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# General Well-being and the Awareness and Perception of Wellness Services

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# General Well-being and the Awareness and Perception of Wellness Services

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Abstract

This study investigated the effects of reading the websites of telephone operated wellness services, compared to reading the websites in addition to a more intensive exposure involving a conversational explanation of the services. Variables of perceived benefits of help-seeking, life satisfaction, and telephone service awareness were all assessed across three testing sessions within approximately seven days. Additionally, mentioning the services to family or friends was assessed at the end of this period. The sample of 32 participants were all female undergraduate students enrolled in Psychology 1000 at Brescia University College. The results of 2x3 mixed ANOVA tests showed a significant increase in telephone awareness generally, and the intensive exposure group showed a significant increase in life satisfaction across time.

## General Well-being and the Awareness and Perception of Wellness Services

Young adults have been identified as a group which tends not to seek help for mental health, despite frequently experiencing mental disorders (Gulliver, Griffiths, & Christensen, 2010). Those who used mental health services within this age group were likely to be less satisfied with quality of life than non-users, a group that did not access mental health services (Huỳnh, Caron, & Fleury, 2016).

Life satisfaction is a component of subjective well-being which assesses the level of satisfaction or fulfillment individuals consider themselves to have attained in their personal life, and most college students regard life satisfaction as important. (Diener, Suh, Lucas, & Smith, 1999). Life satisfaction measures such as the Satisfaction With Life Scale (SWLS) include evaluations of an individual's beliefs concerning how close her life is to her ideal, and if she would change anything if given the opportunity to live life over again (Diener, Emmons, Larsen, & Griffin, 1985). The self perception of an individual's contentment with her life thus far is not objective, and so can be influenced by cognitive distortions present in some forms of mental illness. The presence of mental health problems is associated with reduced life satisfaction (Fergusson et al., 2015; Murphy, McDevitt-Murphy, & Barnett, 2005; Nishida, Richards, & Stafford, 2016). The number of mental health problems also affects life satisfaction in a negative linear relationship: as the number of mental health problems increase from zero to three or more, life satisfaction decreases (Fergusson et al., 2015). The findings of such research has suggested that mental health is a strong predictor of life satisfaction, and may

influence individual desire to maintain or begin efforts to improve a person's own mental health.

Striving for goals that the person has a high ability to attain within her environmental context can predict well-being (Diener et al., 1999). By pursuing goals which are achievable rather than unrealistic regarding mental health in particular, taking incremental steps to seek treatment can help persuade individuals to initiate contact with mental health services. Regarding the type of people who are motivated to set goals, those who have low levels of life satisfaction have a stronger desire for change and are more motivated to alter their life circumstances (Luhmann, & Hennecke, 2017). This would support the hypothesis that participants who have low scores in life satisfaction will be more likely to access assistance such as helpline services than participants with higher scores of life satisfaction. The accessible nature of helpline services may influence participants to recognize that they possess a high ability to attain the goal of seeking help. This is especially pertinent to post-secondary mental health promotion, as the age range of most college students generally includes primarily young adults, an age group where those experiencing mental illness are likely to have only recently begun recognizing or developing symptoms (Eisenberg, Downs, Golberstein, & Zivin, 2009).

Perceived barriers to help-seeking are particularly influential amongst the demographic of young adults, many of whom experience mental illnesses but typically do not to seek help (Gulliver, Griffiths, & Christensen, 2010). Young adults included in that systematic review often reported concerns about confidentiality, transportation, and worry that care would be unavailable when needed as reasons not to seek help. This

suggests that privacy and availability are important factors to examine in assessment of how the clarity of information provided by mental health services online can serve as a deterrent for individuals who are unsure of the efficacy of seeking treatment. For 18- to 29-year- olds in emerging adulthood, the enabling factor most positively associated with mental health service use was an internet search for websites about mental health information (Huỳnh et al., 2016). This finding suggests that mental health promotion should focus on providing accessible information online about mental health services in order to become more accessible to this age demographic. The researchers also proposed that mental health promotion programs in the form of websites operated by universities offering mental health services should ensure that online materials are not difficult to navigate and clearly explain what specifically is available.

Help-seeking theories such as the Help-Seeking Model (HSM) are particularly useful to analyze the majority of the college student demographic within the young adult age group (Rickwood, Deane, Wilson, & Ciarrochi, 2005) favoured by young adults explained by the HSM are supported by current research which has suggested that young adults favour more informal pathways to accessing health information such as searching online (Huỳnh et al., 2016). The HSM assists in explaining how individuals in this age group seek help in ways that are preferably highly accessible and require minimal disclosure of personal information. A method to encourage mental health help-seeking amongst young people suggested by researchers O'Connor, Martin, Weeks, and Ong (2014) was to promote services that are non-confronting such as anonymous phone counselling services. The conclusion that non-confronting services are the preferred option over having to provide identifying information is aligned with a similar

finding that participants were less likely to use mental health services if they considered mental health treatment to be embarrassing (Mojtabai, Olfson, & Mechanic, 2002).

The Health Belief Model (HBM) is a conceptual framework to determine the factors that influence the usage of the public health system and programs designed to assist in health promotion through prevention and detection of illness (Rosenstock et al., 1990; Saleeby, 2000). The model focuses on how decisions are made concerning voluntary health-promoting behaviours such receiving a vaccination for the ‘flu virus or self-examinations for cancer prevention. The HBM consists of multiple constructs which are particularly associated with mental health, such as perceived barriers to seeking help, personal susceptibility to disease or illness, and perceived benefits of help-seeking (Huỳnh et al., 2016; Lindamer et al., 2012). The concept ”perceived benefits” is defined within the HBM as the expectation of positive effects and level of efficacy regarding a recommended action to reduce the disease threat or condition.

A study designed using the HBM suggested that mental health promotion programs should focus on marketing the advantages of these services so as to increase the perceived benefits of seeking help which was the most significant predictor of help-seeking behaviour (O'Conner et al., 2014). The researchers also suggested that presenting this information in the form of a two-person dialogue. This delivery system, and focus on perceived benefits, has yet to be experimentally studied within the literature.

The current study will evaluate life satisfaction and utilize several websites of anonymous telephone counselling or health services. An experimental design will assess what type of exposure has a greater influence on perceived benefits of help-

seeking. Perceived benefits of help-seeking will be measured using the appropriate subscale from the Health Beliefs about Mental Illness instrument (HBMI) developed by Saleeby (2000). Service awareness and service use will be measured for two different exposure groups, one of which will only read the websites and the other group will additionally participate in a discussion about the services. The dialogue portion of the experiment was scripted with opportunities for participants to ask questions after each explanation of the telephone counselling services. This was done to create consistency across the intensive exposure condition and to allow for a conversational tone. Scales for service awareness and service use were created using five-point Likert scales and were developed to have similarity to the SWLS and HBMI measures.

The research hypothesis was that increases in perceived benefits would also reveal increases in service use: a larger increase in both measures of perceived benefits and service use would be found in the intensive exposure group than the exclusively reading group. Service use would be measured by answering either yes or no if participants have contacted any services at a second testing session approximately one week after the initial session. It was predicted that a larger increase in perceived benefits would be seen amongst an intensive exposure group compared to an exclusively reading group. The third hypothesis was that participants with low life satisfaction scores will show a higher increase in service use and perceived benefits amongst the intensive exposure group, compared to those with similar life satisfaction scores in the exclusively reading group. The fourth and final hypothesis predicted that a chi-square test for independence would indicate a higher proportion of participants in

the intensive exposure condition reporting they had mentioned the services to family and friends compared to the exclusively reading group.

## Method

### Participants

Students enrolled in the Psychology 1000 undergraduate course at Brescia University College were eligible to participate in this study, and were recruited through the SONA website (n=32). Participants were given three participation credits across three testing sessions, totaling between approximately one to one and half hours dependent on the experimental group into which they were assigned.

### Materials

Participants filled out a total of 9 documents used for data collection: one Demographics Survey (Appendix A) and eight other questionnaires. The eight other questionnaires measure the following variables: Life Satisfaction, Telephone Service Awareness, Service Use, Perceived Benefits, and Service Mention. The questionnaires the researcher composed to assess Service Awareness and Service Use, utilizing a five point Likert scale and a yes or no option respectively, are the Demographics Survey (Appendix A), Awareness Scale A (Appendix B), and Awareness Scale B (Appendix C). Service Awareness scores were derived from a single question Likert scale assessing self reported awareness of telephone services. Scores on this scale ranged from *1,* indicating no awareness, to *5*, indicating high level of awareness. Service Mention assessing if participants spoke to friends or family about any services approximately one week after learning about the services wes also assessed with a yes or no answer using Awareness Scale B (Appendix C). Life Satisfaction was measured using the

Satisfaction with Life Scale (SWLS), which consists of five items rated on a seven point Likert scale. For the Saisfaction With Life Scale (SWLS) developed by Diener, Emmons, Larsen, & Griffin (1985), scores on this scale ranged from 1, indicating strongly disagree, to 7, indicating strongly agree. A maximal mean score of 7 indicates highest possible life satisfaction, and a score of 1 indicates lowest possible life satisfaction. Perceived Benefits was measured using its sub-scale taken from the Health Beliefs about Mental Illness (HBMI) instrument, which consists of four items rated on a five point Likert Scale. The scoring of the Health Belief Model Instrument (HBMI) developed by Rosenstock (1990) ranged from 1, indicating strongly disagree, to 5, indicating strongly agree. A maximal mean score of 5 indicates highest possible perceived benefits, and a score of 1 indicates lowest possible perceived benefits.

**Procedure**

Participants accessed the Brescia SONA research recruitment website, and were be able to read the Call for Participants (Appendix D), and the available testing session time slots. After having selected a pair of time slots approximately one week apart, the participant arrived at the first research session and was brought to either testing room PURL 1 or 2. The researcher  followed Basic Script (Appendix E) for both experimental groups. The participant was given the Letter of Information (Appendix F) followed by the Consent Form (Appendix G). After obtaining informed consent, the researcher briefly explained the procedures and gave the participant the first package of the following three questionnaires; the Demographics Survey (Appendix A), Questionnaire A measuring Life Satisfaction (Appendix H), and Questionnaire B measuring Perceived Benefits (Appendix I).

After the participant had completed these questionnaires, the reading portion of the wellness resource websites began. Participants were given access to the websites of Telehealth Ontario, the AIDS and Sexual Health Infoline, The Support Line, and Good2talk. After reading these websites, the Exclusively Reading group continued to follow the Basic Script (Appendix E), and the Intensive Exposure group began following the Intensive Exposure Script (Appendix J). The researcher speaking to the Intensive Exposure group then returned to the Basic Script (Appendix E) after the completion of the Intensive Exposure Script (Appendix J).

The Intensive Exposure group involved a more in-depth discussion of the four selected wellness services offered only via telephone, how they operate, and in what scenarios they may be useful to participants. After completion of this discussion, for the Intensive Exposure group, or continuing directly after only viewing the websites for the Exclusively Reading group, participants were given the second package of questionnaires. The second package of questionnaires participants were asked to fill out included: Awareness Scale A (Appendix B), Questionnaire A (Appendix H), and Questionnaire B (Appendix I). Once the participant had finished filling out the questionnaires, data collection for the first testing session was completed.

The second research session was be structured identically for both experimental groups, and did involve bringing the participant to either testing room PURL 1 or 2 for testing. The researcher followed the Second Testing Session Script (Appendix K) to ensure the consistency of dialogue with participants. The researcher then asked the participant to fill out Awareness Scale B measuring Service Awareness and Use (Appendix C), Questionnaire A (Appendix H), and Questionnaire B (Appendix I). After

completion, the researcher then began debriefing and gave the participant the Debriefing Information (Appendix L), participants then received three participation credits.

Other Information: To avoid priming participant expectations the measures collecting information about Service Awareness and Service Use was entitled Demographics Survey (Appendix A), Awareness Scale A (Appendix B), and Awareness Scale B (Appendix C). The Satisfaction with Life Scale (SWLS) was entitled Questionnaire A (Appendix H). The HBMI sub-scale Perceived Benefits was entitled Questionnaire B (Appendix I).

## Results

### Primary Hypotheses Analysis.

A 2x3 mixed ANOVA was conducted with treatment condition as the between subjects factor (ready only, intensive exposure) and time as the within subjects factor, (time 1, time 2, and time 3) to evaluate the second hypothesis. This ANOVA analysis was performed to compare if treatment condition affected changes in perceived benefits, life satisfaction, or telephone awareness over time. The graphs for the above analyses are Figure 1, Figure 2, and Figure 3 respectively for the variables of perceived benefits, life satisfaction, and telephone awareness.

The second hypothesis was not supported, however the other variables involving life satisfaction and telephone awareness did indicate significant results. The second hypothesis stated that perceived benefits would increase over time, and particularly if the intensive exposure group would experience a higher increase in the perceived benefits measure. Mauchly's Test of Sphericity was violated, W=.73, p=.011, so the

Greenhouse-Geisser adjusted values were used. No significant main effect of time F(1.58, 47.29)=.715, p=4.93, or between-subjects effect of treatment condition F(1, 30)= .378, p=.54 on perceived benefits was detected (see Figure 1). This indicates that changes in perceived benefits were not significant generally, and was not affected by the passage of time or treatment group.

Assessing life satisfaction as a within--subjects effect, a significant main effect of life satisfaction was found, F(2,60)=7.01, p=.002 as shown on the graph (see Figure 2). Although significant interaction did not occur between life satisfaction and treatment group F(2,60)= 1.71, p=.19, contrast analysis showed a significant increase, p=.005 in life satisfaction from Time 1 to Time 3 (Mean Difference= -.26, SE=.065), and from Time 2 to Time 3 p=.026 (Mean Difference=.21, SE=.075). Additional post-hoc analysis indicated the Intensive Exposure condition was primarily responsible for this change across time, as a significant simple main effect was found F(2,15)= 8.01639, p=.002 overall, progressing from Time 1(M=4.81,SD=.25) to Time 2(M=4.89,SD=.27) to Time 3 (M=5.16, SD=.27). However the one-way ANOVA performed on the read only group was not significant, F(2,15)=1.19, p= .32 indicating that the read only group did experience somewhat different results from the intensive exposure group, but not a significant difference to indicate a between-subjects difference in the Mixed ANOVA tests. Regarding telephone awareness, Mauchly's test of sphericity was violated, W=.689, p=.002, so the Greenhouse-Geisser adjusted values were used. A significant main effect of time was found F(1.53, 45.78)=.0001, thus the within subject test indicated that telephone awareness increased significantly over time regardless of treatment condition (see Figure 3). No significant interaction occurred between

telephone awareness and condition F(1.53, 45.78)=.240, p=73, and between-subjects effects approached but did not achieve significance, F(1,30)=3.34, p=.077.

The fourth hypothesis was not supported, it compared treatment condition and if the participant mentioned of the services to friends or family was analyzed using a chi-square test for independence. The result was not significant at $p < .05$, $\square^2(2, n=32)= 0.1255$, $p= .72$ which was clear from the nearly identical count in each of the four groups. The read only group had 8 reports for each category of “yes mention” and “no mention”, and the intensive exposure group had 9 participants said they did mention any services, while 8 participants did not.

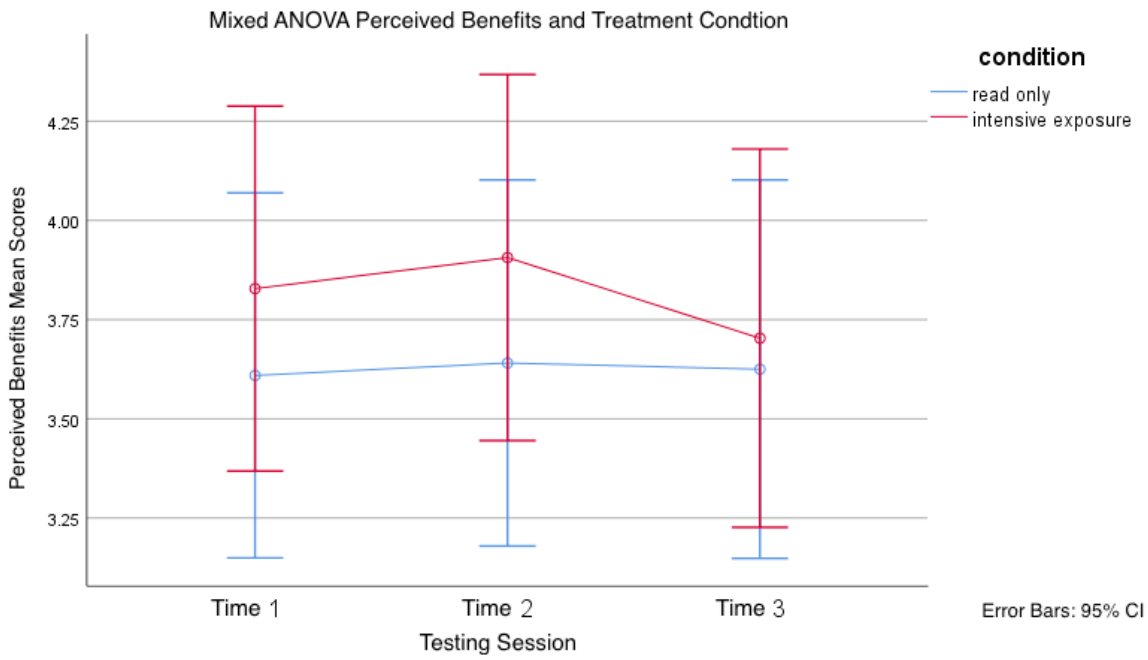


*Figure 1.* Mean perceived benefits scores across three testing sessions, taking place immediately before the intervention, immediately after the intervention, and approximately seven days after the intervention. Lines indicate the treatment condition, and the mean scores across time show no significant main effect of time or treatment condition on perceived benefits scores.

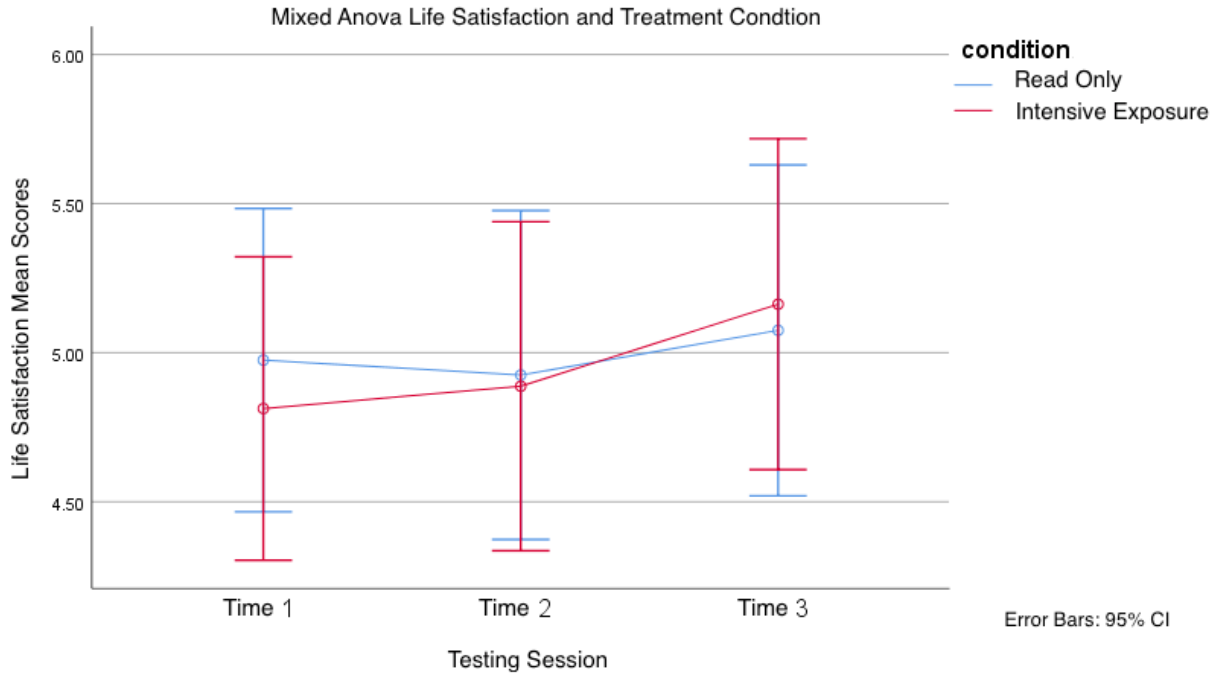


*Figure 2.* Mean life satisfaction scores across three testing sessions, taking place immediately before the intervention, immediately after the intervention, and approximately seven days after the intervention. Lines indicate the treatment condition, and show both groups increasing in life satisfaction, whilst the changes across time in the intensive exposure group alone were also statistically significant.

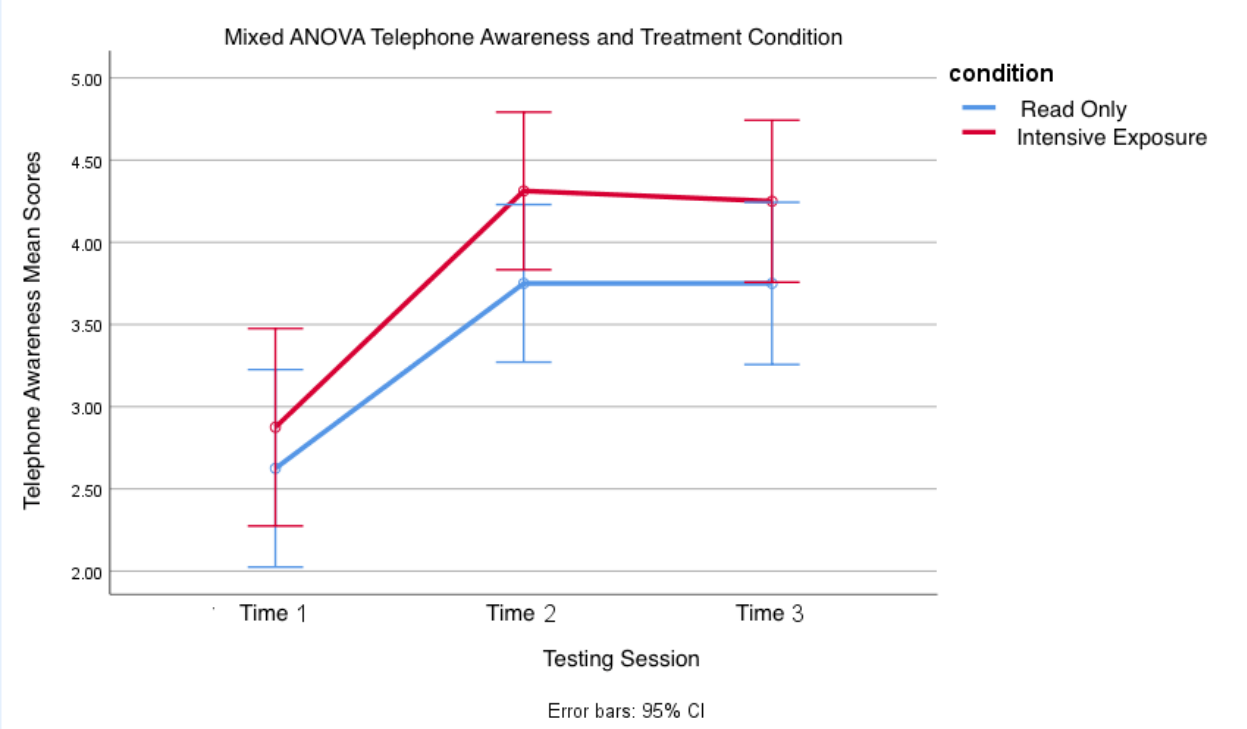


*Figure 3.* Mean telephone awareness scores across three testing sessions, taking place immediately before the intervention, immediately after the intervention, and approximately seven days after the intervention. Lines indicate the treatment condition, showing both groups increase in telephone awareness scores, and the intensive exposure groups remains higher at all testing sessions.

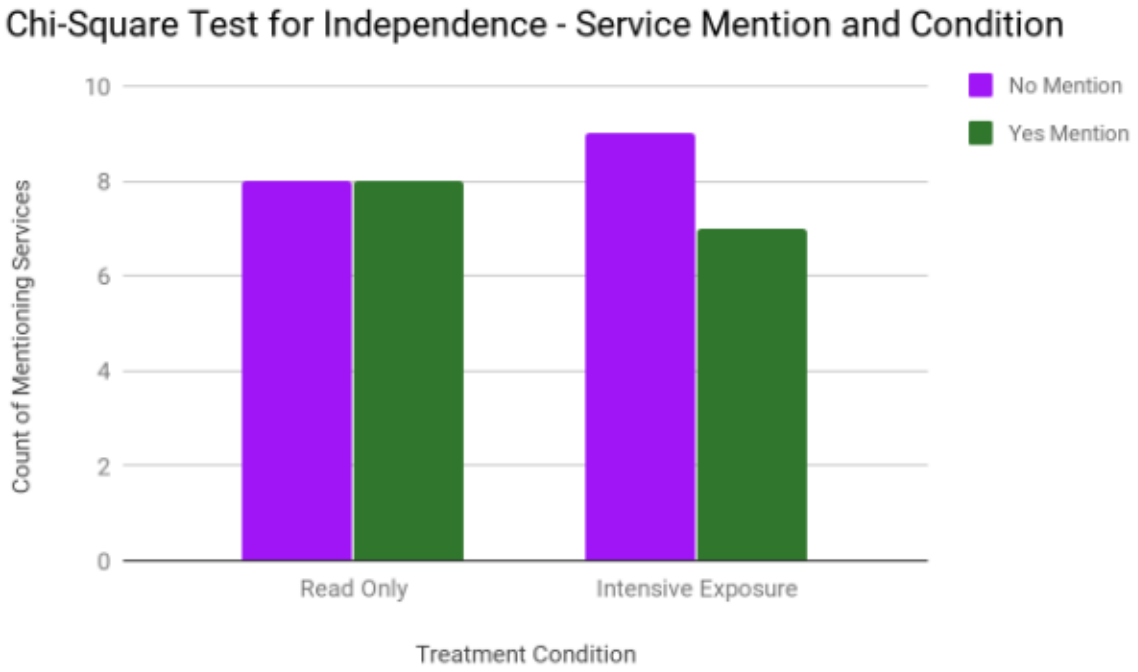


*Figure 4.* A 2x2 chi-square test for independence analyzing treatment condition and mention of services. The count of “Yes Mention” and “No mention” were evaluated with a single question asking if a participant has spoken to friends or family about the telephone services involved in the intervention in the duration of seven days since learning about the services. This measure was self reported at the Time 3 testing session.

**Hypothesis Analysis Problems.**

The third hypothesis was intended to evaluate service use amongst all participants regardless of treatment condition, by separating the participants into low, middle, and high levels of life satisfaction. However, these three groups were significantly different from each other, $F(2,29)= 88.84343$, $p< .00001$ and thus could not be analyzed using an ANOVA. The use of nonparametric tests was explored, however only 2 participants reported service use one week after the intervention at Time 3 of the

total 33 participants, one belonging to each treatment condition (see Figure 4). This lack of service use also rendered the first hypothesis, which intended to evaluate if an increase in perceived benefits would increase service use, as clearly not significant and thus no analysis was conducted.

**Discussion**

The intended purpose of this study was to determine if the type of exposure participants experienced in either treatment group would have an effect on their service use or create a willingness to talk to others about the wellness services, and more internally analyzing their awareness of the services, perceived benefits of help-seeking, and life satisfaction scores. This study contributed to the body of literature on help-seeking and well-being by examining how the above variables were affected by two informal pathways (reading from an online search and peer level conversation), established as effective means for young adults to search for mental health service information. The analyses performed on these three more internal variables showed a variety of results, and were intended to act as alternatives to the current approach of advertising wellness services with posters on university campus. The first and third hypotheses stated a relationship between either treatment condition or life satisfaction category, and service use would indicate a success of the intervention or a particular effect on those reporting low life satisfaction respectively.

Although no larger increase in perceived benefits was found amongst the Intensive Exposure group, there was a significant increase in life satisfaction scores was across all subjects, and particularly higher amongst the Intensive Exposure group. Perceived benefits was hypothesized to be a more powerful indicator of instigating

changes in how health promotion initiatives approach young adults with conversational explanation of services. However, given the past literature on mental health and life satisfaction, relating to young adults and help-seeking in particular (Luhmann, & Hennecke, 2017; O'Connor, Martin, Weeks, & Ong 2014) the increase in life satisfaction should not be ignored as potentially important factor in making contact with mental health services. Especially given that people reporting use of mental health services tend to score lower on life satisfaction than non-users, likely due to the association between the presence of mental health problems and reductions in life satisfaction (Fergusson et al., 2015; Murphy, McDevitt-Murphy, & Barnett, 2005; Nishida, Richards, & Stafford, 2016). Although future research should investigate if this increase in life satisfaction may have been temporary, or due to having a positive social interaction, the possibility remains that students may have evaluated their lives more positively when they felt they had access to resources which could help them, and had improved self-efficacy in their capacity to get help if needed. Future research should include variables of self-efficacy and assess if feeling "prepared" with information about wellness services has implications for life satisfaction and ultimately service use at a more delayed follow-up evaluation beyond the one week period.

The lack of reports of service use was a primary weakness in this study, as two of the four hypotheses predicted an increase in service use by the Time 3 testing session. However, due to the time constraints the period between learning about the telephone services and the follow-up testing session was only approximately seven days. This is a very limited timespan in which to determine if the application of the HBMI construct of perceived benefits is suited to the Help-Seeking Model (HSM) is a useful

explanatory method for how young adults favour more ‘informal’ pathways to health information as indicated by past research (Rickwood, Deane, Wilson, & Ciarrochi, 2005). The short amount of time may not be representative of future service use beyond the seven day period, and future research could evaluate service use after longer durations of time from the teaching intervention to assess this measure with more generalizability than a highly short term time period could accurately determine. Future research could also assess if there is any strong preference between ‘informal pathways’ such as internet searches and conversations with peers, as perhaps students may prefer one over the other for the sake of efficiency which may affect the perceived benefits measure.

The chi-square analysis also sought to determine if any informal pathways were created by the intervention, such that participants themselves were engaging with friends and family in peer level conversations about the services. This analysis was not significant, nor was mentioning services influenced by any other variable such as life satisfaction or previous telephone awareness or past service use. This variable was also limited by the time constraints of the seven day follow-up testing session, however it might be that a personality variable such as extroversion would be more applicable to this particular dimension of the research. This information could be useful in university settings, as the past research stating the preference of young adults to receive mental health service information through informal pathways does not appear to require a method requiring more time spent by staff explaining the services conversationally. The benefits of having near identical counts of conversations with friends and family reported by the read only group indicates that presenting the information about wellness

services may simply require having the information easily located through online means, and many universities now have websites including a specific page for these types of resources.

Outside of the results of analysis, other methodological limitations include the sample size, gender of participants, and potentially the social environment of the university college from which participants were recruited. It is possible that in a sample at Brescia University College, the student population of which is far smaller than Western University main campus itself, participants may have been affected by unique factors such as being situated in a women's college. It is also possible that professors at Brescia may share more information about wellness services before beginning lectures, and this variable regarding what sources established the pre-intervention levels of service awareness was not considered. Future research could consider if the dissemination of wellness service information through professors not directly tied to the services is perceived as formal or informal pathways to help-seeking, or if learning at a majority female environment within a smaller academic institution has any effect.

The ease of accessibility of information seems to be the most important factor, and perhaps universities could consider making an app which could be used on ones phone even if lacking internet access, which is typically the primary means of searching for mental health services. Many universities already have centralized online locations for mental health service information on campus, however the young adult population in particular is prone to not seeking help despite experiencing mental health problems (Gulliver, Griffiths, & Christensen, 2010) and thus the information should be as accessible as possible. It could be suggested that having a link to the pre-existing

university website page on mental health services that is clearly visible on every page, and is quick to navigate to and so does not have to be searched for extensively could be a simple but effective change as well. Placing priority on encouraging help-seeking when needed by making mental health service information easy to access efficiently, and in a confidential manner gives people of all ages a better opportunity to get the help they need without fear of stigma. Given the needs of the young adult population as a demographic often experiencing mental health issues for the first time in their lifespan, this research can serve as a model for how to help people who are unwilling or unsure how they can help themselves.

## Appendix A

## Demographic Survey

Please answer the following questions about yourself, leaving blank any which you would prefer not to answer;

Age: _____

Gender: male_____ female_____ non-binary_____ other_____

Are you an International or Domestic Student? International_____ Domestic_____

Are you a main campus (Western) or affiliate (Brescia/Huron/Kings) student?

Main_____ Affiliate_____

If you are an affiliate student, which campus do you attend?

Brescia_____ Huron_____ Kings_____

How many years of university/college have you completed, including the current school year?____

Do you currently live in residence? Yes_____ No_____

Have you ever lived in residence at Western, Brescia, Huron, or Kings, previously?

Yes_____ No_____

How would you rate your awareness of “mental health/wellness” resources available on campus?

1 2 3 4 5

How would you rate your awareness of “mental health/wellness” resources available off-campus offered specifically via telephone?

1 2 3 4 5

Have you previously/ever accessed any “mental health/wellness” resources available on campus? Yes_____ No_____

If you answered yes to the previous question, how would you consider your overall experience?

Positive_____ Neutral_____ Negative_____

Have you previously/ever accessed any "mental health/wellness" resources available off-campus offered specifically via telephone? Yes_____ No_____

If you answered yes to the previous question, how would you consider your overall experience?

Positive_____ Neutral_____ Negative_____

# Appendix B

## Awareness Scale A

How would you rate your awareness of mental health/wellness resources available on campus?

1 2 3 4 5

How would you rate your awareness of mental health/wellness resources available off-campus offered specifically via telephone?

1 2 3 4 5

## Appendix C

## Awareness Scale B

How would you rate your awareness of mental health/wellness resources available on campus?

1 2 3 4 5

How would you rate your awareness of mental health/wellness resources available off-campus offered specifically via telephone?

1 2 3 4 5

Since the initial session, have you accessed any mental health/wellness resources available on campus? Yes_____ No_____

If you answered yes to the previous question, how would you consider your overall experience?

Positive_____ Neutral_____ Negative_____

Since the initial session, have you accessed any mental health/wellness resources available off-campus offered specifically via telephone? Yes_____ No_____

If you answered yes to the previous question, how would you consider your overall experience?

Positive_____ Neutral_____ Negative_____

Awareness Scale B continued

1. Since the first testing session, have you mentioned any of the wellness services you read about to friends or family?

Yes____ No____

2. If you answered no, would you consider recommending any of the wellness services you read about to a friend or family member in the future?

Yes____ No____

3. If you answered yes, please indicate which wellness service(s) you did talk about with a friend or family member.

The Support Line _____

Telehealth Ontario _____

AIDS & Sexual Health InfoLine _____

Good2Talk _____

Prefer not to say _____

4. If you answered no to the first question, please indicate which wellness service(s) you think you would talk about with a friend or family member in the future.

The Support Line _____

Telehealth Ontario _____

AIDS & Sexual Health InfoLine _____

Good2Talk _____

Prefer not to say _____

# Appendix D

## Call for Participants

Title: General Well-being and Awareness and Perception of Wellness Services

Description:

This study examines general well-being, in addition to the awareness and perception of wellness telephone counselling and health helpline services.

The current study requires participants to complete a total of eight brief single page questionnaires and one demographic survey which will take place across two assessment periods. The first session will take between 40 minutes to 1 hour, and the second session will take between 20 to 30 minutes. The second session will take place approximately seven days after the initial session.

Participants will receive 3 credits for participation in this study.

## Appendix E

## Basic Script

Researcher: Hello, my name is Jessica Jones and I will be conducting the research you are participating in today. I appreciate your participation in this study, and if you would follow me to the testing room we can get started.

Participant will follow the researcher to either testing room PURL 1 or 2 and will be given the Letter of Information (Appendix F) followed by the Consent Form (Appendix G).

Researcher: Please read the following Letter of Information (Appendix F) to obtain more information about my study and the terms of confidentiality which will be adhered to. If you have any questions feel free to ask me, and please write your initials at the bottom of each page.

After the participant has finished reading and initialing the Letter of Information (Appendix F), she will be asked fill out an Informed Consent Form (Appendix G).

Researcher: The next document is the Consent form which I will keep after it is completed, please ask me any questions you have before filling it out and then we can get started with the questionnaires.

The researcher will take the Consent Form (Appendix G) after completion and answering any questions to the participant's satisfaction, and the study will proceed.

Researcher: Please fill out these first three questionnaires using the scales provided or by marking 'X' on the appropriate line on the demographics survey. If you need clarification of an item you can ask me at any time, and take as long as you need to complete them as truthfully as possible.

Once the participant has filled out the first three questionnaires including the Demographics Survey (Appendix A), Questionnaire A measuring Life Satisfaction with the SWLS (Appendix H), and Questionnaire B measuring Perceived Benefits with an HBMI subscale (Appendix I), the reading portion of the online websites will begin.

Researcher: Now I have four different websites of resources available to you as a student, as a resident of London, or as a resident of Ontario. Please take your time reading through the websites and learning about the services offered. Let me know

when you are done looking at all of the websites and we can move on to the next portion of the study.

Once the participant has finished reading all of the websites including Telehealth Ontario, Good2talk, AIDS & Sexual Health InfoLine, and The Support Line, the Exclusively Reading group will continue to follow this script, and the Intensive Exposure group will begin following the Intensive Exposure Script (Appendix J). The Intensive Exposure group will then return to this Basic Script (Appendix E) after the completion of the Intensive Exposure Script (Appendix J).

Researcher: Now, there are three more brief questionnaires I will ask you to fill out that are similar to the first three questionnaires you have already completed. Once again if you have any questions about the items feel free to ask me, and take as long as you need to complete them as truthfully as possible.

Once the participant has filled out the second package of questionnaires including the Awareness Scale A measuring Service Awareness (Appendix B), Questionnaire A measuring Life Satisfaction with the SWLS (Appendix H), and Questionnaire B measuring Perceived Benefits with an HBMI subscale (Appendix I), data collection for the first testing session will be completed.

Researcher: Now you have completed the first testing session of my study, if you have any questions before the second testing session next week and need to get in contact, information for myself and my advisors is on the Letter of Information form. I appreciate your participation on my study and will see you at the following shorter session on (researcher states the scheduled date) which should take approximately 20 minutes

## Appendix F
## Letter of Information

**Project Title:** General Well-being and Awareness and Perception of Wellness Services

**Researcher:** Jessica Jones

**Faculty supervisors:** Dr. Anne Barnfield, Psychology Coordinator, School of Behavioural and Social Sciences, Brescia University College and Professor Dick Shugar, Department of Psychology, Brescia University College

### Letter of Information

1. **Invitation to Participate**
   As a student in Psychology 1000 at Brescia University College, you are being invited to participate in this research study about general well-being and the awareness and perception of wellness helpline services.

2. **Purpose of this Letter**
   The purpose of this letter is to provide you with information required for you to make an informed decision regarding participation in this research.

3. **Purpose of this Study**

   The purpose of this study is to examine general well-being, as well as awareness and perception of wellness telephone counselling and health helpline services. This will be conducted over the course of two sessions, the first of which will include information about these resources.

4. **Inclusion Criteria**

   All individuals in Psychology 1000 at Brescia University College are eligible to participate in this study.

5. **Study Procedures**
   If you agree to participate, you will be asked to fill out a general demographics survey, in addition to eight brief single-page questionnaires about general well-being and the awareness and perception of wellness helpline services. It is anticipated that the entire study will take up to one and a half hours, over two sessions. The study will be conducted in the Psychology Undergraduate Research Laboratory at Brescia. There will be a total of 30 participants in this study.

6. **Possible Risks and Harms**

There are no known or anticipated risks or discomforts associated with participating in this study.

7. **Possible Benefits**
   You may personally benefit from this study through gaining knowledge of wellness resources available to university students and/or the local community.

8. **Compensation**
   You will be compensated with 3 participation credits for your participation in this study. If you do not complete the entire study you will still earn these credits. Participation credits will be awarded after each session, 2 credits after the first testing session, and 1 credit after completion of the second testing session.

9. **Voluntary Participation**
   Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your future academic status.

10. **Confidentiality**
    All data collected will remain confidential and accessible only to me and my faculty supervisors. If the results are published, your name will not be used. Information gathered will be anonymously coded and the scores of individual participants will not be accessible.

11. **Contacts for Further Information**
    If you require any further information regarding this research project or your participation in the study you may contact myself at **jjone72@uwo.ca**, or one of my thesis advisors Dr Anne Barnfield at **abarnfie@uwo.ca**, or Professor Dick Sugar at **rshugar@uwo.ca**

    If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Psychology Honours Thesis Coordinator at 519-432-8353 ext 28116, email: jbmitche@uwo.ca.

12. **Publication**
    If the results of the study are published, your name will not be used. If you would like to receive a copy of any potential study results, please contact Jessica Jones at **jjone72@uwo.ca**

*This letter is yours to keep for future reference.*

# Appendix G

## Consent Form

Project Title: General Well-being and Awareness and Perception of Wellness Services

Study Investigator's Name: Jessica Jones

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All risks and benefits have been explained to me. All questions have been answered to my satisfaction.

Participant's Name (please print):
_____

Participant's Signature:
_____

Date:
_____

Study Investigator Obtaining Informed Consent (please print):
_____

Signature:
_____

Date:
_____

# Appendix H

## Questionnaire A

Please indicate your answer on the following questions using the provided 7-point Likert scale where 1 represents strongly disagree, 2 represents disagree, 3 represents slightly disagree, 4 represents neither agree nor disagree, 5 represents slightly agree, 6 represents agree, and 7 represents strongly agree.

In most ways my life is close to my ideal.

1 2 3 4 5 6 7

The conditions of my life are excellent.

1 2 3 4 5 6 7

I am satisfied with my life.

1 2 3 4 5 6 7

So far I have gotten the important things I want in life.

1 2 3 4 5 6 7

If I could live my life over, I would change almost nothing.

1 2 3 4 5 6 7

# Appendix I

## Questionnaire B

Please indicate your answer on the following questions using the provided 5-point Likert scale where 1 represents strongly disagree and 5 represents strongly agree.

Getting help for emotional or nervous problems would prevent major problems with family and friends.

1 2 3 4 5

Getting help for emotional or nervous problems would increase my ability to function at home and at work.

1 2 3 4 5

Getting help for emotional or nervous problems would make me feel better about myself.

1 2 3 4 5

A burden would be lifted off me if I were to get help for emotional or nervous problems.

1 2 3 4 5

# Appendix J

## Intensive Exposure Script

Researcher: I would like to go over the four wellness services from the websites you just finished reviewing in more depth, and to explain how they work and what can be expected when calling them. Please ask me at any time if you have questions and I will answer them to the best of my ability. I volunteered previously at the London and District Distress Line which has been replaced by The Support Line, and have experience making referrals to and speaking directly with these services myself.

The Support Line is answered by trained volunteers twenty four hours a day, seven days a week.

The Support Line is confidential and not anonymous, which means that when someone calls in they do not record the incoming phone number but they will ask for a name. They ask for a first name because they do write notes to keep on file to assist the volunteers in familiarizing themselves with people who call in. Callers do not have to give a name if it is preferred not to, or if a caller would like them to keep notes in a profile, she can also give a fake name or alias, or her real name if she is comfortable doing so. The Support Line functions as both a referral service and a supportive listening line. The referral service utilizes their database of community resources available to residents of London, and callers can ask directly for a referral when speaking on the phone or may want to speak with the volunteer first and give them a more detailed description of what type of service or community support is being searched for. Many people call in to access the supportive listening service without any need or desire for a referral. They may just be looking to get an outside opinion on an issue they are having with a friend, or are simply having a hard day and want to talk through it with someone who has learned active listening skills. In my own experience getting feedback from callers, it was common that they spoke about feeling validated and more able to handle the situation they were calling about, and that they had a clearer perspective on what they wanted to do moving forward. Do you have any questions about the Support Line service?

Participant may ask any questions she may have about The Support Line which will be answered to the best of the ability of the researcher.

Researcher: Telehealth Ontario is a confidential service answered by Registered Nurses twenty four hours a day, seven days a week. The service is confidential and anonymity is dependent on a few choices callers will be asked to make. Callers can choose not to provide health card information, which is optional, or may choose to

call back later if the line is busy instead of giving them a phone number to call back on. Callers may also ask that the call not be recorded as there will be a disclaimer stating that unless it is asked that the call not to be recorded, it may be used for training purposes. No phone number information is kept on record after the call is made or after the Telehealth nurse has called back.

Calling the Telehealth Ontario service will involve the Registered Nurse asking about symptoms and going through a series of questions in order to determine what level of care to suggest. They will ask about any previous or existing health conditions, and what medications are being taken if any. They may also ask demographic information such as age. Depending on the symptoms, they may refer callers to a nearby walk-in clinic, hospital, or emergency room, however calling this line does not take the place of calling 911 in an emergency situation. The nurse can look up the location of the medical building that can provide the appropriate level of care nearest to the caller. If given health card information, the nurse will be able to fax the details of the call to a healthcare provider at the suggested location to visit if the caller agrees to this transmission of information. If the nurse determines that the condition does not require medical attention, they may suggest ways of taking care of it at home. In my experience making referrals to this service, people tend to find it most helpful to determine the level of care they may need quickly. Another example of feedback has been that people find they have avoided wasting time at a walk-in clinic when they should be at a hospital receiving a level of care unavailable at a clinic. Do you have any questions about the Telehealth Ontario service?

Participant may ask any questions she may have about Telehealth Ontario which will be answered to the best of the ability of the researcher.

Researcher: The AIDS & Sexual Health InfoLine is a confidential and anonymous service run by staff with backgrounds in counselling, social work, and nursing. The hours of operation from Monday to Friday are 10 a.m. to 10:30 p.m., and from 11 a.m. to 3 p.m. on Saturday and Sunday. The AIDS & Sexual Health InfoLine is closed on Statutory holidays such as Canada Day and Labour Day. The counsellors can make referrals to resources throughout the province of Ontario, and the service is anonymous as no name is required and there is no record kept of phone numbers calling in.

The counsellors are able to speak about a wide range of topics relating to sexuality, relationships, birth control, and emergency contraception amongst other subjects relating to sexual health. For example, counsellors can make referrals to nearby sexual health clinics, or facilities to discuss pregnancy or pregnancy options. In my experience making referrals to this service, often people were unsure about what STI testing they should have done and wanted to speak to someone about what to expect

and wanted to feel prepared before arriving at a sexual health clinic. Other people have been searching for more information about changing birth control methods and the safest way to do so. The counsellor will ask how callers heard of the service before ending the call for their own internal statistical information, however it is not necessary to answer if it is preferred not to. Do you have any questions about the AIDS & Sexual Health InfoLine service?

Participant may ask any questions she may have about the AIDS & Sexual Health InfoLine which will be answered to the best of the ability of the researcher.

Researcher: The Good2Talk Post-Secondary Student Helpline which considers students between the ages of 17 and 25 to be their primary focus, however all post-secondary students

are welcome to use the service. Good2Talk is a confidential and anonymous, as they do not have call display and do not record the phone numbers of incoming calls. Good2Talk is structured so that the first person callers speak with can make a referral if that is all that is desired to use the service for. If a caller would like to speak to a counsellor, he will be directly transferred through by the Information and Referral Specialist and can talk to a counsellor with professional qualifications and at least three years of relevant work experience. This direct transfer may require being put on hold, but will not involve dialing any other number as callers will speak with a counsellor as soon as one is available. Callers can talk about any issues related to school directly or about one's personal life, including interpersonal challenges or mental health concerns. If a caller would like to obtain a referral to a service on campus at any time or at the end of her call, she will be transferred back to the Information and Referral Specialist who will find the contact information for the appropriate resource. This will require disclosing which school the caller attends however there is no transmission of information from Good2Talk to the university or college itself. Do you have any questions about the Good2Talk Post-Secondary Student Helpline?

Participant may ask any questions she may have about Good2Talk which will be answered to the best of the ability of the researcher.

Researcher: That concludes this portion of the experiment, do you have any questions about any of the services discussed today?

Once any remaining questions have been answered and after the completion of this Intensive Exposure Script (Appendix J), the rest of the first testing session will return to the Basic Script (Appendix E). This transition will begin with the researcher explaining the second package of questionnaires which includes Awareness Scale A

measuring Service Awareness (Appendix B), Questionnaire A measuring Life Satisfaction with the SWLS (Appendix H), and Questionnaire B measuring Perceived Benefits with an HBMI subscale (Appendix I).

**Appendix K**
**Second Testing Session Script**

Researcher: Hello, thank you for returning for the second testing session, please follow me to the testing room and we can begin.

*Participant will follow the researcher to either testing room PURL 1 or 2 and will be given the Awareness Scale B measuring Service Awareness and Use (Appendix C), Questionnaire A measuring Life Satisfaction with the SWLS (Appendix H), and Questionnaire B measuring Perceived Benefits with an HBMI subscale (Appendix I).*

Researcher: Now, these are final three questionnaires I will ask you to fill out that are similar to the questionnaires you have already completed. Once again if you have any questions about the questionnaire items feel free to ask me, and take as long as you need to complete them as truthfully as possible. I would like to remind you that all information given through your answers will be kept confidential, and will be anonymously coded so that no one will see your name attached to any of the results or calculations.

*Once the participant has completed the questionnaires and any questions from the participant have been answered, she will be given the Debriefing Information (Appendix L)*

Researcher: This document contains the Debriefing Information, which has a more thorough description of my study and the hypothesized findings. If you have any other questions or concerns the contact information for myself and my advisors is provided on this form, as well as on the Letter of Information. Thank you for participating in my study.

## Appendix L
## Debriefing information

***Life Satisfaction, Service Awareness, Service Use, and Perceived Benefits of Telephone Counselling and Wellness Services***

The study you have just participated in investigates the effect of life satisfaction scores and type of exposure to telephone counselling and wellness services on service awareness, service use, and perceived benefits of treatment for emotional/nervous problems. This study used an experimental design in which one group of participants exclusively read the online information provided by the websites of the organizations, and the intensive exposure group was given the same information, in addition to a discussion of those resources with a more thorough explanation with examples of when it could be useful to make contact.

The first hypothesis is that a larger increase in perceived benefits will be seen amongst the intensive exposure group compared to the exclusively reading group. It is also hypothesized that generally, increases in perceived benefits will also reveal increases in service use, and that the intensive exposure group will score higher on both of these measures compared to the exclusively reading group. The final hypothesis is that those who score low in life satisfaction will show a higher increase in service use and perceived benefits compared to those with similar life satisfaction scores in the exclusively reading group. The results of this study could be useful for creating more effective outreach programs to encourage university students to contact telephone counselling and wellness services when it would be beneficial for their mental health and general well-being.

As a reminder, scores will be coded anonymously and the scores of individual participants will not be accessible. Thank you for participating today. If you have any further questions please contact:

***Jessica Jones, jjone72@uwo.ca***
***Dr. Anne Barnfield, abarnfie@uwo.ca***
***Professor Dick Shugar, rshugar@uwo.ca***

For further information:
Counselling at Brescia with Dr. Rhonda Gilby
• Wednesdays and Thursdays 9am-4pm in Ursuline Hall, Room 223
• $100/session, which you can be reimbursed for through your student health plan
• Contact: rgilby@uwo.ca or 519-860-2220

as found on http://brescia.uwo.ca/life/mental-health-wellness/seven-dimensions-of-wellness/emotional/

**Continued**

Brescia's Mental Health and Wellness webpage
http://brescia.uwo.ca/life/mental-health-wellness/

| Organization | Contact Information |
|---|---|
| Good2Talk<br>https://good2talk.ca/about/ | Toll-free:1-866-925-5454<br>dial 2-1-1 and ask to be connected to Good2Talk.<br>Hours: 24/7 |
| Telehealth Ontario<br>https://www.ontario.ca/page/get-medical-advice-telehealth-ontario | Toll-free: 1-866-797-0000<br>Toll-free TTY: 1-866-797-0007<br>Hours: 24/7 |
| Sexual Health and Aids InfoLine<br>https://www1.toronto.ca/wps/portal/contentonly?vgnextoid=d7f87dbbfd510410VgnVCM10000071d60f89RCRD | Toll-free: 1-800-668-2437<br>Local: 416-392-2437<br>Hours: Monday - Friday: 10 a.m. - 10:30p.m.<br>Saturday & Sunday: 11 a.m. - 3 p.m.<br>Statutory holidays: closed |
| Support Line<br>https://cmhamiddlesex.ca/programs-services/support-line/ | Toll-free number: 1(844)-360-8055<br>Local: 519-601-8055<br>Hours: 24/7 |

**For further reading:**

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O'Connor, P. J., Martin, B., Weeks, C. S., & Ong, L. (2014). Factors that influence young people's mental health help- seeking behaviour: A study based on the health belief model. *Journal of Advanced Nursing, 70*(11), 2577-2587. doi:10.1111/jan.12423

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