health literacy in some sustainable way.

9.4.3.2. Prevention and promotion

Recommendation 19
Existing services should focus on their ability to promote the availability of support to students in order to assist with depression and anxiety. As high prevalence disorders cause distress and subsequent decline in social/education functioning inclusive of services available outside of the university setting.
Recommendation 20
First aid style programs should be developed to help staff identify pre-cursors to high prevalence disorders. Such a program would target the Maslow levels and needs that are often the precursor to depression or anxiety, for example, accommodation, financial, health/physical, or learning difficulties. These should be an adjunct to existing mental health first aid courses. The introduction of health and mental health first aid programs to the student mentorship and the first year experience packages should also occur.

Recommendation 21
Resources need to be developed to allow easy identification of students’ social, health, mental health issues, and simple steps to deal with them. These could be in paper-based form or tablet materials and smart phone applications. Whatever option is selected, it needs to be in a format that can be utilised by students and also to staff as an aide memoir.

Recommendation 22
Ensure the development of any future support programs, inclusive of education and health promotion, has the ability to target part-time students as well as postgraduate students who often do not access university campuses as frequently as full-time undergraduate university students.
Recommendation 23

Targeted education, about the use of self-medication and maladaptive coping mechanisms such as the misuse of alcohol to manage psychological distress.

Recommendation 24

Mental health promotion must include information relating to the alternative, non-professional support strategies that could be used to help others, for example, talking to a friend, going for a coffee, attending the movies, or other psychosocial activities. The comments from the research cohort of this thesis outline the avenues wherein they are most likely to seek help: family, friends, partner, and GP.

9.5. Implications of this Research

This section makes meaningful use of the research data in this thesis and utilise the recommendations suggest ways by which these could influence the redevelopment and management of student support services in order to facilitate enhanced service provision to students. The set of proposals incorporated in this section includes structures to address data collection and referral pathways.

This section will also outline potential options for the planning and design of support systems that pertain to ‘form’, that is, the manner support services are afforded a framework and mechanism by which they can be administered and evaluated, thereby aiding the planning and design process. Although in most pure sense, ‘form’ naturally follows ‘function’ to begin the planning process, it is necessary to initiate some form of data collection in order to inform this process. Separate planning initiatives will need to be orchestrated in order to develop processes to
support the sustainability of recommendations outlined earlier in this chapter. Specifically, it is recommended that the redesign process allow for the deliberation on and incorporation of all 32 recommendations individually.

Due to the overwhelming evidence when considering how to change, measure, and affect systems, it appears that key stakeholders concentrate on the debate over centralisation or de-centralisation of services to meet perceived need. The proposed solutions attempt to avoid this debate, often being the catalyst of the status quo. Moreover, the following proposed models will attempt to make sense of core business, in this case student support services, by the use of comprehensive measurement at both the macro and micro levels. This information can be used to either change or enhance the whole system or as useful enquiry about adapting and changing local needs. Importance is placed on the collection of data to measure outcomes, in this case support services, averting service planning becoming an arbitrary process.

9.5.1. Theoretical framework equation

For the purpose of research the theoretical framework, as described in chapter two, comprises an interaction between two theories that utilise essential elements of Maslow’s Hierarchy of Needs and the Health Belief Model. To assist in the conceptualisation of how to change or enhance current student support services and the organisational frameworks they use, an interactive equation has been developed. This framework equation allows for a greater understanding of the help-seeking behaviours exhibited by university students and how they conceptualise needs and the related behaviours in the context of learning environments. The proposal herein is that a complex interaction between the models that will improve how universities understand and provide services to students. The proceeding
example uses a university student’s experience as a way to demonstrate how this new theoretical framework equation.

Maslow’s Hierarchy of Needs enables the identification and understanding of how a student may conceptualise ‘needs’, especially those perceived to be unmet, and how they could drive subsequent help-seeking behaviour in their attainment. For example, a student who does not have stable accommodation will, according to Maslow, feel anxious and tense, ultimately being distracted until this lower level ‘need’ is attained. According to the hierarchy theory, before the student meets such a lower level need, the desire or motivational focus will be lowered on the second level of needs thus potentially impacting on learning outcomes.

The Health Belief Model allows the prediction of how students would then prioritise their needs once identified using Maslow, and the help-seeking behaviour in which they will then engage. Students who having unmet needs such as housing, may attribute a high level of priority, susceptibility and seriousness to the matter, and then, based on their perceived threat analysis, seek a solution. The health belief model adds that variables like knowledge, demographics and structural variables, that is, services available, have a significant influence on any subsequent action. For example, if students have the ability to problem solve and access local real estate agencies or university housing services, coupled with available finances, they will be able to move towards resolving their housing issue.

This interactive modelling will help universities to understand not only why a student has lowered concentration or motivation levels, and higher anxiety and tension when in the classroom, but also the factors influencing their ability to seek help. According to the health belief model if a student has the knowledge of certain demographic and structural variables their likelihood of resolution increases
dramatically. However, issues may arise when a student does not have access to appropriate services and finances, and/or may not have ability to problem solve within the university system. For example, a student who may be homeless, have limited financial means, and is not familiar with the support services at the university and within the local community in which they now reside, may have significant psychological distress and thus an unmet lower need. It could be hypothesised that the anxiety and tension stated by Maslow to exist when an unmet need is present may grow to significant levels if the student is not able to navigate a resolution effectively. According to the health belief model, this may ultimately lead to increased psychological distress, mental illness, physical health problems, academic failure, and withdrawal from university.

The above example suggests that when planning and redesigning student support services, university administrations need to be cognisant of this equation thereby allowing them to understand that psychological distress and potential lowered academic success are not solely a product of issues related to academic learning. In order to understand how need impacts on a student’s ability to engage at university successfully it is important to collect data to inform the planning process. The following will discuss the use of outcome measures within the redevelopment and management of student support services and systems.

9.5.2. Outcomes measures

It is envisaged that the development of appropriate outcome measures could be composed of two distinct groups. The first group contains common or generic outcome measures pertaining to all support services within a university setting. Such measures could be used not only to measure performance and outcome across support services within a university, but could be used to benchmark broadly with
other universities who enter into similar activities, recorded in their Institutional Performance Portfolio. The second group of outcome measures would be more specific in nature and concern discrete support service activities. The purpose of these measures could be twofold: (1) to generate internal reports to measure performance and outcomes within the particular service concerned, and (2) to benchmark discrete services with other similar support services from other universities (see Model 1, figure 9.1).

These outcome measures would need to account for and accommodate subtle variations in the provision of services within and across universities. The use of these measures in conjunction with a benchmarking exercise would allow universities to interrogate specific university support services and their service provision, with the possibility to further investigate optimal outcomes and provision, thus helping understand how form and function variables impact service provision, and their effect on outcomes.

When considering the development of outcome measures it may be useful to view the previously mentioned demarcation of common or generic and specific outcome measures. Below are examples of possible outcome measures that could be developed, utilised, or used as a basis for initial discussion and incorporation in service provision.

9.5.2.1. **Generic outcome measures**

Due to the diverse nature of support systems generic outcome measures must be developed, that is, outcome measures not specific to the type of service provided, but rather the measure should indicate the resolution of a specific problem with which a student presents. Therefore the following outcome measures could be considered:
a) Issue(s) resolved by support service;

b) Issue(s) not resolved and referred to an alternative internal support service;

and,

c) Issue(s) not resolved and referred to an external support service.

Measures (b) and (c) would need to include an indicator of where a referral was made. Using such a simple set of performance indicators would allow university planners to understand the effectiveness of support services and also gain two understandings. In the first instance, was the student presenting to a particular support service that met their needs. If not, to where was that student referred, and was this an internal or external support service. Such information would allow universities to identify connections and possible areas for the development of pathways for such matters as referral and/or the development of more formal agreements in order to facilitate effective support for students’ needs. This would be particularly advantageous for students who had been identified in need of external referral. It could be assumed that internal pathways for referral would have been already established within the university; however this may or may not be the case and a simple mechanism for identifying specific pathways of referral may influence the necessity of the development or strengthening of internal linkages between support services.

Secondly, relevance of such an outcome measure lies in the ability of the measure to identify areas of service need that are not within the capacity and scope of the universities concerned. These may impact heavily on the successful provision of support, and have an impact on such possible indicators already collected within the institutional portfolio as attainment and retention. This is evidenced by a
correlation between psychological distress and student performance and retention (Stallman, 2008).

This set of outcome measures may be useful and possibly influence some of the cost implications for internal support service provision. This pertains if students who present in large numbers, for example, to counselling services. This portends more significant or acute mental health issues for which it would seem reasonable to develop a more formal service agreement with local mental health services. If such an agreement was developed, the impact could reduce the burden time spent by internal services freeing the capacity of internal resources. A further effect could be the reduction of distress to the related students; therefore possibly having an impact on their ability to study and succeed at university, with the subsequent improvement of attrition and retention rates.

Without the collection of such outcome measures the need to develop and form internal and external partnerships is a matter of speculation and therefore not based on actual presentation and need. Subsequently, the development of formal linages and partnerships, both internally and externally, would ensure that pathways are effective and sustainable. Without such agreements inter and intra service level relations are usually associated with personal relationships that may be held. These relationships therefore may be less effective by default and sustainable only with the mobility that inevitability happens within staff profiles of organisations.

9.5.2.2. Specific outcome measures

To extend the use of data collection it will be useful for university support services to consider the collection of specific outcome measures within discrete support services. The purpose of this is to measure outcomes relating specifically to unique provision of support within a particular service. An example of this could be
that the university counselling services, whereby a measure unique to this service may be useful in order to ascertain whether students have their needs met or experience a reduction in symptoms. As indicated in phase two results and discussion, the counselling service could use the Kessler 10 as a measure of psychological distress and utilised in pre and post intervention methodology and analysis.

Other discrete support services may also benefit from the collection of specific outcome measures. For example, university health services could collect information using the General Practice Assessment Questionnaire, GPAQ-R (see Appendix I). This is a 46-question assessment tool developed by the University of Cambridge in 2004 to assess the quality and outcomes of patients who accessed general practice settings for a variety of conditions and illness (Roland, Roberts, Rhenius, & Campbell, 2013). The benefit of outlining these two tools, specific to discreet support services, is that they may be used to evaluate the internal functioning of the service, with specific application to that service as opposed to more generalised outcome measures that may be collected across all support services within the university. It may then be useful for all university health services within a benchmarking framework to measure outcomes in order to see if patient cohorts and presentations are consistent across the university settings. Specific outcome measures may also be used within benchmarking exercises across universities whereby discreet services may be measured against each other to help understand how the form and function of the service may also influence outcomes. This will be further explained in model 3 (figure 9.3) where the nature of the relationship between discreet support services is illustrated.
9.5.3. Models to Explain the Utility of Outcome Measures

Model 1 (see Figure 9.1) explains the proposition for having a centralised database, located in each university, whose sole responsibility is the collection and analysis of generic and specific outcome measures. This could either be a stand-alone database or preferably be linked to an existing organisation-wide database system by adding extra fields to incorporate these additional outcome measures.

It would be essential to ensure that functional reporting mechanisms are provided at both service and university levels, that is, specific to student support services and also at a centralised planning and control facility from a university perspective. The provision of reporting mechanisms at both levels would: (1) allow for discrete support services to monitor and evaluate service provision on a designated basis (weekly, monthly and yearly) to respond to local student need; and (2) allow the university to integrate and provide both short and long term planning processes, inclusive of possible future internal and external partnerships.
Figure 9.1. Model 1 - Representation the flow of data to and from a centralised source.

Figure 9.2, model 2, is a replication of model 1 which allows both the student and service provider to have a clear understanding of pathways. From a student perspective the indication of service provision and referral processes, and from a service provider and university perspective, the pathway of a student and the flow of data internally, would facilitate evaluation and management of service provision.
Model 3 (see figure 9.3) illustrates the proposed relationship between the eight universities using the Institutional Performance Portfolio for the collection and use of comprehensive data. It illustrates how, in this example they could identify five student support services that all have commonalities. The use of specific outcome measures below is an illustration of how data could be either used to measure
performance at an individual site or service, or across a number of similar services over various universities (see vertical arrow in Figure 45).

Also with the use of a generic set of outcome measures (see horizontal arrow in Figure 45) the data can be used to identify the level of performance at a university across all support services and also other universities within the benchmarking framework. In both these cases a particular service or university may then choose to work closely with a service/university whose performances are more favourable, in order to understand their working practices and core business to ascertain if this differs, and has an impact on outcomes. This information enables services to choose and alter custom and practice to affect outcomes.
Figure 9.3. Model 3 - Representing the relationship between the different support services and possible outcome measures collected.

9.6. Concluding Statement

The importance of understanding the impact of help-seeking behaviour involving psychological distress on university students cannot be underestimated. If universities are to provide a holistic approach to learning and academic development, then future consideration and potential re-development of student support services, pastoral care policy and initiatives, staff and student training, and health promotion and prevention strategies will need to occur. Without such consideration it is likely that universities will continue to experience increasing
problems with student retention as such day-to-day issues as housing, finance, age, gender, or comorbidity impact upon a student’s ability to participate in all aspects of university life. In particular universities need to review the type and volume of data collected in order to understand better core business, i.e., its student base. This thesis has demonstrated that at present universities appear not to collect significant information regarding the impact and outcomes of support services they provide.

This thesis has highlighted the various indices influencing students and has provided a range of recommendations that could be adopted in order to attend to such impacts. The proposed outcomes of this thesis will not only bring to light the need to integrate all aspects of the university ‘micro’ community, but extend the relationships and partnerships that exist with the wider or ‘macro’ community.
References


The first year university experience: using personal epistemology to understand effective learning and teaching in higher education.  


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Appendices

Appendix A  Kessler Psychological Distress Scale (K10)
Appendix B  Reavley’s WAVE One Questionnaire
Appendix C  Headspace Psychosocial Assessment Tool
Appendix D  Institutional Performance Portfolio – Technical Document
Appendix E  Phase 1 Letter and Survey
Appendix F  Phase 2 Letter and Survey
Appendix G  Ethics Approval Letter from Edith Cowan University
Appendix H  Student support services Contract Matrix
Appendix I  General Practice Assessment Questionnaire (GPAQ)
Appendix A  Kessler Psychological Distress Scale (K10)
For all questions, please circle the answer most commonly related to you. Questions 3 and 6 automatically receive a score of one if the proceeding question was “none of the time”.

<table>
<thead>
<tr>
<th>In the past four weeks:</th>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. About how often did you feel tired out for no good reason?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. About how often did you feel nervous?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. About how often did you feel so nervous that nothing could calm you down?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. About how often did you feel hopeless?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. About how often did you feel restless or fidgety?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. About how often did you feel so restless you could not sit still?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. About how often did you feel depressed?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. About how often did you feel that everything is an effort?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. About how often did you feel so sad that nothing could cheer you up?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. About how often did you feel worthless?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>


Appendix B Reavley’s WAVE One Questionnaire
<table>
<thead>
<tr>
<th>Section Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. DEMOGRAPHICS</td>
</tr>
<tr>
<td>B. RECOGNITION OF MENTAL HEALTH PROBLEMS</td>
</tr>
<tr>
<td>C. INTENDED ACTIONS TO SEEK HEALTH AND PERCEIVED BARRIERS</td>
</tr>
<tr>
<td>D. BELIEFS ABOUT INTERVENTIONS</td>
</tr>
<tr>
<td>E. STIGMATISING ATTITUDES AND SOCIAL DISTANCE</td>
</tr>
<tr>
<td>F. PHYSICAL ACTIVITY / INACTIVITY</td>
</tr>
<tr>
<td>G. FIRST AID ACTIONS GIVEN</td>
</tr>
<tr>
<td>H. PERCEPTINS OF VU SUPPORT</td>
</tr>
<tr>
<td>K. INTERVIEWER ADMINISTERED K6+</td>
</tr>
<tr>
<td>N. ALCOHOL CONSUMPTION AUDIT</td>
</tr>
<tr>
<td>P. RISKY BEHAVIOURS</td>
</tr>
<tr>
<td>Q. SEEKING HELP</td>
</tr>
<tr>
<td>T. COLLECTION OF CONTACT DETAILS FOR FOLLOW UP</td>
</tr>
</tbody>
</table>

**SMS CALL OUTCOMES**

- No answer
- Answering Machine
- Fax Machine / Modem
- Engaged
- Appointment
- Telstra message / Number disconnected
- Named person not known / Wrong number / Respondent not known
- Person denies being VU student / staff member
- Claims to have done survey
- Not available / Away for duration
- LOTE – (Vietnamese, Arabic, Cantonese, Mandarin, Turkish, Spanish, Croatian, Greek, Serbian, Macedonian) follow up
- LOTE – (Other languages) no follow up – please record language
- LOTE – (Language unknown) follow up to establish language (CATI to treat as appointment)
- (SUPERVISOR USE ONLY) Refused prior (e.g. phoned Orygen Youth Health to opt out after initially signing up)
- Not a residential number
- Stopped Interview (record reason)
- Terminated mid survey
- Remove from list (add to do not call register)
- Ill health / deaf / unable to do survey

**SAMPLE VARIABLES**

- STYPE (STUDENT = 1, STAFF = 2)
- GRP (INTERVENTION =1, CONTROL GROUP =2)
- CAMPUS
- FName
- Middle Name
- SName
- Address
- Email
- TelNum
- AltNum
- Add1
- Add2
- Suburb
- State
- Pcode
INTRO A: Good (...) my name is (...). I'm calling on behalf of Orygen Youth Health from the Social Research Centre. May I please speak to (NAME)?

1. Continue
2. Wants a copy of the letter explaining survey purpose before proceeding (GO TO ALET)
3. Stop interview, make appointment (RECORD NAME AND ARRANGE CALL BACK)
4. Household refusal (ATTEMPT CONVERSION / RECORD REASON) (GO TO RR1)
5. Respondent refusal (ATTEMPT CONVERSION / RECORD REASON) (GO TO RR1)
6. QR LOTE – (Vietnamese, Arabic, Cantonese, Mandarin, Turkish, Spanish, Croatian, Greek, Serbian, Macedonian) follow up (GO TO ALOTE)
7. QR LOTE – Other language identified (no language follow up) (GO TO ALOTE)
8. QR LOTE – Language not identified (make appointment) (RECORD ON SMS)
9. Queried about how telephone number was obtained (DISPLAY ATELQ)
10. Respondent not known (SMS SCREEN)

*(NAMED RESPONDENT)*
S2 I am calling about the MindWise project. As a student / staff member at VU, you previously indicated that you were willing to be contacted by Orygen Youth Health to participate in this study.

The study is being carried out on behalf of VU and Orygen Youth Health Research Centre at the University of Melbourne, and has been approved by VU’s ethics committee.

If you agree to be interviewed, you are free to withdraw from the survey at any time. If for any reason you want to contact one of the researchers at Orygen, I can give you a number for that person.

If you have any ethical concerns about the research, I can also give you a number for that person at Orygen.

If you participate you will receive a coffee voucher and you will also have a one in 12 chance of winning a $50 Coles Myer voucher, the winners will be drawn on 30th April.

This interview should take about 20 minutes of your time. Are you willing to go ahead?

IF NECESSARY: If you feel like you need to talk to someone after this interview, I have the number of a 24-hour help-line service you can call (LifeLine 13 11 14). You can also visit the VU counselling service and I can give you those numbers:
9919 2399 - St Albans campus
9919 8801- Footscray Nicholson campus
9919 4418 - Footscray Park campus

IF NECESSARY: if you need to stop at any time during the interview, we can arrange to complete the interview at another time.

IF NECESSARY: You are able to phone the researcher in charge, Professor Tony Jorm on 9342 3747 if you have any questions or concerns about the survey.

Before we start the survey, could you please tell me what was your age last birthday?

1. AGE (Specify_____) (RANGE 18 TO 80) (GO TO S3)
2. Under 18 (GO TO TERM2)
3. (Refused) (GO TO S2a)

S2a Would you mind telling me which of the following age groups you fall in to? (READ OUT)
1. 18 to 24
2. 25 to 34
3. 35 to 44
4. 45 to 54
5. 55 to 64
6. 65 to 74
7. 75 to 80
8. (DO NOT READ) Refused (GO TO TERM3)
9. (DO NOT READ) Under 18 (GO TO TERM2)

*(NAMED RESPONDENT, 18 YEARS OR OVER)

S3

1. Start survey (GO TO MON1)
2. Wants a copy of a letter explaining survey purpose before proceeding (GO TO ALET)
3. Stop interview, make appointment (RECORD NAME AND ARRANGE CALL BACK)
4. Respondent refusal (ATTEMPT CONVERSION / RECORD REASON) (GO TO RR1)
5. QR LOTE – (Vietnamese, Arabic, Cantonese, Mandarin, Turkish, Spanish, Croatian, Greek, Serbian, Macedonian) follow up (GO TO ALOTE)
6. QR LOTE – Other language identified (no language follow up) (GO TO ALOTE)
7. QR LOTE – Language not identified (make appointment) (RECORD ON SMS)
8. Queried about how telephone number was obtained (DISPLAY ATELQ)

*(WANTS TO RECEIVE A COPY OF THE LETTER)

ALET Would you like to receive a copy of the letter by mail, fax or e-mail?

1. Mail (CONFIRM/RECORD NAME AND ADDRESS)
2. Fax (CONFIRM/RECORD NAME AND FAX NUMBER)
3. E-mail (CONFIRM/RECORD NAME AND E-MAIL ADDRESS)

*(LOTES)

ALOTE Record language

1. Vietnamese
2. Arabic
3. Cantonese
4. Mandarin
5. Turkish
6. Spanish
7. Croatian
8. Greek
9. Serbian
10. Macedonian
11. Other language no follow up (specify_)

*(QUERIED HOW TELEPHONE NUMBER WAS OBTAINED)

PROGRAMR NOTE: IF STYPE=1 DISPLAY “A STUDENT” IF STYPE=2 DISPLAY “A STAFF MEMBER” ELSE DISPLAY “STUDENT / STAFF MEMBER”.

ATELQ As a student / staff member at VU, you previously indicated that you were willing to be contacted by Orygen Youth Health to participate in this study.
OK, that's fine, no problem, but could you tell me the main reason you don't want to participate, because that will help us?

1. No comment / just hung up
2. Too busy
3. Not interested
4. Too personal / intrusive
5. Don’t like subject matter
6. Letter put me off
7. Don’t believe surveys are confidential / privacy concerns
8. Silent number
9. Don’t trust surveys
10. Never do surveys
11. 20 minutes is too long
12. Get too many calls for surveys / telemarketing
13. Ill health / disability / unable to do survey
14. Not a residential number (business, etc) (CODE AS NOT A RESIDENTIAL NUMBER)
15. Language difficulty (CODE AS LANGUAGE DIFFICULTY NO FOLLOW UP)
16. Going away / moving house (CODE AS AWAY DURATION)
17. Asked to be taken off list (add to do not call register)
18. Other (Specify)

Definitely don’t call back
2. Possible conversion

Our call may be monitored by my supervisor for quality assurance purposes. Please tell me if you don’t want this to happen.

1. Monitoring allowed
2. Monitoring not permitted

Before we start, can I just confirm your current status at VU?
Are you currently…

1. A student
2. A staff member
3. Both a student and a staff member
4. Neither a student nor a staff member(GO TO TERM1)

PROGRAMMER CREATE DUMMY VARIABLE FOR SEQUENCING
A0=1 STYPE=1
A0=2 OR A0=3 STYPE=2

*(ALL)
A2. RECORD GENDER

Male
Female

*(ALL)
A3. Are you…

1. An Australian citizen
2. An Australian resident
3. Not an Australian citizen or resident
4. (Don’t know)
5. (Refused)

*(ALL)
A4. What is your country of birth?

1. Australia
2. United Kingdom (incl. England, Scotland, Wales, Northern Ireland)
3. New Zealand
4. China
5. Vietnam
6. Philippines
7. India
8. Hong Kong
9. Republic of Korea
10. Other (Specify____________________)
11. (Don’t know)
12. (Refused)

*(ALL)
A5. Which of these BEST describes your household? (READ OUT)
NOTE: IF HOUSEHOLD DOES NOT READILY FIT CODES – PUT INTO OTHER

1. Couple only
2. Couple with dependent children
3. Couple with non-dependent children
4. Couple with dependent and non-dependent children
5. One parent family with dependent children
6. One parent family with non-dependent children
7. One parent family with dependent and non-dependent children
8. Group household
9. Student residence
10. One person household
11. Other (Specify)
12. (Don’t know)
13. (Refused)

PREA6 IF STYPE=1 (STUDENT) CONTINUE, ELSE STYPE=2 (STAFF MEMBER) GO TO A8
*(STUDENT, STYPE = 1)
A6. Are you currently….. READ OUT
   1. Studying full-time
   2. Studying part-time
   3. (Something else) (Specify)
   4. (Don’t know)
   5. (Refused)

*(STUDENT, STYPE = 1)
A7. What is the level of qualification you are studying?

   13. Postgraduate
       1. Bachelor degree
       2. Associate degree
       3. Advanced diploma
       4. Diploma
       5. Certificate 4
       6. Certificate 3
       7. Certificate 2
       8. Certificate 1
       9. Certificate unspecified (Specify qualification________)
      10. Other (Specify____)
      11. (Don’t know)
      12. (Refused)

PREA8. IF STYPE=1 DISPLAY STUDYING, ELSE DISPLAY WORKING
*(ALL)
A8. And can I confirm which campus you are MAINLY (studying / working) at?
DISPLAY <CAMPUS> FROM SAMPLE

   1. City Flinders
   2. City Flinders Lane
   3. City King
   4. City Queen
   5. Footscray Nicholson
   6. Footscray Park
   7. Melton
   8. Newport
   9. St Albans
  10. Sunbury
  11. Sunshine
  12. Werribee
  13. Campus correct as displayed
  14. (Don’t know)
  15. (Refused)

PREA9. IF STYPE=2, GO TO A13. OTHERS CONTINUE

*(STUDENT, STYPE = 1)
A9. Which if any other VU campuses do you regularly go to?
(MULTIPLES ACCEPTED)
DO NOT DISPLAY CAMPUS FROM A8

   6. City Flinders
   7. City Flinders Lane
   8. City King
   9. City Queen
  10. Footscray Nicholson
11. Footscray Park
12. Melton
13. Newport
14. St Albans
15. Sunbury
16. Sunshine
17. Werribee
18. Don’t regularly go to any other VU campuses ^s
19. (Don’t know) ^s
20. (Refused) ^s

*(STUDENT, STYPE = 1)
A10. In what year did you first start studying at VU?
   21. (Specify__) (RANGE 1990 TO 2010)
   22. (Don’t know)
   23. (Refused)

*(STUDENT, STYPE = 1)
A11. When do you plan to finish studying at VU?
   24. One year or more (Specify__) (RANGE 2010 TO 2020) (GO TO A13)
   25. Six months to one year
   26. Less than 6 months (GO TO TERM3)
   27. (Don’t know) (GO TO A12)
   28. (Refused) (GO TO A12)

*(STUDENT, STUDY COMPLETION YEAR NOT SPECIFIED)
A12. Do you plan to be studying at VU in 2011?
   29. Yes
   30. No
   31. (Don’t know)
   32. (Refused)

*(ALL)
A13. Which of the following currently describes your employment status? READ OUT
   1. Full time employment
   2. Part time employment
   3. Employment on a contract basis
   4. Employment on a casual basis
   5. Not working (DISPLAY IF STYPE=1)
   6. (Don’t know)
   7. (Refused)

PREA13a IF STYPE=2 GO TO PREA14
IF A13=5 CONTINUE ELSE GO TO PREB1

*(STUDENT, NOT CURRENTLY WORKING)
A13a. Are you currently looking for work?
   1. Yes
   2. No
   3. (Don’t know)
   4. (Refused)

PREA14 If STYPE=2 CONTINUE ELSE GO TO PREB1
*(STAFF, STYPE=2)
A14. Are you employed as an...
READ OUT

5. Academic staff member
6. Administrative staff member
7. (Other) (Specify_)
8. (Don’t know)
9. (Refused)

*(STAFF, STYPE=2)
A15. Do you have regular contact with students in the course of your work?

1. Yes
2. No
3. (Don’t know)
4. (Refused)

Section B: Recognition of Mental Health Problems
TIMESTAMP2

*Vignettes
PREB1 IF STYPE=1 (STUDENT) AND A2=1 (MALE), DISPLAY SCENARIO 1, ELSE STYPE=1 (STUDENT) AND A2=2 (FEMALE), DISPLAY SCENARIO 2, ELSE STYPE=2 (STAFF) AND A2=1 (MALE), DISPLAY SCENARIO 3, ELSE STYPE=2 (STAFF) AND A2=2 (FEMALE) DISPLAY SCENARIO 4

PROGRAMR NOTE: If A2=1 (MALE) REFER TO JOHN AND MALE VIGNETTES/REFERENCES THROUGHOUT QUESTIONNAIRE, ELSE A2=2 (FEMALE) REFER TO JENNY AND FEMALE VIGNETTES/REFERENCES THROUGHOUT QUESTIONNAIRE.

B1. Now I am going to ask you about the health problems of a person I will call (John/Jenny). (John/Jenny) is not a real person, but there are people like (him/her). If you happen to know someone who resembles (him/her) in any way, that is a total coincidence.

1. Continue

Scenario 1
John is a 21 year old who has been feeling unusually sad and miserable for the last few weeks. He is tired all the time and has trouble sleeping at night. John doesn’t feel like eating and has lost weight. He can’t keep his mind on his studies and his marks have dropped. He puts off making any decisions and even day-to-day tasks seem too much for him. His parents and friends are very concerned about him.

Scenario 2
Jenny is a 21 year old who has been feeling unusually sad and miserable for the last few weeks. She is tired all the time and has trouble sleeping at night. Jenny doesn’t feel like eating and has lost weight. She can’t keep her mind on her studies and her marks have dropped. She puts off making any decisions and even day-to-day tasks seem too much for her. Her parents and friends are very concerned about her.

Scenario 3
John is a 30 year old who has been feeling unusually sad and miserable for the last few weeks. He is tired all the time and has trouble sleeping at night. John doesn’t feel like eating and has lost weight. He can’t keep his mind on his work and his work performance has suffered. He puts off making any decisions and even day-to-day tasks seem too much for him. His family and friends are very concerned about him.

Scenario 4
Jenny is a 30 year old who has been feeling unusually sad and miserable for the last few weeks. She is tired all the time and has trouble sleeping at night. Jenny doesn’t feel like eating and has lost weight.
weight. She can’t keep her mind on her work and her work performance has suffered. She puts off making any decisions and even day-to-day tasks seem too much for her. Her family and friends are very concerned about her.

*(ALL)  
B2. What, if anything, do you think is wrong with (John/Jenny)?  
(MULTIPLES ACCEPTED)

1. Depression  
2. Schizophrenia/paranoid schizophrenia  
3. Psychosis/psychotic  
4. Mental illness  
5. Alcohol problem  
6. Drugs  
7. Anxiety / anxious  
8. Eating disorder  
9. Low self esteem / low self confidence  
10. Shy  
11. Stress  
12. Psychological/mental/emotional problems  
13. Has a problem  
14. Other (specify)  
15. Nothing ^s  
16. (Don’t know)^s  
17. (Refused) ^s

Section C: Intended actions to seek help and perceived barriers  
TIMESTAMP3

*(ALL)  
C1. If you had a problem right now like (John/Jenny), would you go for help?  

1. Yes  
2. No (GO TO PREC3)  
3. (Don’t know) (GO TO PREC3)  
4. (Refused) (GO TO PREC3)

*(WOULD GO FOR HELP C1=1)  
C2. Where would you go? DO NOT PROMPT  
(MULTIPLES ACCEPTED)

1. Mother  
2. Father  
3. BOTH parents  
4. Other family member or relative  
5. Partner, boyfriend or girlfriend  
6. Friend  
7. A lecturer / teacher (DISPLAY IF STYPE=1)  
8. A VU counsellor (DISPLAY IF STYPE=1)  
9. A supervisor (DISPLAY IF = STYPE=2)  
10. A counselor provided by VU’s Employee Assistance Program (EAP) (DISPLAY IF = STYPE=2)  
11. A VU co worker  
12. Other informal source (Specify)  
13. GP/doctor  
14. Psychiatrist  
15. Psychologist  
16. Counsellor  
17. Helpline  
18. Other professional source (Specify)
19. (Don't know) ^s
20. (Refused) ^s

PREC3 IF C2=1, C2=2, C2=3 OR C2=4 (WOULD SEEK HELP FROM PARENT OR OTHER FAMILY MEMBER OR RELATIVE) GO TO PREC3A. OTHERS CONTINUE

*(NOT PREVIOUSLY MENTIONED SEEKING HELP FROM PARENT(S) OR OTHER FAMILY MEMBER / RELATIVE)
C3. If you had a problem right now like (John/Jenny), would you feel able to talk to your parents / another family member or relative about it?

1. Yes
2. No
3. Not applicable (Parents not available e.g. passed away / estranged / live overseas)
4. (Don’t know)
5. (Refused)

PREC3A IF C2=5 (WOULD SEEK HELP FROM PARTNER, BOYFRIEND OR GIRLFRIEND) GO TO PREC4. OTHERS CONTINUE

*(NOT PREVIOUSLY MENTIONED SEEKING HELP FROM PARTNER, GIRLFRIEND OR BOYFRIEND)
C3a. If you had a problem right now like (John/Jenny), would you feel able to talk to your partner, boyfriend or girlfriend about it?

1. Yes
2. No
3. Not applicable (don’t have a partner, girlfriend or boyfriend)
4. (Don’t know)
5. (Refused)

PREC4 IF STYPE=1 AND C2=6 (WOULD SEEK HELP FROM FRIEND(S)), GO TO PREC5, ELSE STYPE=2 and C2=6, GO TO PREC7. OTHERS CONTINUE

*(NOT PREVIOUSLY MENTIONED SEEKING HELP FROM FRIEND(S))
C4. If you had a problem right now like (John/Jenny), would you feel able to talk to your friends about it?

1. Yes
2. No
3. (Don’t know)
4. (Refused)

PREC5 IF STYPE=1 AND C2=7, (WOULD SEEK HELP FROM LECTURER/TEACHER), GO TO PREC6. OTHERS CONTINUE
*(STUDENT, NOT PREVIOUSLY MENTIONED SEEKING HELP FROM LECTURER / TEACHER (S))

C5. If you had a problem right now like (John/Jenny), would you feel able to talk to your lecturer(s) / teacher(s) about it?

1. Yes
2. No
3. (Don’t know)
4. (Refused)

PREC6  IF STYPE=1 AND C2=8, (WOULD SEEK HELP FROM VU COUNSELLOR), GO TO D1. Others CONTINUE

*(STUDENT, NOT PREVIOUSLY MENTIONED SEEKING HELP FROM VU COUNSELLOR (S))

C6. If you had a problem right now like (John/Jenny), would you feel able to talk to your VU counsellor(s) about it?

1. Yes
2. No
3. (Don’t know)
4. (Refused)

PREC7  IF STYPE=1, GO TO D1, ELSE STYPE=2 AND C2=9, (WOULD SEEK HELP FROM SUPERVISOR), GO TO PREC8. Others CONTINUE

*(NOT PREVIOUSLY MENTIONED SEEKING HELP FROM SUPERVISOR)

C7. If you had a problem right now like (John/Jenny), would you feel able to talk to your supervisor about it?

1. Yes
2. No
3. (Don’t know)
4. (Refused)

PREC8  IF STYPE=2 AND C2=10, (WOULD SEEK HELP FROM VU COWORKER), GO TO D1. Others CONTINUE
**(NOT PREVIOUSLY MENTIONED SEEKING HELP FROM COWORKER)**

C8. If you had a problem right now like (John/Jenny), would you feel able to talk to your VU co-workers about it?

1. Yes
2. No
3. (Don’t know)
4. (Refused)

PREC8A IF C2=10 (WOULD SEEK HELP FROM COUNSELLOR PROVIDED THROUGH VU EAP), GO TO D1. OTHERS CONTINUE

**(NOT PREVIOUSLY MENTIONED SEEKING HELP FROM COWORKER OR VU EAP)**

C8a. If you had a problem right now like (John/Jenny), would you feel able to talk to a counsellor provided by VU’s Employee Assistance Program (EAP) about it?

1. Yes
2. No
3. (Don’t know)
4. (Refused)

**Section D. Beliefs about interventions**

*Section D. Beliefs about interventions*

TIMESTAMP4 *(ALL)*

**D1.** There are a number of different people who could possibly help (John/Jenny). I’m going to READ OUT a list of them and I’d like you to tell me whether you think they would be helpful, harmful or neither to (John/Jenny). Again, if you are unsure, that’s fine, just let me know….

(STATEMENTS)

a. A GP or family doctor
b. A lecturer / teacher (DISPLAY IF STYPE=1)
c. A VU counsellor (DISPLAY IF STYPE=1)
d. A counsellor provided through VU’s Employee Assistance Program (DISPLAY IF STYPE=2)
e. A counsellor not employed by VU
f. A telephone counselling service
g. A psychologist
h. A psychiatrist
i. A close family member
j. A close friend
k. A drug and alcohol service

(Would that be helpful, harmful, neither, or not sure)

(RESPONSE FRAME)

1. Helpful
2. Harmful
3. Neither
D2. Is it likely to be helpful, harmful or neither if (John/Jenny) tried to deal with (his/her) problems on (his/her) own?

1. Helpful
2. Harmful
3. Neither
4. (Depends)
5. (Don’t know)
6. (Refused)

*(ALL)

D3. Do you think the following medicines are likely to be helpful, harmful or neither for (John/Jenny)? Again, if you are unsure, that’s fine, just let me know…. CLARIFY AS NECESSARY: This includes vitamins and herbal medicines.

(STATEMENTS)
a. Vitamins
b. St John’s Wort
c. Antidepressants
d. Medication for anxiety
e. Antipsychotics
f. Sleeping pills
g. Other (Specify_)

(Would that be helpful, harmful, neither, or not sure)

(RESPONSE FRAME)
1. Helpful
2. Harmful
3. Neither
4. (Depends)
5. Don’t know
6. (Refused)

*(ALL)

D4. Do you think the following are likely to be helpful, harmful or neither for (John/Jenny)? (Again, if you are unsure, that’s fine, just let me know…).

(STATEMENTS)
a. Becoming more physically active
b. Getting relaxation training
c. Practicing meditation
d. Having regular massages
e. Getting acupuncture
f. Getting up early each morning and getting out in the sunlight
g. Receiving counselling
h. Receiving cognitive-behavior therapy
i. Looking up a web site giving information about (his/her) problem
j. Reading a self-help book on (his/her) problem
k. Joining a support group of people with similar problems
l. Going to a local mental health service
m. Being admitted to a psychiatric ward of a hospital  
n. Using alcohol to relax  
o. Smoking cigarettes to relax  
p. Using marijuana to relax  
q. Cutting down on use of alcohol  
r. Cutting down on smoking cigarettes  
s. Cutting down on marijuana

(Would that be helpful, harmful, neither, or not sure)

(RESPONSE FRAME)
1. Helpful  
2. Harmful  
3. Neither  
4. (Depends)  
5. (Don't know)  
6. (Refused)

*Section E. Stigmatizing attitudes and social distance

*(ALL)

E1. The next few questions contain statements about (John’s/Jenny’s) problem. Please indicate how strongly YOU PERSONALLY agree or disagree with each statement.

(STATEMENTS)

a. (John/Jenny) could make (himself/herself better (if (he/she wanted
b. (John's/Jenny's) problem is a sign of personal weakness.
   c. (John's/Jenny's) problem is not a real medical illness.
   d. (John/Jenny) is dangerous. (If the respondent is unsure of the meaning of ‘dangerous’ in this statement, inform them it means ‘dangerous to others’)
   e. It is best to avoid (John/Jenny) so that you don't develop this problem yourself.
   f. (John's/Jenny's) problem makes (him/her) unpredictable.
   g. You would not tell anyone if you had a problem like (John's/Jenny's).

(Would that be…)

(RESPONSE FRAME)
1. Strongly agree  
2. Agree  
3. Neither agree nor disagree  
4. Disagree  
5. Strongly disagree  
6. (Don’t know)  
7. (Refused)

*(ALL)

E3. The following questions ask how you would feel about spending time with (John/Jenny).

Would you be happy… (READ STATEMENT)

(STATEMENTS)

a. To go out with (John/Jenny) on the weekend?  
b. To work on a project with (John/Jenny)?  
c. To invite (John/Jenny) around to your house?  
d. To go to (John’s/Jenny’s) house?
e. To develop a close friendship with (John/Jenny)?

Would you say…

(RESPONSE FRAME)
1. Yes, definitely
2. Yes, probably
3. Probably not, or
4. Definitely not
5. (Don't know)
6. (Refused)

*Section F: Exposure to mental disorders
TIMESTAMP6

*(ALL)
F1. In the last 12 months have you had a problem similar to (John's/Jenny's)?

*PROGRAMR NOTE: NEED "HOTKEY" OR SIMILAR TO BE ABLE TO DISPLAY VIGNETTE AS REQUIRED, AS RESPONDENT MAY NEED REMINDING OF DETAIL OF VIGNETTE AT THIS POINT

1. Yes
2. No (GO TO G1)
3. Don't know (GO TO G1)
4. Refused (GO TO G1)

*(HAD SIMILAR PROBLEM F1=1)
F2. What did you think the problem was? (MULTIPLES ACCEPTED)

1. Depression
2. Schizophrenia/paranoid schizophrenia
3. Psychosis/psychotic
4. Mental illness
5. Alcohol problem
6. Drugs
7. Anxiety / anxious
8. Eating disorder
9. Low self esteem / low self confidence
10. Shy
11. Stress
12. Psychological/mental/emotional problems
13. Has a problem
14. Other (specify)
15. Nothing ^s
16. Don't know ^s
17. Refused ^s

*(HAD SIMILAR PROBLEM)
F3. Did you do anything to deal with the problem?

1. Yes
2. No (GO TO F5)
3. (Don't know) (GO TO F5)
4. (Refused) (GO TO F5)

*(DID SOMETHING TO DEAL WITH PROBLEM)
F4. What did you do?
1. Answer given (Specify)
2. Don’t know
3. Refused

*(HAD SIMILAR PROBLEM)*

F5. I am going to READ OUT a list of things you might have done to deal with the problem. I want you to tell me whether or not you did each one. Did you seek help from....

**STATEMENTS**)

a. A GP or family doctor
b. A lecturer/ teacher
c. A VU counsellor (DISPLAY IF STYPE=1)
d. A counsellor provided by VU Employee Assistance Program (DISPLAY IF STYPE=2)
e. A counsellor not employed by VU
f. A telephone counselling service
g. A psychologist
h. A psychiatrist
i. A close family member
j. A close friend
k. A drug and alcohol service

*(RESPONSE FRAME)*

1. Yes
2. No
3. Don’t know
4. (Refused)

PREF6 IF ANY RESPONSE AT F5="Yes", GO TO F7. OTHERS (NO "Yes" RESPONSES AT F5) CONTINUE

*(DID NOT SEEK HELP FROM ANY NAMED PERSON FROM F5)*

F6. Did you try to deal with the problem on your own?

1. Yes
2. No
3. Don’t know
4. (Refused)

*(HAD SIMILAR PROBLEM)*

F7. Which of the following medicines, if any, did you take?

CLARIFY AS NECESSARY: This includes vitamins and herbal medicines.

**STATEMENTS**)

a. Vitamins
b. St John’s Wort
c. Antidepressants
d. Medications for anxiety
e. Antipsychotics
f. Sleeping pills
g. Other (Specify_)

*(RESPONSE FRAME)*
1. Yes
2. No
3. Don’t know
4. (Refused)

*(HAD SIMILAR PROBLEM)

F8. Did you do any of the following to deal with your problem?

(STATEMENTS)

a. Became more physically active
b. Got relaxation training
c. Practiced meditation
d. Had regular massages
e. Got acupuncture
f. Got up early each morning and went out in the sunlight
g. Received counselling
h. Received cognitive-behavior therapy
i. Looked up a web site giving information about your problem
j. Read a self-help book on your problem
k. Joined a support group of people with similar problems
l. Went to a local mental health service
m. Went to a local drug and alcohol service
n. Were admitted to a psychiatric ward of a hospital
o. Were admitted to a drug and alcohol program
p. Used alcohol to relax
q. Smoked cigarettes to relax
r. Used marijuana to relax
s. Cut down on use of alcohol
t. Cut down on smoking cigarettes
u. Cut down on marijuana

(RESPONSE FRAME)

1. Yes
2. No (including “not applicable”)
3. Don’t know
4. (Refused)

PREF9 IF (F5="No" / “Don’t know” / “Refused” FOR ALL STATEMENTS) AND (F7="No" / “Don’t know” / “Refused” FOR ALL STATEMENTS) AND (F8="No" / “Don’t know” / “Refused” FOR ALL STATEMENTS) (IE DID NOT SEEK HELP FROM ANYONE OR DO ANYTHING) AUTOFILL F9=44 AND GO TO G1. OTHERS CONTINUE.
PREF9A IF ONLY ONE SOURCE OF HELP NOMINATED (ONLY ONE “Yes” at F5, F7 AND F8) AUTOFILL F9=44 AND GO TO G1. OTHERS CONTINUE.

*(HAD SIMILAR PROBLEM)

F9. Out of all the people you sought help from and the things you did, which ones helped you the most?

(MULTIPLES ACCEPTED)

*PROGRAMR DISPLAY LIST OF ALL “YES” RESPONSES AT F5 (1 TO 11), F7 (12 TO 18), AND F8 (19 TO 39)

1. A GP or family doctor
2. A lecturer/ teacher
3. A VU counsellor (DISPLAY IF STYPE=1)
4. A counsellor provided by VU’S EMPLOYEE ASSISTANCE PROGRAM (DISPLAY IF STYPE=2)
5. A counsellor not employed by VU
6. A telephone counselling service
7. A psychologist
8. A psychiatrist
9. A close family member
10. A close friend
11. A drug and alcohol service
12. Vitamins
13. St John's wort
14. Antidepressants
15. Medications for anxiety
16. Antipsychotics
17. Sleeping pills
18. Other (Specify_)
19. Becoming more physically active
20. Getting relaxation training
21. Practicing meditation
22. Having regular massages
23. Getting acupuncture
24. Getting up early each morning and getting out in the sunlight
25. Receiving counselling
26. Receiving cognitive-behavior therapy
27. Looking up a web site giving information about (his/her) problem
28. Reading a self-help book on (his/her) problem
29. Joining a support group of people with similar problems
30. Going to a local mental health service
31. Going to a local drug and alcohol service
32. Being admitted to a psychiatric ward of a hospital
33. Being admitted to a drug and alcohol program
34. Using alcohol to relax
35. Smoking cigarettes to relax
36. Using marijuana to relax
37. Cutting down on use of alcohol
38. Cutting down on smoking cigarettes
39. Cutting down on marijuana
40. Other (specify________)
41. None ^s
42. (Don’t know) ^s
43. (Refused)^s
44. (Did not seek any help / do anything) ^s

Section G: First aid actions given
TIMESTAMP?
*(ALL)
G1. In the last 12 months has anyone in your family or close circle of friends had a problem similar to
(John’s/Jenny’s)?

1. Yes
2. No (GO TO PREH1)
3. (Don’t know) (GO TO PREH1)
4. (Refused) (GO TO PREH1)

*(SOMEONE IN FAMILY OR CLOSE CIRCLE OF FRIENDS HAD PROBLEM)
G2. Did just one person have the problem or more than one?

1. More than one
2. Just one (GO TO G4)
3. (Don’t know) (GO TO PREH1)
4. (Refused) (GO TO PREH1)
*(MORE THAN ONE FAMILY MEMBER / CLOSE FRIEND HAD PROBLEM)
G3. Because you know more than one person who had a problem similar to (John's/Jenny's), for the next few questions, I want you to think about the one you know BEST.

1. Continue

*(SOMEONE IN FAMILY OR CLOSE CIRCLE OF FRIENDS HAD PROBLEM)
G4. Did you do anything to help this person?

1. Yes
2. No (GO TO PREH1)
3. (Don't know) (GO TO PREH1)
4. (Refused) (GO TO PREH1)

*(DID SOMETHING TO HELP FAMILY MEMBER / FRIEND)
G5. What did you do?

1. Answer given (specify)
2. (Don't know)
3. (Refused)
Section H: Perceptions of VU support

*(STUDENTS, STYPE=1)

H1. The following questions look at how well the VU community supports students with mental health problems. How well do you think the following people support students with mental health problems?

a. VU teaching staff
b. VU counselling staff
c. Other students

*(RESPONSE FRAME)
1. Very well
2. Well
3. Poorly
4. Very poorly
5. (Don’t know)
6. (Refused)

*(STAFF, STYPE=2)

H2. How well do you think VU supports the following groups of people with mental health problems?

a. Students with mental health problems
b. Staff with mental health problems

*(RESPONSE FRAME)
1. Very well
2. Well
3. Poorly
4. Very poorly
5. (Don’t know)
6. (Refused)

Section K: Depression and anxiety

*(ALL)

K1. The next questions are about how you felt during the past 30 days.

About how often during the past 30 days did you feel NERVOUS—would you say ALL of the time, MOST of the time, SOME of the time, A LITTLE of the time, or NONE of the time?

1. All of the time
2. Most,
3. Some,
4. A little, or
5. None of the time
6. (Don’t know)
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7. (Refused)

*(ALL)

K2. During the past 30 days about how often did you feel HOPELESS?

READ OUT IF NECESSARY

1. All of the time
2. Most,
3. Some,
4. A Little, or
5. None of the time
6. (Don’t know)
7. (Refused)

*(ALL)

K3. During the past 30 days, about how often did you feel RESTLESS OR FIDGETY?

READ OUT IF NECESSARY

1. All of the time
2. Most,
3. Some,
4. A Little, or
5. None of the time
6. (Don’t know)
7. (Refused)

*(ALL)

K4. During the past 30 days, about how often did you feel SO DEPRESSED THAT NOTHING COULD CHEER YOU UP?

READ OUT IF NECESSARY

1. All of the time
2. Most,
3. Some,
4. A Little, or
5. None of the time
6. (Don’t know)
7. (Refused)

*(ALL)

K5. During the past 30 days, about how often did you feel THAT EVERYTHING WAS AN EFFORT?

READ OUT IF NECESSARY

1. All of the time
2. Most,
3. Some,
4. A Little, or
5. None of the time
6. (Don’t know)
7. (Refused)

*(ALL)

K6. During the past 30 days, about how often did you feel WORTHLESS?

READ OUT IF NECESSARY
1. All of the time
2. Most,
3. Some,
4. A Little, or
5. None of the time
6. (Don’t know)
7. (Refused)

*(ALL)

K7. So, thinking about those feelings, would you say they occurred MORE OFTEN in the past 30
days than is usual for you, ABOUT THE SAME as usual, or LESS OFTEN than usual?

1. More often than usual (GO TO K9)
2. About the same as usual (GO TO PREK10)
3. Less often than usual (GO TO K8)
4. Never have these feelings (GO TO PREK10)
5. (IF VOLUNTEERS - Don’t know) (GO TO PREK10)
6. (IF VOLUNTEERS - Refused) (GO TO PREK10)

*(FEELINGS OCCURRED LESS OFTEN THAN USUAL K7=3)

K8. Would that be A LOT less than usual, SOMEWHAT less, or ONLY A LITTLE less than usual?

1. A lot (GO TO PREK10)
2. Somewhat (GO TO PREK10)
3. A little (GO TO PREK10)
4. (Don’t know) (GO TO PREK10)
5. (Refused) (GO TO PREK10)

*(FEELINGS OCCURRED MORE OFTEN THAN USUAL K7=1)

K9. Would that be A LOT more than usual, SOMEWHAT more, or ONLY A LITTLE more than
usual?

1. A lot
2. Somewhat
3. A little
4. (Don’t know)
5. (Refused)

PREK10 IF K1=1 TO 4, ELSE K2=1 TO 4, ELSE K3=1 TO 4, ELSE K4=1 TO 4, ELSE K5=1 TO 4,
ELSE K6=1 TO 4, CONTINUE. OTHERS GO TO NINTRO.

*(RESPONDENT ANSWERED ‘A LITTLE’, ‘SOME’, ‘MOST’ OR ‘ALL’ TO AT LEAST ONE
QUESTION IN THE K6+ QUESTION SERIES)

K10. The next questions are about how some of these feelings may have affected you in the past
30 days. On how many days out of the past 30 were you TOTALLY unable to work or carry
out your normal activities because of these feelings?

1. (Specify days) (RANGE 0-30)
2. (Don’t know)
3. (Refused)

*(RESPONDENT UNABLE TO WORK OR CARRY OUT NORMAL ACTIVITIES FOR 1 DAY OR
MORE DUE TO FEELINGS)

PROGRAMMER NOTE: DISPLAY “NOT COUNTING THAT DAY / THOSE DAYS” IF K10 1=>0

K11. (Not counting that day/ those days), how many days out of the past 30 were you able to do
only half or less of what you would normally have been able to do because of these feelings?

1. (Specify days) (RANGE 0-30, MINUS DAYS SPECIFIED AT K10)
2. (Don’t know)
3. (Refused)

K12. During the past 30 days, how often have physical health problems been the main cause of these feelings?

1. All of the time
2. Most,
3. Some,
4. A Little, or
5. None of the time
6. (Don’t know)
7. (Refused)

Section N: Alcohol consumption - AUDIT

TIMESTAMP10

NINTRO: The next set of questions are about alcohol intake and its effects. There are no right or wrong answers, just choose the answer that is correct for you.

33. Continue

*(ALL)

N1a. How old were you when you had your first drink of alcohol other than a few sips?
INTerviewer NOTE: If respondent unsure, ask for best estimate.

1. (Specify age_) (RANGE 1-65)
2. Not applicable (Have never had a drink of alcohol) (GO TO P1)
3. (Don’t know)
4. (Refused)

*(SPECIFIED AGE / DK / REF WHEN HAD FIRST DRINK N1A=1, 3 OR 4)

N1b. How often do you have a drink containing alcohol?

1. Never (GO TO P1)
2. Monthly or less
3. Fortnightly
4. 2 to 4 times a month
5. 2 to 3 times a week
6. 4 or more times a week
7. (Don’t know)
8. (Refused)

*(REGULARLY DRINKS ALCOHOL)

N1c. What kind of alcohol do you normally drink?

1. Beer – light
2. Beer – mid strength
3. Beer – full strength
4. Wine
5. Spirits
6. Other (Specify__)
7. (Don’t know)
8. (Refused)

*(REGULARLY DRINKS ALCOHOL)

N2. When I use the word “drink” in the next few questions, I mean a “standard drink” which contains 12.5 ml of alcohol. A standard drink is equal to 1 pot of full strength beer, 1 small
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glass of wine or 1 pub-sized nip of spirits. How many standard drinks do you have on a particular day when you are drinking?

INTERVIEWER NOTE: REFER TO HANDOUT FOR STANDARD DRINKS TABLE

1. 1 or 2
2. 3 or 4
3. 5 or 6
4. 7 to 9
5. 10 or more
6. (Don’t know)
7. (Refused)

*(REGULARLY DRINKS ALCOHOL)

N3. How often do you have six or more drinks on one occasion when you are drinking?

1. Never
2. Less than monthly
3. Monthly
4. Fortnightly
5. Weekly
6. Almost daily
7. Daily
8. (Don’t know)
9. (Refused)

*(REGULARLY DRINKS ALCOHOL)

N4. As a result of your drinking, during the last 6 months how often have you…

(STATEMENTS)

a. found it difficult to get the thought of alcohol out of your mind
b. found that you were not able to stop drinking once you had started
c. been unable to remember what happened the night before because you had been drinking
d. needed a first drink in the morning to get yourself going after a heavy drinking session
e. had a feeling of guilt or remorse after drinking

(RESPONSE FRAME)

Would that be…
1. Never
2. Less than monthly
3. Monthly
4. Fortnightly
5. Weekly
6. Daily or almost daily
7. (Don’t know)
8. (Refused)

*(REGULARLY DRINKS ALCOHOL)

N5. Have you or someone else been injured as a result of YOUR drinking?

(READ OUT)

1. No
2. Yes, but not in the last 6 months
3. Yes, during the last 6 months
4. (Don’t know)
5. (Refused)

*(REGULARLY DRINKS ALCOHOL)

N6. Has a relative, friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?
(READ OUT)

1. No
2. Yes, but not in the last 6 months
3. Yes, during the last 6 months
4. (Don’t know)
5. (Refused)

*Section P: Knowledge of NHMRC alcohol guidelines

*(ALL)

P1. Have you heard about Australia’s guidelines for safe levels of drinking?

1. Yes
2. No
3. (Don’t know)
4. (Refused)

*(ALL)

P2. How many standard drinks a day do you think a person can have without risking their long term health?

CLARIFY AS NECESSARY: A standard drink is equal to 1 pot of full strength beer, 1 small glass of wine or 1 pub-sized nip of spirits.

1. 0 drinks
2. 1 or 2
3. 3 or 4
4. 5 or 6
5. 7 to 9
6. 10 or more
7. (Don’t know)
8. (Refused)

*(ALL)

P3. What do you think is the maximum number of standard drinks a person can have on any one occasion without risking injury?

CLARIFY AS NECESSARY: A standard drink is equal to 1 pot of full strength beer, 1 small glass of wine or 1 pub-sized nip of spirits.

1. 0 drinks
2. 1 or 2
3. 3 or 4
4. 5 or 6
5. 7 to 9
6. 10 or more
7. (Don’t know)
8. (Refused)

PRE3 IF N1A=2 OR N1B=1 (DON’T DRINK ALCOHOL), GO TO T1. OTHERS CONTINUE

*(REGULARLY DRINKS ALCOHOL)

P4. Now I have some questions about how alcohol may have affected you in the past 6 months. In the past 6 months, did your use of alcohol cause you to…(READ OUT)

(STATEMENTS)

a. Have a hangover
b. Have an emotional outburst
c. Do less well in your studies, e.g. being late for classes, missing classes, failing to complete assignments (DISPLAY IF STYPE=1)
d. Get so drunk you were sick or passed out
e. Have trouble at home or work
f. Get injured or have an accident
g. Have a heated argument
h. Become violent and get into a fight
i. Have sex which you were unhappy about at the time
j. Have sex which you later regretted
k. Steal property
l. Commit an act of vandalism
m. Get in trouble with the police
n. Be asked to leave a party, pub or club because you were drunk
o. Feel irritable or depressed when alcohol wasn’t available

(RESPONSE FRAME)
1. Yes
2. No
3. (Don’t know)
4. (Refused)

*Section Q: Seeking Help
*(REGULARLY DRINKS ALCOHOL)
Q1. If you felt as if you had a problem with drinking too much alcohol, would you go for help?

1. Yes
2. No (GO TO R1)
3. Don’t know (GO TO R1)
4. Refused (GO TO R1)

*(REGULARLY DRINKS ALCOHOL, WOULD GO FOR HELP Q1=1)
Q2. Where would you go? DO NOT PROMPT (MULTIPLES ACCEPTED)

1. Mother
2. Father
3. BOTH parents
4. Other family member or relative
5. Friend
6. A lecturer / teacher (DISPLAY IF STYPE=1)
7. A VU counsellor (DISPLAY IF STYPE=1)
8. A supervisor (DISPLAY IF = STYPE=2)
9. Employee Assistance Program (EAP) (DISPLAY IF = STYPE=2)
10. A VU co worker
11. Other informal source (Specify)
12. GP/doctor
13. Psychiatrist
14. Psychologist
15. Counsellor
16. Helpline
17. Drug and alcohol service
18. Other professional source (Specify_)
19. Don’t know ^s
20. Refused ^s

Section T: Collection of contact details
TIMESTAMP13
Thank you (...NAME...). This interview is part of an ongoing study and we would REALLY LIKE to call you back towards the end of the year to do another interview as part of this important research. To help us can we confirm your details?

IF NECESSARY, EXPLAIN: This will give you another coffee voucher and another chance to win a $50 Coles Myer voucher.

1. Agree to be re-contacted (CONTINUE)
2. Otherwise (GO TO END)

*(AGREED TO BE RECONTACTED)*

T1a. I have your name down as:

<DISPLAY FNAME, MIDDLE NAME (IF PRESENT) AND SNAME>

Is this correct?

INTERVIEWER NOTE: PROBE FOR MIDDLE NAME

1. Name in sample correct
2. Edit Name: (Specify ____) (EDIT TITLE, FIRST NAME, MIDDLE NAME AND SURNAME IN SEPARATE FIELDS)
3. (Refused)

*(AGREED TO BE RECONTACTED)*

T2telnum The preferred telephone number I have for you is:

<DISPLAY TELNUM>

Is this correct?

1. Yes
2. No – ENTER NEW TELNUM (10 DIGITS, INCLUDE AREA CODE IF LANDLINE)
3. (Refused)

PRET2altnuma IF ALTNUM PRESENT IN SAMPLE CONTINUE, ELSE GO TO T2altnumb

*(AGREED TO BE RECONTACTED, HAS ALTNUM)*

T2altnuma I also have this number as an alternative:

<DISPLAY ALTNUM>

Is this correct?

1. Yes (GO TO T2address)
2. No – ENTER NEW ALTNUM (10 DIGITS, INCLUDE AREA CODE IF LANDLINE) (GO TO T2address)
3. No longer has a mobile / alternative number (GO TO T2address)
4. (Refused) (GO TO T2address)

*(AGREED TO BE RECONTACTED, NO ALTNUM)*

T2altnumb Do you have an alternative number, we could contact you on next time?

1. Yes – ENTER NEW ALTNUM (10 DIGITS, INCLUDE AREA CODE IF LANDLINE)
2. No

*(AGREED TO BE RECONTACTED)*

T2address The address I have is:

<DISPLAY ADD1, ADD2, SUBURB, PCODE & STATE>

Is this correct?

1. Yes
2. No – DISPLAY AND EDIT ADDRESS ONE FIELD AT A TIME WHERE NECESSARY
3. (Refused)
*(AGREED TO BE RECONTACTED)
T2email  And finally can I please confirm your email address?
   <DISPLAY EMAIL>
   1. Email address in sample is correct
   2. Edit sample member email address (ENTER USERNAME AND DOMAIN NAME IN SEPARATE FIELDS)
   3. (Refused)

*(AGREED TO BE RECONTACTED)
T3  We’d also like to get the name and phone number of someone who doesn’t live with you who might be able to help us get in contact with you.

(IF NECESSARY: We’ll only contact this person if we can’t get hold of you at the number you’ve just given us.)

Would that be possible?
   1. Yes
   2. No (no need to give alternative contact person / not moving anywhere) (GO TO PRET6)
   3. (refused) (GO TO PRET6)

*(AGREED TO BE RECONTACTED AND PROVIDE BUDDY DETAILS)
T4  RECORD / EDIT DETAILS OF CONTACT PERSON

   1. First Name:
   2. Surname:
   3. Phone Number: ENTER CONTACTNUM (10 DIGITS, INCLUDE AREA CODE IF LANDLINE)

*(AGREED TO BE RECONTACTED AND PROVIDE BUDDY DETAILS)
T5  Relationship to respondent

   1. Husband/wife/partner
   2. Former husband or wife
   3. Father
   4. Mother
   5. Brother
   6. Sister
   7. Son
   8. Daughter
   9. Father–in–law
  10. Mother–in–law
  11. Brother–in–law
  12. Sister–in–law
  13. Son–in–law
  15. Grandfather
  16. Grandmother
  17. Other male relative
  18. Other female relative
  19. Male friend
  20. Female friend
  21. Employer
  22. Other (specify)
  23. (Refused)
*STUDENT*

T6. It would also be helpful if you could tell us your student number as this may help us to contact you in future. Can I please confirm this?

1. (Specify__) (RANGE 1 TO 7 DIGITS)
2. (Don’t know)
3. (Refused)

*ALL*

END Thanks for participating in this survey. We will send you a coffee voucher in the next few weeks and enter you in the draw to win a $50 Coles Myer voucher. Just in case you missed it, my name is (…) calling on behalf of Orygen Youth Health Research Centre.

If you would like more information about the mental health problems I’ve described I can give you the telephone number of a help line that provides free and confidential information, or alternatively the address of a website. Would you like this telephone number or web address?

IF YES TO PHONE: The number is 1800 18 7263. This is an organisation called SANE Australia. The number is attended during business hours.

IF YES TO WEB: The website address is www.sane.org.au. This is an organisation called SANE Australia.

TERM1 Thanks for being prepared to help out, but for this survey we need to talk to current staff / students at VU.

TERM2 Thanks anyway, but for this survey we need to know your age in order to continue.

TERM3 Thanks anyway, but for this survey we need to speak to people who will be studying at VU for 6 months or more

ALLTERM

1. IntroA=4 Household refusal - not confirmed whether respondent still at number provided
2. IntroA=5 Respondent refusal
3. IntroA=7 QR LOTE – no follow up
4. IntroA=10 Respondent not known
5. S2=2 or S2a=9 Respondent under 18 years of age
6. S2a=8 Respondent refusal to provide age
7. A11=3 (Respondent studying at VU for less than 6 months)
8. S3=4 Respondent refusal
9. S3=6 QR LOTE – no follow up
10. A0=4 Respondent not a current student / staff member at VU
11. All other
Appendix C  Headspace Psychosocial Assessment Tool
headspace
Psychosocial Assessment for Young People

The headspace Psychosocial Assessment guides the interviewer through a series of domains in order to assess areas of difficulty that may be indicative of psychosocial problems.

An expansion of the HEADS assessment
Revised by the headspace Centre of Excellence:
Original publication:
Tips for engagement and interviewing

The note an interviewer strikes at the outset may affect the entire outcome

- Introduce yourself to the young person first
- Ask the young person to introduce you to others who may be present
- This gives the young person a clear message that you are interested in him/her

Don’t begin the interview asking “why are you here?”

- Chat with the young person about lighter, non-threatening topics
- Provide an outline of what’s going to happen, including the range of questions
- Prepare them for the sensitive nature of some of the questions
- Let the young person know they can choose not to answer any of the questions
- Create an empathetic stance by acknowledging they may feel uncomfortable at times

Build rapport so that the young person feels their concerns have been heard

- The young person should come away feeling that someone cares and that it might be useful to return
- Ask open-ended questions so that there is opportunity for rapport building and engagement
- The goal isn’t just to elicit information about what might be ‘wrong’ with the young person

Spend time during the interview asking for feedback

- Check that you understand the young person’s main concerns and difficulties
- Clarify the young person’s goal in coming to the assessment
- Before concluding, ask if they have any questions or anything more to add

Parents, family members, or other adults should not be present during the interview unless the young person specifically gives permission, or requests it

- The amount of time spent with the young person alone depends on his/her developmental age and stage

The importance of the health practitioner’s belief systems and assumptions

Health care providers bring their own set of beliefs and assumptions about young people, based on their own knowledge and experience, which can result in varying levels of tolerance in dealing with particular situations, particularly health risk behaviours.

It is essential to understand youth development and to be aware of the issues that young people might be facing. Young people are appropriately beginning to try out adult behaviours and gain increasing independence from parents and other adults. Taking a respectful stance where young people are seen as responsible and able to make decisions will begin the process of building an effective collaboration between you and the client.

It is important to ask questions in a non-judgmental way that does not imply assumptions, e.g. questions to young women about ‘boyfriends’ assumes heterosexuality, questions about mum and dad assumes a young person lives at home with two parents. If a health care provider is confronted with a situation that is challenging to them and causes a ‘dilemma’, it is suggested the health professional consult with a colleague or refer the young person for developmentally appropriate care.

A youth focus will necessarily include listening carefully to their concerns and their goals in coming to see you, and ensuring their active participation in deciding on what to work on and how to work on it. At the same time, young people are still developing and need support and reassurance. The level of their participation will depend on developmental age and stage.
headspace psychosocial interview domains

The headscape interview covers 10 domains
- Home and Environment
- Education and Employment
- Activities
- Alcohol and Other Drugs
- Relationships and Sexuality
- Conduct difficulties and Risk-taking
- Anxiety
- Eating
- Depression and Suicide
- Psychosis and Mania

PLUS final subsection:
- Summary (Strengths and Difficulties) and Goals

Commence each domain with screening questions

Are there concerns in response to the screening questions?

YES
Proceed to elaborative/probing questions to gain a more comprehensive understanding

NO
Proceed to next headscape domain

Use discretion in terms of how screening and probing questions are framed
- Given the age range of headscape clients (12-25), the young person’s developmental stage needs to be taken into account
- For example, in the Drugs and Alcohol domain, ask a 12-15 year old if s/he drinks or uses drugs, whereas for a 16-25 year old, ask how often they use such substances
Who should use the headspace psychosocial assessment?

Any service provider within a headspace centre could use the headspace psychosocial interview with a young person. It is designed to be used by any practitioner with experience conducting client assessments, including GPs, psychologists, social workers, occupational therapists, mental health nurses, youth workers, or substance use workers.

The use of screening questions, as well as the progression from an assessment of general functioning to mental health difficulties, allows the practitioner to be flexible with regard to the length and depth of their questioning. Nonetheless, the headspace psychosocial interview does contain some sensitive items (e.g. around the experience of abuse) as well as specific mental health content.

Practitioners who do not feel confident to conduct the full interview with a young person should choose only to complete the screening questions (in those domains they feel competent to address), and to refer the young person to another experienced practitioner within the headspace centre for a full assessment if indicated on the basis of their screening responses.

Similarly, a number of additional assessment measures are recommended within several of the domains. If information additional to the probing questions is required (e.g. the Suicide Risk Screener). As these measures are recommended for even further elicitation of mental health difficulties, they should only be administered by GPs, psychiatrists or other mental health professionals, or services providers who are experienced with their use.

The headspace psychosocial interview provides a guide on how to ask questions of young people with mental health problems. Not all questions must be answered, nor do all questions need to be asked in the order suggested. The purpose is to commence with non-threatening questions in order to build rapport with the young person. However, if the young person initiates the interview with statements regarding their presenting problem, this can be explored initially before moving onto the other domains.

Finally, a summary of the issues discussed in the interview can be included at the end of the document, along with the goals the young person has in terms of what they would like to achieve from their engagement with headspace.
Confidentiality

Confidentiality is a major concern of young people. Many headspace clients may be concerned about what they say getting back to their parents, friends, or school teachers/employers. It is therefore important that the extent of - and limits to - confidentiality are discussed from the outset of the assessment, and revisited as necessary throughout any assessment or treatment period with the young person.

Confidentiality means that what is discussed with the young person is not repeated to others, unless it is deemed to be helpful and there is expressed permission from the young person. The three main exceptions where it may be necessary to break confidentiality are when:

1) the young person is at risk of harming or killing themselves,
2) at risk of harming someone else or committing a serious criminal offence, or
3) they are being threatened or harmed (physical/sexual abuse) by someone else.

Many health professionals may also be subject to Mandatory Reporting laws in suspected cases of child abuse and neglect (only mandatory for a young person under the age of 16). The professionals mandated to report vary across the different states and territories (see http://www.aifs.gov.au/nch/pubs/sheets/rs3/rs3.html).

It may also be that disclosure is necessary in order to obtain information from other agencies or to engage other agencies in order to access services for the young person. In this case permission to disclose should be obtained in writing from the young person for non-urgent communications.

Important confidentiality considerations

- Confidentiality is essential to promote young people’s access to health care, especially for sensitive concerns such as mental and sexual health, and substance abuse.
- A young person’s right to confidentiality must be balanced with families’ right to be informed. Confidentiality can be achieved whilst simultaneously encouraging the young person to share important information with their family, where appropriate.
- Involving the young person’s family in treatment can contribute to better mental health outcomes. Clinicians should establish agreement concerning the extent to which information is to be shared with family and friends at the beginning of contact with a young person.
- In Australia, confidential health care is a legal right for competent adolescents. Competence is determined by clinical judgement of the young person’s stage of development and their ability to understand what is being discussed, in the context of the relevant local and national legislation. Workers should check which legislation applies in their jurisdiction. For more information, go to http://www.headspace.org.au/what-works/resources/assessment-interview

Raising and discussing confidentiality with the young person in this interview

- Ask the young person their understanding of confidentiality to begin the conversation.
- Confidentiality must be assured and limits to confidentiality discussed.
- Discuss consent to contact other sources when necessary.
- Decide with the young person what issues will be discussed with parents and the extent to which parents will be involved in ongoing treatment. This is dependent on factors such as age, living arrangements, cultural expectations and the level of autonomy and closeness within the family.

Further information is available at http://www.theshopfront.org/print/24.html
Domain 1: Home and Environment

Screening questions

- Where do you live? Who lives at home with you? How long have you lived there? Is this stable accommodation for you?
- What are your relationships like at home? Are there any problems/fights that worry you?
- Do you feel okay and safe at home?

Example of probing questions

- Do you have any brothers or sisters? How old are they?
- Who are you closest with in your family?
- Have there been any changes in your family/home recently (e.g. someone left/arrived)?
- Are your parents well/OK? What do your parents do for a living?
- What kinds of things do you and your family argue about the most? What happens in the house when there is a fight?
- Is there anything you would like to change about your family? Why?
- Have you ever had to live away from home?
- Are you spending time ‘couch surfing’, moving frequently between friends or relatives?
- Are any agencies involved in your housing or accommodation?

Asking about familial abuse or substance use may be difficult. Using a scenario may facilitate this line of questioning, i.e. “Working with young people I have learned from some that their relationship with their parents is a difficult one; by this I mean they argue and fight. Some young people have told me that they wish their parents did not drink so much or use drugs. Is this a situation in your house? Has anything like this happened to you?”

Notes:

Consider drawing a genogram:

- Male
- Female
- Marriage
- Separation
- Divorce
- Twins
- Adoption
- Pregnancy
- Miscarriage
- Unknown
- Significant loss
- Death
- Non-marriage
- Focal Group of individuals

Page 8
Domain 2: Education and Employment

On the basis of obtaining the young person’s demographic details, you will be aware of whether s/he is at school, working or unemployed. Frame the following questions with this information in mind.

Screening questions

• So you’re at school/working/looking for work. How’s that going?
• Do you enjoy school/work? What do you/don’t you like about it?
• Do you go every day? How many days have you missed over the past 2 weeks? When did your attendance start to decline?
• How do you feel you’re coping with school/work? How do you feel about this?
• Many young people experience bullying at school or at home via the internet or mobile phones, have you ever experienced this?

Examples of Probing Questions

• Are you doing what you want to do at school/work? What would you prefer?
• Tell me about your friends at school/work? How do you get along with your peers? Is your school a safe place?
• Have you ever been treated badly or been in conflicts at school? What happened?
• Have you been bullied? Have you been a bully? Have you been a witness/bystander to bullying? What kind of bullying (face to face, cyber) and what was the content (physical, sexual)?
• How much school/work do you miss? Have you ever been suspended/fired?
• Why is it so tough at school/work? Do you need help with this?
• Does this ever get you down?

Notes
Domain 3: Activities

Screening questions

- What do you like doing?
- What does a usual day involve for you? (Describe for me a normal day in your life?)
- Do you have friends that you hang out with? What kinds of things do you like to do together?
- Do you mainly spend time on your own? Is that OK with you?

Probing questions

- Are most of your friends from school/work or elsewhere? Are they the same age as you?
- Do you have one close friend or a few friends?
- Do you spend time doing things with your family? What do you do?
- What do you do on the weekends?
- Do you ever feel lonely or left out of activities? What happens and how do you feel?

Rate SOFAS (see next page)

Notes
# Social and Occupational Functioning Assessment Scale (SOFAS)

Consider social and occupational functioning on a continuum from excellent functioning to grossly impaired functioning. Include impairments in functioning due to physical limitations, as well as due to mental impairments. To be counted, impairment must be a direct consequence of mental and physical health problems: the effects of lack of opportunity and other environmental limitations are not to be considered.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Superior functioning in a wide range of activities</td>
</tr>
<tr>
<td>91</td>
<td>Superior functioning in a wide range of activities</td>
</tr>
<tr>
<td>90</td>
<td>Good functioning in all areas, occupational and socially effective</td>
</tr>
<tr>
<td>81</td>
<td>No more than a slight impairment in social, occupational, or school functioning (e.g. infrequent interpersonal conflict, temporarily falling behind in schoolwork)</td>
</tr>
<tr>
<td>71</td>
<td>Some difficulty in social, occupational or school functioning, but generally functioning well, has some meaningful interpersonal relationships</td>
</tr>
<tr>
<td>61</td>
<td>Moderate difficulty in social, occupational or school functioning (e.g. few friends, conflicts with peers, coworkers)</td>
</tr>
<tr>
<td>51</td>
<td>Serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job)</td>
</tr>
<tr>
<td>41</td>
<td>Major impairment in several areas such as work or school, family relations (e.g. depressed man avoids friends, neglects family and is unable to work; child frequently beats up younger children, is defiant at home, and is failing school)</td>
</tr>
<tr>
<td>31</td>
<td>Inability to function in almost all areas (e.g. stays in bed all day, no job, home or friends)</td>
</tr>
<tr>
<td>21</td>
<td>Occasionally fails to maintain minimal personal hygiene. Unable to function independently</td>
</tr>
<tr>
<td>11</td>
<td>Persistent inability to maintain minimal personal hygiene. Unable to function without harming self or others without considerable external support (e.g. nursing care and supervision)</td>
</tr>
<tr>
<td>0</td>
<td>Inadequate information</td>
</tr>
</tbody>
</table>
## Domain 4: Alcohol and Other Drugs

The following questions should take into account the young person's developmental stage.

For those aged 12-15, begin questions with “Do you...?” For those aged 16-25, begin with “What do you...?”

### Screening questions
- Do you drink? Smoke? Have you tried or used drugs? What have you tried?
- What do you like about it? What don’t you like?
- Have you regularly used alcohol or drugs to help you relax, calm down or feel better?
- Have you had any problems with family, friends, police (or courts) related to drinking or using drugs?
- Would any of your friends or family say you have a problem with drinking or drugs?

### Probing questions
- What were you drinking the last time you got drunk (or stoned/high)? Why? Could you remember everything? How did you get home?
- How do you (and your friends) take drugs?
- Do any of your family drink, smoke or use other drugs? If so, how do you feel about this? Is it a problem for you?
- In the last three months, what is the longest time you have gone without any alcohol or drug use?
- Have you tried to have any periods without alcohol or drug use and how did these go?
- Have you ever thought about changing or reducing your drug and alcohol use?

### Consider ASSIST item

<table>
<thead>
<tr>
<th>Substance</th>
<th>In your life, which of the following substances have you ever used? (NON-MEDICAL USE ONLY)</th>
<th>No (If No go onto the next drug)</th>
<th>Yes</th>
<th>In the past three months, how often have you used each of these substances (1 = drug, 2 = drug etc.)?</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Tobacco products (cigarettes, cigars, etc.)</td>
<td>0 1</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Alcoholic beverages (beer, wine, spirits, etc.)</td>
<td>0 1</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Cannabis (marijuana, pot, grass, hash, etc.)</td>
<td>0 1</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Cocaine (coca, crack, etc.)</td>
<td>0 1</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Amphetamines (speed, diet pills, ecstasy, etc.)</td>
<td>0 1</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Inhaled (nitrous, glue, petrol, paint thinner, etc.)</td>
<td>0 1</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Inhalants (Valium, Serpex, Flohydrin, etc.)</td>
<td>0 1</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K)</td>
<td>0 1</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Opioids (heroin, morphine, methadone, codeine)</td>
<td>0 1</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Other - specify</td>
<td>0 1</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please note:** If a young person answers yes to ever injecting a drug (item k), they should be referred to a GP for appropriate Sexually Transmitted Infection (STI) and Blood Borne Virus tests. See [http://www.sti.gov.au/__data/assets/pdf_file/0012/117571/GP_STI_Testing_Tool.pdf](http://www.sti.gov.au/__data/assets/pdf_file/0012/117571/GP_STI_Testing_Tool.pdf)

### Notes
Domain 5: Relationships and Sexuality

Consider commencing with an opening statement, such as “As part of our assessment we ask all young people about relationships and about sexuality. We don’t make assumptions about people’s sexual orientation, and we see a lot of people who are gay, bisexual, or questioning their sexuality.”

**Screening questions**

- Are you in a relationship? (If no: Have you ever been in one? If yes: What’s your relationship like?)
- Do you identify as straight/bisexual/gay/lesbian? (Or: Are you attracted to males or females or both? Or if no relationship: Even though you haven’t had a relationship yet, are you interested in boys or girls? Perhaps you’re not sure?)
- For young people who identify as same sex attracted: Have you ever had any negative experiences about being gay/bisexual/lesbian?

**Probing questions**

- Have you ever had sex, perhaps in a relationship or perhaps casual sex (this can include oral, anal or vaginal sex)? If no, skip the next 2 questions
- Have you had sex in the last 12 months? If no, skip next question
- Have you been tested for sexually transmitted infections in the last 12 months? If no, the young person should be referred to a GP for appropriate STI tests (either within your headspace centre, or to an external GP or sexual health clinic) See [http://www.stpu.nsw.gov.au/cms/docs/117571_GP_STI_Testing_Tool.pdf](http://www.stpu.nsw.gov.au/cms/docs/117571_GP_STI_Testing_Tool.pdf) for information.
- For young people who are sexually active: Do you use any form of protection? What sort? Do you ever have unprotected sex?
- Have you ever felt pressured or uncomfortable about having sex? (Use clinical judgement as to whether to probe further, depending on young person’s response. Depending on your experience and training in managing disclosures of sexual abuse, you may follow up with: Have you ever been abused, or been forced into having sex? Who did this? When?)

**Notes:**
Domain 6: Conduct difficulties and Risk Taking

Screening questions

- Have you deliberately harmed or injured yourself – like cutting, burning, or scratching yourself – when not feeling suicidal?
- When did it start? How often? Do you do this to manage stress, emotions, to cope? Have you had to get medical assistance for this?
- Have you put yourself in unsafe situations (e.g. unsafe sex, risky driving)?
- Have you ever wanted to hurt someone else? Have you acted on this? What has stopped you from doing anything?
- Do you often feel out of control (with your behaviour)?

Probing questions

- Many young people get frustrated with others. Have you ever felt like this or acted on your frustrations? How?
- Have you ever thought about or felt like hurting someone else?
- Have you ever done something on the spur of the moment that you later regretted?
- Do you get in lots of arguments with your family because they have problems with your behaviour?
- Are you in trouble at school? Do you feel picked on by teachers?
- Have you ever been involved with the police? Have you ever been charged?
- Do you belong to a group/gang? (Note: If you don’t know the answer, it’s ok. You don’t have to tell us.)

Notes:

Do you have any tattoos or body piercings? Where did you get these done? If not at a licensed tattoo parlour or beautician, the young person should be referred to a GP for appropriate STI and Blood Borne Virus tests. See http://www.stipu.nsw.gov.au/cms_docs/117571_GP_STI_Testing_Tool.pdf for information.
Domain 7: Anxiety

Screening questions

- It’s normal to feel anxious in certain situations (e.g., heights, public speaking). Are there times when you feel unusually anxious, nervous or stressed?
- Have you ever felt really anxious all of a sudden – e.g., for no reason at all? What was it like? (Consider describing some common symptoms, e.g., heart racing, shortness of breath, fear of losing control...)
- Do you think you feel more anxious or worry more than your friends?
- Are there situation or objects that you avoid because you feel too anxious? How does this affect your day-to-day life?

Probing questions

- Do you worry a lot about things that you have no control over (e.g., bad things you see on the news)?
- Do you ever find yourself having to do things over and over, like touching, counting, washing your hands many times, or checking things to make you feel better?
- Do you obsess about things, or get stuck on things, like your homework or appearance having to be perfect? Do family or friends think you obsess about things? What types of things?

Notes
Domain 8: Eating

Screening questions

• Do you worry about your body or your weight?
• What do you like or not like about your body?
• Do you try things to manage your weight (e.g., extreme restriction of your food intake, exercising excessively)?
• Have there been any recent changes in your weight?
• Are any of your family members or friends worried about your weight or your attitude towards your body/food?

Probing questions

• Does it ever seem as though your eating is out of control?
• Have you ever made yourself throw up on purpose in an attempt to control your weight?
• Do you believe yourself to be overweight or fat even if others tell you that you aren’t?
• Have you ever taken diet pills?
• How often do you exercise and what do you usually do?

Notes
Domain 9: Depression and Suicide

Screening questions

• Do you feel sad or down more than usual? Have you ever felt that way in the past? For how long?
• Have you lost interest in things that you usually like doing?
• Are you having trouble sleeping?
• Do you find yourself spending less and less time with friends or family? Would you rather just be by yourself most of the time? Why?

Probing questions

• Have you ever tried to hurt yourself (e.g., cutting) to calm down or feel better?
• Have you started using alcohol or drugs to help you relax, calm down or feel better?
• Have you thought you would be better off dead or wished you were dead?
• Have you thought about suicide? Do you have a suicide plan?

Consider a suicide screen

<table>
<thead>
<tr>
<th>In the past month did you:</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Think that you would be better off dead or wish you were dead?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>b) Want to harm yourself?</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>c) Think about suicide?</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>d) Have a suicide plan?</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>e) Attempt suicide?</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>f) In your lifetime: Did you ever make a suicide attempt?</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

Scoring:

Suicide assessment: No current risk 0 points  Low  1 – 5 points
Moderate 6 – 9 points  High  >=10 points

TOTAL (add all numbers circled): _____

Notes:
Domain 10: Psychosis and Mania

Screening questions

- Sometimes, especially when feeling stressed, people can hear or see things that others don’t seem to hear or see. Has this ever happened to you? How often? Does it cause you distress?
- Have you found yourself thinking that someone was out to get you?
- Have you found yourself feeling really up or racy, or feeling like you can take on the whole world?
- Have you ever gone for days without sleep? How long?

Probing questions

- Have you ever felt like you have special powers that other people don’t have or are especially important in some way? What was this like?
- Have you felt that things around you had a special meaning intended just for you?
- Have you felt like someone or something outside of yourself has been controlling your thoughts, feelings, actions, or urges?
- Have you ever felt like your thoughts were less private than usual? For example, like your thoughts are broadcast so that everyone can know what you’re thinking? Or that people can read your mind?

Notes
Summary and Goals

Brief summary of presenting issues

Provide an overall summary of the domains in which the young person was having difficulty and those in which they were coping well. Provide feedback to the young person of your impression of the psychosocial interview. In most cases, you can identify strengths and potential, as well as problem areas, and discuss both in order to offer a balanced view.

Consider using a formulation framework, addressing the four P's

- **Predisposing factors**: aspects of the client's background that make him/her susceptible to presenting with the given problems (e.g. history of mental illness in family).
- **Precipitating factors**: immediate issues or events that have caused the client to present with or experience these problems or symptoms now (e.g. recent life experiences/stressors, bullying etc.).
- **Perpetuating factors**: factors that cause the client's symptoms/problems to continue or to progressively get worse (e.g. conflict in home, low social support, poor coping strategies).
- **Protective factors**: help improve the client's situation or symptoms.

Notes

Goals for engaging with headspace

Ask the young person what they would like to get from their experience with your headspace centre. Ask if there are specific problems that they would like to work on and what outcomes they hope to achieve.

Notes
Suggestions for wrapping up the interview

Give the young person an opportunity to express any concerns you have not covered

- Ask him/her for feedback about the interview (e.g. “I’ve asked you a lot of questions today, but is there anything we haven’t covered that you think is important to understand your situation?”)
- Remind them that they are welcome to call you or to come back in to talk about something important to share that may later remember

Ask the young person who they can trust and confide in and why they trust that person

- This is important if you have not already identified a trusted adult in the client’s life
- Tell the young person that he/she now has you as someone who can be trusted to help with problems and to answer questions
- Let them know you are interested in them and you want to help them lead a fuller, healthier life

For young people who demonstrate significant risk factors, relate your concerns

- Ask if they are willing to change or are interested in learning more about ways to deal with their problems, leading to a discussion of potential follow-up and therapeutic interventions
- Many young people do not recognize dangerous life-style patterns because they see their activities not as problems but as solutions. The challenge lies in helping the young person to see health risk-taking behaviours as problems and helping to develop better strategies for dealing with them

A youth focus will ensure their active participation in deciding what to work on and how to work on it

- Listen carefully to the young person’s concerns and their goals in coming to see you
- Young people are still developing and need support and reassurance
- Some of their executive and regulatory skills aren’t fully developed, so adult guidance and reassurance can still be very necessary

If the young person’s life is going well, say so:

- In most cases, you can identify strengths and potential, or real weaknesses, and discuss both in order to offer a balanced view

Conclusion

Treating young people with respect and engaging them in a process that allows their participation in determining goals and a management plan to meet these goals is essential. Assuming that young people are doing their best (i.e. understanding adolescent development) and using non-judgemental and open questions will facilitate a collaborative working relationship with the young person. Confidentiality is going to be upmost their minds and this is an ongoing conversation with any young person attending the service.

For more information on using a shared decision making framework, please refer to the Centre of Excellence’s evidence summary on shared decision making for mental health (http://www.headspace.org.au/what-works/resources/-evidence-summaries).
Appendix D  Institutional Performance Portfolio – Technical Document

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COMPARATIVE COHORTS/BENCHMARKS USED IN 2013

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<th>Regional Universities Network Cohort</th>
<th>Non-Aligned (See Benchmark Groups)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The University of Sydney</td>
<td>Central Queensland University</td>
<td>Australian Catholic University</td>
</tr>
<tr>
<td>The University of New South Wales</td>
<td>University of Ballarat</td>
<td>Bond University</td>
</tr>
<tr>
<td>The University of Melbourne</td>
<td>Southern Cross University</td>
<td>Charles Sturt University</td>
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<td>Monash University</td>
<td>The University of New England</td>
<td>Deakin University</td>
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<td>Macquarie University</td>
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<tr>
<td>The University of Western Australia</td>
<td></td>
<td>MCD University of Divinity</td>
</tr>
<tr>
<td>The Australian National University</td>
<td></td>
<td>Swinburne University of Technology</td>
</tr>
</tbody>
</table>

Australian Technology Network Cohort
Curtin University of Technology
University of South Australia
Royal Melbourne Institute of Technology
University of Technology, Sydney
Queensland University of Technology

Innovative Research Universities Cohort
Charles Darwin University
Flinders University
Griffith University
James Cook University
La Trobe University
Murdoch University
The University of Newcastle

Data Clarification
Performance of the institution is included in the cohort/ benchmark results.

For comparative purposes, time series data is calculated on groups recorded in 2010.

At the institutional level:
1. The University of New South Wales includes Australian Defence Force Academy data in historical series.
2. The University of Tasmania includes Australian Maritime College data in historical series.
3. The University of Newcastle, Murdoch University, Central Queensland University, Southern Cross University, The University of New England and University of Southern Queensland have selected Benchmark Groups outside their respective cohorts.
4. Regional Universities Network (RUN) were introduced in 2012.
Benchmark Groups:

Australian Catholic University: Griffith University, Deakin University, La Trobe University, Queensland University of Technology, University of Canberra, University of Western Sydney;

Bond University: The Group of Eight member universities;

Charles Sturt University: Deakin University, James Cook University, Swinburne University, The University of New England, University of Tasmania and University of Wollongong;

Central Queensland University: University of Ballarat, Southern Cross University, University of New England, University of Southern Queensland, University of the Sunshine Coast, Charles Sturt University and Charles Darwin University;

Deakin University: Curtin University, Griffith University, Macquarie University, The University of Newcastle, University of South Australia and University of Wollongong;

Edith Cowan University: Victoria University, University of Western Sydney, University of South Australia, Charles Sturt University, Deakin University, Griffith University and La Trobe University;

Macquarie University: The Group of Eight member universities;

MCD University of Divinity: Bond University and The University of Notre Dame Australia;

Murdoch University: Griffith University, Deakin University, Macquarie University, University of Tasmania, University of Wollongong, La Trobe University;

Southern Cross University: The University of New England, University of Southern Queensland, Central Queensland University, University of the Sunshine Coast, University of Ballarat, University of Canberra, La Trobe University and Deakin University;

Swinburne University of Technology: The Australian Technology Network member universities;

The University of Newcastle: Griffith University, Macquarie University, Queensland University of Technology, University of Tasmania, The University of Western Australia and University of Wollongong;

The University of New England: Central Queensland University, Charles Sturt University, Southern Cross University, University of Southern Queensland, James Cook University, University of Ballarat and University of the Sunshine Coast;

The University of Notre Dame Australia: Australian Catholic University, Bond University, Edith Cowan University, Murdoch University and University of Ballarat;

University of Canberra: The University of Newcastle, Charles Darwin University, Flinders University, Griffith University, La Trobe University;

University of Southern Queensland: Southern Cross University, University of the Sunshine Coast, The University of New England, University of Ballarat, Central Queensland University and Charles Sturt University;

University of Tasmania: The University of Adelaide, The University of Newcastle, University of Wollongong, The University of Griffith, Macquarie University, Deakin University and James Cook University;

University of Western Sydney: Deakin University, Griffith University, The University of New England, The University of Newcastle, Charles Sturt University and University of South Australia;

University of Wollongong: Griffith University, Macquarie University, University of Tasmania and University of Technology, Sydney;

Victoria University: Australian Catholic University, Edith Cowan University, Swinburne University, University of Canberra, University of South Australia and University of Western Sydney.
Appendix E  Phase 1 Letter and Survey
To the Student Support Service Manager/Coordinator,

You are invited to participate in an ethics approved study (Edith Cowan University Ethics Committee) which is being conducted as a requirement toward the degree of Doctor of Philosophy at Edith Cowan University, Perth, Western Australia (WA). The study will aim to profile the experiences of students and the services to which they could seek help or in the suspected case of many, not seek help.

This profile will then assist in the implementation of a quantitative review of service provision, that is, how does the provision of university support services to students affect their psychological distress? It is envisaged that this information might then assist in making recommendations for operational policies relating to student management and retention within universities in Australia and potentially globally.

Participation is voluntary, if you choose to participate in this research; you will be required to complete a survey this should take no more than twenty (20) minutes to complete. There is no right or wrong answers and your involvement will be beneficial in increasing the current body of knowledge.

If at any point you feel uncomfortable about a question or do not wish to answer you are not compelled to complete the questionnaire. By completing the questionnaire it is implied that you consent to the study. In keeping with legal requirements the data will be filed in a locked cabinet for a period of five years, at which time paper data will be shredded and electronic data will be deleted. The information provided will be accessed by me and my research supervisors, Professor Cobie Rudd, Professor Alfred Allan and Dr Michael Monisse-Redman.

If you have any further questions or concerns regarding the study or if you wish to obtain a copy of the final results please contact me at r.bostwick@ecu.edu.au or 0419 947 085; alternatively you can contact my research supervisor Professor Cobie Rudd via email at cobie.rudd@ecu.edu.au.

If you have any concerns or complaints about the research project and wish to speak to an independent person, you may contact:

Research Ethics Officer
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027
Phone: (08) 6304 2170
Email: research.ethics@ecu.edu.au

Thank you for your participation in my research.

Sincerely,

Richard Bostwick (PhD Candidate)
Principal Researcher
UNIVERSITY SUPPORT SERVICES SURVEY

University Name: ________________________________

Service Name: ________________________________

Please indicate the types of support services that are provided:

- □ Sporting/recreational support
- □ Student guild
- □ Caring for children of students [crèche]
- □ Legal services
- □ Counselling services
- □ Health and medical support
- □ Accommodation support
- □ Employment/ careers advice
- □ Financial affairs service
- □ Library support
- □ Learning/ skills for study support
- □ Overseas/ international student support
- □ Welfare support
- □ Student information services
- □ Other [Please Specify Below]

What are the operational days and hours of the service? [Please Circle]

Monday   Tuesday   Wednesday   Thursday   Friday   Saturday   Sunday

Hours of operation on days indicated: ________________________________

Is this service provided on all sites (campuses)? [Please Circle]   Yes   No

If No, then on which campus is the service provided? ________________________________

What is the primary method of intervention delivery? [Please Indicate]
□ Face to face
□ Telephone
□ Electronic medium

What is the current number of students registered with your program?

[Blank]

How many times would a student access your service? [Please Indicate]

☐ Occasional [as needed]
☐ Weekly [how many times _______________]
☐ Monthly [how many times _______________]
☐ Other [please specify ____________________]

What is an average length of time that a student would engage in your program for a single intervention?

[Please specify in hours] [Blank]

What is the total number of sessions/occasions of service for a twelve-month period?

[Blank]

What is the age of students accessing your service? [Please Indicate]

☐ under 18
☐ 18 to 24
☐ 25 to 34
☐ 35 to 44
☐ 45 to 54
☐ 55 to 64
☐ 65 to 74
☐ 75 to 80

How many of the student’s accessing your service are:

Male [Blank]
Female [Blank]

How many students accessing your services are in:

[Blank]
<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 3</td>
<td>Year 4</td>
</tr>
</tbody>
</table>

### How many of the student’s accessing your service are:

- An Australian citizen
- An Australian resident
- Not an Australian citizen or resident

### How many students accessing your service were born in:

- Australia
- United Kingdom (England, Scotland, Wales, Northern Ireland)
- New Zealand
- China
- Vietnam
- Philippines
- India
- Hong Kong
- Republic of Korea
- Other [Please Specify Country ________________________]

### How many of the students accessing your service are:

- Single
- Couple with no children
- Couple with dependent children
- Couple with non-dependent children
- Couple with dependent and non-dependent children
- One parent family with dependent children
- One parent family with non-dependent children
- One parent family with dependent and non-dependent children
- Group household
- Student residence
- One person household
- Other (Specify)
(Don’t know)
(Refused)

How many students accessing the service are:

- Studying full-time
- Studying part-time
- Something else [Please Specify ________________]

What is the level of qualification of the students accessing your service (no.):

- Bachelor degree
- Associate degree
- Advanced diploma
- Diploma
- Certificate 4
- Certificate 3
- Certificate 2
- Certificate 1
- Certificate unspecified [Please Specify ________________]
- Other [Please Specify ________________]
Appendix F  Phase 2 Letter and Survey
Default Question Block

Dear Participant,

You are invited to participate in an ethics approved study (Edith Cowan University Ethics Committee) that is being conducted as a requirement toward the degree of Doctor of Philosophy at Edith Cowan University, Perth, Western Australia (WA). The study will aim to profile the experiences of students and the services to which they could seek help or in the suspected case of many, not seek help.

This profile will then assist in the implementation of a quantitative review of service provision, that is, how does the provision of university support services to students affect their psychological distress? It is envisaged that this information might then assist in making recommendations for operational policies relating to student management and retention within universities in Australia and potentially globally.

Participation is voluntary, if you choose to participate in this research you will be asked to complete an electronic questionnaire; this should take approximately 20 minutes to complete.

There is no right or wrong answers, and your involvement will be beneficial in increasing the current body of knowledge. You will be asked to provide a suitable e-mail address in order for the follow-up survey to be sent to you after a period of four months. No other identifying information will be asked for.

If at any point you feel uncomfortable about a question or do not wish to answer you are not compelled to complete the questionnaire. By completing the questionnaire it is implied that you consent to the study. In keeping with legal requirements the data will be filed in a locked cabinet for a period of five years, at which time paper data will be shredded and electronic data will be deleted. The information provided will be accessed by me and my research supervisors, Professor Cobie Rudd, Professor Alfred Allan and Dr Michael Moniasse-Redman.

If you have any further questions or concerns regarding the study or if you wish to obtain a copy of the final results please contact me at r.bostwick@ecu.edu.au or 9419 047 085; alternatively you can contact my principal research supervisor Professor Cobie Rudd via e-mail at cobie.rudd@ecu.edu.au.

If you have any concerns or complaints about the research project and wish to speak to an independent person, you may contact:

Research Ethics Officer
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027
Phone: (08) 6304 2170
Email: research.ethics@ecu.edu.au

If you would like any further information or support regarding help-seeking for psychological distress following the completion of this survey you can contact the:

In Victoria: Nurse on Call 1300 606 024 or visit www.health.vic.gov.au/mentalhealth/services for your local mental health service.
In Western Australia: Mental Health Emergency Response Line on 1300 555 788 or Health Direct on 1800 022 222.

Thank you for your participation in my research.

Sincerely,

Richard Bostwick (PhD Candidate)
Principal Researcher

For the purpose of follow-up please add your student email address below:
For the purpose of analysis please indicate which university you are enrolled at:
- Edith Cowan University
- Deakin University

Demographics
Which of the following age groups do you fall in to?
- Under 18
- 19-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75-80

Gender
- Male
- Female

Are you
- An Australian citizen
- An Australian resident
- Not an Australian citizen or resident
- Don't know

What is your country of birth?
- Australia
- United Kingdom (incl. England, Scotland, Wales, Northern Ireland)
- New Zealand
- China
- Vietnam
- Philippines
- India
- Hong Kong

Qualtrics Survey Software

☐ Republic of Korea
☐ Europe
☐ United States of America
☐ Other

Which of these BEST describes your household?
☐ Couple only
☐ Couple with dependent children
☐ Couple with non-dependent children
☐ Couple with dependent and non-dependent children
☐ One parent family with dependent children
☐ One parent family with non-dependent children
☐ One parent family with dependent and non-dependent children
☐ Group household
☐ Student residence
☐ One person household
☐ Other, please specify

Are you currently
☐ A student
☐ A staff member
☐ Both a student and a staff member
☐ Neither, please specify

What is the level of qualification you are studying?
☐ Bachelor degree
☐ Associate degree
☐ Advanced diploma
☐ Diploma
☐ Certificate 4
☐ Certificate 3
☐ Certificate 2
☐ Certificate 1
☐ Certificate unspecified
☐ Other, please specify


Page 3 of 15
Are you currently
○ Studying full-time
○ Studying part-time

In what year did you first start studying?
○ Specify year
□ Don’t know

When do you plan to finish studying?
□ One year or more
□ Six months to one year
□ Less than six months
□ Don’t know

Do you plan to be studying at university in 2013 or 2014?
□ Yes
□ No
□ Don’t know

Which of the following currently describes your employment status?
□ 1. Full-time employment
□ 2. Part-time employment
□ 3. Employment on a contract basis
□ 4. Employment on a casual basis
□ 5. Not working

Are you currently looking for work?
□ Yes
□ No

Recognition of mental health problems
Please review the following scenarios relating to two fictional characters - John/Jenny. Although they are not real people there are people like them. If you happen to know someone who resembles them in any way, that is a total coincidence.
Scenario 1

John is a 21 year old who has been feeling unusually sad and miserable for the last few weeks. He is tired all the time and has trouble sleeping at night. John doesn’t feel like eating and has lost weight. He can’t keep his mind on his studies and his marks have dropped. He puts off making any decisions and even day-to-day tasks seem too much for him. His parents and friends are very concerned about him.

Scenario 2

Jenny is a 21 year old who has been feeling unusually sad and miserable for the last few weeks. She is tired all the time and has trouble sleeping at night. Jenny doesn’t feel like eating and has lost weight. She can’t keep her mind on her studies and her marks have dropped. She puts off making any decisions and even day-to-day tasks seem too much for her. Her parents and friends are very concerned about her.

Scenario 3

John is a 30 year old who has been feeling unusually sad and miserable for the last few weeks. He is tired all the time and has trouble sleeping at night. John doesn’t feel like eating and has lost weight. He can’t keep his mind on his work and his work performance has suffered. He puts off making any decisions and even day-to-day tasks seem too much for him. His family and friends are very concerned about him.

Scenario 4

Jenny is a 30 year old who has been feeling unusually sad and miserable for the last few weeks. She is tired all the time and has trouble sleeping at night. Jenny doesn’t feel like eating and has lost weight. She can’t keep her mind on her work and her work performance has suffered. She puts off making any decisions and even day-to-day tasks seem too much for her. Her family and friends are very concerned about her.

Intended actions to seek help and perceived barriers

If you had a problem right now like John/Jenny, would you go for help?

- 1. Yes
- 2. No
- 3. Don’t know

Where would you go? (MULTIPLES ACCEPTED)

- 1. Mother
- 2. Father
- 3. BOTH parents
- 4. Other family member or relative
- 5. Partner, boyfriend or girlfriend
- 6. Friend
- 7. A lecturer / teacher
- 8. A university counsellor
- 9. A supervisor
- 10. A counsellor provided by the university’s Employee Assistance Program (EAP)
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If you had a problem right now like John/Jenny, would you feel able to talk to your parents/another family member or relative about it?

- Yes
- No
- Not applicable (Parents not available e.g. passed away / estranged / live overseas)
- Don't know

If you had a problem right now like John/Jenny, would you feel able to talk to your partner, boyfriend or girlfriend about it?

- Yes
- No
- Not applicable (don't have a partner, girlfriend or boyfriend)
- Don't know

If you had a problem right now like John/Jenny, would you feel able to talk to your friends about it?

- Yes
- No
- Don't know

If you had a problem right now like John/Jenny, would you feel able to talk to your lecturer(s) / teacher(s) about it?

- Yes
- No
- Don't know

If you had a problem right now like John/Jenny, would you feel able to talk to your university counsellor(s) about it?

- Yes
- No
- Don't know
If you had a problem right now like John/Jenny, would you feel able to talk to your supervisor about it?

○ 1. Yes
○ 2. No
○ 3. Don't know

If you had a problem right now like John/Jenny, would you access online information or seek help via social networking or the like?

○ 1. Yes
○ 2. No
○ 3. Don't know

**Beliefs about interventions**

There are a number of different people who could possibly help John/Jenny. From the list below please indicate which ones would be helpful/harmful or neither to John/Jenny.

<table>
<thead>
<tr>
<th></th>
<th>Helpful</th>
<th>Harmful</th>
<th>Neither</th>
<th>Depends</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A GP or family doctor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. A lecturer/ teacher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. A university counsellor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. A counsellor provided through university's Employee Assistance Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. A counsellor not employed by a university</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. A telephone counselling service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. A psychologist</td>
<td></td>
<td></td>
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<tr>
<td>8. A psychiatrist</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>9. A close family member</td>
<td></td>
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<tr>
<td>10. A close friend</td>
<td></td>
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<td></td>
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<tr>
<td>11. A drug and alcohol service</td>
<td></td>
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<td></td>
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<tr>
<td>12. An online acquaintance/friend</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>13. An internet based source of information</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Is it likely to be helpful, harmful or neither if John/Jenny tried to deal with (his/her) problems on (his/her) own?

○ 1. Helpful

Do you think the following medicines are likely to be helpful, harmful or neither for John/Jenny? (Clarify this as needed: This includes vitamins and herbal medicine)

<table>
<thead>
<tr>
<th></th>
<th>Helpful</th>
<th>Harmful</th>
<th>Neither</th>
<th>Depends</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Vitamins</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>b. St John's Wort</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>c. Antidepressants</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>d. Medication for anxiety</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>e. Antipsychotics</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>f. Sleeping pills</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
</tbody>
</table>

Do you think the following are likely to be helpful, harmful or neither for (John/Jenny)?

<table>
<thead>
<tr>
<th></th>
<th>Helpful</th>
<th>Harmful</th>
<th>Neither</th>
<th>Depends</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Becoming more physically active</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>b. Getting relaxation training</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>c. Practicing meditation</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>d. Having regular massages</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>e. Getting acupuncture</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>f. Getting up early each morning and getting out in the sunlight</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>g. Receiving counselling</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>h. Receiving cognitive-behaviour therapy</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>i. Looking up a website giving information about (his/her) problem</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>j. Reading a self-help book on (his/her) problem</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>k. Joining a support group of people with similar problems</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>l. Going to a local mental health service</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>m. Being admitted to a psychiatric ward of a hospital</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>n. Using alcohol to relax</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>o. Smoking cigarettes to relax</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>p. Using marijuana or other drugs to relax</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
</tbody>
</table>
Stigmatizing attitudes and social distance

The next few questions contain statements about (John's/Jenny's) problem. Please indicate how strongly YOU PERSONALLY agree or disagree with each statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. (John/Jenny) could make (himself/herself) better (if he/she) wanted.</td>
<td></td>
<td></td>
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<tr>
<td>b. (John's/Jenny's) problem is a sign of personal weakness.</td>
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<tr>
<td>c. (John's/Jenny's) problem is not a real medical illness.</td>
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<tr>
<td>d. (John/Jenny) is dangerous. (If the respondent is unsure of the meaning of 'dangerous' in this statement, inform them it means 'dangerous to others').</td>
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<tr>
<td>e. It is best to avoid (John/Jenny) so that you don't develop this problem yourself.</td>
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<tr>
<td>f. (John's/Jenny's) problem makes (him/her) unpredictable.</td>
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<tr>
<td>g. You would not tell anyone if you had a problem like (John's/Jenny's).</td>
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</tr>
</tbody>
</table>

The following questions ask how you would feel about spending time with John/Jenny.

Would you be happy...

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes Definitely</th>
<th>Yes Probably</th>
<th>Probably Not</th>
<th>Definitely Not</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. To go out with (John/Jenny) on the weekend?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>b. To work on a project with (John/Jenny)?</td>
<td></td>
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<tr>
<td>c. To invite (John/Jenny) around to your house?</td>
<td></td>
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<tr>
<td>d. To go to (John/Jenny)'s house?</td>
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<tr>
<td>e. To develop a close friendship with (John/Jenny)?</td>
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</tr>
</tbody>
</table>

Exposure to mental disorders

In the last 12 months have you had a problem similar to (John's/Jenny's)?

☐ 1. Yes

☐
2. No
3. Don’t know

What did you think the problem was? (MULTIPLES ACCEPTED)
1. Depression
2. Schizophrenia/paranoid schizophrenia
3. Psychosis/psychotic
4. Mental illness
5. Alcohol problem
6. Drugs
7. Anxiety/anxious
8. Eating disorder
9. Low self esteem/low self confidence
10. Shy
11. Stress
12. Psychological/mental/emotional problems
13. Has a problem
14. Other, please specify
15. Nothing
16. Don’t know

Did you do anything to deal with the problem?
1. Yes
2. No
3. Don’t know

What did you do?
1. Answer given, please specify
2. Don’t know

Below are a list of things you might have done to deal with the problem. Please indicate whether or not you did each one.

(Did you seek help from.....)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. A GP or family doctor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. A lecture/teacher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. A university counsellor</td>
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<tr>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>-----</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>d.</td>
<td></td>
<td></td>
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<tr>
<td>e.</td>
<td></td>
<td></td>
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<tr>
<td>f.</td>
<td></td>
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<td>g.</td>
<td></td>
<td></td>
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<tr>
<td>h.</td>
<td></td>
<td></td>
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<tr>
<td>i.</td>
<td></td>
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<tr>
<td>j.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k.</td>
<td></td>
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</tr>
</tbody>
</table>

**Did you try to deal with the problem on your own?**

- [ ] 1. Yes
- [ ] 2. No
- [ ] 3. Don't know

**Which of the following medicines, if any, did you take?**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Vitamins</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. St. John's Wort</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Antidepressants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Medications for anxiety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Antipsychotics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Sleeping pills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Other, please specify</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Did you do any of the following to deal with your problem?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>c.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
<td></td>
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<tr>
<td>e.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
h. Received cognitive-behaviour therapy
i. Looked up a web site giving information about your problem
j. Read a self-help book on your problem
k. Joined a support group of people with similar problems
l. Went to a local mental health service
m. Went to a local drug and alcohol service
n. Were admitted to a psychiatric ward of a hospital
o. Were admitted to a drug and alcohol program
p. Used alcohol to relax
q. Smoked cigarettes to relax
r. Used marijuana or other drugs to relax
s. Cut down on use of alcohol
t. Cut down on smoking cigarettes
u. Cut down on marijuana or other drugs

Out of all the people you sought help from and the things you did, which ones helped you the most? (MULTIPLES ACCEPTED)

☐ 1. A GP or family doctor
☐ 2. A lecturer/teacher
☐ 3. A university counsellor
☐ 4. A counselor provided by university's EMPLOYEE ASSISTANCE PROGRAM
☐ 5. A counselor not employed by university
☐ 6. A telephone counselling service
☐ 7. A psychologist
☐ 8. A psychiatrist
☐ 9. A close family member
☐ 10. A close friend
☐ 11. A drug and alcohol service
☐ 12. Vitamins
☐ 13. St John's wort
☐ 14. Antidepressants
☐ 15. Medications for anxiety
☐ 16. Antipsychotics
☐ 17. Sleeping pills

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19. Other medication or professional, please specify
☐ 19. Becoming more physically active
☐ 20. Getting relaxation training
☐ 21. Practicing meditation
☐ 22. Having regular massages
☐ 23. Getting acupuncture
☐ 24. Getting up early each morning and getting out in the sunlight
☐ 25. Recasing counseling
☐ 26. Recasing cognitive-behaviour therapy
☐ 27. Looking up a web site giving information about (his/her) problem
☐ 28. Reading a self-help book on (his/her) problem
☐ 29. Joining a support group of people with similar problems
☐ 30. Going to a local mental health service
☐ 31. Going to a local drug and alcohol service
☐ 32. Being admitted to a psychiatric ward of a hospital
☐ 33. Being admitted to a drug and alcohol program
☐ 34. Using alcohol to relax
☐ 35. Smoking cigarettes to relax
☐ 36. Using marijuana to relax
☐ 37. Cutting down on use of alcohol
☐ 38. Cutting down on smoking cigarettes
☐ 39. Cutting down on marijuana
☐ 40. Other, please specify
☐ 41. None
☐ 42. Don't know
☐ 43. Did not seek any help (I do anything)

First aid actions given
In the last 12 months has anyone in your family or close circle of friends had a problem similar to (John's/Jenny's)?
☐ 1. Yes
☐ 2. No
☐ 3. Don't know

Did just one person have the problem or more than one?
(If just "one" person, move to question H)
☐ 1. More than one
2. Just one
   ○ 3. Don’t know

Because you know more than one person who had a problem similar to [John’s/Jenny’s], for the next few questions, I want you to think about the one you know best.

Did you do anything to help this person?
   ○ 1. Yes
   ○ 2. No
   ○ 3. Don’t know

What did you do?
   ○ 1. Answer given, please specify
   ○ 2. Don’t know

Perceptions of university support

The following questions look at how well the university community supports students with mental health problems.

How well do you think the following people support students with mental health problems?

<table>
<thead>
<tr>
<th></th>
<th>Very Well</th>
<th>Well</th>
<th>Poorly</th>
<th>Very Poorly</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. university teaching staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. university counseling staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Other students</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How well do you think the university supports the following groups of people with mental health problems?

<table>
<thead>
<tr>
<th></th>
<th>Very Well</th>
<th>Well</th>
<th>Poorly</th>
<th>Very Poorly</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Students with mental health problems</td>
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For all questions, please indicate the answer most commonly related to you. Questions 3 and 6 automatically receive a score of one if the proceeding question was “none of the time”.

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Appendix G Ethics Approval Letter from Edith Cowan University
26 June 2012

Mr Richard Bostwick
49 Moran Court
BEACONSFIELD WA 6323

Dear Mr Bostwick

I am pleased to write on behalf of the Research Students and Scholarships Committee who have approved your PhD research proposal: University Support Systems, Help-Seeking Behaviour (HSB) and the Management of Undergraduate Student Psychological Distress.

I also wish to confirm that your proposal complies with the provisions contained in the University’s policy for the conduct of ethical research, and your application for ethics has been approved. Your ethics approval number is 7946 and the period of approval is 25 June 2013 to 26 July 2014.

Approval is given for your supervisory team to consist of:

Principal Supervisor: Professor Cobe Rudolf - ECU
Associate Supervisor: Professor Alfred Allas
Associate Supervisor: Dr Michael Monizze - Redman

The examination requirements on completion are laid down in Part VI of The University (Admissions, Enrolment and Academic progress) Rules for Courses Requiring the Submission of Theses available at: http://www.ecu.edu.au/GIPS/legal_legs/unit_rules.html

Additional information and documentation relating to the examination process can be found at the Graduate Research School website: http://research.ecu.edu.au/grs/

Please note: the Research Students and Scholarships Committee has resolved to restrict doctoral theses to a maximum of 200,000 words with a provision that under special circumstances a candidate may seek approval from the Faculty Research and Higher Degrees Committee for an extension to the word length. (RSSC 99/14).

I would like to take this opportunity to offer you our best wishes for your research and the development of your thesis.

Yours sincerely,
Patricia Brown
Senior Student Progress Officer
Research Assessments – SSC

Principal Supervisor: Professor Cobe Rudolf - ECU
Associate Supervisor: Professor Alfred Allas
Associate Supervisor: Dr Michael Monizze - Redman
Appendix H  Student support services Contract Matrix
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<tr>
<td>Prof Colleen Hayward</td>
<td>Manager</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:tracey.edwards@ecu.edu.au">tracey.edwards@ecu.edu.au</a></td>
<td><a href="mailto:international@ecu.edu.au">international@ecu.edu.au</a></td>
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<td>Helen Nicholls-Stary</td>
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<tr>
<td><a href="mailto:peterc@deakin.edu.au">peterc@deakin.edu.au</a></td>
<td><a href="mailto:helen.nicholls-stary@deakin.edu.au">helen.nicholls-stary@deakin.edu.au</a></td>
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<td>03 5227 2538</td>
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</tr>
<tr>
<td>Jillian Miller</td>
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<td></td>
</tr>
<tr>
<td><a href="mailto:jillian.miller@unisa.edu.au">jillian.miller@unisa.edu.au</a></td>
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<tr>
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<tr>
<td>Bronwyn Dillon</td>
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</tr>
<tr>
<td><a href="mailto:b.dillon@griffith.edu.au">b.dillon@griffith.edu.au</a></td>
<td><a href="mailto:international@griffith.edu.au">international@griffith.edu.au</a></td>
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<tr>
<td>07 3735 7032</td>
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<tr>
<td>Karen Jackson</td>
<td>Manager</td>
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</tr>
<tr>
<td>Moondani <a href="mailto:Balluk@vu.edu.au">Balluk@vu.edu.au</a></td>
<td><a href="mailto:ns@vu.edu.au">ns@vu.edu.au</a></td>
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<td>03 9919 2370</td>
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<tr>
<td>Ray Eldridge</td>
<td>Lee Elliott</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:reldridge@csu.edu.au">reldridge@csu.edu.au</a></td>
<td><a href="mailto:lelliott@csu.edu.au">lelliott@csu.edu.au</a></td>
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<tr>
<td>02 6933 2185</td>
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<tr>
<td><a href="mailto:badanami@uws.edu.au">badanami@uws.edu.au</a></td>
<td><a href="mailto:internationalstudy@uws.edu.au">internationalstudy@uws.edu.au</a></td>
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<td>1800 032 669</td>
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<tr>
<td><a href="mailto:indigenous.enquiries@latrobe.edu.au">indigenous.enquiries@latrobe.edu.au</a></td>
<td><a href="mailto:iso.aw@latrobe.edu.au">iso.aw@latrobe.edu.au</a></td>
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<td>03 9479 3817</td>
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<tr>
<td>Support Service 10</td>
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<tr>
<td>Manager</td>
<td>08 6304 3881</td>
<td></td>
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<tr>
<td><a href="mailto:Frieda@ecu.edu.au">Frieda@ecu.edu.au</a></td>
<td>Glenda Jackson</td>
<td></td>
</tr>
<tr>
<td><a href="mailto:j.jackson@ecu.edu.au">j.jackson@ecu.edu.au</a></td>
<td></td>
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<tr>
<td>John Devereaux</td>
<td>03 9251 7674</td>
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</tr>
<tr>
<td>Manager</td>
<td>Vanessa Matthews</td>
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<tr>
<td><a href="mailto:accommodation@unisa.edu.au">accommodation@unisa.edu.au</a></td>
<td>08 8302 2305</td>
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<td>Joanna Peters</td>
<td>07 3735 7893</td>
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<tr>
<td>Helen Watkins</td>
<td><a href="mailto:colin.macdonald@vu.edu.au">colin.macdonald@vu.edu.au</a></td>
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<td><a href="mailto:b.watkins@griffith.edu.au">b.watkins@griffith.edu.au</a></td>
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<tr>
<td>Colin Macdonald</td>
<td>03 9919 4970</td>
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<td>James Kelly</td>
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<tr>
<td><a href="mailto:m.torney@latrobe.edu.au">m.torney@latrobe.edu.au</a></td>
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<tr>
<td>Michael Torney</td>
<td>02 4570 1248</td>
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<td>Manager</td>
<td>02 4736 0642</td>
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<td><a href="mailto:Living@latrobe.edu.au">Living@latrobe.edu.au</a></td>
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<td><a href="mailto:Living@latrobe.edu.au">Living@latrobe.edu.au</a></td>
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Appendix I  General Practice Assessment Questionnaire (GPAQ)
General Practice Assessment Questionnaire

We would be grateful if you would complete this survey about your doctor and general practice. They want to provide the highest standard of care. A summary from this survey will be fed back to them to help them identify areas for improvement. Your opinions are very valuable. Please answer ALL the questions you can by putting an X in one box unless more than one answer is allowed. There are no right or wrong answers and your doctor will NOT be able to identify your individual answers. Thank you.

The Doctor / Nurse I saw today was ___________________________ for myself / my child / other.

About Your Visit to the GP Today

How good was the GP at:

Q1. Putting you at ease?
   - Very good
   - Good
   - Satisfactory
   - Poor
   - Very poor
   - Does not apply

Q2. Being polite and considerate?
   - Very good
   - Good
   - Satisfactory
   - Poor
   - Very poor
   - Does not apply

Q3. Listening to you?
   - Very good
   - Good
   - Satisfactory
   - Poor
   - Very poor
   - Does not apply

Q4. Giving you enough time?
   - Very good
   - Good
   - Satisfactory
   - Poor
   - Very poor
   - Does not apply

Q5. Assessing your medical condition?
   - Very good
   - Good
   - Satisfactory
   - Poor
   - Very poor
   - Does not apply

How good was the GP at:

Q6. Explaining your condition and treatment?
   - Very good
   - Good
   - Satisfactory
   - Poor
   - Does not apply

Q7. Involving you in decisions about your care?
   - Very good
   - Good
   - Satisfactory
   - Poor
   - Does not apply

Q8. Providing or arranging treatment for you?
   - Very good
   - Good
   - Satisfactory
   - Poor
   - Does not apply

Q9. Did you have confidence that the GP is honest and trustworthy?
   - Yes, definitely
   - Yes, to some extent
   - No, not at all
   - Don’t know/can’t say

Q10. Did you have confidence that the doctor will keep your information confidential?
    - Yes, definitely
    - Yes, to some extent
    - No, not at all
    - Don’t know/can’t say

Q11. Would you be completely happy to see this GP again?
    - Yes
    - No

Please add any comments about the GP:

GPAQ® © 2013 is reproduced with the kind permission of the Universities of Manchester & University of Cambridge. GPAQ incorporates the Primary Care Assessment Survey (PCAS), with permission from Dr. Oliver Gath Salford creator of PCAS. www.gpao.org GPAQ V4 Page 1 of 4
### About Receptionists and Appointments

**Q12** How helpful do you find the receptionists at your GP practice?
- [ ] Very helpful
- [ ] Fairly helpful
- [ ] Not very helpful
- [ ] Not at all helpful
- [ ] Don't know

**Q13** How easy is it to get through to someone at your GP practice on the phone?
- [ ] Very easy
- [ ] Fairly easy
- [ ] Not very easy
- [ ] Not at all easy
- [ ] Don't know
- [ ] Haven't tried

**Q14** How easy is it to speak to a doctor or nurse on the phone at your GP practice?
- [ ] Very easy
- [ ] Fairly easy
- [ ] Not very easy
- [ ] Not at all easy
- [ ] Don't know
- [ ] Haven't tried

**Q15** If you need to see a GP urgently, can you normally get seen on the same day?
- [ ] Yes
- [ ] No
- [ ] Don't know / never needed to

**Q16** How important is it to you to be able to book appointments ahead of time in your practice?
- [ ] Important
- [ ] Not important

**Q17** How easy is it to book ahead in your practice?
- [ ] Very easy
- [ ] Fairly easy
- [ ] Not very easy
- [ ] Not at all easy
- [ ] Don't know
- [ ] Haven't tried

**Q18** How do you normally book your appointments at your practice?
(please X all boxes that apply)
- [ ] In person
- [ ] By phone
- [ ] Online
- [ ] Doesn't apply

**Q19** Which of the following methods would you prefer to use to book appointments at your practice?
(please X all boxes that apply)
- [ ] In person
- [ ] By phone
- [ ] Online
- [ ] Doesn't apply

*Thinking of times when you want to see a particular doctor:*

**Q20** How quickly do you usually get seen?
- [ ] Same day or next day
- [ ] 2-4 days
- [ ] 5 days or more
- [ ] I don't usually need to be seen quickly
- [ ] Don't know, never tried

**Q21** How do you rate how quickly you were seen?
- [ ] Excellent
- [ ] Very good
- [ ] Good
- [ ] Satisfactory
- [ ] Poor
- [ ] Very poor
- [ ] Does not apply

*Thinking of times when you are willing to see any doctor:*

**Q22** How quickly do you usually get seen?
- [ ] Same day or next day
- [ ] 2-4 days
- [ ] 5 days or more
- [ ] I don't usually need to be seen quickly
- [ ] Don't know, never tried

**Q23** How do you rate how quickly you were seen?
- [ ] Excellent
- [ ] Very good
- [ ] Good
- [ ] Satisfactory
- [ ] Poor
- [ ] Very poor
- [ ] Does not apply
Thinking of your most recent consultation with a doctor or nurse

Q34 How long did you wait for your consultation to start?
- Yes
- No
- Don’t know

Q25 How do you rate how long you waited?
- Excellent
- Very good
- Good
- Satisfactory
- Poor
- Very poor
- Does not apply

Q26 Is your GP practice currently open at times that are convenient to you?
- Yes
- No
- Don’t know

Q27 Which of the following additional opening hours would make it easier for you to see or speak to someone? (please mark all that apply)
- Before 8am
- At lunchtime
- After 6:30pm
- On a Saturday
- On a Sunday
- None of these

Q28 Is there a particular GP you usually prefer to see or speak to?
- Yes
- No
- There is usually only one doctor in my surgery

Q29 How often do you see or speak to the GP you prefer?
- Always or almost always
- A lot of the time
- Some of the time
- Never or almost never
- Not tried at this GP practice

(IF you haven’t seen a nurse in the last 6 months please go to Q37)

Q30 How good was the Nurse you last saw at:
- Very good
- Good
- Satisfactory
- Poor
- Very poor
- Does not apply

Q31 Giving you enough time?
- Very good
- Good
- Satisfactory
- Poor
- Very poor
- Does not apply

Q32 Listening to you?
- Very good
- Good
- Satisfactory
- Poor
- Very poor
- Does not apply

Q33 Explaining your condition and treatment?
- Very good
- Good
- Satisfactory
- Poor
- Very poor
- Does not apply

Q34 Involving you in decisions about your care?
- Very good
- Good
- Satisfactory
- Poor
- Very poor
- Does not apply

Q35 Providing or arranging treatment for you?
- Very good
- Good
- Satisfactory
- Poor
- Very poor
- Does not apply

Q36 Would you be completely happy to see this nurse again?
- Yes
- No
Thinking about the care you get from your doctors and nurses overall, how well does the practice help you to:

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<td>□ Very well</td>
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<td>□ Unsure</td>
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<th>Q38 Cope with your health problems</th>
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<td>□ Very well</td>
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<th>Q39 Keep yourself healthy</th>
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<tr>
<td>□ Very well</td>
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<tr>
<td>□ Unsure</td>
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<tr>
<td>□ Not very well</td>
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<th>Q40 Overall, how would you describe your experience of your GP surgery?</th>
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<tr>
<td>□ Satisfactory</td>
</tr>
<tr>
<td>□ Poor</td>
</tr>
<tr>
<td>□ Very poor</td>
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<td>□ Yes, definitely</td>
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<td>□ Yes, probably</td>
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<td>□ No, probably not</td>
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<tr>
<td>□ No, definitely not</td>
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<td>□ Don't know</td>
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<td>□ 5 75 or over</td>
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<tr>
<td>□ I don't know / can't say</td>
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<td>□ 2 Black or Black British</td>
</tr>
<tr>
<td>□ 3 Asian or Asian British</td>
</tr>
<tr>
<td>□ 4 Mixed</td>
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<td>□ 5 Chinese</td>
</tr>
<tr>
<td>□ 6 Other ethnic group</td>
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<th>Q46 Which of the following best describes you?</th>
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<td>□ 1 Employed (full or part time, including self-employed)</td>
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<tr>
<td>□ 2 Unemployed / looking for work</td>
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<tr>
<td>□ 3 At school or in full time education</td>
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<td>□ 4 Unable to work due to long term sickness</td>
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<td>□ 5 Looking after your home/family</td>
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<tr>
<td>□ 6 Retired from paid work</td>
</tr>
<tr>
<td>□ 7 Other</td>
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Finally, please add any other comments you would like to make about your GP practice: