Brief report: Impact of classroom presentations about health and help-seeking on rural Australian adolescents’ intentions to consult health care professionals

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Low rates of help seeking and poor access to health care for Australian adolescents are problems particularly in rural areas (Booth et al., 2004). Adolescents indicate that they are not likely to seek help for health concerns (Booth et al., 2004) and are particularly reluctant to seek professional help for mental health problems (Wilson, Deane, & Ciarrochi, 2005). Rural and small regional communities often have greater structural barriers such as limited numbers of providers and longer wait times which reduce access to health care professionals (Quine et al., 2003). However, there are also individual factors such as heightened concerns about anonymity and confidentiality, stronger ethos of self reliance and stoicism that may be barriers to help seeking in rural settings (e.g., Quine et al., 2003).

In order to improve access to primary health care, general practitioners in rural Australia report wanting greater opportunities to consult and to promote their services to young people outside of the usual office consultation setting (Kang et al., 2003). They also want training in collaborative approaches and outreach strategies. In addition, youth health workers want improved relationships with other service providers such as GPs and especially with schools (Kang et al., 2003). Young people themselves say they prefer to see professionals that they know and trust (Booth et al., 2004).

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To address these issues the Building Bridges-GP-Team program was developed and is an extension of an equivalent GP-only training program (see Wilson, Deane & Fogarty, 2004). The Building Bridges-GP-Team program involves training health professionals about; adolescents’ help seeking barriers and ways to address these barriers in primary health care; developmental issues relevant to adolescent’ health care seeking, and; classroom management, presentation strategies, and elementary teaching skills. Training is based on a Participant Manual which specifies each of these knowledge sets in more detail (Wilson et al., 2004). Following this training the team comprising a GP and another health professional (e.g., Drug and Alcohol case worker) present a structured lesson of 90 min duration in high school classes. The lesson plan has the following structure and components.

(1) Introduction that (a) normalizes the process of consulting GPs and other health professionals for different types of physical and mental health problems, (b) describes the professional training of presentation team members as well as ways each professional can help, (c) explores young peoples experiences with health care professionals in the past and ways to overcome unhelpful prior experiences when seeing a health care professional in the future.

(2) Question time and presenter led discussion to answer student’s health related questions written by students in preparation for the presentation.

(3) Presentation of information about practical issues involved in consulting a health care professional including, (a) structure of a typical consultation, (b) confidentiality, (c) obtaining and using Medicare cards, (d) costs and billing, (e) finding your own health care professional, (f) communicating with a health care professional, (g) patient responsibilities, (h) making the most of the consultation and (i) feelings and thoughts that stop young people visiting a health care professional.

(4) Conclusion and review. Throughout the session student interaction with the presenters is encouraged.

Such initiatives are not isolated to Australia and fit within broader service provision frameworks that go beyond specialist mental health services alone. For example, in the United Kingdom, Tier 1 of child and adolescent mental health services provide universal services such as mental health promotion, delivered by practitioners who are not mental health specialists, that is GPs, health visitors, school nurses and others (Health Advisory Service, 1995). The current study examined whether presentations delivered by a GP with another health professional in schools were able to increase students’ intentions to consult a local health professional while reducing perceived barriers to seeking health care in a sample of rural and regional adolescents.

Method

Participants and procedure

Permission and ethical review was provided by the New South Wales Department of Education and Training and the University of Wollongong Human Ethics Committee, respectively. Participants were a total of 506 adolescents recruited from two public high schools from a regional city (pop. 57 557), one Catholic and public high school from a medium sized rural town
(pop. 11,228) and three public high schools from separate small rural towns (pop. <7000), all in the Riverina region of New South Wales, Australia. Fifty-one percent were female and 96% described their cultural affiliation as “Australian.”

Participants were assigned to a Trial or Control group based on school year with Year 10 students in the Trial groups and Year 9 students in the Control groups. The Trial groups received Building Bridges-GP-Team presentations from a local GP and one other primary health care provider (e.g., nurse, generalist psychologist, Drug and Alcohol case worker) while the Control groups received no presentation. At baseline, before each presentation, students with caregiver permission and who provided their own consent completed an anonymous but coded questionnaire that asked them to rate their help seeking barriers and intentions to consult a health care professional for each listed health problem. Two follow-up periods of 4 weeks (Trial group A, \( n = 171 \)) and 8 weeks (Trial group B, \( n = 120 \)) following the presentations were compared to examine whether any benefits of the presentations were able to be maintained up to 8 weeks. Control groups A (\( n = 115 \)) and B (\( n = 100 \)) did not receive the presentations and completed the same evaluation questionnaires at 4 and 8 weeks, respectively. Chi-square tests found no significant differences between groups on either gender composition or cultural affiliation (both \( p’s > .20 \)), but as expected those in the Trial group were on average one year older (\( M = 15.3 \) years) than those in the Control groups (\( M = 14.3 \) years).

**Measures**

*Help seeking intentions* were measured by items adapted from the General Help Seeking Questionnaire (GHSQ; Wilson, Deane, Ciarrochi, & Rickwood, 2005). Six items with the same general structure asked “If you have (problem type), how likely are you to talk to a (help source) about it?” The three problem types were “a physical health concern”, “a personal problem like relationship difficulties with friends, family, or at school” and “an emotional problem like being depressed or stressed out”. The two help sources were “General Practitioner” and “health care professional other than a GP” (see Note Table 1). In the present study all intentions items were averaged and used as a scale to represent help seeking intentions. Cronbach alpha coefficients ranged from 0.71 to 0.76 across both time points and all groups.

*Barriers to Engagement in Treatment* were measured by 11 items that assessed perceived barriers to consulting a health care professional. Example items are: “I feel comfortable talking to a GP who I don’t know” and “I believe a GP has time to listen to my problems” (see Note Table 1). Cronbach alpha coefficients ranged from 0.76 to 0.86 across both time points and all groups.

**Results**

Table 1 presents the means (SDs) for two independent pairings of the Trial and Control groups A and B. For groups A and B at Time 1, there were no significant differences on the intentions or barriers measures between the Trial and Control groups with the exception that for the comparisons at 4 weeks (A) the Control group started with significantly higher intentions than the Trial group, \( F(1,284) = 4.26, p = .04 \), (see Table 1). Two independent 2(Trial/Control group) x 2 (T1-T2) MANOVAs, one for A and one for B were conducted. Significant direct effects were found for Time for both A (Wilk’s Lambda \( F(2,283) = 4.88, p<0.01 \)), and B (Wilk’s Lambda \( F(2,283) = 4.26, p = .04 \)).
Discussion

Although students were not randomly assigned to the Trial and Control groups the results are promising. Increases in intentions to seek professional health care appeared to occur as a result of the intervention at 4 weeks and at 8 weeks post-presentation. The Control group started with slightly higher help seeking intentions than the Trial group at baseline (in the 4-week condition). This raises questions about whether the Control group did not change due to having less room to improve. This is unlikely because the Control group mean scores were only 3.38 on a scale that went to 7. In addition, the Control group did not differ from the Trial group at baseline in the 8 week comparisons but the Trial group showed significant improvement while the Control group did not.

It is also worth noting that although the Trial groups’ intentions increased, they remained below those of the Control groups at follow-up in both conditions. This is most likely due to differences between the Year 9 and Year 10 students who comprised Control and Trial groups, respectively. It is possible that the older Year 10 students in the Trial group have developmentally higher levels of individuation, autonomy and self-sufficiency. A study of 495 adolescents in Grades 7 to 12 found early adolescents had higher needs for support and help from parents than did late adolescents (Levpušček, 2006). Similarly, younger adolescents in our study may have a greater tendency to intend to seek help from other adult figures such as health professionals. Future research could test this possibility by including measures of separation-individuation.

Despite the improvements in intentions to seek help in Year 10 students, intentions still remained relatively low overall and adolescents’ perceived barriers to engaging in treatment were
unchanged. While intentions have been found to predict self reports of subsequent help seeking behavior in adolescents 3-weeks later, these relationships varied considerably dependent on the source of help and were relatively low for General Practitioners (range $r_s = .48$ intimate partner to $r_s = .10$ GP) (Wilson et al., 2005). It is likely that the 3-week period used in that study was too short of a time period to allow sufficient attendances to a General Practitioner to reliably detect an intention–behavior relationship. This highlights the need for further research to assess actual health professional consultations subsequent to the school presentations.

Since adolescents’ beliefs predict their health care intentions (e.g., Marcell & Halpern-Felsher, 2005), it is possible that outcomes from the presentations would be improved by greater emphasis on health beliefs identified as specific to rural communities (e.g., confidentiality, stoicism, discomfort with disclosure, Quine et al., 2003). A more controlled trial with random allocation and an attention control condition is needed to identify benefits and limitations of the program subsequent to these revisions.

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References


