Improving Student Access and Utilization of Mental Health Services

on a University Campus

A thesis presented by

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Abstract

This study used a case study approach to better understand the role of a Counselling and Development Centre at a public University in Hong Kong in encouraging student participation in a mental health enhancement program. Data were collected using semi-structured, in-depth interviews and focus group, and analyzed using general inductive analysis. The study focused on the lived experiences of six education leaders and twelve undergraduate students to make sense of the interconnected factors that affected the help-seeking decision process. This study used Health Belief Model as a framework for explaining the possible factors that encourage or prevent an individual from seeking help for mental health problems and help to help answer the following research question: What is the role of the a Counselling and Development Centre in encouraging student participation in a mental health enhancement program?

Finding from this study supports previous research finding demonstrating the influential impact of culture on mental health issues, and the need for implement holistic mental health service programs. This study also makes an importance contribution to the literature by offering a new perspective about mental health education. Finding support that early prevention strategies is able to reduce risk factors of developing mental health problems and decrease the tendency towards illness contribute to the onset of some mental disorders. Finding from this study suggest including mental health education as part of the curriculum in the Hong Kong education system. Recommendations include providing culturally relevant curricula to students, providing in-house resources support and appropriate training to university administrators, and promoting mental health issues involve parents and families in child's education and foster relationships between home, university, and community to enhance the mental health education of students.

Key words: Culture, cultural determinants, loss of face, idioms of distress, help-seeking.
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Chapter 1: Introduction to the Study

Globally, one in four people in the world is suffering from different symptoms and types of mental illnesses (World Health Organization [WHO], 2011). Depression and anxiety disorders were common mental disorders that affect general functional and working capacity. A study by the World Health Organization (WHO) in 2011 found that more than 500 million people suffer from various types of mental illness, such as depression and anxiety disorders, such disorders worsening the global economy in loss of productivity each year. All too often, people tend to hold negative beliefs about mental illness. The negatives stereotype and attitude surround mental illness is that people with mental health problem were violent and crazy. These common myths about mental health problems make matters worse and make recovery much more difficult. Mental illnesses have long been a taboo topic in many societies because of the ubiquity of cultural stigmas attached to mental illness. It is not common for individuals with mental illness to be casted as violent and dangerous (Lauber & Rössler, 2007). Many people with mental disorders subsequently refuse to get help or adopt a victim position because of these strong cultural stigmas. Such behaviors have delayed individuals from getting treatment and have negatively influenced the mental health help-seeking attitudes of youth and young adults, possibly having an effect on suicidal behavior patterns of students (Bertolote & Flieischmann, 2002).

The purpose of this case study was to better understand the role of a Counselling and Development Centre (CDC) at a public University in Hong Kong in encouraging student participation in a mental health enhancement program. Yin (2008) has defined a case study as an empirical inquiry that investigates a contemporary phenomenon within its real-life context. It aims to explore a social science phenomenon through analysis of various sources of data to
explore the case and answers the research questions. The case study approach allowed different
types of exploration of an issue in a real-life setting. It was particularly useful to employ when
the researcher needed to conduct an in-depth examination of a particular phenomenon. At this
stage in the research, the mental health program organized by CDC was defined as strategies to
improve student’s access to mental health service on a university campus. Knowledge generated
was expected to inform the program administrator about the obstacles that prevented students
from seeking help and to provide useful information on how to improve the program structure to
support future implementation. Furthermore, understanding the connections between cultural
factors and help-seeking intentions could counteract the underutilization of mental health
services at the university.

This chapter began with a brief overview of research related to mental health issues
among university students in Hong Kong to provide a brief context and background for the
study. Several cultural issues are discussed, including the importance of cultural sensitivity; the
influence of campus culture on students’ intentions to seek mental health services; the cultural
impact of societal beliefs related to mental health; and the formation of social stigma and
perceptions. The problem statement, research problem, and research question for this study are
presented. Finally, the theoretical framework that serves as a lens for this study is introduced and
explained.

**Background and Context**

According to data from the Government of the Hong Kong Special Administrative
Region, Department of Health, Coroner’s Court (2016), there were 921 cases of suicide in 2015
in Hong Kong. Youth and young adults accounted for almost 6% of all suicides, adding up to
approximately one death per week in that year. In the period between 2004 and 2014, a total 789
deaths for ages 15 to 24 occurred. Mental disorders represented a major risk factor associated with youth and young adult suicide. Suicide was not in itself classified as a mental illness in Hong Kong. Rather it was classified as a serious potential consequence of treatment avoidance or delayed treatment for mental illness. As of 2017, statistics indicated that suicides among youth and young adults attending universities continued to be a serious problem area, and scholars have consistently documented that a distressing lack of support on mental health treatment exists for this population (CSRP, 2016). Research has been commissioned to examine how cultural differences in attitudes towards mental illness were related to help-seeking behavior. For example, traditional Asian practitioners frequently provided treatment for "illness" and Western-trained physicians provide treatment for "disease" (Kuo & Kavanagh, 1994; Yamaguchi, Ling, Kim, & Mino, 2014). In some Asian countries, such as China and Japan, society viewed abnormal behavior as an act of the “devil” (Fan, 1999). Winne (2004) revealed the diverse effects of Chinese culture and society on mental health issues and asserted that cultural barriers included the traditional family structure, beliefs of mental health treatment, and fear of loss of face. These cultural conceptions and practical experiences of stigma have been found to be potential barriers that prevented youth and young adults from seeking help.

Stereotypes and myths about individuals with mental illness were widespread in Hong Kong media and society and have significantly contributed to an underutilization of mental health services (Mann & Chong, 2016). Specifically, cultural stigmas regarding mental illness powerfully influenced students’ help-seeking behavior; this has become a modifiable risk factor for student suicide. Researchers have found a strong connection between peer stigmatization and help-seeking behaviors (H. Chen et al. 2014; S. X. Chen & Mak, 2008; Kung, 2003; Mo & Mak, 2009). Perceived stigma appears to have a differential impact on attitudes toward formal and
informal help-seeking behaviors. Despite these findings, understanding the various cultural factors that shaped students’ help-seeking intentions and behavior could provide valuable information regarding what influences the behavioral decisions of youth and young adults who needed assistance with mental health problems. Therefore, this study also sought to examine the effectiveness of the mental health program organized by the CDC at a local university to improve student’s access to mental health service on the university campus. The next section of this chapter further analyzes the significance of the problem.

**Rationale and Significance**

The rationale for this study was the researcher’s interest in expanding research on traditions and customs in Chinese culture to address mental health issues. This was because society in general has stereotyped views about people with mental illness and how they affected others. This issue was particularly acute in Asian cultures, a factor that was explored in Chapter 2 in greater detail. In many Asian contexts, societal beliefs classified individuals with mental health issues as violent and dangerous. Given that the suicide rate among youth and young adults in Hong Kong has been consistently rising, examining taboos regarding mental health issues and cultural factors that contributed to a serious lack of understanding concerning mental health problems could provide important insights into help-seeking behavioral patterns in this context. This goal then was precisely to examine the role of cultural factors that influence attitudes towards mental health help-seeking behaviors.

Expanding existing research on traditions and customs in Chinese culture with a study based at a public university in Hong Kong has implications for the enduring impact that embedded values have on peoples’ behavior. It could also help to identify areas where behavioral change regarding help-seeking behavior could occur. In this case, the Confucian ideological
system that still applies today and which constituted a code of ethics in modern Hong Kong will be analyzed.

Understanding the influence of cultural factors that affected mental health help-seeking behavior was an important goal for practitioners and for scholars who addressed student wellbeing and who were engaged in reducing suicide rates. Examining the ways in which an individual's identity was influenced by cultural factors such as social norms, educational level, family values, and personal habits could provide important insights into behavioral patterns and could assist in the design of effective prevention strategies. Finally, this study has implications for the promotion of early intervention strategies in the university setting that could positively change the perceptions of the students at risk of mental illness. The earlier identification of available resources could provide a more effective way to identify the emotional needs of university students (Green et al., 2001). The ultimate goal is to describe in detail the barriers to help-seeking intentions of students with mental health issues in Hong Kong and to identify what changes could be made to engage them more deeply in help-seeking behaviors.

Research Problem and Research Question

The quickly growing numbers of students committing suicide have drawn public attention to the prevalence of common mental disorder and academic stress of Hong Kong students. Hong Kong’s high-pressure education system inflicted long lasting effects on the physical health and mental health of students. McMichael and Hetzel (1975) identified poor mental health as a significant factor contributing to withdrawal from of studies and academic failure. McMichael and Hetzel (1975) also highlighted the relationship between the psychological effects of stress on mental health and academic success. The study confirmed that withdrawing from studies during the first academic year was frequently preceded by poor mental
health. Unfortunately, stigma associated with mental illness made mental health a taboo topic that was rarely discussed openly in the university setting. Timely referrals could greatly improve the mental health conditions of students. It was imperative, therefore, that school administrators educated students with positive mental health concepts and made referrals for appropriate treatment by identifying the early symptoms of mental illness.

Mental health promotion and prevention in universities played an important role in a student’s ability to study effectively. The school-based mental health program that was the focus of this study aimed to provide prevention and early intervention services to offer prompt diagnosis and to prevent mental problems in their initial stages. Through school-based mental health services, students with mental health concerns could be identified earlier and be more easily access services. Exploratory research on the effectiveness of universal school-based mental health programs has demonstrated positive outcomes in improving student’s mental health and well-being. Other studies confirmed that school-based mental health programs integrated with youth education have an effect on reducing internalizing problems (Garcia-Ortega et al., 2013; Park & Sunyoung, 2017; Stoltz et al., 2012). Yet, another obstacle was traditional Chinese culture which often impedes Hong Kong students from seeking mental health services in the university setting. Scholars have reported that stigma surrounding mental illness, which was particularly salient in Chinese culture, leads to an absence of treatment for problems such as depression (Abdullah & Brown, 2011; Corrigan & Kleinlein, 2005; Corrigan & Wassell, 2008). Some of the harmful effects of stigma could include isolation, loneliness, bullying, and harassment; these could prompt ill patients to hide their symptoms and avoid seeking help because of fear and shame.
A lack of mental health literacy has also led to stigmatization and discrimination among people with mental illness, resulting in lower rates of help seeking. Mental health promotion programs have received increasing attention as useful strategies to improve mental health literacy and to promote early identification of mental disorders, significantly reducing stigma. Stigmas impacted people in different ways. Stigma occurred when people internalize negative public attitudes and bought into society’s misconceptions and judgmental perspectives. Culture played a significant role in shaping threat perception and stigma in Chinese society. Abdullah and Brown (2011) explained culture as “shared attributes, belief systems, and value orientations that a group of people have in common and that influence their customs, norms, practices, social institutions, and psychological processes” (p. 935). The traditional perception that people with mental health problems were violent and dangerous has led to the exclusion of mentally ill patients from many aspects of Chinese community life. In short, culture shaped how individuals perceive and responded to people with mental illness, and these stereotypes had significantly affected the help-seeking attitudes of ill patients, resulting in treatment avoidance, delay of care, and discontinuation of treatment.

The purpose of this study with students at a public university in Hong Kong was to understand the role of the CDC in encouraging student participation in a mental health enhancement program. This qualitative study was guided by the following overarching question:

What is the role of the Counselling and Development Centre (CDC) in encouraging student participation in a mental health enhancement program?

In reality, the history and experience of a mentally ill patient may truly reflect the difficulties that they faced in relation to addressing mental health issues. This study sought to explore the challenges faced by CDC in the implementation of the mental health enhancement program at a
public university in Hong Kong. Cultural factors, particularly those that embrace traditional Chinese culture, affected the state of body and health and added a layer of complexity to the research problem.

**Key Terminology**

This section provides definitions of the key terms drawn from scholarly studies to provide a reference for the reader.

**Culture.** According Abdullah and Brown (2011), culture refers to the “shared attributes, belief systems, and value orientations that a group of people have in common and that influence their customs, norms, practices, social institutions, psychological processes” (p. 935).

**Cultural determinants.** The term cultural determinants is used in this study to describe and help understand the cultural factors contributing to help-seeking behaviors, such as the level of acculturation and traditional beliefs about mental health.

**Loss of face.** According to Kuo and Kavanagh (1994), losing face in Chinese culture means loss of authority or honor. The Chinese hide their emotions to avoid stigma and shame to “save face.”

**Idioms of distress.** Arnault (2009) defined an idiom of distress as “a collection of physical, emotional and interpersonal sensations and experiences labeled by the individual as optimal or abnormal, and identified as important” (p. 260).

**Help-seeking.** Help-seeking refers to the process of obtaining external assistance to eliminate concerns about mental health (Arnault, 2009).

The following section of this chapter will include an exploration and discussion of the health belief model which will serve as the theoretical lens for this study.
Theoretical Framework

This study used the health belief model (HBM) as a framework for explaining the possible factors that encouraged or prevented an individual from seeking help for mental health problems. The framework placed primacy on individual constructs of beliefs and attitudes, while acknowledging the factors that affected the help-seeking decision to address mental health problems. The model included six constructs: perceived susceptibility, perceived severity; perceived benefits; perceived barriers; cues to action, and self-efficacy. The six constructs were hypothesized to explain and predict health behaviors. Janz, Champion and Strecher (2002) explained that HBM was built on value expectancy theory, or the person’s desire to maintain wellness or to seek treatment based on expectancies for success and subjective task values. The six constructs that made up the HBM involved valuing behavioral change and expecting a certain outcome from the behavioral change. This was particularly useful for evaluating a program designed for increasing mental health awareness and appropriate mental health utilization. The application of the HBM in mental health education practice provided a guide for the school administrators to plan cost-effective mental health programs for students in the university setting.

Historical and Contemporary Foundations of the Framework

The HBM (Rosenstock, 1966) was originally developed in the early 1950s by social phycologists at the U.S. Public Health Service to explain the failure of people to adopt preventative health strategies for the early detection of disease. The model hypothesizes that people were likely to make change on health behavior when the following four conditions occurred: (a) the person believes that the problem has serious consequences (perceived severity); (b) the person feels at risk of health problems (perceived susceptibility); (c) the person believes that the threats will be decreased by a specific behavior change (perceived benefits); and (d) the
person trusts that barriers to the behavior change could be overcome (perceived barriers). Based on experimentation over the years, the HBM was expanded by Becker in the 1980s. The four major constructs have been modified by the inclusion of demographic and structural variables. These variables included culture, age, sex, knowledge of a given disease, and level of education, all which affect health-related behaviors. In addition to the four constructs and other variables, two elements were added to the model related to what actually drives a person to make a behavioral change. These two elements were cues to action and self-efficacy. Cues to action were elements that would activate the readiness for change of an individual; examples included media reports and advice from others. Self-efficacy, meanwhile, refers to individual’s belief in their capacity to engage in health promotion behavior. In summary, cues to action and self-efficacy affected the perceptions of susceptibility, severity, benefits, and barriers; therefore, they determined whether or not an individual accepted or rejected preventative health services or adopts healthy behaviors.

Within the HBM framework, the six constructs were useful to explore perceptions about mental illness and mental health service utilization. For example, high perceived susceptibility to illness may increase appropriate utilization and decrease the physical barriers to treatment. Zhang, Snowden, and Sue (1998) asserted that the HBM is an effective framework for guiding research in defining the multidimensional construct of culture from different angles to outline the cultural barriers that affected access to professional health care. Cultural researchers often examined barriers to treatment in different populations (Lefley, 2000; Morris et al., 2011, Kastanakis and Voyer, 2014). In general, Asian individuals often describe a person with mental illness as a devil; culturally, this has contributed to an avoidance of people seeking professional help because of the perceived stigma surrounding mental illness and negative labelling effects.
(Arnault, 2009). So, if it was perceived that Asian groups share a socially significant belief about mental illness as violent and dangerous, and they attribute criminal and abnormal behavior to mental health symptoms, this affected their propensity to use primary medical care and to seek social support for somatic experiences. Arnault (2009) discussed the fact that Asian culture was deeply rooted in Confucian values; expressions of negative emotions were broadly considered to disrupt the harmony of the collective in this context. This led to a suppression of emotions to avoid contributing to social disharmony which resulted in low perceived susceptibility.

According to HBM, an individual’s perception of susceptibility may impact health behavior. Individual responses to the perceived problem will be limited if the perceived susceptibility was too low. Thus, individual responses to the perceived problem were related to cultural beliefs, values, and social structures. This established the foundation for choosing HBM as a theoretical framework for exploring cultural influences on mental health help-seeking behavior.

As Figure 1 illustrates, there were two main types of factors that influenced people to take action for disease prevention: factors related to readiness to change and factors related to modifying factors that encourage or inhibit action. For example, a level of higher education tended to increase the perceived susceptibility, and this directly influenced an individual health behavior. As shown in Figure 1, some modifying factors included personality, risk or threat perceptions, and the influence of beliefs about barriers. The model hypothesized that a higher level of perceived risks could lead to a higher possibility of behavioral change, in which the perceived benefits help deceased the risk perception of a health-related decisions and behavior, while the perceived barriers interfered health behavioral change. In addition, culturally relevant information was needed to better understand individual behavioral options. The HBM model helped identify cultural factors that affected peoples’ interactions and personality variables, as
illustrated in the literature review of this study. This aligned with the socio-cognitive approach and provided a strong understanding of how people interpreted their way of living within the context of a particular culture (Waldstein and Adams, 2006). The HBM also provided a useful focus for the researcher to evaluate different types of cultural barriers that hinder an individual from seeking help, and it was recognized for its significance in making sense of how health service providers encouraged help-seeking behavior in healthcare settings, which was directly pertinent to this study.

Figure 1: Health Belief Model. Adapted from Stretcher, V., & Rosenstock, I. M. (1997). The Health Belief Model. In Glanz, K., Lewis, F. M., & Rimer, B. K., (Eds.), Health Behavior and Health Education Theory, Research and Practice. San Francisco: Jossey-Bass.

The HBM theorized an individual’s beliefs about their susceptibility to a health-related problem and their risk perceptions of the benefits of taking precautionary action to prevent the problems. Apart from the field of health studies, the HBM offered educators or school administrators a theoretical direction for evaluating the effectiveness of school-based mental
health programs among university students. The HBM was particularly useful for research that focused on the uptake of health services and human development, given that the model was developed to help understand an individual’s response to the use of preventive services to address concerns regarding prevention and. As a methodology, the HMB provided a framework through variables and constructs to encourage an understanding of what prompts an individual to realize their susceptibility to health conditions, thus inspiring positive health behavior. Henshaw et al. (2009) emphasized that the HBM was derived from socio-cognitive theory within an integrated approach to understand health behavior and possible reasons for behavioral change. This study took inspiration from the HBM in its utilization of mental health care services as a theoretical framework and in its overarching goal of improving student access to mental health services on a university campus.

**Components of the Model**

The original HBM that consisted of the four primary variables has been modified by Rosenstock and his colleagues (Rosenstock, 1966; Rosenstock et al., 1988). In addition to the four primary variables (susceptibility, severity, benefits, and barriers), cue to action and self-efficacy were added to the HBM in 1966 and 1988, respectively. This new perspective took into account aspects more precisely related to the challenges of changing habitual unhealthy behaviors. Rosenstock (1996) emphasized the critical role of health-related constructs in understanding an individual’s beliefs regarding health and the intention to seek help. The HMB construct of self-efficacy provided a relatively comprehensive review of the impact of cultural factors on mental health help-seeking behavior. Moreover, traditional Confucian values also influenced student psychosocial development in Hong Kong.
The model has been applied to understand an individual’s response to symptoms of illness and behaviors related to mental health problems. The HBM components provide a framework from which to predict an intention to seek psychological help in relation to mental health problems; this could assist school administrators in developing early intervention strategies that positively promote mental health concepts; it served as a framework for understanding the mental health perceptions of students. The HBM placed attitudes and perceptions at its center. The most significant factor influencing attitudes was the societal view of mental illness. The effect of stigma associated with mental illness was a long-lasting one, and it was believed that stigma was one of the major self-created barriers to help-seeking. One of the strengths of the HBM was the use of constructs to encourage help seeking and to improve knowledge about mental illness and the positive behavior of students. Among the six constructs, perceived barriers was the most important factor in influencing behavioral change and in predicting and explaining health-related behaviors. According to Zhang, Snowden & Sue (1998), the main barriers to utilization of mental health services included cultural beliefs regarding mental illness in various ethnic populations. Henshaw and Doan (2009) conceptualized mental health care utilization by using the HBM; the authors emphasized that the model is particularly useful in examining cultural differences in health perceptions and that it “provides dynamic representation of the decision-making process” (p. 423). The HBM was applicable to this context because it served as a theoretical model that could be used to implement health prevention programs. In the culture of Hong Kong, talking about mental health in the university still remained taboo. The model clearly explained the factors for leading health behavior change. It described the variables of HBM constructs and operationalized health concepts that could influence the decision-making of an individual. It first recognized that behavior was determined
by intentions. The behavioral intention, such as cultural perceptions of mental health, contributed to a better understanding of the changes in an individual's attitudes and beliefs regarding help-seeking.

**Critics of the Model**

Although the HBM provided an effective framework for understanding how to effectively structure a mental health prevention program and how to influence behavioral change, all of which affected the help-seeking intentions, there were some limitations to its application. Orji et al. (2012) criticized the model for lacking clear rules for combining the variables. The researchers posited that the individual constructs were individually related with health behavior and no connecting effect existed between each formulated variable. In a model with mediation effect, the independent variable offers explanations of how two variables were related, which in turn predicted the study outcome. However, this study was aimed at exploring the independent relationships between each component and the reported health behaviors. Therefore, the lack of clear rules of combining variables offered flexibility that made the HBM applicable to understanding the health behavior of an individual’s intention, in this case the university student population which was the focus of this study. Another limitation of the HBM was that the model did not account for socio-economic factors that may hinder the help-seeking decision-making process (Roden, 2004). Roden (2004) claimed that behavioral change was not a simplistic process, rather it required an understanding of social dimensions like religion, family, or culture. These social factors played a prominent role in influencing the help-seeking behavior of an individual. Therefore, this study includes a literature review of cultural influences on help-seeking attitudes among students. In the literature review that regarding the traditional Asian
cultural influences on help seeking, a more comprehensive analysis could be used to replenish the variables that were not identified in the HBM.

**Rationale**

The HBM was one of the oldest health behavior theories, and it provided a complex model for explaining and predicting health-related behavior for the participants in this study. It readily functioned as an appropriate lens for exploring student perceptions towards behavior related to mental illness. The HBM was different from other health behavior theories like the theory of planned behavior (TPB). The TPB model included only attitudes and perceived behavioral control as the determinants of intention. In the HBM, perceived benefit and perceived severity were the two main components that predicted a variety of behaviors. The HBM viewed health behavioral change as based on striking a balance between the barriers to and benefits of action of an individual's behavior. Since the HBM encouraged people to take action, a model such as this that centralized the factors associated with mental health promotion was instructive in analyzing the problem of practice. The effective predictors of mental health behavior became an important indicator for program administrators to design an effective mental health educational campaign for students. The HBM also identified the barriers that inhibited students from help seeking and from developing effective health promotion strategies to improve student access to mental health service unitization.

**Application of the Model**

This aim of this study was to identify barriers to mental health services in one university from the viewpoints of students and professional counsellors. It also aimed to make recommendations and suggestions to improve student access to mental health services in university campus. The fundamental concept of the HBM was that an individual’s behavior was
affected by their personal beliefs regarding health and the available resources for help seeking. For example, increasing an individual’s perception of the severity of the illness symptoms increased the likelihood of seeking treatment. The model identified the key factors that influenced an individual's belief regarding accessing improved circumstances (perceived susceptibility), their belief of how serious the consequences were (perceived severity), their belief in the value of the recommended action to reduce risk of illness (perceived benefits), and their belief in the actual cost of following the new health behavior (perceived barriers). These beliefs were particularly useful in predicting an individual’s health behavior, in prompting a desire to make a health change (cue to action), and in teaching and informing the student about accurate health information that reduced stigmas about mental illness. This served as a framework for designing and refining each element of this study and design.

Due to an alarming increasing trend in suicidal behavior, the need to understand the risk factors contributing to suicide has become more urgent. Research supported the claim that the underutilization of mental health services among college students at high risk for suicide was affected by trends and culture factors, which have a considerable influenced on mental health help-seeking behavior. The key element of the HBM, which focused on avoiding negative health consequences, applied directly to the overarching research question of this study that focused on improving student access and utilization of mental health services. The model helped in identifying the barriers that inhibited help seeking; thus, the program director could use the research findings to develop effective intervention strategies or health education programs dedicated to the improvement of students’ mental health wellbeing.
Summary

The increasing number of suicides among Hong Kong students has raised concerns about mental health on university campuses. This study aimed to investigate the effect of one school-based intervention program, based on the HBM, on mental illness among students; it also aimed to provide suggestions to improve the effectiveness' of health promotion strategies in the university setting. The study also intended to examine the cultural effect on students’ perceptions towards seeking help, and to understand the cultural factors that affected the mental health help seeking behavior of these individuals.

The literature review in Chapter 2 examined students’ perceptions regarding both mental illness and the perceived cultural barriers to mental health help-seeking behavior, through empirical testing of existing research. Chapter 3 described the research methodology and approach.
Chapter 2: Literature Review

Globally, the scale of undiagnosed and unaddressed cases of mental illness continued to be significant, and it has been identified as one of the major risk factors leading to suicide. In this context, the need for clearer understanding mental health problems is prominent. To date, scholarly literature has identified a significant relationship between psychiatric diagnosis and suicide attempts (Bertolote & Fleischmann, 2002; Eglantina, Artemisa, Vera, & Eralda, 2015). These studies have highlighted that cultural factors were of critical importance in the formation of stigmas that influenced mental health help-seeking attitudes. They have confirmed that identifying cultural risk factors that impacted help-seeking and help-service use among university students has become a priority for administrators and practitioners in the education sector. Identifying the cultural barriers to help-seeking in a student population was the focus of this study. The study also focused on the development of early intervention strategies that could improve student access to mental health services on one university campus.

During the 2015/2016 academic year, there were 22 students in Hong Kong who committed suicide, eight of whom were attending university. Negative perceptions regarding mental illness, including stigmatizing portrayals and mental health literacy and social discrimination, have influenced the help-seeking behavior of mentally ill patients and have contributed to an increase in the rate of student suicide in Hong Kong. The following literature review, through a critical examination of the existing research, addressed the various cultural factors affecting perceptions regarding health beliefs and the causes of disease, how mental illness could be cured, and the way that patients seek help. The review sought to examine the perceived cultural barriers to mental health help-seeking behavior through empirical testing of existing research assertions. Four strands of literature were reviewed to provide insights into the
world of mental health, specifically related to one mental health program designed to foster
cultural awareness at one university. The first strand of this study outlined several concepts of
the educational system in Hong Kong. The exam-oriented system has long been criticized for
creating a stressful learning environment. Students in Hong Kong were required to get high
scores to show their ability through various tests, quizzes, and examinations. Exam stress
threatened students’ mental health and had become one of the main causes leading to suicide
amongst teenagers and young adults The second strand of this literature review explored the role
of cultures play in shaping students’ perceptions regarding mental illness (Campbell & Long,
2014; Chan; Cao & Gao, 2015; Lauber & Rössler, 2007; Ravindran & Myers, 2012;). Central to
this strand is the notion of traditional Chinese culture associated with mental health stigma-
related concepts, which had a powerful impact on public perceptions regarding mental health and
help-seeking behavior among the Chinese population (Kam, 2006; Kuo & Kavanagh, 1994). The
third strand of this review provided an overview of current trends in mental health problems
around the world. It presented information derived from existing literature and the World Health
Report, documenting estimates of the prevalence of mental disorders. Finally, the fourth strand
of this literature review conducted a systematic review of interventions, including behavioral
interventions as well as medication therapy, aimed at preventing and managing mental health
disorders. Reviewing these bodies of literature in combination was vital to understand the role
that culture played in influencing the mental health help-seeking behavior of Hong Kong
university students. It was also essential to the formulation of recommendations to university
administrators who designed mental health intervention programs aimed at improving student
access to mental health services in the university setting.
**Education Landscape in Hong Kong**

Hong Kong’s educational system was heavily influenced by the British model. In this context, the government has been providing nine years of free primary and secondary education in public sector schools since 1978. The government has offered 12-year free primary and secondary education to all students in public sector schools since 2008. After years of discussion, the 3-3-4 academic structure was implemented in higher education in 2012, with a 3-year curriculum at the senior-secondary level and a 4-year path at the university. Though the government claimed that these new academic reforms articulate international education developments in the 21st Century more effectively and that they brought significant benefits to Hong Kong students, the higher education system still faced many more challenges today, and entry into local universities was tougher than ever. According to the Hong Kong Examinations and Assessment Authority, a total of 57,649 candidates registered for the Hong Kong Diploma of Secondary Education Examination (HKDSE) in 2017/2018. However, the number of openings in publicly funded degree programs for university students is 15,000. Among all candidates, 21,264 students obtained the minimum score required for admission to the University, which meant that only about 40% of the students applying for admission were accepted. Poon and Wong (2008) claimed that Hong Kong’s education system was highly selective and competitive. The low university acceptance rate made both students and teachers experience enormous pressure. The authors emphasized that the examination-oriented education system in Hong Kong had also been affected by traditional Chinese culture. Historically, examinations constituted a mechanism used to select bureaucrats for official government positions. Many Chinese viewed education as a means to upward social mobility that would bring wealth. Therefore, Chinese society today still attached significant importance to academic success. In Hong Kong, parents have reported high
expectations for educational attainment for their children since kindergarten. Students have to take many public examinations to prove their intelligence and to fight for a seat to university. If the student failed an examination, they risked dismissal from the university. As a result, Hong Kong students were driven towards rigorous study, and they experienced high level of stress in this exam-oriented culture.

Consequences of the Pressures of the Hong Kong Educational System

The major challenge in Hong Kong’s educational system was the exam-oriented culture. Students were being asked to cope with exams beginning in elementary school. The Territory Wide Assessment (TSA) was introduced by the Hong Kong Education Bureau in 2004. The TSA was an assessment mainly to test Primary 3, Primary 6, and Secondary 3 students’ performance in Chinese Language, English Language, and Mathematics. Upon completion of the six-year secondary education, students took the HKDSE with the goal of obtaining the minimum admission scores for admission to a local university. Students have no choice but to take the HKDSE to meet university entrance requirements. The highly competitive study environment as well as the importance attached to academic achievement by schools and parents has created a severe exam stress that affects students’ mental health in varying ways. The Hong Kong educational system's high competitiveness from kindergarten right up to university has worsened the mental health of students.

Considerable research has revealed that Hong Kong students suffer alarming mental health problems. The Hong Kong Federation of Youth Groups conducted a survey in 2017 with a sample of 3,441 secondary and tertiary school students in Hong Kong, in which 50% of them showed signs of depression and 40% complained about stress during the new academic semester. J. P. Wong et al. (2006) conducted a web-based survey with 7,915 university students in Hong
Kong to examine the prevalence of mental health problems. The results revealed that 21% of students had symptoms of depression and 41% had symptoms of anxiety. Stress levels were higher in first-year students. Lun et al. (2018) conducted a survey with 1,119 full-time undergraduate students attending the eight universities in Hong Kong to investigate the prevalence of depression and anxiety among university students. The study revealed that 68.5% of students reported symptoms of depression, and 54.4% per cent reported symptoms of anxiety. The study resulted contributed to increasing concerns about the mental health problems of university students in Hong Kong.

Zang and Kirkpatrick (2011) described the various problems that students faced on account of this exam-centric education system. Zang and Kirkpatrick (2011) conducted a study with 43 high school students to explore the negative influences of the exam-oriented educational system. Results revealed that an exam-oriented educational system restricted students’ ability to learn and repressed personality formation and the development of other abilities. The exam-centric educational system also increased academic pressure and decreased students’ time for sleep. The report *Overall study hours and student well-being in Hong Kong*, presented by the Legislative Council in 2017, revealed that the parenting culture in Hong Kong also contributes to the long study hours of students. The total study time could add up to about 55 hours on average for the five-day school week, including school time, homework time, and private tutoring. Students also have to spend an inordinate amount of time preparing for the various exams. Examinations were the only method used to measure academic performance, and entrance to university was contingent on strong exam scores. Inadequate sleep and high academic stress has been revealed to negatively deteriorate the development of students’ physical and mental strength.
Salili, Lai, and Leung (2004) conducted a quantitative investigation to explore the influence of cultural factors on help-seeking intentions and academic performance. 571 students were selected from high schools in Hong Kong and Montreal, Canada for the study. The results indicated that Hong Kong students were under great pressure to perform well in class because of cultural factors. Salili et al. (2004) posited that cultural values such as collectivism have a prominent effect on students’ achievement behaviors and the on the development of intrinsic motivation. The standard of achievement was high in Hong Kong, largely because of the traditional culture. Chinese parents considered that academic excellence was the only path to success, and they linked future job prospects to academic performance. Therefore, a student was motivated towards academic excellence as a means to please the family and to give parents hope. Salili et al. (2004) highlighted a major difference between Chinese students and Canadian students – the achievement goal orientation. Chinese students adopted performance goals with the intention of passing exams, while Canadian students preferred a learning goal orientation with the intention of gaining knowledge. Salili et al. (2004) emphasized that adhering to a performance goal could influence motivation for learning motivation and increase pressure; indeed, asking students to perform better and better resulted in severe academic stress.

**Academic Stress and Health Outcomes among Students**

Stress and anxiety were common disorders for students living in fast-moving cities like Hong Kong. The Mental Health Foundation (MHF) in United Kingdom defined stress as a feeling of being abnormal pressure and identified it as a significant factor contributing to behavior change and emotional disturbance. In Hong Kong, students easily have suicidal feelings due to exam stress and pressure. MHF claimed the signs and symptoms of stress included anxiety, irritability, or low self-esteem. Common reasons that caused stress in contemporary
society include a heavy workload, an unhappy life, and financial problems. In school, many students have reported that stress arises when they were preparing for exams, mastering lots of homework, and engaging in many extracurricular activities. MHF further explained that stress was a response to a threat in a situation, whereas anxiety was a reaction to the stress. The American Psychological Association (APA) posited that physical health, such as heart disease and high blood pressure, was significantly associated with stress. Chellamuthu and Kadhiravan (2017) emphasized that anything that created a challenge or threat to life is a stressor, and that stress was unavoidable in daily life. Chellamuthu and Kadhiravan (2017) posited that stress has reduced academic performance, hindered students’ ability to be involved in campus life, and potentially led to self-destructive behavior. Chellamuthu and Kadhiravan (2017) conducted a study with a sample of 200 high school students in India to explore the relationship between academic stress and mental health. The findings indicated that students were frustrated from their academic results and were frequently upset by poor grades obtained in class. The study confirmed a relationship between academic stress and mental health problems among high school students and indicated the need for understanding academic stress among students.

Lal (2014) defined academic stress as “mental distress with respect to some anticipated frustration associated with academic failure or even unawareness to the possibility of such failure” (p. 123). Lal explained that there were four components of academic stress including academic conflict, academic pressure, academic frustration and academic anxiety. Lal (2014) further explained causes of academic stress among students, which included components such as dating, adjusting to a new campus environment, engaging in extracurricular activities, parental pressure, and peer pressure; all of these have the potential to lead to high stress among students. Weidner, Kohlmann, Dotzauer, and Burns (1996) presented a study that examined the change in
heavy behavior as a function of academic stress. Weidner et al. (1996) conducted a survey with
the sample group of 169 undergraduate students in the United States. The results revealed that
the health behavior of students deteriorated under the times of academic stress, and academic
stress has an important role in regulating positive and negative behavior. Khan, Altaf, and
Kausar (2013) posited that a significant relationship existed between stressful school life and
academic performance. The high level of stress leading to many psychological problems, such as
anxiety and depression, impacted students’ academic achievement. Khan et al. (2013) conducted
a study to examine the impact on academic stress on student performance; their sample consisted
of 150 university students in Islamabad. Results revealed that the higher level of stress suffered
by the student, the lower their academic achievement; stress hindered the ability to study
efficiently. Khan et al. (2013) explained that students experienced stress due to different factors
including the high expectation of parents, fear of failing exams, and keen competition among
classmates. Therefore, there was a great need for the promotion of promoting positive mental
health in school environments.

Conclusion

In review, this body of literature underscored the damaging impact of the exam-centric
educational system for students in Hong Kong. The over focus on rote learning has decreased
student’s interest in learning and has negatively affected physical strength and mental health.
Related to patterns of suicide among Hong Kong students, problems of academic overload and
poor student mental wellbeing have been existed for a long time. Academic stress was especially
hard on students who have long study hours and diverse extra-curriculum activities. The impact
of academic stress on mental health was also far-reaching. Students who were suffering from a
high level of academic stress have a higher propensity to develop mental and physical illness,
including heart attacks, muscle pain, and high blood pressure. This review could assist school administrators and parents to make a collective effort to improve students’ physical and mental health.

**Cultural Issues**

The term “culture” comes from a French term from the 20th Century, which was derived from the Latin *colere*, meaning to tend to the earth and grow, to cultivate and nurture (Dykstra, 2009). Cultures consisted of group norms for personal behavior that influence people’s lives in many ways, including where they live, where they worked, and what they believed. In a similar vein, Lederach (1995) also found that culture was a way of life for a group of people that shared the same knowledge, language, beliefs, and values (p. 9). This section focused on the perceptions of individuals related to cultural factors, as a tool to understand the impact of culture on mental health perceptions, characterized by behavioral differences.

**Cultural Perspectives of Mental Illness**

Culture had a profound effect of mental health beliefs and on society’s reaction to the mental health problems. Several studies have examined the impact of global cultural systems on mental health perceptions (Lefley, 2000; Morris, 2011, Voyer and Kastanakis, 2014). Lefley (2000) discussed two types of global cultural systems, individualistic and collectivist cultures, and their potential effect on cultural variables. He explained that individualistic cultures emphasized self-interest, where the self was autonomous and independent of others. Cultural norms in this context were related to individual rights and boundaries and less concern existed regarding the interest of others. The United States was one of the examples of a typical individualistic society. In collectivist cultures, meanwhile, where family was the center, and individual family members were committed to the values and needs of a group or community,
which was considered more important than individual self-interest. In this context, the patient-family relationship was one of the critical factors that affected responses to mental health issues (p. 230).

Morris (2011) further examined the cultural influence of individualistic and collectivist cultures on people’s responses to help-seeking. He emphasized that that collectivist cultures in Asian countries were known as “in-group”/ “out-group” communities, where family and close friends were all in the “in-group,” while everyone else was in the “out-group” (p. 106). When an individual is having a problem, he or she tends to seek family support (in-group) instead of professional help (out-group). Therefore, mental health treatment in individualistic cultures was often viewed as an acceptable form of treatment from within a scientific explanation, while the Asian perspective tended to view mental illness as a personal weakness, and seeking psychological support was considered a punishment for past wrongs committed by the family. Voyer and Kastanakis (2014) also observed differences in help-seeking behaviors across cultures and provided an overview of different psychological mechanisms to explain help-seeking behavior could be culturally determined. He offered a conceptual framework to explain the different mechanism through which cultural conditions shaped perceptions and cognition. Voyer and Kastanakis (2014) conducted extensive research to identify the differences between Eastern and Western cultures, and he uncovered significant cultural differences in perceptual and cognitive processes. Such differences may affect people’s perceptions of help-seeking behavior and cognition. The study revealed that the Confucian values in collectivist Eastern cultures aimed to achieve harmony within a society; help-seeking may hurt the harmony of a group and was commonly considered as a sign of weakness and shame. In contrast, individualist cultures in Western countries had features of an independent self-construal, in which people were more
likely to have an independent view of themselves and society, and they were seen as autonomous. Therefore, collectivist cultures perceived and processed more during diagnostic processes than individualist cultures (p. 19).

Cultural and religious teachings have a prominent effect on beliefs about the origins of mental illness. Kleinman (1988) claimed that culture influenced the meaning imparted to mental illness, which depended on the cultural beliefs concerning the cause of mental illness, stigma surrounding mental illness, and the medication and treatment system. Perceptions of mental illness were clearly influenced by culture. Knis-Matthews et al. (2012) conducted in-depth interviews with four people from different ethnicities (American South Asian-Indian; American West Indian; African American, and Arabic) to discuss how their cultural identities interacted with the symptoms and perceptions of mental illness. The results revealed that all participants felt isolated from family and friends because of cultural viewpoints regarding mental illness within their culture. One of the participants claimed that a primary cultural value in the West Indies community was that a boy child was expected to be a strong male figure and provider for the family, so men were not supported to exhibit weaknesses. Another participant even claimed that there were very few mentally ill Indian people, so people with mental illness were crazy and insane. Cultural meanings of illness had diverse impact on whether people were motivated to seek treatment and how people cope with mental health symptoms. Campbell and Long (2014) conducted a study to examine the impact of culture on help-seeking behavior and service use for depression among Black Americans. The results revealed that the cultural factors shaped strong beliefs on treatment engagement that “black people don’t get depressed and “therapy is for white people”. The findings demonstrated a dynamic impact of culture, race, and ethnicity on mental
health illness. Therefore, people were generally reluctant to enter into treatment because the belief system characterizing traditional cultures.

**The Characteristics of Traditional Chinese Culture**

Chinese culture reflected the customs and traditions of one of the world’s oldest cultures with its root embedded in a history of more than six millennia. Confucianism was the cornerstone of traditional Chinese culture, and its unique Confucian characteristics had been passed down from generation to generation. Chen (2011) posited that harmony and peacefulness were at the core of traditional Chinese culture and emphasized that human desires and morality were mutually exclusive, so people may suppress their own desires and control their behavior in order to set the mind at peace (p.36). Chinese culture valued harmony and benevolence, which could lead to Chinese people suppressing their emotional problems to avoid discrimination. Thus, for Confucius, the highest objective was to maintain a harmonic balance in society though reciprocity and obedience. Family was another important aspect of Chinese culture. Fan et al. (2017) claimed that the uniqueness of family structure might suppress the individual’s desires and preferences, prioritizing fitting them into the collectivistic culture. They also emphasized that the unique family structure might have influences on family function and that mental health disorders might occur due to the malfunctioning of the family system. Traditional Chinese families had a feature of authoritarian and hierarchical position within the family. Each family member has a specific role and the male individual has a dominance position that telling other member what to do and what not to do; any physical or mental illness could ruin a family's reputation.

Confucianism was a philosophy that has had perhaps the greatest influence on Chinese culture. Indeed, Confucianism established the foundations of Chinese culture. The influence of
Confucianism on mental health concepts had been debated in multicultural contexts for decades in Chinese society. The philosophy of harmony from within Confucianism had underpinned Chinese culture in both China and Hong Kong (Chan, Cao, & Gao, 2015). Collectivist discussed a traditional Confucian interpersonal style, “Zhongyong thinking” (Doctrine of the Mean), and its relation in balancing the emotion and maintaining strong well-being among the Chinese. The study revealed that individuals with Zhongyong’s belief would never express their negative emotion to others. In other words, “Zhongyong thinking” has provided sufficient guidance for Chinese young adults on how to perfect oneself. This played an important role in regulating behavior to maintain interpersonal harmony. Chinese people believed that humans should maintain harmony with nature, and mental health implied a balanced emotion (Kuo & Kavanagh, 1994). At the individual and interpersonal levels, Chen (2011), introduced different ways to maintain harmony and balance. All levels emphasized harmony as a significant feature between oneself and others and encouraged individuals to restrain their emotions to maintain balance in life.

In traditional Chinese society, family was a key component. The psychiatric stigma was often attached to family because most Chinese families felt ashamed to ask outsiders for help (Ng, 1997). Society projected an image of mentally ill people as having feelings of sadness, shamefulness, and loneliness. The Chinese tended to adopt a stigmatizing view of mental health problems and labeled people with mental illness as dangerous and violent (Lauber & Rössler, 2007). Building on this research, Lauber and Rössler (2007) found that Chinese societies used negative terms to denote mental disorders, such as “jingshen-fen-lie-zheng” (mind-split-disease) (p.167). This psychiatric labelling effectively created a long-lasting impact on mental health stigma in Chinese societies, and these prejudices led to stigma and discrimination. The
stereotype that mentally ill people were dangerous made these patients reluctant to admit to their problems, not to mention seeking help, and the widespread stigma became a barrier to mental health care services. This explained the reason for the low utilization of mental health services in China (Herrick & Brown, 1998).

Mental Health in Hong Kong and Its Relation to Chinese Culture

Tracing the situation back to Hong Kong, the Government of the Hong Kong Special Administrative Region formed the Committee on Prevention of Student Suicides in 2016. The Committee was responsible for investigating the causes of the high suicide rate among students and for making recommendations on appropriate remedial measures. The Committee’s investigative report (S. F. Yip, 2016) was released in November 2016 and provided an analysis of local fatal student suicide cases. The report highlighted depression and poor mental health as the common mental health problems on college campuses; it also identified a lack of mental health support for students as one of the major risk factors for students’ suicidal thoughts and suicidal behaviors. The author claimed that poor mental health was related to lower academic achievement and high stress, which decreased the ability to work or study. The report also suggested that different entities, such as the healthcare sector, schools, families, the social welfare sector, and the media, should work together to promote mental health programs and curriculum and to enhance the overall psychological well-being of students.

Lam et al. (2004) examined traditional cultural values in the context of suicidal ideas and behaviors in Hong Kong among a sample of 2,427 adolescents, aged between 14 to 18 years old. The results indicated that 95% of those surveyed held solid traditional Chinese cultural beliefs and values, with an emphasis on rules, order, and duty (Lam et al., 2004). If these beliefs and values were deviated from, this was regarded as a breaking of rules or orders, resulting in
psychological distress and suicidality. Another significant risk factor accounting for youth suicide attempts in Hong Kong was parental divorce or separation (Wan & Leung, 2010). In addition to cultural influences on individuals’ perceptions, subsequent studies indicated that culture was of critical importance in formation of stigma (Abdullah & Brown, 2011; Ngai et al., 2012). Cultural values, norms, and socialization were all variables that could be closely examined when studying the impact of stigma on mental health. The notion of stigma could provide a unifying perspective in an ethnic group and an understanding of cultural beliefs about the origins and nature of mental health problems.

Culture influences threat perception and stigma among various cultural groups. Yamaguchi et al. (2013) surveyed 1,024 young people living in Asian countries to discern knowledge and attitudes regarding mental health issues. Students in their sample reflected a negative attitude toward people with mental health problems. Students generally viewed mentally ill patients as “crazy.” This stigma stereotyped that people with mental health illness were dangerous to others was widespread. Cultural variations affect the definition of mental health and responses to mental health problems. Angermeyer and Matschinger (2003) examined the impact of the labelling effect toward people with mental health problems. The findings indicated that the labeling effect has hindered the development of mental health rehabilitation services and has increased the social distance between the public and the mentally ill patients. The labelling effect reduced the intention of ill patients to seek proper treatment when they were troubled by mental illness. Kuo and Kavanagh (1994) explored the link between traditional Chinese stories and health beliefs. They found that Chinese novels powerfully shaped beliefs about health. The Chinese believed that emotions can affect peoples’ health conditions and that mental illnesses were caused by a lack of harmony in emotions. In this study, people viewed
emotional disturbance as the result of dysfunctional organs and believed that the causes of mental illness were influenced by ancestral spirits. Thus, people tended to hide mental health symptoms to avoid isolation. This culture of emotional avoidance tended to stigmatize mental health problems.

Ngai et al. (2012) conducted a quantitative investigation on the beliefs and attitudes of British and Chinese young adults among a sample of 318 students, analyzing survey data collected in a Mental Health Condition Perceptions Questionnaire. The results indicated that students who had exposure to both Eastern and Western cultures experienced less stigmatization. The Western students were less likely to consider mental illness as horrible disease than the Chinese group, and they generally believed that mental health problems could be successfully addressed. This finding revealed that Chinese participants held more negative views toward mental illness and the level of stigma associated with mental health problems was higher than for the Chinese than for those in the Western group.

Stigma was defined as a mark of disgrace (Yamaguchi et al., 2013, p. 274). Corrigan & Kleinlein (2005) identified two main types of mental illness stigma, that were public stigma and self-stigma that impacted people differently. Public stigma referred to the beliefs of a majority toward people with mental illness, for example, the mistaken belief that violence was a symptom of mental illness. Self-stigma occurred when people internalize public attitudes and bought into society’s misconceptions (Corrigan & Kleinlein, 2005; Corrigan & Wassell, 2008). The Mental Health Association of Hong Kong conducted a survey with 2,351 people in 2016, revealing that 5.5% of the respondents had signs of clinical depression and an additional 9.1% scored at a medium level on the depression index. These statistics revealed a great need for mental health services. However, according to the Statistical Report conducted by the Hong Kong Hospital
Authority (the Authority) in the years 2014-2015, a total of 38,809 visits were recorded at private and public hospitals managed by the Authority. Compared to the seven million residents in Hong Kong, the total number of visits in 2014-2015 reflected an underutilization of mental health services. One possible factors for the underutilization rate was the stigma against mental illness in Chinese society.

Help-seeking Patterns

Studies have consistently showed that a large number of people, from different regions of the world, were affected by mental disorders; a large proportion of these people did not seek professional help which made the problem even worse (Cleary, 2002; Deane, Wilson, & Ciarrochi, 2001; Kerebih, Abera, & Soboja, 2017). Kerebih et al. (2017) defined help-seeking as “an active and adaptive process of attempting to cope with a problem” (p. 208) which consisted of both formal and informal help-seeking patterns; nonetheless, only a small proportion of people with mental disorders will seek help from others. The rate of help-seeking for mental health problem was generally low. Deane et al. (2001) highlighted that young people preferred the informal help of friends but not the formal help of professionals when they encountered problems. Many young people even indicated a decision of not seeking help from others for personal emotional and suicidal thoughts. One of the most common reasons for not seeking help was the stigma surrounding mental health problems, which often led to stereotyping and discrimination. Cleary (2002) highlighted the relationship between culturally specific presentations of symptoms and mental health problems. Culture-specific perceptions of shame regarding mental illnesses making many people away from seeking help for mental health problems. The investigations on cultures and different types of shame and stigma in relation to mental illnesses could help to understand people’s help-seeking intentions.
In Hong Kong, the negative image of mental health treatment and stigma related to mental illness hindered young adults from appropriate and timely treatment. Studies on the utilization of mental health services in Hong Kong have shown negative attitudes towards seeking treatment and underutilization of services (Chiu, 2002). It was likely not a big surprise that people who suffered from mental health issues were not willing to seek treatment because the culture of Hong Kong upheld many Chinese traditions which discouraged seeking help. Parents have a strong influence on their children's upbringing; therefore, parents’ and others inappropriate responses to those with mental health problems in the long history of the world still affected children’s mindset in this area. Fear could often make the problems worse and created a negative attitude towards the intention to seeking help among the university students in Hong Kong.

Help-seeking attitudes of Chinese people

The influence of culture on help-seeking behavior was well documented (Arnault, 2009; Lee & Eaton 2009; Mojaverian, Hashimoto, & Kim, 2013). Studies have indicated a lower likelihood of seeking professional help amongst those exhibiting higher levels of adherence to traditional culture (Lee & Eaton, 2009). Lee and Eaton (2009) emphasized that a Korean elderly immigrant who had lived more than a half century with a collectivistic and Confucian culture would likely experience cognitive behaviors that prioritized obligation to the family structure and values for a harmonious family life. Seeking help from others was considered to bring shame to the family. Lee and Eaton’s study revealed that shame, victim blame, and an unwillingness to reveal family problems to outsiders were the major factors that decreased help-seeking behavior. Similarly, Mojaverian et al. (2013) examined the effect of cultural differences on help-seeking behavior among East Asian and American populations. The result revealed that East Asians who
believed in collectivistic cultures emphasized the harmonic balance within the group and emphasized first and foremost that each individual was connected in a larger social unit. In contrast, the Americans who believed in individualistic cultures emphasized independence, regarding each individual as autonomous and distinct from others or social units.

Several studies have examined the potential impact of cultural factors on help-seeking intentions for mental health problems among the Chinese population (H. Chen et al. 2014; S. X. Chen & Mak, 2008; Kung, 2003). S. X. Chen and Mak (2008) emphasized that the cultural factors of an individual were important factors in understanding the usage of mental health services and help-seeking intentions surrounding mental health problems. Chin et al. (2015) conducted an investigation to gauge the help-seeking preferences of patients with depressive symptoms among a sample of 10,179 Chinese people. They conducted a survey and analyzed self-reported data collected from patients who had received mental health treatment from healthcare professionals over a 12-month period. Results indicated that only 24.9% of the respondents sought help from psychiatrists. In a similar study, Shek (1998) surveyed help-seeking patterns among a sample of 751 Chinese in Hong Kong. Results revealed that 56.6% of the respondents said that they would not seek help from others when they had problems. These studies have shown a significant correlation between Chinese culture and avoidance of help-seeking.

Mo and Mak (2009) explored the linkage between Chinese culture and help-seeking initiatives using a theory of planned behavior. Mo and Mak (2009) discovered that an individual’s belief system was an important factor that affected help-seeking initiatives and emphasized that an individual who has an unfavorable attitude toward mental illness was more likely to delay mental health treatment because of stigma. They stated that the culture in China
emphasizes interpersonal relatedness that encompass harmonies with other people, compliance with bilateral interaction, concerns for face loss, as well as attention to oneself with regard to community and family relations (p. 676). The emphasis on harmony and loss of face could be explained and interpreted as a feeling of shame or embarrassment in Chinese culture, and the stigma associated with loss of face influenced beliefs on the origins and nature of mental diseases. The authors thus concluded that these cultural values played an important role in shaping the beliefs of an individual as well as the “perceived control levels over behaviors in this setting (Mo & Mak, 2009, p. 676). The researchers conducted a survey in China to compare the attitudes toward help-seeking with populations that had experienced various levels of Western influence, with a sample of 747 college students from four cultural groups: Mainland Chinese, Hong Kong Chinese, Chinese Americans and European Americans. Results revealed that Mainland Chinese had less favorable attitudes toward acknowledging emotional problems and were less willing to ask for mental health staff’s help. Significant finding of this investigation was that the impact of cultural traditions appeared to be an important factor affecting the help-seeking behavior of an individual. The researchers identified that cultural might affect perceived efficacies of Western-based physiological treatments (p. 443). Thus, those who have more exposure to Western norms and practices were more likely to have favorable attitudes toward help-seeking because Western culture approached mental health disorders from a scientific and medical perspective – as compared to a spiritual or supernatural one.

A qualitative study by H. Chen et al. (2014) discovered that Chinese adolescents suffering from the problems of mental health were unlikely to ask for a psychiatrist’s helps, and their help-seeking initiatives were significantly affected by self-stigma. Chinese culture has strongly influenced individuals’ health literacy. Participants in that study reported feeling “Yeah,
I’m weak, I cannot look after myself well” (p. 361). The researchers also found that, for individuals who had mental health problems, more pessimistic help seeking attitudes were related to low self-efficacy (p. 361). Traditional Chinese society held superstitions as well as discriminatory beliefs in terms of the problems of mental health, and H. Chen et al. (2014) found that Chinese culture in general defined the problems of mental health as the results of poor ideals or poor moral character, while other people considered them to be one mental illness which was dangerous and aggressive, to ensure to avoid from people suffering from psychological health problems (p. 361). Thus, the mental health patients were reluctant to seek help from professionals because they do not want to be discriminated by societal norms or shunned – in short, losing face was a profound risk to take.

Kung (2003) carried out research for examining the impact of personality traits as well as cultural values upon help-seeking behavior among a sample of 1,747 Chinese Americans. The study analyzed secondary data from a strata-cluster survey collected through a Chinese American Psychiatric Epidemiological Study. Results indicated that 75% of the respondents had never sought help for emotional problems (Kung, 2003). This was because Chinese culture was at odds with seeking help due to mental health (Kung, 2003, p. 111) and cultural teaching also repressed emotional vulnerabilities and feelings (Kung, 2003, p. 112). Kung (2003) also asserted that individual personality traits might influence help-seeking behaviors. For example, a “hardy” individual with strong self-control may be more motivated to seek help. According to Kung, tough people actively handled real-life challenges, interacted with other people and social organization (p. 113) and people that have one high internal locus of control hold (p. 112). However, the findings revealed that in general, the Chinese had a lower of internal locus of control than the American group for conventional Eastern culture tended to stress respect,
acceptance of destiny and adherence to authority, this was completely different from the Western culture, which emphasized people’s control of environments (p. 113).

Hwang, Myers, Abe-Kim, and Ting (2008) investigated cultural influences on the development of illness. They analyzed the illness development process by using the Cultural Influences on Mental Health model. The results indicated that the cultural experience of an individual would affect their perception of an illness. Examples of cultural influences reported by the researchers included cultural differences in concealment of the problem, which might affect the individual’s perception and help-seeking initiative. Another significant finding from this investigation was that the impact of cultural factors appeared to be an artifact of knowledge about mental health issues, suggesting that increasing cultural competence could improve the treatment effect (Hwang et al., 2008). For example, Chan et al. (2015) noted that Chinese people tended to report more somatic symptoms towards mentally ill patients because they were highly influenced by traditional values such as harmony and benevolence.

In addition, Wong (2007) conducted epidemiological studies on the help seeking pathways in the Chinese population within Hong Kong. Results revealed that people in China usually encountered lengthy delays in receiving effective mental health treatment. Wong (2007) discovered that the potential factors shaping the help seeking behaviors were related to cultural forces. He claimed that people in Asia have utilized natural, supernatural, societal, psychological and somatomedical explanations for understanding the reasons for psychiatric disorders (p. 54) and did not have sufficient knowledge for recognizing any symptom of the mental illness. Karmer et al. (2002) emphasized that culture “has an effect on the diagnosis and treatment of mental disorders” (p. 227). They explained that traditional family values, such as values of harmony or benevolence, were most likely to be found in Asian groups. This cultural value
system “shapes the expression and recognition of psychiatric problems” (p. 228). For example, Chinese groups stated that they believed that mental disorders were caused by evil spirits, so ill patients often “delay or avoid seeking professional help” (p. 228), a factor that radically contributed to the treatment gap. Thus in sum, the low rates of service utilization were due to stigmatization and perceived barriers to professional care.

**Conclusion**

In review, this body of literature underscored the cultural impact of mental illness stigmas and individual perceptions and attitudes toward mental illness. The literature supported that health beliefs regarding mental illnesses were deeply rooted in Chinese culture and had evolved in line with the negative stigma, which substantially impacted attitudes regarding help-seeking behaviors for mental health illnesses. A strong association between culture and help-seeking behavior was also presented. The literature revealed how culture framed people’s perceptions and influenced human beliefs and behavior. Mental illness was stigmatized in traditional Chinese culture, and the stigma attached to mental illness remained common in Chinese society. Cultural and social factors in the global population were found to be the most significant factors affecting help-seeking initiatives. This revelation has the potential to have a substantial impact on improving students’ mental health literacy, as the literature provided a clear approach for university administrators to have a better understanding of students’ cultural values, beliefs, and practices from their own perspectives.

**Mental Health Overview**

Mental health disorders involved disturbance in the thinking and behavior of an individual. The term mental health was commonly defined to be a hybrid of absence of one mental disorder. According to the APA’s definition, mental illnesses were related to poor mental
health and stresses as well as problems functioning within family, work or social activities. Mental health was defined by World Health Organization (WHO) as one state of wellbeing in which individuals realized their own capabilities, were able to handle normal life stress, work fruitfully and productively, and contributed to their communities. The mental health was considered to be a continuum with stress on establishing positive psychological well-being.

Mental illness could have far-reaching effects on well-being, disrupting a person’s life and creating challenges. Mental illnesses were common in the world. WHO’s 2011 World Health Report recorded that an estimated 450 million people were affected by different types of mental disorders, from depression and anxiety, to more serious psychiatric disorders; approximately 0.8 million people passed away because of suicide each year. The life span of people suffering from serious mental disease was short compared with normal people due to physical illness.

Conversely, poor physical health could negatively impact mental health. Mental health was defined as “one state of balance in oneself and between oneself and his or her social and physical environments” (Sartorius, 2002, p. 3). It could be interpreted as a purely positive mind functioning, marked by feeling of happiness, and it was used to describe psychological and emotional health. Galderisi et al. (2015) identified three core components of mental health: emotional regulation, empathy, and flexibility. Emotional regulation was the ability to manage one’s own emotions, i.e. to react rationally when facing challenging situations. Empathy was the ability to feel others emotions and communicate with others in an effective way, i.e. to be kind to others and stop negative thoughts. Flexibility was the ability to cope with changes in different circumstances, i.e. to adapt to changes in the workplace and re-establish control. Disturbances of these components may result in mental illness. This section focused on students’ mental health, beginning with a general discussion of global mental health issues, including the prevalence of
mental disorders, and continuing with a synthesis of what factors affect student responses to mental health problems.

**Global Mental Health**

Globally, an estimated 450 million people have a behavior or mental disorder (WHO, 2011). Steel et al., 2014 identified the incidence rate of common mental psychiatric disorders, and estimated that 24 million people face schizophrenia, 37 million people have Alzheimer's, 50 million people were affected by epilepsy, and 120 million in the world have depression. Among all, depression has been found to be one of the most common disorders people experience, and it has become one leading cause of overall global disease burden (McLoughlin, 2002). The estimated number of the people suffering from depression in total raised by 18.4% from 2005-2015 (WHO, Global Health Estimates, 2017). One of the major contributors to the high depression rate was the shortage of social workers, psychologists, psychiatric nurses and psychiatrists; this shortage constituted one of the major obstacles in offering care and treatment in such middle- and low-income countries like India. Another reason for the high depression rate was the negative effect of social stigma related to mental illness that causes a reluctance and lack of willingness to ask for help due to mental health issues. Bertolote and Fleischmann (2002) noted that “mental disorders are a significant risk factor for people’s suicide” (p. 183), and their studies revealed that more than 90% of individuals committing suicide had one psychiatric diagnosis before dying. WHO (2011) also reported that nearly 1 million people committed suicide every year, and mental disorders is a leading cause of suicide. These alarming health trends make psychological health a worldwide priority.

Psychological health was a critically important issue in the world today and had led to the development of concept of worldwide mental health. The concept of worldwide mental health
involved developing knowledge, attitudes, for addressing mental disease globally (Bemme & D’souza, 2012). Patel and Prince (2010) offered a common definition of global mental health. Patel and Prince (2010) identified global mental health as priority issue of communities, and they stressed the importance of aiming to achieve equity in mental health services for people worldwide. Several studies have highlighted the high morbidity of common psychiatric disorders, like anxiety and depression, affecting people across all regions of the world (Ansseau et al., 2004; Steel et al., 2014; WHO, 2011). People who suffered from mental illnesses were often unable to receive treatment due to stigma, a lack of mental health literacy, and financial resources. A global social and scientific movement called the Movement for Global Mental Health was launched on October 10, 2008. The Movement sought to promote actions to cope with the global need for mental health services (Collins et al, 2011). There were two principles for the Movement: evidence about effective treatment and human right of people suffering from psychiatric disorders. It has gathered a group of people influenced by psychiatric disorders as well as individuals who represented society, for example policy makers and scientists, to build up a virtual headquarters in an online platform for members to share ideas, initiate activities, and seek help with other members. Therefore, addressing global mental health issues was an essential step to addressing broader development issues such as justice and human rights, social inclusion, equity, and community stewardship.

Student Mental Health

Mental disorders were very common among students nowadays and there was a demonstrated concern worldwide regarding the trend of an increase in students’ suicidal behavioral and emotional problems. Suicide took place during the whole life span and was the second leading cause of death in 15 to 29-year-old people worldwide in the year of 2015. People
with mental illness did have a higher chance of suicidal thoughts than the people without mental illness. However, the symptoms of mental disorders were often unrecognized, possibly due to the impact of spirituality on mental health. The APA conducted a survey in 2013 that revealed that about one-third of college students in United States had experienced depression and had difficulty functioning because of the stress of college. The Institute for Public Policy Research conducted a study in the United Kingdom universities that revealed that the total number of students disclosing mental health problems in the first year increased fivefold and reached 15,395 in ten years. In accordance with the Chinese China’s Center for Disease Control and Prevention, the suicide was the major cause of death for young people, and the suicide rate of the country was the highest worldwide. The data had clearly pointed out the alarming increase number of students with psychiatric problems, manifested in levels of stress, depression, and anxiety of students.

The Centre for Suicide Research and Prevention (CSRP) at the University of Hong Kong recorded an annual average of 23 student suicides from 2010 to 2014. The problem of student suicide grew worse in 2016, with 22 young people committing suicide at the university in the first four months of the 2016/17 academic year. The CSRP considered mental health issues as one of the main risk factors contributing to suicide among youth and young adults. According to data available from the Hospital Authority, the caseloads of adolescent and child mental teams increased from 18,900 in the year of 2011 to 28,800 in the year of 2016, with a rise of over 50% within half a decade. A previous poll from Baptist Oi Kwan Social Service involved 15,560 students from secondary schools, and it also discovered that over half of those surveyed demonstrated depression symptoms while a fourth showed anxiety signs. The Center for Health Protection (2017) reported that 3 out of 100 Hong Kong people between the ages of 16-75 had
depression. The report highlighted the fact that over 60% of the diagnosed patients did not seek help from health professionals and that mental disorders affect one in four people in Hong Kong. Moreover, high prevalence rates of psychological distress were found among undergraduate students in Hong Kong. The University of Hong Kong and the Tertiary Institutions Health Care Working Group (2003) have conducted an online survey with a sample size of 14,073 participants from 10 tertiary education institutes in Hong Kong. The results revealed that 32% of respondents reported moderate to extremely severe depressive symptoms, and 49% of respondents suffered from similar levels of anxiety. Clearly, the mental health of students was not only one clinical problem, but one a crucial social problem which influenced an increasingly number of students as well as their family members.

**Conclusion**

The literature review section provided an overview on mental health in a global context and identified the worldwide incidence of common psychiatric disorders. The basic mental health concept highlighted in this review was multifaceted; it was important for the public to understand the impact of mental illness related to the social and emotional wellbeing of individuals and communities. This has substantial influence in areas such as student mental health programs or global mental health movements, and it was useful for the policy makers or school administrators to have boarder view of what could be implemented in the future. The literature also indicated a significant number of students were suspected to have different levels of mental health problems in school. However, they were reluctant to seek help because of the negative effects of psychiatric labeling on individuals with psychological disorders. The need for the promotion of an anti-stigma concept in schools and universities to dispel stereotypes about mental illness was crucial.
Intervention

Intervention refers to a process that provides the support of a specialist and other forms of intervention for an individual who is suffering from or showing an early symptom of mental health disease. Intervention plays a crucial role in reducing the progress or preventing a mental health disease; it is also useful as a tool to improve the physical and mental health of an individual. Early intervention, such as improving diagnosis and treatment and timely referrals, could have life-changing consequences and a significant positive impact on mental health problems. Society has a wide range of interventions for preventing mental health illness and for assisting people suffering from any problem related to mental health. For example, for people with a mild mental illness with well-controlled symptoms, an early intervention program may be sufficient. However, for the person who was suffering schizophrenia, psychiatric medications such as drug treatment combined with psychotherapy could be more effective. This section focused on intervention strategies for mental disorders, beginning with a general discussion of how early intervention was important to minimize the impact of mental illness and continuing with a synthesis of what intervention strategies or therapies were available.

Early Intervention and Prevention Program

Early intervention and prevention programs targeted for mental health promotion could help people who were particularly at risk of mental illness. The programs included campaigns to reduce the stigma of mental illnesses, mental health education programs, and stress management courses. McGorry et al., (2008) posited that efficient use of early specialist treatment was the first step in the establishment of successful early intervention. Treatment covered both early intervention programs and the specific treatment of disease’s earlier stage with drug and psychological intervention. McGorry et al., (2008) also emphasized the importance of the
development of youth friendly services in improving the acceptability of high-quality mental health services. Youth-friendly mental health service referred to intervention and prevention programs that addressed students’ particular requirements to help them overcome obstacles that made the student willing to access conventional mental health services. McGorry, et al., (2008) asserted that such measures were capable of reducing disorder severity and of removing disability, although impairment cannot be completely avoided. Therefore, early intervention was of great importance for young people and children, given that their mental health disease could result in long-term and profound consequences.

Reavley and Jorm (2010) conducted a review to assess the effectiveness of early intervention and prevention programs in the arena of mental health for students receiving higher education. Evidence supported that normative and motivational intervention that were delivered utilizing computer programs or face-to-face sessions serves as an effective way in intervening early in students’ emotional trajectories, thus preventing anxiety and depression. Moreover, they pointed out that skill-based programs that incorporate feedback and practice of supervised behavior, like those that aimed at building relaxation, mindfulness, or cognitive-behavioral skills, were effective in decreasing the level of psychological distress for higher education students. The early evidence also revealed that the existence of a mental health service center on campus was essential to detecting students’ mental health problems and reducing psychological distress.

In Hong Kong, it was estimated that the population was 7.43 million in 2018, making it among the most densely populated areas worldwide. Diagnostic delay was common in such an overcrowded urban city. Maintaining sound mental health as well as improving citizen well-being presents severe challenges in Hong Kong. Marshall et al. (2005) emphasized that delay in diagnosis or in the initiation of treatment were likely to decrease the chance of recovery.
Providing early intervention for students with emotional or mental distress was vital. The Hospital Authority has launched an Early Assessment Service for Young People with Early Psychosis (E.A.S.Y) program for young people with early psychosis. The program emphasized the prompt detection of psychosis and acute care. If the person with early psychosis could not be treated in a prompt manner, this might bring serious consequences to the person’s psychological development. Besides carrying out an educational campaign for raising public awareness regarding early psychosis, E.A.S.Y also provides one one-stop service which allowed people who seek medical care to get early assessments and early treatment under proper circumstances.

Stigmatization and stereotypes of mental illness were due to biased beliefs and a lack of knowledge; hence, stigma reduction must begin with youth education that enhances knowledge and that provides tools for changing the intended behavior. The Hong Kong Jockey Club Centre for Suicide Research and Prevention, founded in 2012, was based at the Faculty of Social Sciences of the University of Hong Kong. Its purpose was to develop efficient preventive measures against suicide and to build evidence-based indigenous working models via the collaboration between practitioners and researchers. Its ultimate aim was to offer education and training to deal with psychosis and to formulate public health policy to handle suicide problems, as one method of public health strategy. Moreover, The Centre for Adolescent Mental Health Prevention and Intervention, established in June 2011, has received financial support from The Hong Kong Jockey Club Charities Trust. The center aimed to promote positive mental health and to provide one stop services for the adolescent with mental health concerns. Mental health promotion usually involved the model of positive mental health, instead of mental ill health, which was the expected result of the intervention of health promotion. Apart from the non-governmental organization services, the government also established a Review Committee on
Mental Health for reviewing existing policies in the area of mental health to facilitate the development of mental health services in Hong Kong. Prevention and early interventions in mental health could be utilized for promoting good mental health, so that mental disorders could be prevented for students in Hong Kong.

**Mental Health Intervention in School**

Effective school-based intervention programs in mental health were effective in improving the campus environment and reducing the likelihood of secondary effects such as family disruption, school drop-out, and risk of suicide. Several studies have evaluated the effectiveness of school-based intervention programs in enhancing the mental health of students (Fazel, Hoagwood, Stephan, & Ford, 2014; Hoagwood & Erwin, 1997; Hoare et al., 2017; Winzer et al., 2017). Hoagwood and Erwin (1997) emphasized that school was an ideal setting for addressing mental health and for implementing public health strategies. Hoagwood and Erwin (1997) conducted a literature review during 1985-1995 that provided an overview of school-based mental health services for students; the review found that teacher consultation, social skills training, and cognitive-behavioral therapy were three effective intervention strategies for improving student’s mental health in school. The studies explained that cognitive-behavioral therapy and teacher consultation employed a behavioral consultation approach. The objective of consultation was to offer one explanation for the reason of the occurrence of behavior as well as to formulate an intervention strategy for the prevention of emotional problems. Both programs have had beneficial effects on symptom reduction and on the improvement of functioning. Hoagwood and Erwin (1997) also conducted a review of the program of social skills training and locus of control for students in middle schools with behavioral programs; the results supported that participants in training exhibited a marked shift
within the locus of control and could manage the emotional or behavioral problems more effectively.

Fazel et al. (2014) emphasized that schools provided a natural context to promote students’ mental health and suggested that the mental health intervention programs incorporated into school systems could have a significant positive impact on students' academic achievement and mental wellness. Fazel et al. (2014) asserted that schools were increasingly concerned about the influence of mental health problem on educational attainment and progress; thus, the existing school-based mental health intervention program was designed for much needed assessment. The program studied by Fazel et al. (2014) is specifically designed for those who were at risk of acquiring a mental disorder. Fazel et al. (2014) asserted that screening problems related to mental health along with efficient early intervention could provide an effective approach to improving mental health outcomes as well as educational attainment. Fazel et al. (2014) recommended a three-tiered approach for conceptualizing the range of intervention strategies for preventing students from suffering from psychiatric problems. The three tiers were indication, selective, and universal intervention. The universal intervention was for every student, followed by the intervention for helping the students who were selected and at risk of mental disorders, and finally one treatment intervention tier applied to students in need of medication. The strategies for integrating the three intervention tiers in one school system has allocated resources in a more effective way and has reinforced a continuum of care service structure for students.

Winzer et al. (2017) conducted a systematic literature search to examine the effect of mental health interventions on students in higher education. The review supported that mental health intervention programs in universities overall led to an improvement in mental health knowledge and help seeking attitudes. The content of the program studied included video
components, one-on-one presentations, educational curriculum, and discussion guides. The studies suggested that the intervention of mental health problems as well as the support of early intervention for higher education students should account for individual students through a whole-school approach. The WHO has described a whole-school approach as holistic with an organized set of policies and procedures for the school community to facilitate the promotion of positive mental health. It was an approach with an emphasis on school policy and on campus environment, but it also incorporated individual-level factors. Examples include the MindMatters program in Australia and the Geelong Grammar School Applied Model for Positive Education. Both programs were school-based mental health program that followed a whole-school approach. Hoare et al. (2017) also stated the importance of implementing a whole-school approach in fostering positive mental health education in a school system and further explained the framework of the whole-school approach. Their framework included three areas of intervention within a school system: (a) school curriculum, teaching, and learning; (b) school ethos, organization, and environment and (c) school partnerships and services. Hoare et al. defined a school system as an interdependent component with varied functions that interacted to produce outcomes in a complex educational setting (p. 56). The proposal of the whole-school approach aimed to incorporate the complexity of the school setting by implementing intervention programs among students, teachers, parents, other members of the school community.

**Therapy**

Medicine still constitutes a major treatment modality for many mental illnesses. Pharmacy intervention could also play an important role in the primary care of mental health patients by establishing monitoring of medication (Shah et al., 2010). Medication paired with psychotherapy was the most effective way to promote recovery. The National Institute for Health and Clinical
Excellence (2010) posited that talk therapy is an effective treatment for clinical depression. Talk therapy involved listening and talking, occasionally about very emotional and private issues concerning distress. The therapists received training to listen sensitively and attentively, always respecting the feelings of patients and maintaining a non-judgmental stance with the patients so that they could begin to find their own answers. It could be a powerful tool in confronting emotional problems. During sessions, the therapists listened to patients and helped them find their own solutions to their problems. The patients were given time and a safe space to complain, cry, or even shout out. This offered an opportunity to them to think of their own problems in a safe place with someone who encouraged them and respected their decisions and opinions. Therapists explored how the problems of these patients contribute to the feelings of depression, and they help patients discovered their own solutions and provide them with tools to change their behavior or transform negative thoughts. For example, many students have an increasing sense of dread as examination season comes and lack confidence to successfully take an exam. Talk therapists could help the students to obtain a much clearer picture of difficulties related to their emotional problems and related symptoms.

**Conclusion**

Prompt diagnosis and early intervention in school could lead to life-changing and significant positive consequences for the mental health of students. For instance, educators were often the first to notice students’ mental health problems; timely intervention and support could be markedly reduce the recurrence, duration, and severity of mental disease as well as relevant social disadvantages. The literature indicated that schools played a key part in students’ development and were considered crucial in identifying mental disorders in young people, starting with increased awareness about mental illness on campus. Furthermore, mental health
and education could be advanced when mental health objectives include efficient schooling as well as positive education. These actions required the school administrators to acknowledge the barriers that the students encountered when utilizing mental health services in school. In sum, mental health was an indispensable component of personal development and healthy living; it was best obtained through the involvement of multiple levels of support and advocacy in the school community.

**Summary**

The literature review is the foundation for future research on the effect of mental health program on improving student’s access to mental health service within schools. In this literature review, connections between help-seeking behavior and mental health programs were explored. The main goal of a mental health program was to cultivate educators’ and students’ mental health literacy and to help increase access to mental health care. The literature review has suggested that the students’ perceptions of stigmatization towards mental illness may be changed by effectively executing school-based mental health prevention or intervention programs. The second element discussed in this literature review was the influence of cultural factors on mental health. The traditional Chinese culture was explored in this study. A third conclusion of this review of literature is the exam-oriented education system in Hong Kong that causes mental health problems for students. This study was not intended to suggest ways or methods to cure the mental illness; its goal instead was to bring more attention to mental health promotion and prevention on the level of policy making and in the arena of resource distribution in school settings.
Chapter 3: Research Design

This study explored the effectiveness of mental health programs organized by the Counselling and Development Centre (CDC) at a public university in Hong Kong on improving student mental health and well-being. The following chapter described the study’s research design and provided support for the researcher’s methodological choices. In the first part of this chapter, the research approach was discussed. The second part of the chapter focused on the research procedures, explaining how this study was conducted, including a discussion of ethical consideration, the researcher’s bias, and possible limitations.

Research Question

The central research question driving this study was: What is the role of the CDC in encouraging student participation in a mental health enhancement program? Collecting data that highlights cultural factors affecting the feasibility and usefulness of the program in regards to the needs of university students constitutes the sub-goal of the study. In the research, one collective case study design which was formed by constructivist grounded theory analysis approaches was performed for developing one framework for program evaluation from the participants’ perspective.

Qualitative Research Approach

This study utilized a qualitative approach to understand the research problem. Qualitative research was an effective strategy for methodical exploration as well as understanding about complicated issues within real-life settings. According to Fossey, Harvey, McDermott, and Davidson (2002), a qualitative approach was aimed at addressing questions about understanding the experience dimension and meaning of social worlds and human’s lives (p. 717). The qualitative approach was suitable for understanding the participant’s experiences and perceptions.
of a particular phenomenon and how their experiences impact their behavior. Ponterotto (2005) also asserted that one goal of qualitative research was to illustrate and explain research participants’ experience within context specific settings (p. 128). In qualitative research, researchers were interested in exploring the meaning of a particular phenomenon (Merriam, 1988). The researcher placed emphasis on seeking understanding regarding the meaning of human actions and experiences. Other characteristics of qualitative research include learning directly from participants to find out how people make sense of their lived experiences and the meaning that they attach to a social phenomenon (Creswell, 2007; Hatch, 2002; Pietkiewicz & Smith, 2012). By identifying the complex relationships between culture and help-seeking behavior in a natural setting, this researcher aims to identify meaningful impacts and remedial measures through qualitative inquiry (Hatch, 2002). With that in mind, the researcher became the “main data collection instrument” to examine how participants’ experiences affect particular aspects of their lives and behavior within a specific cultural context (Teherani, Martimianakis, Stenfors-Hayes, Wadhwa, & Varpio, 2015). In other words, qualitative studies hold strong explanatory power to interpret historical or culturally significant phenomena in the social world (Szreter, 2011). As such, a qualitative approach was considered the most appropriate to question types that need to explore detailed data over one sample that was not particularly large.

For the purpose of this study, qualitative methods were most compatible with the research goals. First and foremost, the purpose of this study was to determine whether the mental health program organized by CDC was useful in improving students’ access to mental health services and resources at one university. Qualitative approaches were widely applied to evaluations for exploring specific program facets as well as for giving voice to the experiences of participants (Vaterlaus2011). Qualitative approaches offer detailed information, which helps program
administrators enhance the quality of mental health programs. Qualitative research played a powerful role in evaluating the program because it often described the policy settings guiding the program and its implementation and explains the meaning of these experiences regarding particular social phenomenon (Creswell, 2007). Therefore, qualitative research was useful to both the education practitioner and the counselor who were involved in program design.

The study sought to evaluate effectiveness of the CDC program and investigate how the university students interpret mental illness through the lens of an appropriate theoretical framework and methodological decisions that allowed for a thorough exploration of the research problem. The study’s philosophical underpinnings and methodology were described in the sub-sections below.

**Philosophical Assumptions**

This study grounded in the tradition of constructivist-interpretivism, which posited that learning – and thus knowledge creation – was an active and constructive process between researchers and participants (Ponterotto, 2005). The constructivist approach to research has the intention of learning from participants’ lived experiences to understand a specified phenomenon (Schwandt, 1994). Constructivist researchers contend that reality was constructed by the human mind (Mertens, 2005), so they relied on participants’ lived experiences to explain specific social phenomenon. Throughout the research process, the constructivist researcher and the participants mutually co-constructed the meaning to the answers to and interpretations of the research questions, and they together discovered how people made sense of their lives, what they made of their experiences, and, in the case of this study, and how these experiences affected help-seeking behaviors. In other words, the constructivist-interpretivist paradigm derived its foundation from and aligned directly with qualitative research methods (Ponterotto, 2005).
Methodology

Case study was the methodological approach selected for this study. Qualitative research through case study would help researchers go beyond the statistical results of quantitative research as well as had an understanding of behavioral condition from the perspectives of participants. Merriam (1998) stated that the case study method has its origin within the qualitative approach; qualitative research was located in interpretive method for social realities as well as in illustration of human life experiences. The first case study within social science might be carried out by Pierre Guillaume Frédéric le Play, who was an economist and sociologist during the 19th century studying family budget. The approach has been applied to anthropology, psychology and sociology since the early 20th century. The development of grounded theory resulted in resurgent case study research. Extensively applied to the fields of anthropology, psychology, humanities and education, this approach has become a credible research design when conducting an in-depth exploration of social and human behavioral problems.

Merriam (2009) illustrated case study research by the features: heuristic, descriptive and particularistic aspects, emphasizing its specific entity, qualitative nature and purpose, as well as motivation for understanding and describing findings. Case studies were particularistic in nature given that they were focused upon one particular event, situation, phenomenon or program. A descriptive case study produces one thick and rich description of phenomena under studies. Hermeneutics was a theory of interpretation. Hermeneutical theorists and researchers “look for meaning embedded in human experience” and illuminate the reader’s understanding about the phenomena under the studies (Wagstaff et al., 2014, p. 2). The case study approach with heuristic qualities will explain the reason behind a problem, for example, what were the effects of a program and why did participants become involved? (Gerring, 2006). In addition, Yin (1984)
noted 3 types of the case studies: explanatory, descriptive and exploratory. First, exploratory case study explored phenomena within data that serve as points of interest to researchers. Second, descriptive case study described natural phenomena that occur in data in question. Third, explanatory case study closely examined data at deep and surface levels for explaining phenomena that emerges from data.

A case study focused on a particular unit to conduct an in-depth study. It could prove particularly useful to obtain a comprehensive picture of that particular unit so that an in-depth analysis could be achieved. Yin (1984) explained that the case studies were empirical inquiries which investigated contemporary phenomena in details under the realistic context, particularly when boundary between context and phenomena was not apparent. Merriam (1998) contended that the case study was one especially appropriate design if researchers showed interest in processes in the field of education. Education studies embraced the case studies to be an approach to evaluating program design as well as providing relevant suggestions to policy makers to support social and educational change. Therefore, case study had the most flexibility among research designs, enabling researchers to maintain holistic features of the realistic event when exploring the empirical event.

Moreover, Yin’s (1993) Application of the Case Study Research stated that the case study was an appropriate research method while phenomena under studies could not be easily distinguished from the context (p.3). For example, studies in educational research could be conducted using the case study approach. In the case of this study, data collected through focus group discussions and observations were recorded to obtain in-depth information regarding students’ perceptions on mental health issues and how their perceptions affected their help-seeking behavior. Yin (1984) recommended that case study research was best fit for answering
questions which began with "how" or "why." This research would examine the process of an international university in Hong Kong in its efforts to support student access to mental health services. This coincided with Yin (1984), who posited that the case study was a unique way to observe the natural phenomena that existed from within a dataset. During the investigation process, the participants tried to explain their own perspectives toward the world and the researcher attempted to decode their perspectives. In this study, the case researcher adopted an active role in the process of program evaluation and outcomes; she examined the phenomenon of the effectiveness of the program by complete reconstruction, observation and case analysis under investigations. In a nutshell, case study method had the capacity to provide instruments to the researchers for studying complicated phenomenon in the contexts, and enabled researchers to understand the phenomenon from different perspectives. In short, the case study involved both the participant making sense of the phenomenon, and the researcher making sense of how the participant made sense of that complex phenomenon, otherwise known as the double hermeneutic.

**Rationale for Using the Case Study Approach**

For this research, the case study approach was used to provide insight into the lived experiences of the students being studied, and, in turn, it would offer the researcher the possibility of understanding these experiences in-depth including how they possibly impacted the students’ behavior. Thus, the outcome of a case study helped describe or explore data within realistic environments, and also helped interpret the complexity of a real situation that might not be seized by survey or experimental research (Zainal, 2007).

This study, an evaluation of program effectiveness on changing students’ perceptions towards mental illness, aligned well with case study research. First of all, case study research
method involved data interpretation, analysis and collection associated the real world as well as perceptions and behaviors of people within the case. In this research, the researcher examined the program documents, such as program policies, procedure manuals, and participants’ records and administrative reports for each of the program activities. Secondly, the case study offered contexts to the data by providing one more complete picture of what took place within program, which represented an excellent opportunity to highlight the project’s effectiveness, identify challenges in the project, and suggest areas for improvement. It followed that participants should have valuable insights to share about their experiences, yielding a robust body of evidence to be analyzed. Next, the case study method enabled multi-faceted, detailed exploration of complicated issues under the practical setting. According to Yin (2014), researchers had to find out cases as well as specific types of the cases to carry. Yin (2014) suggested single case studies if researchers intended to possess the capability of studying cases using analysis of data in the case analysis. The case study had two observable effects related to the research questions for this study: program effects and cultural effects. Through the case study approach, this researcher evaluated the program regarding the program design and identified areas for improvement, which ultimately helped strengthen the mental health status of the university students. The case study design offered researchers one systematic means of observing important client variables to determine if changes were necessary. The impact of interventions were also be examined. Given its focus on the meaning individuals attributed to experiences and real-world phenomenon, an exploratory case study approach was methodologically suited to address the research question exploring the contemporary real-life phenomenon through detailed contractual analysis.
Participants

Case study research was generally conducted using a sample of individuals that could best inform the research questions and enhance understanding of the phenomenon under study. A purposive sampling technique was used to select participants for the study. The population of this study was comprised of undergraduate students from different nationalities who were enrolled in the mental health program organized by CDC at the public university. Undergraduates who had enrolled in the mental health program were invited to participate in a focus group discussion. The program administrator and school counselor implementing the program were invited for individual interviews.

Sample Characteristics

A sample was defined as a subset of the population which was comprised of some members selected from the population. For individuals, semi-structured interviews with open-ended questions was used to gather research information. The interview sample included the program administrators, staff, and school counsellors. Email invitations was sent out individually. Each of these individuals received an invitation asking them to consider participating in the research study. According to Creswell (2007), individual interviews with up to 10 people was the recommended number of participants for qualitative research. The researcher’s goal was to secure six to eight participants for individual interviews in this study. For focus group discussions, the researcher solicited the help of the CDC to identify students who met the criteria for the study. The sample included both male and female students who had completed the mental health program organized by CDC at the public university. Participants in this study were aged 18 to 25 years old. Qualitative research often focused on a group of respondents who had been purposefully selected to gain valuable and detailed information through the research process.
Merriam (1998) recommended the size of each focus group within qualitative research was five to eight participants, and a range within this size was considered a manageable group. The researcher’s goal was to arrange two to three groups to fully inform all important elements of the phenomenon being studied.

**Sampling Techniques**

Sampling techniques could be used in conjunction with one another very easily or could be used alone in a qualitative research. In this study, purposive sampling was chosen as a tool for informant selection. Participants was recruited using purposive sampling so that all participants have experienced the phenomena being studied (Creswell, 2007). According to Patton (2002), purposive sampling was one technology extensively applied to qualitative research to identify and select information rich case for the highest-efficiency usage of finite resources, involving the identification and selection of groups of individuals or individuals who were particularly experienced with or knowledgeable on the phenomena of interest. Merriam (1998) defined purposive sampling as a method that helped the researcher to recruit participants from a population that they were interested in studying. Purposive sampling in qualitative research provided a researcher with rich information to study, given that the recruited participants were well experienced in a particular phenomenon. In that vein, this study sought to recruit participants who had completed or implemented the mental health program and who were willing to share their experience through the interview process.

**Research Site**

The research site selected for this study was an institution in Hong Kong that had been publicly funded for more than a half-century. It was one of the eight funded institutions by the University Grants Committee with an undergraduate population of 7,000 local students and 450
international students. The male to female sex ratio was 1:1.7. Demographic statistics for the
selected research site indicated a balanced student population. CDC was a center set up by the
selected university to offer mental health education and timely counseling services on campus.
The CDC was committed to empowering the students to develop their social capabilities and
emotional resilience. A public university was selected as a research site for this study for two
reasons. First, the public university tended to more closely follow the Hong Kong education
system, with students who had taken a public entrance exam; the setting appropriately reflected
the academic problems that students in general were facing. Second, a local university with a
proactive approach to mental health represented a diverse community of living for students. Data
was collected at the selected university in a natural setting, mainly through focus groups and
individual interviews, to understand the mental health policies and programs at the university.

Procedures

This study utilized a qualitative research design. Qualitative research designs usually
included any combination of four types of data collection procedures including interviews,
observations, document analysis, and audiovisual material (Creswell, 2007). The decision to use
the qualitative case study as a methodology was based on the premise that this approach typically
provided the researcher with the tools to explore complex phenomena within a given context.
Permission from the university was obtained to gain access to the research site. A letter
(Appendix A) explaining the study and asking for cooperation and permission to conduct the
study was sent to the university Principal. This study’s data collection and analysis procedures
followed standard requirements included in the Institutional Review Board (IRB) guidance
document and was described in the following sub-sections.
Data Collection

The data collection strategy in this study included the use of multiple types of resources such as document analysis, interviews, and participant observation. After securing approval from the IRB in accordance with the local requirements, data was collected in three phases.

Phase one: Documents analysis. Analysis of curricula documents from the program was used as a preliminary dataset to identify the goals and objectives of the program. Review of documents included using analysis of content as well as others for analyzing and summarizing printed materials as well as existing information (Simons, 2009). Curriculum documents were collected from program administrators, including program logs, meeting minutes, participant records, policy statements, training manuals/materials and so on. The documents were useful in the development of a thorough understanding about program, the strategies, goals, participants and activities. The documents were also useful in the development of a thorough understanding about program, the strategies, goals, participants and activities. A preliminary analysis of the mental health program and its emphasis on improving student access to mental health services were conducted by using this dataset.

Phase two: Interviews. Merriam (1998) stated that interviews were often a major source of qualitative data collection for understanding the phenomenon under study (p. 91). The interviewer was capable of pursuing detailed topic-related information as well as follow-up involving certain respondents using questionnaires to further investigate their responses. There were two type of interviews employed in this study to collect data: individual interviews and focus groups.

Individual interviews were used to explore the perceived needs, facilitating elements, and barriers to implement the mental health program on campus. A mix of more open-ended and less
structured interviews, semi-structured interviews, were adopted. Semi-structured interview allows participants and interviewer to flexibly discuss issues or details. Flexibility allows the researcher to follow up regarding interesting and important issues that come up during the interview (Wood, Burke, Byrne, Enache, & Morrison, 2016). The information obtained from semi-structured interviews not only provides answers to the questions, but the story behind the answers and gave new insights into the social phenomenon (Teherani et al., 2015). The interview questions posed focus on the experience of recruiting students to join the mental health program and promoting mental health services on campus. Therefore, semi-structured 45 to 60-minute interviews with approximately six to eight participants (program administrators, staff, and school counsellors) were conducted. The steps for collecting data from an individual interview were as follows:

**Step one.** The research sent a targeted email (see Appendix B) to specific program administrators, staff, and school counsellors at the research site that she knew personally to invite them to participate in the study.

**Step two.** The researcher sent a personalized email (see Appendix C) within 24 hours to all participants that expressed interest sharing more details about the study with the interview guide and consent form (see Appendices D and E). The interview guide served the purpose of acquiring the background of the participants’ lives; the researcher asked the participants to read the project description clearly. The research also offered to answer any additional questions that the participants might have before agreeing to participate in the study and before signing the consent form.

**Step three.** The researcher arranged an initial meeting with the participants. The purpose of the meeting was to explain the study in detail, understand participants’ backgrounds, and obtain
informed consent. This was conducted either in person, if that was convenient for the participant, or via Skype.

**Step four.** The researcher conducted 60 minutes in-depth interviews with each participant. The researcher sought each participant’s permission to audio tape record before the interview starts. Open-ended questions were designed to facilitate meaningful discussion.

**Step five.** The researcher transcribed the interview immediately—without using an outside service—to keep the information as accurate as possible. After transcription was completed, the researcher sent the interview transcript to each participant for confirmation and clarification. The researcher also spent extra time with the participant after each interview, to provide an opportunity for them to read the transcript and make clarifications regarding the research topic.

As recommended by Rubin and Rubin, (2011), using probes would prompt participants to respond in ways that helped grasp a broader context of the participants’ experiences. For example, the use of continuation probes, such as “So…?” and “And…?” as a signal to demonstrate that the researcher was actively listening. These interviews were recorded for transcribing and coding. Yin (2009) pointed out that interviews were one of the most important sources of data that allowed a researcher to collect valuable information to identify the participants’ perceptions. Each interview needed to have an interview guide, starting with a schematic presentation of questions that helped the participants to have a better understanding of the research topic (Jamshed, 2014). In this study, background questions that related to the role of the participant in program implementation and the number of years organizing the program were presented first. Specifically, questions about the norms and beliefs of the participants with regard to mental health were explored as these individuals might have different values, beliefs, and norms which might not be emphasized in an individual interview.
Phase three: Focus groups. Focus group interviews were considered to be another important source of data collection. In this case, they involved a small group of respondents who were enrolled in the mental health program organized by CDC at the public university. Jamshed (2014) stated that focus group interviews served to bring a group of people together in a discussion setting so they might share their insights and perceptions, thus providing a deeper understanding of the phenomenon being studied and allowing the researcher to explore the participants’ thoughts. Jamshed (2014) emphasized that the optimal time for each discussion was around 90 minutes, and optimum group size appeared to be five to eight participants per group. In this study, the goal was to arrange two to three focus group discussions to fulfill a wide variety of purposes, such as to determine need for the program, to discuss the program design, to identify ways for program improvement, and to conduct outcome evaluation. The questions designed for the focus group interview aimed to examine the results of program outcomes for students and to suggest methods of improvement. Group interaction between participants during focus group discussion encouraged rich and varied communication and stimulated new ideas through discussions that might not occur during individual interviews. In addition, participants within a focus group might respond very differently to the same topic of interest. It was one of the best ways to exchange viewpoints and discuss disagreements between participants. The steps for collecting data from focus group discussions were as follows:

Step one. A recruitment email (see Appendix F) sent to the CDC at the research site to solicit their help in recruiting students. Students who had enrolled in the mental health program were welcomed to join the study. This email briefly described the purpose of the study. Students who were interested in joining the study were asked to respond to the researcher directly.
Step two. The researcher posted flyers or an advertisement on the public billboards at the research site. Information, such as recruitment details and the purpose of the study, were included.

Step three. The researcher sent a follow up email (see Appendix G) to the students who expressed interest in participating in the study within 24 hours of receiving their notification. The letter asked the participants to confirm their participation through email. The researcher then sent out the consent form (see Appendix H) to the students. The protocol described how potential research participants will be contacted for interviews and follow-up procedures.

Participants were given a coupon for $100 Hong Kong dollars or the U.S. equivalent ($12.50) as gratitude for their assistance and participation in the study.

Step four: Direct observation was useful in providing additional information (Yin, 1989). Cultural differences and understandings constituted one of the areas of interest were explored in this study; these topics might provoke intense discussion among local students and overseas students. The simplest method was for the observer of the focus group to take notes of the discussion during the session as well as observation notes, such as body language, facial expression, and emotional expression in detail. This type of information provided observation data for analytical purposes. Though focus groups were a productive method that could be used to determine the strengths and weaknesses of a program, disagreements and irrelevant discussion which distracted from the main focus resulted in excessive data (Miller, 2000). The researcher guided the focus group back on track when these occurred.

Data Storage and Management

Properly storing interview data was essential for protecting confidentiality, especially when conducting research on sensitive topics. In this context, data was protected by using
encrypted data storage. Pseudonyms were used to mask each participant’s identity. All audio recording and transcript files were encrypted and password protected. The researcher was the only person who would have access to the files. Audiotapes or audio files were destroyed immediately after transcription. Physical documents, such as handwritten notes, signed consent form and evaluation paper were locked in a locked metal cabinet with no access of outsiders, except the researcher. Privacy issues were also be addressed when presenting the data in the researcher’s thesis; no identifiable description or characteristics, such as the participant’s name, the name of the school, or the exact location of the study, were mentioned.

**Data Analysis**

An inductive approach was employed for data analysis. This inductive approach started with the collection of data from transcription. The interview transcription was one word to word written documentation of taped interviews. Transcribed interview and notes from the document analysis were analyzed using content analysis, which was an extensively utilized qualitative research method, allowing the collected qualitative data to be systematically analyzed, hence a large amount of text was transformed into a highly organized and concise summary of key results (Haggarty, 1996). Merriam (1998) emphasized that one of the major benefits of context analysis was flexibility, which allowed the researcher to employ a reflective process to capture interview data and produce insightful analysis. During the analysis process, the categories of coding were directly derived from data of text, providing opportunities to researchers for coding as well as categorizing data into themes, which offered a better understanding of the particular phenomenon as well as individual experiences of a specific population.

Miles and Huberman (1994) suggested conducting content analysis in the following three phrases: conclusion, display and reduction of data reduction served as the first stage of the
analytic process, and it provided an opportunity for the researcher to select or simplify data that was relevant to the particular research question. Miles and Huberman (1994) also suggested the researcher developed initial codes at this stage, because coding helped to connect the data from various sources and led to the identification of useful themes. Data display served as the next stage of analytic process. Data display process helped researchers capture the significant data associated with particular questions of research and linked the data across similar themes. Miles and Huberman highlighted the process of memoing in the context of qualitative research methodologies. Memoing was a process of recording the ideas and reflections of the researcher. Reflective notes helped the researcher understand why they made certain choices at the beginning of the study, and to see how the thinking changed throughout the research process. Finally, the researcher drawn data conclusions from the displayed data in a variety of ways. In this study, data analysis was conducted according to these steps:

Step one. Step one of the data analysis process involved reading and re-reading the transcribed interview texts (Erlingsson & Brysiewicz, 2017). This step allowed the researchers to gain a general understanding of what the participants were talking about. During step one, the researcher listened to the audiotapes and read and re-read the transcripts, including all handwritten notes, to obtain an idea of what the participants were expressing. The researcher started dividing the transcript data into smaller pieces of information and categories, thus organizing the data into meaning units.

Step two. Step two involved labelling the condensed meaning units by formulating codes and mapping the diversity of data to reflect the data in new ways (Richards & Morse, 2012). The researcher provided a shortened version of the same text in order to keep the central meaning intact. During this step, the researcher kept reviewing the transcripts, made explanatory notes,
and abstracted the meaning units from each interview transcript. This step aimed to reduce the empirical data into decontextualized data and to formulate codes across individual participants.

**Step three.** The third step focused on coding. Erlingsson and Brysiewicz (2017) defined coding as a reflective process, which meant identifying and condensing meaning units; indeed, coding and categorizing were not one-time events, but a continuous process until the new raw data came out to reflect the initial analysis. The coding analysis involved a two-level process: formulating codes and categorizing the data into themes. The researcher created codes to identify meaning units, divide large data sets into smaller units, and put the pieces together again from condensation to descriptions and concepts. The purpose of this step was to make initial interpretations and identify emergent themes from within the interviews.

**Step four.** In the fourth step, the researcher looked for the connection across all the data in hand, including the interview transcripts, physical documents, and field notes, to identify the overarching themes. The researcher also analyzed documents and incorporated coding content into themes for them similar to how focus group or interview transcripts were analyzed (Bowen, 2009). Ultimately, the researcher established a final set of themes that help to answer the research questions (Erlingsson & Brysiewicz, 2017). Repeating step one to four for each interview until data saturation was reached.

**Step five.** The final step of the data analysis process was reporting. The researcher reported the insights gleaned from the analytic process and present the results by generating a variety of reports under each theme. Thus, in sum, the content analysis provided a comprehensive process for a researcher to identify information that involved a meaningful message between the evolving themes and the body of data.
Ethical Considerations

Creswell (2007) emphasized that the researcher was “accountable for respecting needs, rights, desires and values of the informant” (p. 258). It was especially important that the researcher was mindful of several ethical issues during the research process. The researcher first submitted a summary of the study to the IRB for approval prior to contacting participants. To comply with the IRB’s requirements regarding the protection of the rights, privacy, and welfare of human subjects participating in this study, the researcher prepared a Participant Information Sheet to inform people why the information was being collected and how it was used. This was one of the best ways to explain the nature of the data collection and to assure participants that their privacy was protected. In addition, qualitative researchers must consider the sensitivity of this research topic. Establishing an environment of confidence in confidentiality was important to reduce the response effects to sensitive questions. In this study, the researcher considered trustworthiness, credibility, transferability, and dependability as valid trustworthiness strategies to ensure the rigor of the qualitative research findings.

Trustworthiness

This research design was qualitative. The trustworthiness of qualitative content analysis was often presented by using terms such as credibility, dependability, conformability, and transferability (Lincoln & Guba, 1985). According to Creswell (2007), validation was an important step in the process of achieving credibility and trustworthiness. Numerous validation strategies were used to check the accuracy of the findings and to ensure the results were credible. The four criteria for establishing trustworthiness were individually discussed below:

Credibility. Credibility was the first criterion that must be addressed in establishing trustworthiness. This was because credibility involves confirming that research results were
believable of credible. Using multiple data gathering approaches result in the acceptance of validity and reliability when data of different sources were consistent and comparable. Therefore, looking for sustained engagement in qualitative research could build trust and establish a long-term contact with the participants (Creswell, 2007). This study used member checking (see Appendix E) and triangulation to address credibility. The method of triangulation was also a useful tool to address the credibility of the collected data (Patton, 1999). The researcher used multiple forms of data collection, such as individual interviews, focus groups with observations, and document analysis, to develop a comprehensive understanding of the study phenomena. The researcher kept all the raw data, such as interview notes, observation notes, consent form, and documents collected from participants for crosschecking (Lincoln & Guba, 1985). Member-checking was employed in this study as one tool in the process to increase the credibility and validity of the research (Creswell, 2007). The researcher sent each participant their interview transcript via email as a form of member-checking and confirmation, allowing them to make changes to the material and/or to add any additional information.

**Transferability.** Transferability in qualitative research was synonymous with generalizability or external validity. According to Lincoln and Guba (1985), transferability was applicability of one set of findings to other settings; in qualitative research, this was obtained through thick description. Thick description referred to a way to describe the possible meanings of a specific phenomenon in order to generate conclusions that were transferable to other situations (Geertz, 2008). In this study, the researcher provided a rich account of descriptive data from the participants during the interview process and made explicit connections to the research context and underlying assumptions. By providing that information, other researchers and
practitioners might be able to infer that the research results were the same or similar in their own situations.

**Dependability.** Dependability played a significant role in trustworthiness as the dependability confirms the findings of research study to be repeatable and consistent (Lincoln & Guba, 1985). The researcher used the code-recode strategy. During the code-recode process, the researcher coded the same data twice and gave one week of a gestation period between each coding to see whether the results were consistent (Chilisa & Preece, 2005). Moreover, the researcher used a tape-recorder and transcribed the interview data right after each interview to avoid faulty memory and to ensure dependability.

**Confirmability.** The concept of confirmability was akin to objectivity (Shenton, 2004). Confirmability in qualitative research aimed to verify the results that were shaped by the participants and to avoid researcher bias (Lincoln & Guba, 1985). In this study, the researcher looked at her own background and positionality to see how these influenced the research process. Then the researcher kept and maintained a reflective journal to record what was happening in the data analysis and in the interpretation process, with regards to the researcher’s own research values, interests, and perceptions. Maintaining and utilizing a reflective research journal allowed researchers and reader to see research process messiness clearly.

**Potential Research Bias**

The researcher’s interest in this topic was grounded in her personal experience living with a young family member suffering from major depression. This family member refused to get his depression treated, and he even rejected a diagnosis of mental illness because he had experienced the everyday stigma arising from mental illness and had been stereotyped as a dangerous person. Briscoe (2005) pointed out that positionality could affect the researchers’ perceptions and
produce unfair research outcomes. In this study the researcher recognized her bias and strive to keep it in check when collecting, interpreting, and reporting data. Keeping good records of research activities, such as interview documents, observation notes and reflexive journals, helped to reduce researcher bias. To maintain the validity and reliability of findings, the researcher access reliable references on how to prepare research questions objectively, as biased questions would influence respondents’ answers. The researcher used interpretive inquiry as a form of qualitative inquiry to avoid personal bias (J. K. Smith, 1992). Additionally, the researcher strived to understand the phenomenon by accessing the meanings that participants themselves assign to the data, using their own words, and stepping back from imposing her own perspective.

**Limitations**

Lack of rigor was the greatest concern with the case study approach. According to Yin (2009), the researcher in qualitative case study research was the primary instrument of data collection and analysis; there was no control over the data collection. Qualitative research was starkly different from quantitative research methods, which deal with numbers and anything that was measurable to systematically investigate a phenomenon. The case study research method enabled the researcher to closely examine the data without following such rigid, systematic procedures and leaves room for researcher bias to creep in into the findings and conclusions. Further limitations involved the issues of generalizability. Case study researched most frequently draws on the accounts of a small number of research participants. Yin (1994) considered case study research an interpretation microscopic image because of the limited sample size. It might be difficult for the researcher to find significant relationships from the data, given that small sample sizes might prevent the findings from being extrapolated or may limit the scope of analysis. It might not be possible to arrive at agreement due to studying small units.
Chapter 4: Findings and Analysis

The purpose of this study was to assess the effectiveness of the mental health program organized by Counselling and Development Centre at a public university in Hong Kong in improving students’ access to mental health services and resources. The author used qualitative inquiry and a case study research design to understand the program design and development through the lived experiences of six education leaders and 12 undergraduate students and to make sense of the interconnected factors that impact the decision to seek mental health. In-depth interviews with individual participants provided essential knowledge related to the mental health program at the university. The focus group interview revealed the unique experience of each participant and cultural variations that affected the help-seeking decision process. After reviewing the procedures described in Chapter 3, this chapter includes a profile of each participant and a description of the major themes and their associated subthemes.

Explanation of Data

Data analysis began with the researcher identifying the key factors through an inductive approach. After transcribing the interviews and the notes from document analysis, the researcher read through the data twice before engaging in content analysis. Merriam (1998) emphasized that flexibility is a benefit of content analysis, as it allows the researcher to employ a reflective process to capture interview data and produce insightful analysis. The second phase involved coding. According to Miles and Huberman (1994), coding was a way to categorize text in order to identify themes among the collected data. The process of assigning meaning units to the data allows the researcher to identify several passages of the text that share the same code and quick identification of target segments relating to the study. Reviewing the data identified several meaning units that appeared to be similar, revealing commonality among the emerging themes.
and subthemes. After the meaning units were assigned, the researcher clustered the meaning units into categories and transformed the data into expressions. During the analysis, the coding categories were directly derived from data or text, which offered a better understanding of the particular phenomenon and the individual experiences of a specific population. After the individual analysis was done, a composite set of question was formed to be used in the focus group dialogue. The research finally combined all the data collected from the six individual interviews and two focus group discussions to identify interconnectivity and commonality across the data. This analysis transformed and created a descriptive narrative that explained the data.

**Participant Profiles**

**John**

John had devoted a third of his life to teaching. When John accepted his appointment, it was clear to him that empowering students so they could contribute to the community was a priority. John emphasized that teaching was a challenging and hard profession because society was always changing and had little room for stability. Throughout his time teaching, John observed that the university experienced a resurgence of student activism, particularly in response to administrative decisions related to student affairs. Improving students’ relationships with teachers has positive impact on students’ social and emotional development. John also discovered that today’s students were not as strong as their predecessors and not as prepared for the challenges. He saw that the rate of depression and anxiety had increased substantially among students. For John, it was a matter of health education. John believed “no health without mental health.” John allocated a portion of his teaching resources to address the mental health needs of students. Through a series of activities such as assembly, talk, competition, and picnics, John was able to better understand students’ minds. Recently, John had a chance to play a role in
designing and implementing mental health program for university students. In an effort to support the university moving forward, John developed a mental health lesson plan as a guiding framework. John stepped up to help stressed students to reduce the risk of anxiety, stay healthy and do well in schools.

**Mary**

Mary was an associate professor in the Department of Sociology at the university. Mary had been teaching for 20 years and had worked with students at both the undergraduate and postgraduate level. Mary started her teaching career after completing her master’s degree in Canada, returning to Hong Kong to teach in 2005. Mary saw herself as a “transformer” of knowledge from West to East so students could embrace a culturally diverse learning environment. Mary believed that students from different cultural backgrounds had a range of protective and risk factors that contributed to the mental health of youth. This was because culture has a prominent effect on cognitive and perception processes. Mary had a unique background: she acquired experience with mental health promotion at various teaching institutions in Canada before returning to Hong Kong. These working experiences provided Mary with a holistic approach to mental health care in the education sector. During her time teaching at the public university in Hong Kong, she was appointed as a member of the Internationalization Advisory Committee. Mary strived to provide students with numerous opportunities for internationalization, as well as to create a culture of positive mental health. Taking the pledge to create a culturally responsive learning environment that offers benefits to student’s mental health at the university was a strategic initiative that will be developed and executed over the next 3 years.
Daisy

Daisy had been working as a certified counsellor at the university for more than 10 years. Daisy had extensive training and experience offering a wide range of support to students who were experiencing moderate to serious mental health disorders. Daisy’s work history included working as a teacher and school counsellor in a subsidized secondary school, where she provided holistic mental health assessments and effective support for students with mental health problems that need treatment. This experience gave Daisy the opportunity to understand students’ perceptions of mental health and led her to focus her career in the mental health field. Daisy recalled that mental health was a taboo topic during her time as a student. No one would ever tell someone about a mental health problem. She witnessed one of her classmates who suffered from depression but was afraid to seek help because she was concerned that doing so could negatively affect her social life. Daisy understood that there was a strong desire to foster positive mental health initiatives in schools. Daisy therefore started to think of launching a school-based mental health intervention program. For Daisy, mental illness “is nothing to be ashamed of” and “a matter of public perception.” With the goal of increasing mental health literacy among students, Daisy and her team launched various classes in relaxation, mediation, and class in order to reach out to youngsters and teach them how to cope with their weaknesses in different areas like family, study, and love affairs. Daisy believed that education was the only way to change perceptions about mental health.

Terry

Terry was a certified counsellor in the Students Affairs Office at the university. Terry had completed a master’s degree in counselling with a specialization in pediatrics or youth counselling. Terry had extensive work experience dealing with youth services. Terry was a social
worker on a psychiatric ward in a public hospital before joining the university as a counsellor. Terry’s experience on a psychiatric ward gave him a strong desire to take action to prevent mental health problems from occurring. Terry viewed himself as a family therapist who worked with youths or students experiencing mental illness. Terry emphasized that listening was the key to open the heart of students. With that in mind, Terry had designed a mental health assessment program for students to determine whether they would benefit from seeking mental health treatment throughout the therapeutic process. Terry believed that the assessment program would help the university identify the risk factors associated with students developing mental health problems. Terry emphasized that preventive interventions were based on the risk level of the population targeted for mental health interventions.

Peter

Peter had worked in youth services for over 30 years. He worked most of his career in education sector that helping students recognize the capacity and abilities they could have and helping them develop the strategies for dealing with stress. Being a program administrator at the university, his major tasks were to design and develop programs for students to rebuild their confidence, improve their adaptability to modern stressful work life, and maintain positive mental health. Peter believed that illness was always caused by overwhelming levels of distress, feelings of sadness, loneliness and isolation, and most of all the feeling of being disconnected from people and society: “Disconnected is the key factor for illness.” Therefore, understanding the needs of students was the first step to treating mental health problems. Peter also emphasized mental health literacy among those who suffered from mental disorders. His work experience told him that students did not have adequate mental health knowledge to deal with mental health issues. Students tend to be self-centered and shy, and they were reluctant to talk about mental
health issues in public. Peter suggested a broad strategic initiative through school-based interventions or peer-support approaches to increase students’ health knowledge and encourage a positive lifestyle change. This could also involve improving students’ mental health literacy through training, education, and shared working practices.

Anna

Anna was the program administrator at the university. She had expertise in creating events that engaged attendees and met all the needs and goals of the organization. Her current project focused on promoting mental health on campus and designing program that focus on understanding mental health beliefs and biases. During her time of employment, Anna completed a year-long program in mental health training. The training program prepared her for the role of mental health leader, as it aimed at promoting students’ awareness of mental health and fostering an empathetic campus culture. Anna’s description of mental illness, as it relates to the general perception on campus, was that it was a “physical disease.” People with mental illness could be treated by medicine in the early stages. However, the social stigma towards mental illness kept suffering people away from treatment. For Anna it was a matter of education to break down the barriers and “make the society more open.” As such, Anna embarked upon several health initiatives that focused on increasing mental health literacy, attitudes, and behavior among all students and teachers.

Summary

In summary, the data revealed the lived experiences of teachers, counsellors, and program administrators. The participants described the positive impact of having good mental health and expounded upon the social stigma attached to mental illness. Each participant offered rich descriptive insight into the interrelated components of navigating cultural perceptions and
help-seeking intentions. The following section provides a composite of the data across the six participants and two focus group discussions, revealing the three themes and 10 subthemes that emerged from this effort to understand the areas or critical success factors essential to the university community in improving students’ access to mental health services on campus.

Review of Data

The three major themes revealed through the data were: Cultural perceptions, Implementation challenges, and Program strategies. The 10 subthemes that appeared were: Attitude towards mental illness, Relationship between culture and help-seeking intentions, Mental health literacy, Resources and initiatives, Role of traditional education system, Social media, Social stigma, Importance of mental health, Mental health programs, and Curriculum change and innovation. A visual of the themes and subthemes was in Table 1. These themes and subthemes describe how a mental health program helps students with mental health issues, explain the complex help-seeking process as it relates to culture, and reveal the program implementation challenges associated with participants’ first-hand, lived experiences.

Table 1

Themes and Subthemes

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<th>Theme</th>
<th>Subtheme</th>
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<tr>
<td>Cultural perceptions</td>
<td>Attitudes towards mental illness</td>
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<td></td>
<td>Relationship between culture and help-seeking intentions</td>
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<td>Mental health literacy</td>
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The case study method obtained information from the participants’ experiences as they directly participated in program design, implementation, and activities. The following sections introduce each theme, followed by narratives of the pertinent subthemes. They will first talk about cultural perceptions toward mental illness and cultural issues, then flow into the implementation challenges that the participants discovered, and finally discuss program strategies for the future. The sections were organized based on the relevance of each theme, as it became evident that the themes and subthemes were interrelated. This chapter only presents the findings related to the research question. Their relationship to the theoretical framework and practice will be presented in chapter 5.

**Theme One: Cultural Perceptions**

One of the specific barriers to mental health care that the participants highlighted in the interviews was cultural influences. The participants described how culture influences the meaning that people assign to mental illness and the way that people seeking for mental health treatment. Historically speaking, mental illness has been viewed in Chinese culture in a religious and spiritual traditions. The participants discussed cultural influence toward mental illness in terms of cultural beliefs, help-seeking intentions, and mental health literacy; these three subthemes were presented in the following subsections.

**Attitudes towards Mental Illness**

Attitudes could positively or negatively affect a person’s behavior and perception. It could be described in terms of three components: affective, behavioral, and cognitive. *Affective component* was emotion or feeling toward a person or object. It involves emotional experiences and normally stands in the way of attitude change; for example, people were scared of ghosts. *Behavioral component* refers to the tendency to react towards objects and influences how we
behave; for example, people will scream if they see a ghost. *Cognitive component* refers to a person’s belief and knowledge about the attitudinal object; for example, fear of ghosts was based on beliefs that ghosts were evil, murderous, and dark. Attitudes toward mental illness influenced how some of the students navigated their help-seeking intention. However, attitudes toward mental illness varied across participants.

**A treatable physical disease.** Mary, Terry, and Anna viewed mental disorders as a physical disease, just like any other medical illness, but there was a clear distinction made between human body and mind. Mental disorders were associated with mood swings, like depression and bipolar disorder, while physical diseases were associated with physical health problems like heart disease. They were both diseases with different symptoms.

Mary stated that mental and physical health should not be treated as separate entities. This was because poor mental health could negatively impact on physical health conditions and the ability to fight on chronic diseases. For example, stress has been heavily correlated with high blood pressure and high cholesterol levels. Mary argued that both mental and physical illnesses were treatable. For example, people will usually take aspirin when they have a fever. However, medication or treatment for mental illness depends on conditions. There was no single treatment and medication may not fully cure mental illness. Mary has even met a student with emotional problems who was always crying in class and isolated herself. When Mary discovered students with emotional problems, she tried to approach them or direct them to seek professional help. Mary concluded, “She finally came back to class with a stable mood.” Mary’s strategy for handling mental health problems was to find the right match and method of treatment and be proactive to help.
Similarly, Terry saw mental illness as a medical condition that affects psychological disorders. Mental health has a direct or substantial impact on maintaining good physical health. One of the most common myths was that mental illness was not a physical health problem. But that was not true. Though the exact cause of mental illness was not yet known, it was becoming clear through research that many mental health disorders were due to psychological and environmental factors such as stress, chronic diseases, and attitude towards mental illness. People may believe the mentally ill patient has a spiritual illness; even patients may believe that “this depression was part of her spiritual experience”. This stigma towards mental illness been identified as a major factor in community’s reluctance to seek help for a mental health problem. Terry stated: “if we treated such people with mental illness as the way we treat people with the flu, so that early treatment could be given to control some of the mental health symptoms”.

Anna also viewed mental illness as a treatable physical disease. Anna held a similar view as Mary, stating that the types of treatment were depends on the facility, conditions and individual factors. For example, family and friend support could be an effective treatment for people in the early stages of a mental health problem. Anna had experience dealing with a teenager with autism and attention-deficit disorder. Her experience told her the only way to solve the problem was to find the right antidote. Anna was able to introduce a “time-off” plan for the teenagers, scheduling the most difficult subjects in the morning when the students were fresher and less fatigued. Anna emphasized that change will not happen overnight. The ADHD self-help strategy requires practice, patience, and a positive attitude. Like Terry, Anna did not want to discriminate against any students with mental illnesses, and therefore educating students with adequate mental health knowledge toward people with mental illness plays an important role and taking a further step in creating medical practices with an anti-stigma orientation.
Crazy about mental illness. All participants in the focus group thought that society holds stigmatizing views about mental illness. Participants stated that ideas about mental illness that were perpetuated by words like “crazy” include the idea that people with mental illness were divorced from reality, irrational, incapable of making decisions, or dangerous. Participants said that talking to others about mental health could be scary for a number of reasons: “I do not want to upset my friend,” “I don’t know how my parents will react,” “teacher will ask too many questions,” and “friend will see me as monster and get away from me.” Participants said they joined this mental health program because the problem was a compulsory course under the co-curricular learning curriculum. Co-curricular learning strives to promote mental health through informal educational modes including seminars, workshops, and experiential learning activities. The students showed a significant overall decrease in stigma after acquiring knowledge about mental health, but only at an individual level; the campus culture as a whole still held a negative view towards mental illness.

Relationship between Chinese Cultures and Help-Seeking Intention

A second subtheme that emerged across the data was how participants described the influence of Chinese cultures on intentions to seek help. This subtheme took on a variety of cultural issues, from philosophical framings such as Chinese cultural superstitions, the cult of face, and collectivistic cultures, to recognize cultural competence in mental health care and improve the help-seeking intention of students.

Chinese cultural superstitions. Confucianism, as a foundation of traditional Chinese culture, is different from Western religions in terms of supernatural beings. Chinese culture was rich in customs, traditions, and superstitions. Terry described mental health perceptions as based on superstitious ideas and religious beliefs. Superstitious belief of mental illness may lead to
seek help from a nonmedical practitioner, such as attending a worship ceremony or seeking help from a sorceress, which might hinder treatment of mental health disorders. Daisy’s belief in Chinese cultural superstitions was similar to Terry’s, that Chinese religions were often associated with superstition. Many Chinese still believed that mental health problem is caused by spirit possession; therefore, these were not associated with a tendency to seek help or mental healthcare. Daisy stated: “Social stigma is the reason that makes people seek comfort in superstitions rather than doctors,” and the culture was a main reason people believe in superstition. Participants from the focus group also postulated a superstitious belief on a continuum of mental illness. Participants said that Chinese culture believed that mental illness was due to lacking of harmony of emotions or by evil spirits, with mental illnesses like clinical depression and schizophrenia were being mistaken for possession by an evil spirit. One participant stated:

I thought people with mental illness might react inappropriately, talk to themselves or have abnormal behavior. For example, sometimes the news reported that someone walks on the street without clothes, shouting loudly at the bus stop or using a knife to hurt someone without purpose. I will take people with this abnormal behavior has mental health problems.

The cult of face. John described *face* as one’s public image in social contexts. This concept is very important in Chinese cultures that have a collectivist identity. Students were reluctant to share their problems, especially the Chinese students, because seeking help means embarrassment, ostracism and bring shame to the family. John stated: “Men can’t live without face, trees can’t live without bark”: admitting problems or failure was very difficult in Chinese society. “Saving face” was such a strong belief that becomes an important concepts in
understanding the Chinese behavior. Similarly, Mary’s experiences mirrored John’s concept of the cult of face. Mary started by telling how culture gives meaning to mental illness and thinking that admitting a problem means losing face with family in Chinese culture. Mary asserted: “A family’s ugliness should never be publicly aired;” perhaps face could be best defined as dignity or prestige. So Chinese students often hide mental illness for fear of alienating friends and were reluctant to seek help from mental health problems.

Collectivistic cultures. Peter’s approach to cultural perception was slightly different than the other participants. Peter focused on the cultural differences between East and West from the education perspective. Peter stated: “Western culture teaches people to be more open minded, while Eastern culture tends to make people more self-centered and shy;” this was a matter of education. By and large, cultures in the West tend to be more individualistic whereas people from the East were more collectivist. People from collectivistic cultures were more likely to see themselves as connected to others, so disclosing one’s problems to another could be treated as a result of malfunction in one’s in-group. Therefore, people from collectivistic cultures were more reluctant to seek help when compared to people from individualistic cultures.

Mental Health Literacy

The third subtheme that emerged from the data related to mental health literacy. The interview transcripts and the focus group discussions revealed that students with limited mental health knowledge were more likely to demonstrate negative attitudes towards mental health help-seeking.

Mary posited that at her university: “students mixed up the concept of mental health and mental illness.” when Mary invited students to join the mental health program, a student told her, “I don’t have mental illness.” Mary described her experience promoting mental health prevention
program in the university as challenging. Students used many inappropriate and destructive words, such as “psycho,” “mental,” or “crazy” to describe mental illness. Mary noted that not everyone at the university was a specialist or professional doctor, so the university did not talk about a program for mental health treatment, but rather prevention. Prevention in mental health could reduce the social and economic burdens due to mental disorders. This mirrored Peter’s emphasis on mental health knowledge. Peter posited that people from different countries suffered the same illnesses and faced the same woes. Peter questioned why people in Western countries would have less stigmatization towards people with mental illness than those in Eastern countries. One explanation was education. The Western countries developed a standardized mental health education program for all student and staff groups; however, the Chinese still had weak or limited knowledge of mental health. Peter stated: “Many of our students are still thinking that mental health is untreatable, it is not a disease, but something related to spiritual illness.”

Participants from the focus group demonstrated an apparent limited knowledge about mental health issues as physical diseases. One participant stated:

Definitely not. There was no cure for mental illness. If I tell my teacher that I am suffered from mental illness, they will send me to Castle Peak Hospital and will not let me to go out because they afraid me will hurt someone unintentionally. I also heard from my friend that the medicine for mental illness has challenging side-effects like extremely tiredness, bring damage to the brain and people may have problems when they stop taking the medication. Once I took this life-long medication, it will affect my social life in future. In other, the metal illness was untreatable, the doctors will only give me
medication to stop my social life and trap me in the hospital. While other people will see me as monster.

Therefore, seeking to assess participants’ knowledge about and attitudes toward mental illness could be helpful in understanding help-seeking behavior and designing appropriate mental health strategies on campus.

**Conclusion**

The participants described cultural perceptions towards mental illness in regard to attitudes, cultural beliefs, and mental health literacy related to the help-seeking intention. Participants said that negative attitudes towards individuals with mental illness affected the mental health services received by the students. A few of them stated the wrong ideas about mental illness, perpetuated by words like “crazy,” “mad,” “cuckoo,” or “nuts.” This was also shown in body language by ignoring them in a conversation. Such discriminative attitudes made mental health promotion more challenging in the university. Participants also said that a positive attitude about mental health could lessen mental health distress and may protect against mental health disorders.

Participants thought cultural issues such as Confucianism, the cult of face, and collectivistic culture negatively affected the help-seeking behavior of students. They felt Confucianism evoked emotional functions in the process of help-seeking, while the cult of face and collectivistic cultures discouraged the mental health help-seeking intention. Chinese mental health services were rooted in Confucianism, which has an impact on personality, coping styles, help-seeking, and attitudes and behaviors towards mentally ill patients. The feeling of face and the collectivistic culture in a Confucian society were barriers that discouraged the students from
expressing their feelings. The most important was the fact Chinese Confucian culture emphasizes self-control and deemphasizes emotional expression.

Participants felt that lack of understanding of mental health hurts people with mental illness. Some participants said one of the reasons for negative attitudes and behavior towards people with mental illness was a lack of mental health knowledge. One participant described the situation as intimidating for mentally ill patients and reflected the mental health literacy of students. As a rule, participants described students as lacking literacy. The university was responsible for providing correct knowledge to its students.

**Theme Two: Implementation Challenges**

Participants reported four main challenges to implementing the mental health program at the university. These included: lack of financial resources and teacher support; traditional modes of teaching and learning, the damaging impact brought by social media, and social stigma toward mental illness.

**Resources and Initiatives**

One of the biggest issues participants discussed as they talked about implementing a mental health program was the lack of resources and support from the university. Four of the six participants articulated various aspects of the problems they faced while implementing the mental health program for students. John said the heavy administrative demands impeded teachers’ core jobs. He described his experience as follows:

Teachers nowadays are facing the challenge of the excessive administrative load by working longer hours. Many of my colleagues reported that their working hours increased after the launch of new academic reform in 2012. The 3+3+4 reform was the new academic structure proposed the students to receive six-year secondary education
and four-year higher education. Through curriculum and assessment changes, teachers are facing heavy administrative workloads, such as purchase of office supplies and textbooks, program evaluation and accreditation and additional research work. The various kinds of documentation and administrative requirements, which take teachers away from their role of emotional education. The teachers were doing their best to provide quality teaching and learning to students, but sometimes failed to provide support for student’s emotional needs.

Mary said the biggest concern for her in implementing the mental health program at the university was the lack of financial resources. Mary said the university was funded by the public, and funding from the University Grants Committee should be used to support student activities related to teaching and learning. Mary emphasized that teaching and research were always a priority at the university, so only a limited budget was allocated for mental health promotion. Mary expanded the conversation by discussing the advantages of allocating more resources to addressing mental health issues. Mary suggested funding for setting up mental health clinics or a center at the university. She said:

A mental health center in the university could bring attention to the need for promoting good mental health of students and provide training for teachers to identify students at risk. If we noticed the student got the sign or symptoms of mental health, we can direct the students to the center and ask for immediate help.

Daisy revealed an extreme scarcity of manpower resources dedicated to mental health services at the university. She said:

There were many students in need of mental health support in the university. However, we only have five certified counsellor in the Counselling and Development Centre, but
we have almost 10,000 full-time students. The mental health services in the university have not been well equipped to face the resulting mental health care needs of large amount of students.

Peter talked about the need for mental health to be integrated into the school curriculum. Peter identified the impact that poor mental health has on learning and academic achievement and expressed that the main challenge was to let the student know the benefits of participation in a mental health program. Peter said:

Mental health awareness was an important issue and early intervention could lead to more positive outcomes for the students who were in need of emotional support. I think mental health program needs to be integrated into the school curriculum and made it as a compulsory course for students that will help them increase understanding about mental health. The goal was to improve the mental health knowledge and reduce the stigma attached to mental health issues by bringing about constructive change in students' attitudes towards mental health problems.

Role of Traditional Education System

Participants described how the traditional education system limited interactions between emotions, actions, and thoughts, as well as how the narrow focus of an examination-oriented education culture increased the mental health concerns of students at the university. For John, educators strive to prepare the students for the “real world” that exists around them and “student used to be proactive and take responsibility for their education.” However, John asserted that the modern education system remains exam-oriented, relies on rote memorization, and uses test scores as the primary criteria for analyzing the knowledge and skills of students. Therefore, “students these days were not as mature as their predecessors and require more support on their
students.” Students focus on studies and generate the desired academic outcomes, and schools lack the passion to commission mental health support effectively.

Terry engaged faculty, staff, and students. Terry’s youth service and outreach youth work involved giving information directly to students on issues relating to mental health. Terry said, “anxiety student is quite common in school” and the traditional education system has a significant role to play in raising mental health issues among students. The traditional education system puts pressure on children to achieve high levels of academic success, “making students anxious and depressed.” Terry’s experience working with student counselling services told him that students were experiencing high academic stress and universities were experiencing an increase in mental health problems. However, it was sad to say that most education institutions only recognize students’ performance as it relates to academic achievement. Educators put almost all resources in support of improving teaching or achieving a higher ranking in the education industry, but seldom allocate resources to aspects other than academic performance. Terry asserted that students experiencing mental distress only receive minimally adequate mental health support in school because the institutions do not provide their students with the required resources or treatment.

Participants in the focus group expressed that the exam-oriented education system creates a lot of stress for them. Participants stated: “I was stressed out about the exam,” “The exam and school projects were killing me,” and “The education system is destroying my health”. All of the participants expressed that they were suffering from academic stress and the stress built up in the psyche of the students due to their inability to perform up to expectations in academic performance. Few participants said that the rapid speed of political change caused stress and anxiety about their student life. One participant stated:
There were so many people experience psychological distress, not only students. I don’t think there was any specific medication for stress. Stress will not go away after receiving the treatment, problem still exists. We still have to faces the exam, projects, financial problems, etc. The stress will only go if all the exam and homework disappeared.

**Social Media**

Social media has a detrimental effect on student help-seeking intentions, which made the implementation of mental health programs at the university were more challenging and difficult. Daisy stated, “I have seen technology have a negative influence on mental health issues”. She explained the media reports often link mental illness with criminal, violence and crime. Some of the reported even describe the mentally ill patients a dangerous person that harm people in the street. Daisy shared her experience while promoting the mental health program at the university. She claimed the biased image of mental illness painted by the media influences students’ help-seeking intentions and their belief in mental health issues. Therefore, mental health programs in school have typically achieved very low participation rates.

Most millennials use social media. It was common for students to get help or support from social media. Participants in Group 1 described how social media navigated their help-seeking decision process. Nearly all of the participants stated that the prevalence of social media, such as healthy and therapy apps, WhatsApp, or Instagram, greatly affected their help-seeking behaviors. They all agreed that “online help-seeking” was the most convenient way for them to find solutions when they met problems. However, it was found that social media became a barrier that discouraged students' help-seeking. One participant stated:

I’ve had experiences of posting on social media about depression. I shared my own personal story with some unknown friends met in the internet. However, people
responded in a stigmatizing and negative way. I’ve had to step away from social media for a month after seeing harmful posts.

Some participants expressed that the internet was not a reliable source and that medical information found there may not be accurate. The wrong information may even worsen the mental health situation of students and make the health promotion process more complex. In addition, Participants in Group 2 described how social media addiction was linked to mental health risks. Participants said that social media was part of their life: “We can’t live without mobile phone,” “We will make friend online,” “We chat with friends via social media app, we seldom talk face to face.” Social media has changed society and the way that people communicate. Half of the participants expressed that they have encountered cyber bullying. Of those who responded that they were cyberbullied, the majority said that it was due to appearance and love affairs. Participants described differing responses, stating “I will take revenge by posting bullying comments,” “I will ignore them,” “I felt frustrated when every time I received the bullying messages, because I can’t stop spreading it.” Almost all participants expressed that social media negatively affected their mental health, especially suffering from “Facebook envy.” One participant stated:

Facebook is making me unhappy. My friends always posting photo of good scenery and nice foods or staying up to date with their relationship status. I will measure myself against their status, successes, and situations. Comparing myself to others on Facebook deepen my feelings of self-doubt or self-esteem.

Social Stigma

Almost all participants reported that the stigma of mental illness was one of the foremost challenges deterring students from seeking treatment and increasing the challenges of mental
health promotion. After reviewing the data, it appears that participants experienced difficulty assessing the mental health of students and said they often could not tell whether their students’ encountered emotional difficulties due to the stigma attached to mental illness. Participants said the stigmatized situation at the university inhibited students from seeking help. John stated that in Chinese society, the general public makes people with mental illness into monsters, which prevents students from reaching out and getting help. Mary also considered the Chinese conception of mental illness as an important factor that affected help-seeking intentions. Mary said admitting a mental health problem meant losing face in a Chinese family, which explained why many Chinese people hide problems instead of seeking help. Terry thought that the general public discriminated people with mental health problems and classified the mentally ill patients as abnormal. Peter and Anna talked about stigmatization and shame toward mental health problems that impact their well-being and daily life. Peter said society in general has stereotyped views that mentally ill patients will hurt people. Such negative images affect their employment. Therefore, people were not willing to let someone know they were suffering from mental illness. Anna felt the shameful attitude towards mental illness worsened a person’s illness and can lead to a reluctance to seek and accept help. Nearly all of the participants described social stigma and discrimination as making mental health problems worse and stopping people from talking about it. Additional phrases were found in raw data. John, for example, said help-seeking was a process of finding and receiving support from others. Anna said that social stigma “affects their help-seeking intention” because “suffering from mental illness is very shameful.” Social stigma appeared to result in feeling shame about having mental health problems or even thoughts that “talking about mental health issues is wrong.”
Half of the participants also expressed that reducing the stigma of mental illness may contribute to effective help-seeking. Mary explicitly stated that “destigmatization may lead to increased readiness to seek help.” Similarly, Peter said, “reduce the stigma surrounding mental health issues could bring about positive impact on students’ knowledge and attitudes about mental illness” and thereby “minimize the challenges of promoting mental health” at the university.

**Conclusion**

Participants reported four main challenges to implementing the mental health program at the university. These included: lack of resources to support program promotion, the exam-oriented education system, the impact of social media, and the stigma surrounding mental disorders. Participants felt that common barriers to mental health promotion, such as stigma and discrimination, and financial barriers were the major obstacles to implementing the mental health program at the university. Nearly all of the participants reported that the funding issue was among the most frequently cited barriers to mental health promotion and that the stigma of mental illness affected the help-seeking intention of students. For example, participants reported financial resource challenges and a shortage of manpower to scale up mental health services; most of them felt teaching and research were always a priority at the university. They felt more resources should be allocated to mental health education.

Participants felt that the traditional education system limited interaction between emotion and action, and the examination-oriented education culture worsened the mental health of students. The greatest stressors that participants felt affected the students included examinations, assignment, project, academic score, parental pressure and their expectation of academic achievement. Mental health concerns specific to students included depression, anxiety, and
attention deficit hyperactivity disorder. Participants said they had experienced students with mental illness who had difficulty accessing mental health services. They also felt the university, schools, teachers, parents, and society at large should join efforts to foster a change in the exam-oriented culture and create more space for students’ active learning.

Nearly all of the participants said that the social stigma attached to mental illness was one of the foremost challenges that hindered students’ access to mental health services at the university. Participants reported various forms of exclusion or discrimination towards mental illness and emphasized that social stigma existed from the group level to the community level. The threatening image of mental illness prevents students from reaching out to get help. Participants said that the media play an important role in perpetuating social stigma, because most media portrayals of mental illness were stereotypical. Participants also felt the use of social media was damaging to the mental health of students and gave rise to symptoms of anxiety and depression. One participant talked about the comparison mode in social media use, emphasizing that keeping up with social media was making students anxious.

**Theme Three: Program Strategies**

The third major theme that emerged from the data was *Program strategies*. When asked about the Centre’s needs and challenges when promoting the mental health program at the university, participants talked about the importance of mental health and the university’s current program. Program strategies that capitalized on strengths or opportunities elicited subthemes about the change of curriculum and innovation and how the recommended changes could improve student access to mental health services at the university.
Importance of Mental Health

One of the subthemes that was revealed in the transcripts was how the participants described the importance of mental health. John stated, “The most important aspect of mental health was an optimistic attitude or positive thinking.” He explained that a positive mindset could improve mental and physical health in various ways: good mental health could provide students with the confidence to walk through challenging situations. Mary described mental health as a core element for an individual to thrive. Like John, Mary said mental fitness was a kind of robustness that helps students deal with small and big hurdles in their life.

Terry talked about mental health in terms of emotional intelligence. Emotional ability was particularly relevant to maintaining a stable life in the community. Terry described mental health as “a key to relationships, personal and emotional well-being.” Similarly, Daisy described mental health as “an ability to handle ones’ emotional fluctuations.” Anna linked mental health to physical health, stating: “Mental and physical health is fundamentally linked... your psychology affects your physiology.” She explained that if an individual experienced a mental health problem for a long time, it would worsen the physical condition as well.

Participants from Group 1 and 2 described the important components of mental health. Participants stated: “good mental health that allows one to enjoy life,” “ability to cope with negative situations,” “help to build positive self-image,” and “sense of self-satisfaction.”

Mental Health Program

The second subtheme that emerged across the data was the current program offered by the university. This subtheme took on a variety of program structures and the program goal. This section also includes the data collected through document examination. Documents such as program policies, course evaluations, and participants’ records were collected for review. Table
elucidates various program details in order to obtain information about current mental health programs or services provided by the university.

Table 2

*Mental Health Program*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Program</th>
<th>Program goal</th>
<th>Participant rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>John</td>
<td>Mental Health First Aid Program</td>
<td>To strengthen student’s awareness and increase mental health literacy of students.</td>
<td>High</td>
</tr>
<tr>
<td>Mary</td>
<td>Mental Health Ambassador Program</td>
<td>To promote a caring culture on campus.</td>
<td>High</td>
</tr>
<tr>
<td>Terry</td>
<td>Psychological Assessment Program</td>
<td>To test the personality, interpersonal relationship and career interests in order to enhance self-understanding of students.</td>
<td>Low</td>
</tr>
<tr>
<td>Daisy</td>
<td>“Understand yourself”; “How to cope with depression”; and “Enneagram” etc.</td>
<td>To help students reaching out for help with personal or emotional problems.</td>
<td>Low</td>
</tr>
<tr>
<td>Peter</td>
<td>Emotion GOGOGO</td>
<td>To teach students how to deal with stress and release it.</td>
<td>Low</td>
</tr>
<tr>
<td>Anna</td>
<td>Mental Health Enhancement Program</td>
<td>To eliminate discriminations and break prejudices against mental illness.</td>
<td>Low</td>
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Participants also described the benefits students would gain from participating in the mental health program, and some participants described how mental health programs benefitted the university on a macro level. For example, John said that over 1,200 students and staff have completed the Mental Health First Aid Course and feedback from participants in the course has
received high levels of satisfaction with both program content and outcome. Comments like “Everyone should have knowledge of mental health issues,” “It made me look at mental health in a different way,” and “Trainer’s passion for mental health and the need for supports shines through and really inspire me” were received in end-of-course evaluations. In a similar vein, Mary was implementing a mental health prevention program for students to promote a caring culture on campus. Mary stated that prevention was the key “to treating mental health problems,” as it was able to reduce the symptoms of mental health disorders. Moreover, Terry described a time when he was promoting a mental health assessment program to students at the university. However, the participant rate was extremely low. Terry explained that the social stigma surrounding mental illness was the main reason students did not participate in assessment programs. He repeated a student’s words: “doing mental health assessment means that they were having mental illness.”

Participants in Group 1 revealed student perspectives on mental health program. Participants stated: “I think the mental health program is useful”, “the program can raise awareness and mental health literacy” and “boost knowledge and confident in dealing with mental health issues”. However, all of the participants had a negative response when asked to join the mental health program. Participants stated: “this is not part of the curriculum”, “I don’t have mental health problem” and “my friends will misunderstand me of having mental illness if I join the program”.

Curriculum Change and Innovation

The data also revealed the subtheme *Curriculum change and innovation*. Participants discussed various strategies for creating a university environment that supported and promoted
positive mental health and wellbeing. Participants talked about the role of education in mental health.

Daisy and Terry both described the role of education in promoting wellbeing and preventing the development of mental health problems. Being an expert in a field of youth counselling or services in the respective university provided both of them with additional information about youth mental health development. Terry was aware that stigma and its impact on help-seeking affected the utilization rate of counselling services and that there was an urgent need to develop more comprehensive support services and interventions for students. Terry suggested creating a workshop or small class regarding practical components, such as career interests or financial planning, that students would find congruent with their development. This would let students know mental health was more than an illness. On the other hand, John’s teaching experience acknowledged that not all student problems required the attention of counsellors. Self-help was more important in today’s society. John suggested educating students to recognize, manage, and express health emotions and feelings or physiological problems. Mental health education should be made compulsory in all schools, and it is important to help teachers and schools design a curriculum that will enrich the student knowledge in mental health in an age-appropriate way.

Mary affirmed, “Good physical and mental health is at the heart of ensuring students were ready for the society.” Mental health training is a great way to keep students physically healthy as well as improve their mental wellbeing. Mary suggested providing compulsory training for teachers in order to give them an overview of the most common mental illnesses and disorders, ways to spots the symptoms of mental illness, and how to get help for at-risk students.
Moreover, mental health education needs to be integrated into the school curriculum, thereby improving mental health literacy and reducing the social stigma around mental health issues.

**Conclusion**

In conclusion, participants described the program strategies of activities and programs that fostered positive mental health among students and strengthening university assets to prevent mental illness and enhance students’ well-being and quality of school life. Based on their reports, all of the participants seem to have implemented at least some of the effective strategies that the university was expected to deliver. These included a psychological assessment program, mental health first aid program, and emotional detection. All of the participants felt their skill set was up to standards, but the program did not have a medium or high participation rate. They felt more training was needed to remove the social stigma.

Participants all said they had implemented mental health programs to strengthen student awareness and increase their mental health literacy. Some participants felt these programs were useful, while others questioned the low participation rate. Every participant felt it was important for the university to include mental health education in class, and every participant thought it was important to create a caring culture at the university. Three participants said that mental health education should be made compulsory in class. Participants said mental health education is crucial for the youth to learn at younger stage as they will be more prepared if they encountered mental health issues in later stage. Moreover, the mental health education could help to reduce the stigma attached to mental illness and lessen the distressing impact of mental health help seeking. Mental health education could go a long way towards helping eradicate the stigmas associated with mental illness.
Conclusion

In-depth analysis of the interview data from six participants and 12 students uncovered three major themes and 10 subthemes that describe the participants’ lived experience with implementing or participating in the mental health program at the university that was aimed at improving student access to mental health services. The three major themes that were revealed through the data were: Cultural perception, Implementation challenges, and Program strategies. The 10 subthemes that appeared were: Attitudes toward mental illness, Chinese culture, mental health literacy, Resources and initiatives, Traditional education system, Social media, Social stigma, Importance of mental health, Mental health programs, and Curriculum change and innovation.

This chapter highlighted the findings that answer the central research questions. Mental health issues were increasing among students, as the problems that the university was facing. The Counselling and Development Centre has provided various mental health programs for students in order to strengthen their awareness and improve their mental health literacy. However, the campus as a whole has not changed as the needs of students have changed: the services implemented at the university have not caught up with rapid developments in society. The traditional education system was deteriorating the mental health of students; while programmatic interventions have been available for students, they have low participation rates. Regarding the promotion of mental health education, university educators have too many responsibilities to address and limited support was given. This mismatch between the goal of mental health promotion and the real situation at the university resulted in educators feeling overwhelmed and mental health services for students being underserved. These findings reflect the need for real and meaningful change in educators’ ways of thinking and behaving, and they reveal the help-
seeking attitudes and concerns of students when making complex help-seeking decisions. The emerging themes and subthemes also reflect aspects of the literature review and the help belief model that educators could use to plan future mental health promotion programs. Chapter 5 will explore the findings of this study as they relate to the theoretical framework, literature review, and the selected methodology, as well as provide an analysis of the data as it related to the research questions.
Chapter 5: Discussion and Implications for Practice

The main objectives of this study were to understand more about the experiences of the teachers, counsellors, and program administrators who were implementing the mental health program at a university in Hong Kong and to provide recommendations for improving student access to mental health care and resources at the university. This study was designed to understand more about the challenges that the teachers, counsellors, and program administrators were facing, especially as they respond to mental health related issues at the university.

The educators were constantly looking for ways to offer attention to the mental health needs of students; however, the university primarily was a place of academic growth. Addressing students’ mental health needs becomes increasingly important because students were coming to the university with a variety of emotional stresses and needs. According to a web-based survey with 7,915 university students in Hong Kong about the prevalence of mental health problems, 21% of students had symptoms of depression and 41% had symptoms of anxiety (J. P. Wong et al., 2006). In addition, a survey conducted by the Hong Kong Federation of Youth Groups in 2017 with a sample of 3,441 secondary and tertiary school students in Hong Kong, showed that 50% of them showed signs of depression and 40% complained about stress during the new academic semester. The increasing mental health problems in the university affect the lives of students, thus necessitating the educators’ response.

Hoagwood and Erwin (1997) emphasized that school was an ideal setting for addressing mental health issues among students and for implementing mental health strategies. However, there were increasing challenges to promoting positive mental health in traditional academic areas and create a caring culture in the university. At the forefront, the university was trying to meet the mental health needs of students and improve their access to mental health care services,
responding to the implementation challenges by increasing understanding and reducing the stigma around mental health issues

The main theoretical framework applied to this research was the health belief model (HBM). HBM was built on value expectancy theory and involves valuing behavioral change and expecting a certain outcome from it. When students experience mental health problems, there could be numerous negative responses that impact their help-seeking behaviors. Educators supporting students’ mental health issues at the university need to understand their help-seeking intention and know the factors that encourage or hinder help-seeking behaviors. It was also critical to provide a guide for educators to plan cost-effective mental health programs for students in the university setting.

Summary of Major Findings

Chapter 4 presented three major themes and 10 minor themes that emerged from the data as participants described their experience with implementing or participating in the mental health program at the university. The three major themes included: Cultural perception, Implementation challenges, and Program strategies. The 10 minor themes that appeared were: Attitude towards mental illness, Relationship between culture and help-seeking intention, Mental health literacy, Resources and initiatives, Role of the traditional education system, Social media, Social stigma, Importance of mental health, Mental health programs, and Curriculum change and innovation. Through the interview process, the researcher determined what factors were essential to improving student access to mental health services at the university. Although the themes and subthemes were interconnected, the data enabled the researcher to better understand the help-seeking intention of students. These findings from this study suggest:

- Culture influences the help-seeking behaviors of students.
Challenges to implement and sustain holistic mental health service programs.

Strategies for promoting mental programs.

These findings will be discussed below and presented alongside the theoretical framework, the literature, and the research design. Additionally, the research will discuss the implications of this study, identify limitations, and provide avenues for future research.

**Changing How Students Understand Mental Health and Promote Active Help-Seeking**

The first finding of this study was the influence of culture on mental health, which supports previous research about the impact of global cultural systems on mental health perceptions (Lefley, 2000; Morris, 2011, Voyer & Kastanakis, 2014). According to HBM, an individual’s perception of susceptibility may impact health behavior. The findings revealed that students with low perceived susceptibility may deny that they were at risk for contracting mental illness. Arnault (2009) posited that Asian culture leads to a suppression of emotions to avoid contributing to social disharmony; this results in low perceived susceptibility. This aligns with the findings that the Confucian culture in Chinese society, which emphasizes self-control and deemphasizes emotional expression, discourages students from expressing their feelings. Based on the experiences of teachers, counsellors, and administrators in designing and implementing the mental health program at the university, there was a need to strengthen student awareness and increase their mental health literacy. John and Mary discussed multiple examples of how cultural beliefs influenced the meaning that people assigned to mental illness and the way of mental health help seeking. For example, teachers and program administrators discussed how collectivist culture and “the cult of face” in Confucian society discouraged students from seeking mental health help. They also felt Confucianism evoked emotions in the process of help-seeking.
One of the biggest reasons why the educators had to address cultural issues was because culture explains mental illness based on a set of beliefs and practices, which play a significant role in shaping threat perception and stigma in Chinese society (Abdullah and Brown, 2011). The findings revealed that mental illness in Chinese culture has been viewed in a religious and spiritual context. Despite the concerns discussed, it was likely that culture still was a great central unifying force that could be harnessed for mental health promotion and illness prevention. Therefore, the teachers and program administrators discussed the importance of cultural change through mental health promotion as a strategy for improving student access to mental health services at the university. Previous studies had confirmed that school-based mental health programs integrated with youth education reduce cultural influences (Garcia-Ortega et al., 2013; Park & Sunyoung, 2017; Stoltz et al., 2012).

Cultural barriers to seeking help make it difficult for students to address their mental health concerns. The University of Hong Kong and the Tertiary Institutions Health Care Working Group (2003) revealed the high prevalence of psychological distress among undergraduate and graduate students in Hong Kong; statistics indicated that suicides among university students continue to be a serious problem. Cultural issues were a significant factor and barrier to seeking help. Moreover, few students receive mental health care through the university due to the stigma surrounding getting help, biased beliefs, and lack of mental health knowledge (H. Chen et al., 2014). So, while society in general has discriminated views towards mental disorders, school was an ideal setting for addressing students’ mental health issues and for implementing mental health strategies (Hoagwood & Erwin, 1997).

While addressing barriers to seeking help was not a new concept, recent research shows that providing effective school-based intervention programs in mental health was effective in
creating a caring campus culture and reducing the likelihood of secondary effects such as family disruption, school drop-out, and risk of suicide (Fazel, Hoagwood, Stephan, & Ford, 2014; Hoagwood & Erwin, 1997; Hoare et al., 2017; Winzer et al., 2017). Research indicates that mental health programs that were intensive, target students, and were implemented by schools with health professionals lead to the most significant gains in improving students’ mental health. Hoagwood and Erwin (1997) also concluded that implementing a program of social skills training and locus of control for students with behavioral programs led to a marked shift within the locus of control, helping them manage emotional or behavioral problems more effectively.

Teachers participating in the interviews also indicated the importance of mental health education for students. Fazel et al. (2014) emphasized that schools provide a natural context for promoting students’ mental health and suggested that mental health intervention programs incorporated into school systems could have a significant positive impact on students’ academic achievement and mental wellness.

The prevention strategies were similar to those of the HBM, which theorizes that individual beliefs about susceptibility to a health-related problem and risk perceptions of the benefits lead to taking precautionary action to prevent the problems. In other words, it was not just addressing the issues that arise but ensuring that all students have the mental health support they need to prevent the occurrence of mental illness. The model utilized an integrated approach to understanding health behavior and possible reasons for behavioral change and helped identify the barriers that inhibit help-seeking intentions among students. This applies directly to the overarching research question of this study, which focuses on improving student access and utilization of mental health services. Literature states that mental health programs that address
students’ particular requirements could help students overcome obstacles that make them unwilling to access conventional mental health services (McGorry et al., 2008).

Findings from this study support previous research indicating that traditional Chinese culture negatively impacts help-seeking intentions among students (Chen, 2011). The counsellors and teachers discussed the relationship between Chinese culture and help-seeking intention. It was found that the Confucian tradition, such as “Zhongyong thinking” and collectivistic cultures, has a great impact on the help-seeking attitude and behavior of Chinese students (Lefley, 2000; Yang et al., 2016). Mary and Ruby mentioned that help-seeking may hurt the harmony of a group and was commonly considered a sign of weakness and shame. Moreover, students in Hong Kong held solid traditional Chinese cultural beliefs and values with an emphasis on rules, order, and duty (Lam et al., 2004). They reflected a negative attitude toward people with mental health problems (Yamaguchi et al. 2013) and were likely to delay mental health treatment because of the stigma.

**Identifying Challenges that need to be addressed for Successful Program Implementation**

The second finding from this research was that the way the university is offering mental health services to students has not addressed the challenges discussed in previous research and literature. Teachers indicated that the volume of administrative work and the demand for research has increased in recent years, yet they were being asked to provide more mental health support to students. In some cases, there was no additional manpower, leaving all the counselling services to the university counsellors. Counsellors indicated that the university only has only five serving almost 10,000 full-time students, and the counselling services were mainly for students who were already having mental health problems. In addition, while participants were aware of the mental health first aid program and the mental health enhancement program, the educators
did not have the time, resources, or training to implement it. Moreover, teachers, program
administrators, and counsellors indicated that the large workload and scarcity of manpower
resources did not leave them room to promote mental health services at the university. Finally,
they mentioned the lack of financial support from the university, which made advocating for and
implementing mental health programs difficult.

Another factor playing into implementation challenges was the traditional educational
system and perceptions of high academic achievement. The highly competitive study
environment as well as the importance attached to academic achievement make student academic
performance a priority; therefore, most resources were utilized for teaching and research.
Resources for addressing mental health services and treatment were limited. Teachers indicated
that academic achievement in traditional education systems was significantly related to higher
scores and academic knowledge. Students easily get stressed out about keeping good grades, and
a high level of stress leads to many psychological problems (Kausar, 2013). Moreover, the
impact of stress has been defined by several important national organizations, including the
Mental Health Foundation (MHF) in the United Kingdom and the American Psychological
Association (APA) in the United States. MHF stated that stress arises when students were
preparing for exams, mastering lots of homework, and engaging in many extracurricular
activities; it further explained that anxiety was a reaction to stress. In addition, APA posited that
physical health, such as heart disease and high blood pressure, were significantly associated with
stress. It was recommended that mental health programs promote positive school environments
and policies that support the mental wellness of students.

Literature over the past few decades has revealed that exam-centric education systems
worsen the mental health of students (Zang & Kirkpatrick, 2011; Salili, Lai, & Leung, 2004).
Teachers and counsellors indicated that students were experiencing high academic stress and universities were experiencing an increase in mental health problems. For some students, the education system was destroying their health. In some cases, even though emotional support was given, students did not take advantage of it and still struggled academically. In worse scenarios, academic stress reduces academic performance, hinders students’ ability to be involved in campus life, and potentially leads to self-destructive behavior (Chellamuthu & Kadhiravan, 2017). Teachers and counsellors indicated that they were aware of a student’s emotional problems, yet the social stigma attached to mental illness affected their help-seeking intention.

The description of stigma was similar to what was mentioned in the research and literature. Students tend to adopt a stigmatized view of mental health problems, label people with mental illness as dangerous and violent (Lauber & Rössler, 2007), and feel too ashamed to ask outsiders for help (Ng, 1997). Some students projected an image of mentally ill people as having feelings of sadness, shamefulfulness, and loneliness. This psychiatric labelling created a long-lasting mental health stigma in society as well as at the university. Students also indicated that the media play an important role in perpetuating social stigma. In some cases, students’ social media habits were harming their mental health. Students mentioned that the rise of social media allowed the world to be constantly and conveniently connected; however, the overuse of social media pointed to a rise in symptoms of anxiety and depression.

In addition, counsellors and program administrators indicated that the social stigma attached to mental illness was one of the foremost challenges that hinders students’ access to mental health services in the university. The stigma of mental illness has often been considered a potential cause of reluctance to seek help and of low utilization of mental health services (Herrick & Brown, 1998). Literature over the past few decades has recommended how to
increase the readiness to seek help through reducing the stigma surrounding mental illness (Cleary, 2002; Deane, Wilson, & Ciarrochi, 2001; Kerebih, Abera, & Soboja, 2017). Reducing the stigma of mental illness may contribute to effective help-seeking and minimize the challenges of implementing mental health programs at universities. Moreover, the potential factors shaping help-seeking behaviors were similar to those of the HBM, which proposes that behavioral changes modify students’ risk factors, such as individual perception and perceived threat, and encourage help-seeking intentions. In other words, the model uses individual perceptions about mental illness and help-seeking intention as a guiding framework for behavior change.

**Mandating Mental Health Education to Improve the Mental Health Knowledge of Students**

The third finding of this study was that mental health education should be made compulsory at the university to improve the mental health knowledge of students. This finding further supports the HBM, which focuses on avoiding negative health consequences, applies directly to the overarching research question of this study, and focuses on improving student access to mental health services. According to the HBM, an individual must perceive that help-seeking behavior will provide strong positive benefits and prevent the negative mental health outcome. The program administrators discussed the mental health program currently offered at the university, but the program has a low participation rate and mental health issues have become a growing problem among students and academics. Yip (2016) highlighted depression and poor mental health as common mental health problems on college campuses and identified a lack of mental health support for students as one of the major risk factors for students’ suicidal thoughts and behaviors. Winzer et al. (2017) supported this lack of education around mental health and suggested changes to curriculum. Both teachers provided a unique lens for studying curriculum
change at a university. At the university, the programs offered have only been available for addressing the mental health problems and have not been an effective strategy for addressing the emotional needs of students. However, the university does not offer any mental health education for students. In some cases, mental health training was a great way to keep a student physically healthy as well as improve mental wellbeing (Reavley & Jorm, 2010). In addition, teachers indicated that there were no programs at the university for the prevention of mental disorders. However, the early prevention strategies was able to reduce risk factors of developing mental health problems and decrease the tendency towards illness contribute to the onset of some mental disorders (Marshall et al., 2005; McGorry et al., 2008). Moreover, according to the counsellors, programs at the university were focusing on counselling services with not enough counsellors, and were addressing too many implementation challenges to be effective for students who need mental health support.

Whether or not mental health education were available, the teachers discussed the importance of mental health in relation to positive thinking. Health benefits provided by positive thinking may include lower rates of depression, lower levels of stress, and better psychological and physical well-being. Sartorius (2002) defined mental health as “one state of balance in oneself and between oneself and his or her social and physical environments;” it can be interpreted as purely positive mind functioning. Nearly all participants indicated that good mental health helps people self-generate more positive emotions in daily life. In discussing individual experiences, teachers and program administrators identified that mental health screening and assessment could be useful to identify the early symptoms of mental health disorders. In addition, teachers and counsellors indicated that timely referrals could greatly improve the mental health of students and the need for mental health services at the university.
Moreover, according to the teachers’ experiences, increasing teachers’ understanding and concerns for students with mental illness means that early identification was needed to provide appropriate mental health support. This research supports McMichael and Hetzel (1975), who asserted that early intervention and prompt diagnosis to detect mental illness in an early stage could have significant impact on mental health treatment.

The theoretical framework that guided this study revealed the predictive power of the health seeking intention in relation to mental health problems, which was a useful strategy for helping educators design early intervention and prevention strategies that positively promote mental health at the university. By using the framework, educators were able to identify the key factors that influence a student’s belief in the value of the recommended action for reducing the risk of illness. For example, a high perceived susceptibility to illness may increase appropriate utilization and decrease the physical barriers to treatment. This framework was particularly useful in predicting an individual’s health behavior and in prompting a desire to make a health change. In other words, the university may reduce the need for more expensive intervention and treatment for more severe episodes of mental illness. Fazel et al. (2014) recommended a three-tiered approach to intervention and prevention that targets various needs in students’ mental health. All three tiers identify students who were at risk of mental disorder and suggest appropriate treatment intervention. The three tiers intervention strategy could allocate resources in a more effective way and reinforce continuum of care for students. Mental health intervention should be taken seriously as an integral part of the curriculum in order to reduce the impact of mental disorders on society and the university (McGorry et al., 2008). Current literature supports a different level of early intervention and prevention to support student mental health (Fazel, Hoagwood, Stephan, & Ford, 2014; Hoare et al., 2017; Winzer et al., 2017).
Program administrators and teachers indicated that the university was a great venue for using prevention and intervention strategies in teaching, educating, and promoting resilience skills to prevent or diagnose social and emotional problems among students. Existing research shows that intervention and prevention at the school level could be effective. Winzer et al. (2017) conducted a systematic literature search to examine the effect of mental health interventions on students. The review concluded that mental health intervention programs in universities led to an overall improvement in mental health knowledge and positive help-seeking attitudes among students. These findings support current research that a whole-school approach to mental health education could be effective for fostering positive mental health in a school system (Hoare et al., 2017). The World Health Organization described a whole-school approach as having a set of policies and procedures that a university community uses to facilitate the promotion of positive mental health. Changing school curriculum was one aspect of the whole-school approach, which matches teachers’ views about incorporating the complexity of the school setting when implementing mental health education. Teachers and program administrators were aware of programmatic intervention and the benefit of tiered intervention; however, there were too many different issues and students at once. Hoagwood and Erwin (1997) suggested three effective intervention strategies for improving students’ mental health in school. Mandating mental health education at the university was an effective way to break down stigma and misconceptions about mental illness. It could give educators the support they need to address the emotional needs of all of their students and improve their access to mental health care through training and education.

Conclusion
This study set out to answer the overarching research question: What is the role of the Counselling and Development Centre in encouraging student participation in a mental health enhancement program? Three main findings were drawn from an analysis of the data. First, this study recognized the influence of culture on students’ mental health perception and help-seeking behaviors. Second, the challenges of implementing mental health programs have not been addressed. Third, mental health education could lead to a university environment where students were able to recognize when they were dealing with mental health issues and feel they could ask for help. The study identified how educators worked together while implementing and coordinating the mental health program, focusing specifically on the various barriers and challenges to accessing mental health service. These findings support the health belief model, which focuses on individual constructs of beliefs and attitudes, as an effective framework for changing students’ help-seeking behavior towards mental health issues. However, the findings also highlighted that the framework was far from implementation as the challenges remain unchanged.

**Recommendations for Practice**

Several recommendations result from these findings in the areas of mental health support, change of curriculum, and program implementations. The findings were relevant to teachers, university counsellors, program administrators, and university policymakers, as well as the government.

The first recommendation from this research was that teachers, counsellors, and program administrators need additional support if they were to implement mental health programs at the university. There needs to be more discussion and support for educators from university management and the government. Discussion and advocacy should focus on the mental health of
students and the challenges the educators were facing in supporting the mental health needs of students. It should address the current literature and research about the effectiveness of early intervention. The discussion about social and cognitive aspects must be pushed mainstream, so that mental health issues could be discussed in an open forum that develops solutions to mental health problems and provides feedback on mental health education. The university must also offer professional training to teachers regarding student mental health issues to improve the mental health literacy and skills at spotting mental health problems of their students, as well as knowledge for teaching and managing students with externalized behavioral problems.

In addition to supporting the promotion of mental health education, university administrators and the government must invest in additional staff and resources in order to address the mental health needs of all students. The findings provide a challenging and negative response to the workload crisis that teachers were facing. These findings serve as a warning to the university and the government that continued increases in teacher workloads, performance targets, and curriculum changes drive many teachers out of the profession to focus on administrative work. University administrators and the government must provide additional support to reduce workload pressures, as well as take the steps that teachers think could improve the current situation. In addition, the university administrators must consider hiring additional counsellors to handle the increasing number of mental health cases, as the heavy burden on the workload of the counsellors was unavoidably affecting the quality of mental health services, in terms of the time and service the counsellors could devote to each student. Finally, in order for the HBM to be fully realized, university administrators must bring mental health awareness into the lives of all students in the university community through mental health education initiatives and dialogue, as well as the time to implement, collect, and review data.
The second recommendation of this study was that advocacy services that helping students with mental health problems and to make sure their voices heard and break down the wall of prejudice they may encounter. In order for the university to be fully aware of the mental health issues that the students were facing, students need to speak up. Advocacy services may include support to students when they feeling isolated, assistance with cultural needs, and conversations when students have repressed risks into a mental health crisis. The students need a setting where they feel comfortable and that was easy to access. Students who were suffering from mental health issues may feel shame about speaking up when they need help, as mental health topics remain a taboo topic in society and mental health treatments were known to be challenging. As one participant stated, “No one would ever tell someone with mental health problem.” Advocacy services were targeted to changing students’ perceptions on mental health issues and their help-seeking behavior in order to ensure appropriate and timely treatment by providing support and preventing issues from intensifying.

The third recommendation of this study was that university administrators must find ways to reduce the social stigma attached to mental illness. For students participating in this study, there was such a strong stigma around mental illness that people seek comfort in superstitions rather than mental health care. In addition, there were no ideas for promoting greater social equity for people with mental illnesses or contacting the stigmatized group to replace faulty perceptions in order to reduce prejudice and discrimination. Due to the catastrophic effects of mental health stigma, mental health treatments like therapy and psychotropic meditation were not common in society. University administrators must take action to reduce stigma by educating people who have mental illness, their families, peer groups, and the general public. Through
mental health education, all students will learn to accept mental health conditions, recognize the need of treatment, endorse the help-seeking intention, and improve their mental health literacy.

A fourth recommendation was that the university administrators and the government review the Hong Kong education system. The traditional education system has been criticized for its overemphasis on academic outcomes and creating unhealthy competition among students. Depression and anxiety have become a common mental health problem among university students. The possible reasons for anxiety and depression in students range from pressure over homework to exam results. In addition, the low university acceptance rate makes both students and parents experience enormous pressure. As one participant stated, “The exam and school projects were killing me.” However, society still values the traditional path of higher education far more than mental health education. These findings support that mental health education has positive impact on students’ academic achievement and social development. University administrators and the government should consider including mental health education, especially culturally relevant curricula that was both informed by culture and meets the psychological needs of students, as part of the curriculum in the Hong Kong education system.

Another recommendation of this study is the need to study the various cultural competences that support mental health practice. This research is focused on the cultural values in Chinese culture. However, a holistic approach needs to be adopted to change campus culture. Future research should note the differences between the East and the West in conceptualizing mental illness and investigate different cultural concepts to help educators develop the best mental health practices for students with different cultural backgrounds. One important note is that educators will need to access resources on a worldwide basis through attending conferences, seminars, and workshops in order to keep up-to-date mental health information for their students.
A final recommendation from this research was that the responsibly for student mental health could not rest solely with the university. Mental health was a public health issue, so advocates involve parents and families in child's education and foster relationships between home, university, and community to enhance the education of all our students. The findings have revealed the diverse effects of culture and society on mental health. Stigma reduction must start in early childhood education. Parents need to create a culturally responsive environment for children and provide support to their social and cultural development. Teachers need better training to support students with mental health needs. The university must tap into additional resources for mental health services in order to reduce the load on university counsellors. The university has launched the Mental Health First Aid program, which aims at increasing mental health literacy and enhancing students’ confidence about helping someone who was developing a mental health problem. This could be a model for sister institutions that were interested in promoting student mental health. The literature indicated that student mental health is not just a university concern, but a societal issue with ripple effects from school to the workplace and the community. All stakeholders must partner to discuss mental health issues in order to offer effective support for mental health challenges that students face today.

**Recommendations for Future Research**

A few areas were worth investigating further in order to add to the literature on the effectiveness of mental health prevention or intervention program. There needs to be more study and research into the types of mental health program that benefit the health of students. Looking at prevention and early intervention efforts were worthwhile for understanding more about the decision-making process that was required to effect change. Future research should include school-based prevention programs and the role of prevention in behavioral health to increase
students’ academic success and improve their help-seeking behaviors. Current research continues
to talk about the importance of mental health; however, this future research would identify
students who were likely to profit from preventive strategies in terms of both mental health and
physical health, and how preventive strategies enhance students’ resilience against adversity.

Additionally, since there were many students who experience mental health problems,
further insight regarding mental health clinics and different types of mental health services in the
school setting would help numerous students overcome help-seeking barriers and facilitate early
identification of mental health concerns. For example, barriers exist for families seeking mental
health support, including financial challenges, shortages of mental health providers,
transportation arrangements, time, and stigma-related concerns. Mental health support was often
unable to be obtained due to problems in reaching care services. It will be up to individual
schools to create a safe and healthy environment for addressing students’ mental health needs.

Another area that worth further study was the provision of mental health education to
students and their integration into mainstream education. This research highlighted the desperate
need for educational reform and a more enlightened education system with teaching methods that
are less exam-driven. Mental health education must be made compulsory in all schools in Hong
Kong, given growing concerns about mental health problems. A way to introduce fundamental
education reform may be to conduct a larger quantitative study that would include the voices of
teachers, students, parents, and society. Additional research could reference the education model
for mental health at school and help university educators create a more robust conception of
future education development.

The final area worth investigating was the experience of psychiatric patients. The voice
and perspective of such patients was missing from this research. This research highlighted
educator and student perspectives about the implementation of a mental health program at the university. Future research should focus on psychiatric patients’ perspectives on stigma and discrimination as well as behavioral change surrounding mental health stigma, identifying why seeking help was difficult, and the recovery from a mental health condition was long and complex. Additional research on recovery from mental illness could let students know that psychiatric patients could recover from mental illness to lead full and satisfying lives.

**Conclusion**

The recommendations of this study flowed from the literature; health belief model; and the experience of university counsellors, teachers, program administrators, and students. If these recommendations were implemented, it was possible to reduce the stigma around mental illness and improve students’ access to mental health services at the university. If mental health education were incorporated into the existing education system through implementation of HBM, schools were well on their way to creating a less stigmatized and more caring culture within the university that were responsive to students’ mental health concerns.

This research has provided a deeper look into the challenges facing educators when implementing a mental health program at the university. It identified both the challenges that the educators face when trying to give mental health support to the students and the students’ shared experience of participating in the mental health program. This study allowed the researcher to grow as an educational leader and understand more about the type of prevention and intervention needed to create a system that helps students before they reach a mental health crisis.

As student mental health issues continue to increase and the demand for mental health services on campuses continues to grow, schools will continue to be called upon to provide mental health support to their students. Educators and schools need to be up-to-date on the most
current practices to support students, especially those who have mental health concerns. While these findings do not mention education reform, they provide a community starting point for future education developments that were needed to respond to the increasing mental health needs of students in Hong Kong.
Appendix A

Permission Letter to Conduct Research in School

Dear Mr. Cheng,

My name is Rebecca and I am a doctoral student at Northeastern University (NEU) and I am working on my dissertation. Currently I am working on a thesis proposal to study the mental health program in university campus. The purpose of this letter is to request permission to conduct a research study at your University.

My interest is to study the mental health issues in the university, in particular, to understand the mental health perception from various perspectives. My plan is to focus on how program administrators, along with the teachers and counsellors, contributed to implementing the mental health enhancement program at the university. Data will be collected from a small group of approximately six staff members (6 individual interviews) and twelve students (2 focus groups). The voluntary participants will be a combination of administrators, teachers, counselors and students. Following your approval, I will apply to the NEU Internal Review Board for further approval to conduct research with human subjects.

The proposed study will examine how program administrators, staff and university counselors worked together while implementing and coordinating the mental health enhancement program, focusing specifically on the various barriers and challenges to accessing mental health service on a university campus. The study will explore, through the lens of students, how the Counseling and Development Centre is successful in improving students’ access to mental health services on university campus.

Please contact me directly at (852) 9736-8170 or if you have additional questions. Thank you in advance for your time and consideration. I look forward to hearing from you regarding this request.

Respectfully,

Doctoral Candidate 2018
Appendix B

Recruitment Letter – Individual Interview

Dear Administrators, Teachers and Counselors:

My name is Rebecca and I am a doctoral student at Northeastern University (NEU) in Boston and I am working on my dissertation. I am asking that you consider participating in the study. Your participation is completely voluntary and if you decide to participate, you may opt out of the study at any time.

The title of the research is *Improving Student Access and Utilization of Mental Health Services on a University Campus at a public university in Hong Kong*. The purpose of this study is to identify how program administrators, teachers and university counselors worked together while implementing and coordinating the mental health enhancement program, focusing specifically on the various barriers and challenges to accessing mental health service. Data collection will include individual interviews, focus groups and a review of training materials. There will be one individual interview per participant. Each individual interview will take approximate one hour and the focus group will be about one- and one-half hours long. I would like to interview two administrators, two teachers, two counselors individually and approximate twelve students in two focus groups. All interviews and the focus group will be held after the school day at a mutually agreed location.

Your participation is important to the success of the research study and all of your responses are confidential. I will never use your name in a study report, and I will never share your personal facts or contact information with anyone else. I store all study information in secure facilities on locked systems and destroy personal data after the study is complete. Your participation is completely voluntary, you may stop participating at any time and you may decide not to answer any specific question.

Please contact me at (852) 9736-8170 or choy.b@husky.neu.edu if you are interested in participating in this study or would like a copy of this consent letter. Thank you for your attention and consideration.

Thank You,

Doctoral Candidate 2018
Dear Administrators, Teachers, Counselors and Students:

Thank you for your interest in participating in the individual interview for the study on Improving Student Access and Utilization of Mental Health Services on a University Campus.

The individual interview is planned to occur in Hong Kong after the school day between January and June 2019. Each interview will be made of people with similar experiences regarding the mental health enhancement program organized by the Counselling and Development Center, in order to develop knowledge about the processes involved in implementation and experience after the completion of program.

The Informed Consent Form is attached for your easy reference. The information collected in this study will remain confidential and will only be used to for this doctoral thesis project.

I appreciate your honesty and willingness to assist with this important research. If you have any questions about the individual interview, please contact me at (852) 9736-8170 or choy.b@husky.neu.edu.

Thank You,

Doctoral Candidate 2018

College of Professional Studies
Northeastern University
Appendix D

Interview Protocol – Individual Interview

Time of Interview:

Date:

Interviewer:

Interviewee: (Administrators, Teachers or Counselors)

The purpose of this study is to identify how program administrators, staff and university counselors worked together while implementing and coordinating the mental health enhancement program, focusing specifically on the various barriers and challenges to accessing mental health service.

The purpose of this study is to identify how program administrators, teachers and counselors worked together while implementing and coordinating the mental health enhancement program, focusing specifically on the various barriers and challenges to accessing mental health service. Data collection will include individual interviews with program administrators, teachers and counselors with last approximate 1 hour.

Part I: Introductory Question Objectives (5-10 minutes). Build rapport, describe the study and answer any questions (informed consent form will be reviewed and sign here).

Thank you very much for taking the time to talk with me today. As the email mentioned, the purpose of this study is to identify how program administrators, teachers and university counselors worked together while implementing and coordinating the mental health enhancement program. Your insights into this issue will help me to better understand the challenges or opportunities that the university community is facing. Any details which might identify you will not be shared with other individuals. You should feel free not to provide any information you do not wish to share with me or to end the interview at any time. If you wish to end the interview early, any information you have provided up to that point will be included in the study data unless you ask me not to include it. If it’s okay with you, I will be tape recording our conversation since it is hard for me to write down everything while simultaneously carrying an attentive conversation with you. Do I have your permission to record this interview? (if yes, thank the participant and turn on the recording equipment; if no, I will take notes instead). I will also be taking written notes during the interview. I can assure that everything you say will remain confidential and only a pseudonym will be used when quoting from the transcripts. The audio recordings will be destroyed after the after transcribed and I
will be the only person who have access to the data. Do you have any questions about the purpose or the process of this interview?

To meet out ethics requirements at the university, you must sign the consent form I have with me (see Appendix E). Essentially, the consent form tells you important information about this research study. Please feel free to look over the consent form and ask any questions that you may have about this form or the interview process?

The interview will last approximately one hour. During the interview process, I have several questions that I would like to cover. If you do not wish to answer a question, you may skip it and go to the next question or stop the interview at any time. Do you have any questions at this time?

**Part II: Objectives (50 minutes):** Obtain the participant’s insight, in his/her own words, into their experiences in implementing the mental health enhancement on the university campus.

I would like to hear about your experiences in your own words. To do this, I am going to ask you some questions about your background information or experiences that you have when implementing or designing the mental health enhancement program.

Questions for individual interviews:

**Background Information**

Gender:

Race:

Ethnicity

What is the highest level of education that you have completed?

What area of specialty is your degree in?

What is your current job title?

How long have you worked in your current position?

What is the role(s) you played in implementation of mental health enhancement program?

(Administrators/teachers/counsellors)

What past experience(s) prepare you for this role?

**Individual Perspective**
1. What is your definition of mental illness?

2. What aspect or goal of mental health is most important to you?

3. How does culture affect mental health perception?

4. To what extent, do you agree social stigma and discrimination make mental health issues are on the rise?

**Program Development**

5. What types of programs does the Centre offer and why?

6. How the program can help students with mental health problems?

7. What are the perceived needs, challenges and opportunities of the Centre when promotion the program?

**Experiences**

8. Tell me about a time when you had to approach students with mental health needs. What kinds of problems did you have to overcome in order to help the students?

9. How did you handle interactions with students have mental health problems? What was the outcome?

**Future Planning**

10. What do you think the university can do in the future to improve the student’s access to mental health services in school?

*Wrap up – That’s concludes the questions for today’s interview. Before we wrap up, do you have any questions?

Thank you for your willingness to participate in this research study.*
Appendix E

Signed Informed Consent Form – Individual Interview

Northeastern University, College of Professional Studies

Investigator Name:  Principal Investigator – Dr. Daniel Volchok
                       Student Researcher – Bayee Rebecca Choy

Title of Project: *Improving Student Access and Utilization of Mental Health Services on a University Campus*

You are invited to participate in a research study conducted at Hong Kong Baptist University. This form has important information about the reason for doing this study. Please read this form carefully and ask any question you may have before agreeing to take part in this study.

**Why am I being asked to take part in this research study?**

The program administrator, staff, and school counselor who were involved in implementing the mental health enhancement program will be recruited to participate in this study. The proposed sample included administrators, teacher educators and counselors. I will gather their perspectives and understandings in order to describe the perceived needs and challenges when implementing the program on a university campus. I proposed to conduct six individual interviews, including two administrators, two teacher educators, and two counselors. Participants have all participated in implementing the mental health enhancement program at the university. Age, gender, ethnicity/race, socio-economic status, education level, and health will not limit inclusion in this study.

**Why is this research study being done?**

The purpose of this study is to identify how program administrators, teachers and university counselors worked together while implementing and coordinating the mental health enhancement program, focusing specifically on the various barriers and challenges to accessing mental health service. The procedure will be a single case study conducted at a public university in Hong Kong that has implemented the mental health enhancement program.

**What will I be asked to do?**

The researcher will be looking for you to participant in the following ways:
1. Either participate in an individual interview that will be audio taped
2. Participate in a member checking process to verify the consents of the interviews and interpretations of the primary research.
3. The researcher will collect field notes.
4. The researcher will review the program documents.

Your participation is voluntary and you can opt out at any time without penalty.

**Where will this take place and how much will it take?**

Individual interviews will take approximately one hour each and take place after school. The time and location of the meeting should be decided keeping in view the convenience of the participants. Locations for the interviews may include the conference room or meeting room in campus or held at an alternatives site at the convenience of the participants.

**Will there be any risk or discomfort to me?**

There are no physical risks associated with this study.

**Will I benefit by being in this research?**

There are no direct benefits offered to participants. Potential benefits to others include community and universities in Hong Kong.

Potential benefits to community include a better understanding of students’ perspectives on issues related to mental health and well-being, such as students’ perceptions of factors that act as potential barriers to the utilization of mental health services, which could raise community awareness on the value of mental health prevention and healthy lifestyles.

Potential benefits to the universities in Hong Kong that implement mental health education: the recommendations may assist the principal and institutions to get recognition for the mental health education, and to improve the mental health program and make them more effective.

**Who will see the information about me?**

Your part in the study will be completely confidential. Pseudonyms will be used for all study participants. Only the researcher has access to the data. No identifiable description or characteristics, such as the participant’s name, the name of the school, or the exact location of the study, will be mentioned in the study or publications.

**If I do not want to take part in the study, what choices do I have?**

If you do not want to participate in this study, you do not have to sign this form.
What will happen if I suffer any harm from this research?

There are no known significant risks involved in being a participant in this study.

Can I stop my participation in this study?

Your participation is completely voluntary and you may stop participating at any time without penalty.

Who can I contact if I have questions or problems?

Please contact Bayee Rebecca Choy at (852) 9736-8170 or via email at choy.b@husky.neu.edu or Dr. Daniel Volchok who is overseeing my research at d.volchok@northeastern.edu if you have any questions about this study.

Who can I contact about my rights as a participant?

If you have any questions about your rights as a participant, you may contact Nan C. Regina, Director, Human Subject Research Protection, 360 Huntington Avenue, Mail Stop: 560-177 Boston, MA 02115, Tel: (617) 373-4588, Email: n.regina@northeastern.edu. You may call anonymously if you wish.

Will I be paid for my participation?

You will be offered a coupon for $100 Hong Kong dollars or the U.S. equivalent ($12.50) as gratitude for their assistance and participation in the study.

Will it cost me anything to participate?

There is no cost to participate in this study.

I have read, understood, and had the opportunity to ask questions regarding this consent form. I fully understand the nature and character of my involvement in this research program as a participant and the potential risks. I agree to participate in this study on a voluntary basis and understand that I can depart from the research study at any time.

________________________________
Research Participant (Printed Name)

________________________________                                               ___________________
Research Participant (Signature)                                                           Date
Appendix F

Recruitment Letter – Focus Group

Dear Students,

My name is Rebecca and I am a doctoral student at Northeastern University (NEU) in Boston and I am working on my dissertation. I would like to invite you to take part in a focus group about the use of mental health service on a university campus. The focus group should last no longer than one and a half hours.

The focus group will provide an opportunity for you to share your experiences with and thoughts about the Mental Health Enhancement Program organized by the Counseling and Development Center and your mental health perception, in a casual environment and with complete confidentiality. Your participation is important to the success of the research study and all of your responses are anonymous.

If you would like to take part in the focus group, please let me know by contacting me at (852) 9736-8170 or choy.b@husky.neu.edu. To compensate you for your time, all attendees will receive a coupon for $100 Hong Kong dollars.

We hope that you will be able to join us for this important discussion.

Thank You,

Doctoral Candidate 2018

College of Professional Studies

Northeastern University
Appendix G

Follow-Up Recruitment Email – Focus Group

Dear Students,

Thank you for accepting my invitation to talk about the Mental Health Enhancement Program organized by the Counselling and Development Center. The focus group discussion is planned to hold after the school day between January and June 2019. It will be a small group, about six people.

The Informed Consent Form is attached for your easy reference. The information collected in this study will remain confidential and will only be used to for this doctoral thesis project.

I appreciate your honesty and willingness to assist with this important research and we will have a coupon of $100 for you at the end of the session. If for some reason you won’t be able to join us, please call as soon as possible so we can invite someone else. If you have any questions, please contact me at (852) 9736-8170 or choy.b@husky.neu.edu.

Thank You,

Doctoral Candidate 2018

College of Professional Studies

Northeastern University
Appendix H
Signed Informed Consent Form – Focus Group

Northeastern University, College of Professional Studies

Investigator Name: Principal Investigator – Dr. Daniel Volchok
Student Researcher – Bayee Rebecca Choy

Title of Project: Improving Student Access and Utilization of Mental Health Services on a University Campus

You are invited to participate in a research study conducted at Hong Kong Baptist University. This form has important information about the reason for doing this study. Please read this form carefully and ask any question you may have before agreeing to take part in this study.

Why am I being asked to take part in this research study?

Undergraduates who were completed the mental health program will be recruited to participate in a focus group discussion. The proposed sample included both local students and international students. I proposed to conduct 2 groups of 6 people for a discussion. Participants have all completed the mental health enhancement program organized by the Counseling and Development Centre. The participants will be of a traditional undergraduate college age, approximately 18 to 25 years old. Gender, ethnicity/race, socio-economic status, education level, and health will not limit inclusion in this study.

Why is this research study being done?

The purpose of this study is to investigate the experiences of student’s participation in a mental health enhancement program and examine the impact of the program on students' perceptions of the mental health. The procedure will be a single case study conducted at a public university in Hong Kong that has implemented the mental health enhancement program.

What will I be asked to do?

The researcher will be looking for you to participate in the following ways:

1. Participate in a focus group discussion of no more than twelve participants that will be audio taped.

2. Participate in a member checking process to verify the consents of the interpretations of the primary research.

3. The researcher will collect field notes.
4. The researcher will review the program documents.

Your participation is voluntary and you can opt out at any time without penalty.

**Where will this take place and how much will it take?**

The focus group discussion will last approximately one and a half hours and take place after school. The time and location of the meeting should be decided keeping in view the convenience of the participants. Locations for the focus group may include the conference room or meeting room in campus or held at an alternatives site at the convenience of the participants.

**Will there be any risk or discomfort to me?**

There are no physical risks associated with this study, but there is a possible risk of loss of confidentiality or privacy due to focus group setting. Participants will be informed prior to the beginning of the focus group that confidentiality cannot be guaranteed in a group setting, however, participants will be asked to keep information shared during the session private.

**Will I benefit by being in this research?**

There are no direct benefits offered to participants. The anticipated benefits to participating in this study are to learn more about a mental illness and understanding the influence of culture on the help-seeking intention.

**Who will see the information about me?**

Your part in the study will be completely confidential. Pseudonyms will be used for all study participants. Only the researcher has access to the data. No identifiable description or characteristics, such as the participant’s name, the name of the school, or the exact location of the study, will be mentioned in the study or publications.

**If I do not want to take part in the study, what choices do I have?**

If you do not want to participate in this study, you do not have to sign this form.

**What will happen if I suffer any harm from this research?**

There are no known significant risks involved in being a participant in this study. However, the nature of focus groups prevents the researcher from guaranteeing confidentiality. Researchers will remind participants to respect the privacy of fellow participants and not repeat what is shared in the focus groups to others. Researchers will keep my name or any information that may identify me confidential in any reports or transcripts. Researchers will store or archive data in a secure and locked file cabinet.
Can I stop my participation in this study?

Your participation is completely voluntary and you may stop participating at any time without penalty.

Who can I contact if I have questions or problems?

Please contact Bayee Rebecca Choy at (852) 9736-8170 or via email at choy.b@husky.neu.edu or Dr. Daniel Volchok who is overseeing my research at d.volchok@northeastern.edu if you have any questions about this study.

Who can I contact about my rights as a participant?

If you have any questions about your rights as a participant, you may contact Nan C. Regina, Director, Human Subject Research Protection, 360 Huntington Avenue, Mail Stop: 560-177 Boston, MA 02115, Tel: (617) 373-4588, Email: n.regina@northeastern.edu. You may call anonymously if you wish.

Will I be paid for my participation?

You will be offered a coupon for $100 Hong Kong dollars or the U.S. equivalent ($12.50) as gratitude for their assistance and participation in the study.

Will it cost me anything to participate?

There is no cost to participate in this study.

I have read, understood, and had the opportunity to ask questions regarding this consent form. I fully understand the nature and character of my involvement in this research program as a participant and the potential risks. I agree to participate in this study on a voluntary basis and understand that I can depart from the research study at any time.

________________________________
Research Participant (Printed Name)

________________________________
Research Participant (Signature) Date
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