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### Association Between Adolescents Perceived for Behaviour In Accessing Mental Health Services

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#### Abstract

The government of Indonesia provides programs to make it easier for adolescents to access mental health services. Adolescents are very vulnerable to mental and emotional health disorders, but there is low coverage of mental health services in primary health care. This study uses the theory of health belief models to examine how adolescents perceive having access to mental health services. This study used a cross-sectional design for 55 unmarried adolescents (15-24 years old) in Yogyakarta with a total sampling technique. Most adolescents (83.6%) perceive many barriers to accessing mental health services, so their self-efficacy becomes low (53.7%). Nevertheless, they have cues to act reasonably well (58.2%). Adolescents who perceive barriers ( $p$ -value = 0.007) and cues to action ( $p$ -value = 0.031) have a significant relationship with the behaviour of accessing mental health services. Meanwhile, perceived susceptibility ( $p$ -value = 0.909), perceived severity ( $p$ -value = 0.420), perceived benefits ( $p$ -value = 0.980), and self-efficacy ( $p$ -value = 1,000) did not have a significant relationship. The findings demonstrated that adolescents have sound cues to action in accessing mental health services, but low self-efficacy is thought to be the barrier.

#### Introduction

Mental health is the most crucial aspect of achieving complete health. Physical and mental wellness are equally vital. According to the World Health Organization (WHO), health is an excellent physical, psychological, and social condition, not only the absence of disease or weakness (WHO, 2013). The suicide rate in Indonesia is 11.4% per 100,000 people, possibly due to a lack of psychological support and proper health care (Kementerian Kesehatan Republik Indonesia, 2018). The number of people aged 15 and up who suffer from mental and emotional illnesses was 19 million. Meanwhile, up to 12 million people suffer from depression (Purwaningsih & Nurmala, 2021), and as many as 7 out of 1000 families have family members who have schizophrenia ((Kementerian

Kesehatan Republik Indonesia, 2018). Mental and emotional illnesses affect 14% to 20% of adolescents, and 50% of all cases identified with mental-emotional illnesses began before age 14, and three-quarters began before age 24 (Saam & Guidance, 2017). Adolescent health concerns physical changes, psychological problems, emotions, and intellect that can lead to conflict within adolescents; impact health is quite an issue today. Nowadays, we frequently hear about the prevalence of adolescent brawls, promiscuity, and even stress leading to suicide due to uncontrolled adolescent psychology and emotion. If we can identify the source of the problem, we can prevent it from recurring with proper treatment. The problem of Internet gaming disorder must be a concern of government and cross-sectoral to prevent the

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4 development of this problem in Indonesia as a protective way for adolescents. Internet gaming disorder is one of mental disorder (Arnani, 2021). Adolescents with online game addiction could increase mental health disorders by 1.57 times more than adolescents without online game addiction (adjusted odd ratio = 1.57 (1.28–1.94);  $p \leq 0.001$ . with internet game disorder, 21.7% had moderately severe/severe depression, and 11.4% had severe anxiety (Alhamoud *et al.*, 2022; Purwaningsih & Nurmala, 2021). Thus, the significance value of  $p = 0.000$  between cyberbullying and mental health. It can be interpreted that there is a relationship between cyberbullying victimization and mental health in adolescents (Ningrum & Amna, 2020).

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Similarly, the Special Region of Yogyakarta has a 10% prevalence of mental and emotional illnesses. Mental and emotional illnesses affect one out of every 1,000 people over 15. One person suffers from emotional and mental illnesses (Health Office of Special Region of Yogyakarta, 2018). DIY is currently the second province with the highest number of cases of severe mental problems after Bali (Safitri, 2016). Adolescent mental health cases are increasing, as are mental health services (MHS). Counselling is included in MHS for adolescents, and Primary health care (PHC) provides it. MHS, on the other hand, have not been fully utilized. MHS is not being implemented in every PHC. Another reason is the number of health workers and the knowledge of adolescents, who are still less concerned about mental health, making it harder to recognize and treat mental health cases correctly (Orji *et al.*, 2012)

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Individual behaviour in seeking treatment in health services is relatively low. Individuals still have a vulnerable perception of the behaviour of accessing health services (Az Zachra, 2019). Adolescents prefer to access online mental health information rather than coming to MHS. They perceived themselves to have relatively high digital health literacy, rating themselves at a mean score of 3.7 (SD = 0.5) out of 5, indicating a strong sense of self-efficacy. However, if they felt anxious or relieved after finding online health information, they rarely discussed findings with health professionals, even though they were open to discussing and

helping them find information online correctly (Taba *et al.*, 2022).

According to the findings of a preliminary survey among adolescents in Yogyakarta, there were around five people with mental problems. The municipal government's strategy for dealing with this problem is to hold MHS socialization. Youth representatives attended The function only (Annisa & Nurmala, 2018). Meanwhile, early detection results on 64 teens revealed that 15.6%, or up to ten teenagers, experienced severe depression, 10.9%, or seven teenagers, experienced anxiety, and 6.3%, or four teenagers, experienced anxiousness (Ningrum & Amna, 2020). Adolescents in Yogyakarta are under much pressure; although psychological services are available at the PHC, they are underutilized. Furthermore, the Youth Information and Counseling Center is an excellent place for adolescents to talk about everything youth-related, including adolescent mental health. This study is critical to conduct with teenagers in Warungboto because it can provide an overview of teenagers' perceptions regarding access to mental health so that solutions and alternative solutions can be created to solve the problem of access to mental health services for teenagers, which is still low. It is hoped that this research can provide input for service providers to provide adolescent mental health services according to the needs of adolescents in the area.

Most adolescents regard mental illness as a severe issue. They believe religious rites can alleviate mental illnesses (Onoruoiza *et al.*, 2015). A study into the behaviour of adolescents seeking MHS is required. This study describes adolescent perceptions toward MHS access. Adolescents' perceptions of the seriousness and susceptibility to mental health illnesses are used to make the assessment. The study was then repeated to assess teenagers' perceptions of the benefits and barriers to obtaining MHS. Furthermore, the study examined teenagers' self-efficacy and cues to action in accessing MHS. It evaluated adolescents previously examined for early diagnosis of mental health problems in earlier trials. This is advantageous in this study because adolescents' mental health status is more intimately related to their perceptions of MHS.

## Methods

This is a quantitative study with a cross-sectional approach. Participants are 55 unmarried adolescents aged 15 to 24 and youth organisation members in Warungboto, Yogyakarta. The respondent's inclusion criterion is to be willing to engage in this study by thoroughly completing the questionnaire, having lived in Yogyakarta for at least the last six months, and being fluent in Indonesian. Participation did not highlight the history of access to teenage mental health treatments. For two months (August - September 2020), they completed online surveys using a total sampling technique to acquire primary data. The link to the questionnaire was sent to respondents, who were then taken to a page with details about the study and their position as participants. They then forwarded participants to the previous consent form. If so, it went on to complete the questionnaire. The research team presented a reward in the form of digital currency to the participants as a token of appreciation.

The research team designed the questionnaire, information sheets, informed consent, and online survey. Data were collected using a self-administrated questionnaire in eight sections as follows: Part (A) had sociodemographic characteristics (age, sex, education level, and regular activities); Part (B) involved the behaviour of access to MHS; Part (C) comprised perceived susceptibility related to mental health disorder among adolescents; Part (D) identified perceived severity of adolescents related to mental health disorder; Part (E) explored perceived of benefit to access adolescents MHS; Part (F) mentioned perceived barriers to access MHS; Part (G) was clarified cues to action among adolescents, and part (H) confirmed the self-efficacy of adolescents to access MHS in their city. The questionnaire tested its validity and reliability. It was carried out on thirty adolescents at Jogokariyan Village, Yogyakarta, who were in different locations but had similar characteristics to the participants. Each question item in the questionnaire was tested using product moment for validity and Cronbach's alpha for reliability. If the value of  $p > 0.3$ , then it is declared valid and if the value of  $p > 0.6$  is declared reliable. The fourteen questions about adolescent behaviour in using

MHS were all deemed valid. There is only one question on the perceived hurdles to getting MHS that is invalid from the twelve questions about the perception of teenage susceptibility to mental disorders. Up to three items are invalid on perceived rewards, perceived seriousness, and cues to act. Two questions on the self-efficacy variable, however, are invalid. The question is removed from the study and not used if the question item is invalid. When all of the variables were shown to be reliable by statistical testing, the same was valid for reliability.

Data were coded and entered into SPSS v22.0 for data analysis. We used the chi-square test for standard data and the Spearman rank test for abnormal data. Chi-square tests were employed to investigate the bivariate relationship between outcome variable behaviour of accessing MHS towards independent variables, specifically perceived susceptibility, perceived severity, perceived benefits, cues to action, and self-efficacy. The variable of perceived barriers was tested with Spearman rank. The Research Ethics Committee of Universitas Ahmad Dahlan approved this protocol, 012008035, on September 4, 2020. Research explanations and consent from participants have been carried out before the study. This was an anonymous survey, and participation was voluntary. All the data of participants were strictly kept confidential.

## Results and Discussion

This study uses the theory of health belief models (HBM) to examine how adolescents perceive having access to MHS. Depression and anxiety disorders are adolescents' most common mental health disorders, with estimated prevalence rates of 5% and 8%, respectively (Lawrence *et al.*, 2015; Polanczyk *et al.*, 2015; Sadler *et al.*, 2018). However, hardly two-thirds of adolescents with anxiety or depression seek and receive professional care. Only a tiny percentage of young people receive MHS (Lawrence *et al.*, 2015; Sadler *et al.*, 2018). As a result, this study focuses on examining teenage behaviour in accessing MHS. Adolescents' judgments of susceptibility and severity in coping with mental health illnesses are referred to as assessment and adolescents'



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perceptions of the benefits and barriers of MHS access (Syamlan *et al.*, 2022). This study will also evaluate self-efficacy and cues to action.

Of 55 participants, most belonged to late teens (17-24 years). The age category is divided into early adolescents (15-16 years) and late adolescents (17-24 years) based on the Minister of Health regulation number 25 of 2014. Only 17% of the participants were female, and 49.1% were students at elementary to junior high school (Table 1). However, 40% said they had worked. According to their confession, half of the participants have one to more than two communities they join in their leisure time. They recognize that participation in the

community can be stress-coping when facing a problem. The median score of the behaviour variable was 4 (SD=2.679), and the mean score was 4.4. Half of the participants have poor behaviour in accessing health services. They do not attend adolescent MHS. Mental health issues have never been obtained from schools. In addition, they also prefer to discuss with friends and look for online information sources rather than coming to health services or discussing with parents.

Some adolescents have an excellent perceived susceptibility to mental health disorders (Table 1). They consider that accessing MHS routine is one way to avoid mental health

Table 1. Sociodemographic and HBM Variables Summary of Participants (N=55)

| Characteristics                   | Overall (%) | Mean ±SD    | Median ±SD  | P     | CI                      | r      |
|-----------------------------------|-------------|-------------|-------------|-------|-------------------------|--------|
| <b>Age (years)</b>                |             | -           | -           | -     | -                       | -      |
| 15-16                             | 12,7        |             |             |       |                         |        |
| 17-24                             | 87,3        |             |             |       |                         |        |
| <b>Sex</b>                        |             |             |             |       |                         |        |
| Male                              | 69,1        |             |             |       |                         |        |
| Female                            | 30,9        |             |             |       |                         |        |
| <b>Education level</b>            |             |             |             |       |                         |        |
| Less than high school             | 49,1        |             |             |       |                         |        |
| High school/ university           | 50,9        |             |             |       |                         |        |
| <b>Employment status</b>          |             |             |             |       |                         |        |
| Unemployed                        | 60          |             |             |       |                         |        |
| Employed                          | 40          |             |             |       |                         |        |
| <b>Behaviour in accessing MHS</b> |             | 4.44        | 4±2.679     | -     | -                       | -      |
| Good                              | 58,2        |             |             |       |                         |        |
| Poor                              | 41,8        |             |             |       |                         |        |
| <b>Perceived susceptibility</b>   |             | 31.64±3.884 | 32.00       | 0,909 | 0,884<br>(0,473- 1,650) | -      |
| Good                              | 50,9        |             |             |       |                         |        |
| Poor                              | 49,1        |             |             |       |                         |        |
| <b>Perceived severity</b>         |             | 34.84       | 34±4.017    | 0,420 | 1,409<br>(0,757- 2,621) | -      |
| Severity                          | 56,4        |             |             |       |                         |        |
| No severity                       | 43,6        |             |             |       |                         |        |
| <b>Perceived benefits</b>         |             | 36.20       | 36±4.089    | 0,980 | 1,100<br>(0,590- 2,050) | -      |
| Good                              | 54,5        |             |             |       |                         |        |
| Poor                              | 45,5        |             |             |       |                         |        |
| <b>Perceived barriers</b>         |             | 43.53       | 46±7.489    | 0,001 |                         | -0,450 |
| Many barriers                     | 83,6        |             |             |       |                         |        |
| No barriers                       | 16,4        |             |             |       |                         |        |
| <b>Cues to action</b>             |             | 32.89±3.253 | 33.00       | 0,031 | 2,164<br>(1,137- 4,119) | -      |
| Good                              | 58,2        |             |             |       |                         |        |
| Poor                              | 41,8        |             |             |       |                         |        |
| <b>Self Efficacy</b>              |             | 27.31       | 27.31±2.993 | 1,000 | 0,978<br>(0,524- 1,825) | -      |
| Good                              | 47,3        |             |             |       |                         |        |
| Poor                              | 53,7        |             |             |       |                         |        |

N number of participants

Source: Primary Data, 2020.

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problems. In contrast, the disorder will worsen if they do not get professional help immediately. Participants who perceived susceptibility to poor behaviour as much as 11 (39.3%) is smaller than good behaviour as many as 17 (60.7%) (Table 2). Similar results were also shown in the variable perceived severity of mental health disorders and perceived benefits in accessing adolescent MHS. Some participants feel that mental health disorders are a severe problem, but not for others. They also think mental health disorders can interfere with daily activities and social relationships with others. Adolescents perceive that the benefit of accessing MHS is that they can perform early detection or screening related to their mental health status. This can add value to them, mainly supported by high self-efficacy. However, the results of this study reported that participants' self-efficacy did not have a significant relationship with behaviour in accessing MHS (p-value=1.000). Of participants with low self-efficacy and poor behaviour, as many as 12 people are smaller than participants with low self-efficacy but behave as well as 17 people.

On the other hand, these results can be masked by high cues to act so that adolescents can behave well (p-value=0.031). Fourteen participants did not have cues to action with poor behaviour compared to the participants who did not have good behaviour and sound cues to action, many as nine people (Table 2). They often seek mental health information online and attend health services on their initiative. Meanwhile, adolescents feel they have many barriers to accessing health services (Table 1). The median score was 46 (SD=7.489), and the mean score was 43.53. Adolescents feel that mental health is not an important issue. Spearman's rank test shows a correlation r value of -0.450 with moderate relationship strength. However, the p-value indicates a significant relationship between perceived barriers and behaviour in accessing MHS (Table 1). In addition, they are afraid of being stigmatized and lazy, and they claim to be busy and do not have time to come to professional services. Adolescents more often share experiences with friends to find solutions to their problems.

Table 2. The Results of Correlation Among Study Variables

| Variable                 | Category | Behaviour in Accessing MHS |      |      |      |
|--------------------------|----------|----------------------------|------|------|------|
|                          |          | Poor                       |      | Good |      |
|                          |          | n                          | %    | n    | %    |
| Perceived susceptibility | Poor     | 12                         | 52.2 | 15   | 46.9 |
|                          | Good     | 11                         | 47.8 | 17   | 53.1 |
| Perceived severity       | Poor     | 12                         | 52.2 | 12   | 37.5 |
|                          | Good     | 11                         | 47.8 | 20   | 62.5 |
| Perceived benefits       | Poor     | 11                         | 47.8 | 14   | 43.8 |
|                          | Good     | 12                         | 52.2 | 18   | 56.3 |
| Self-efficacy            | Poor     | 12                         | 52.2 | 17   | 53.1 |
|                          | Good     | 11                         | 47.8 | 15   | 46.9 |
| Cues to action           | Poor     | 14                         | 60.9 | 9    | 28.1 |
|                          | Good     | 9                          | 39.1 | 23   | 71.9 |

Source: Primary Data, 2020.

According to the chi-square test, only one variable corresponds with teenage behaviour in accessing MHS. Cues to action are experiences, events, physical symptoms, or the surroundings that motivate people to act. Individual interpretations of action cues are believed to drive people to engage in healthy behaviours. It will be easier to take action if the individual already has confidence. The signal to act is Health motivation, which refers to the disparity between persons regarding health quality and readiness to be motivated to maintain health. Individuals driven to maintain their health are prompted to engage in health-related behaviours (Conner, M., & Norman, 2017). A similar study found that acting is closely associated with follow-up medication behaviour in depressed cases. Cues to action that initiate disease-relief measures. Cues to action include a recent visit to a doctor (e.g., a primary care doctor) and the level of nonclinical emotional health assistance. Primary care practitioners were cited as a vital cue to action (Lilly *et al.*, 2020; Nobiling & Maykrantz, 2017).

Furthermore, this study found a link between perceived barriers to behaviour and teenage MHS access. The Spearman's rank test demonstrated this association. One HBM theory component that harms individuals who are barriers to healthy behaviour is perceived barriers. The HBM theory's goal in dealing with health problems is individuals' perceived barriers to change. Individuals will assess the difficulties encountered. Individuals who are perceived to be impediments are evaluated by modifying their conduct. The obstacles

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determine individual conduct people exist (Buglar, M.E., White, K.M., Robinson, 2010). The correlation coefficient value of 0.450 suggests the variables have a strong association. However, the link is skewed, meaning adolescents who see numerous barriers to MHS will act out (Doll *et al.*, 2022). Adolescents are unclear whether they want professional assistance with their problems. A preference to rely on oneself is a crucial obstacle preventing adolescents from seeking professional help. According to some parents, adolescents may have inherited this coping method after witnessing their parents. Older teenagers and adolescents who have never sought professional help appear to be particularly anxious about dealing with their difficulties on their own and feel 'too proud' to seek professional assistance (Radez, Reardon, Creswell, Orchard, *et al.*, 2021). A person's perceived benefit is the benefit they feel when they make a preventive effort. People who believe they are vulnerable to disease will respond with the anticipated benefits.

Adolescents do not yet believe in the serious consequences of mental health illnesses; thus, they do not need services. Depression and other mental illnesses, according to one respondent, were not as severe as mental disorders. Adolescents can handle difficulties by themselves without the assistance of MHS (Widati & Siddiq, 2022). According to the findings of the meta-analysis, teenagers face barriers due to a lack of understanding about mental health and access to MHS (Putri *et al.*, 2021; Radez, Reardon, Creswell, Lawrence, *et al.*, 2021; Shi *et al.*, 2020). Furthermore, teenagers' lack of understanding of mental health causes them to have a negative perspective of their vulnerability and the significance of being affected by mental health illnesses. The findings show that teenagers who believe they are not at risk for mental health illnesses have limited access to these services. The same is true for adolescents who believe that mental health illnesses do not have significant consequences.

One of the most essential perceptions for adolescents to embrace healthy activities is their perceived susceptibility. Adolescents with poor susceptibility may dispute that they are at risk of acquiring mental illnesses. As

a result, these teenagers can participate in non-access to MHS behaviours. As a result, teenagers are less likely to want to attend MHS (Efendi *et al.*, 2022). Adolescents with a strong perception of vulnerability are more likely to be influenced by health problems and seek MHS to help them lower their risk of mental health disorders (Brandye D. Nobiling & Maykrantz, 2017). Adolescents' lack of awareness and perception of the gravity of mental diseases is a primary reason they do not seek MHS. In such a situation, adolescents should have positive perspectives on the benefits of receiving MHS to help them act better when dealing with mental health illnesses. Perceived benefit is a person's estimation of the utility or value of a behaviour change that will lessen the person's chance of getting a disease (Setiyaningsih *et al.*, 2016).

A similar study found a link between the prevalence of depression and the perceived health advantages of getting mental health information (Akhther & Sopory, 2022). Several studies have also found that compared to visiting PHC, adolescents frequently use the internet and social media to seek mental health information (Arnani, 2021). Accessing mental health services through primary health care has several advantages, including accountability for the content of the information and an accessible site to examine the experiences of people with similar health concerns. It can then minimize shame when seeking information directly from friends, interlocutors, or experts and empower by understanding the disease and learning about self-care. Perceived benefits might aid decision-making when embracing new technology or services. Perceived health advantages are people's assessments of the benefits of using social media to communicate about their health (Akhther & Sopory, 2022; Lee, 2009; Li *et al.*, 2018).

According to the findings of this study, respondents did not perceive any benefits from their behaviour in accessing MHS. Adolescents prefer to relieve or prevent stress by playing with friends, practising physical activities, watching movies, and engaging in positive behaviours rather than using MHS, indicating that respondents' self-efficacy in carrying out good behaviour in accessing MHS remains low.

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It was established that there is no substantial association between teenage self-efficacy and MHS access behaviour. Furthermore, as many as fifteen kids show self-efficacy and good behaviour when accessing MHS. This figure exceeds the twelve responders who lack self-efficacy and misbehave. Of course, different internal and environmental factors influence self-efficacy.

Internal and external causes can hamper adolescents' behaviour in accessing health care. Internal issues frequently lack understanding of mental health and adolescent views. The perception of adolescents seeking professional help in dealing with mental health concerns is highlighted. Meanwhile, external factors primarily identified by research focus on ambient attitudes, unfavourable stigmatization of teenagers who seek MHS, and the restricted availability of mental health practitioners (Putri *et al.*, 2021; Radez, Reardon, Creswell, Lawrence, *et al.*, 2021). In a prior study, self-efficacy and problem-solving were direct and indirect determinants of mental health. Furthermore, emotional self-efficacy is vital to adolescent well-being (Andretta & McKay, 2020; Parto, 2011). In a prior study, self-efficacy and problem-solving were direct and indirect determinants of mental health. Furthermore, emotional self-efficacy is an essential factor in adolescent well-being.

The study's shortcomings were that it did not differentiate between teenagers with mental health conditions; therefore, the results are more general. As a result, the findings of this study cannot tell whether teenagers' bad conduct in accessing MHS is due to the teenager not being diagnosed with a mental health issue. Furthermore, the number of participants and the breadth of this study are still modest. Another disadvantage is that no healthcare providers or professionals were triangulated in this study. Furthermore, the researchers did not thoroughly examine MHS's program. It is intended that further researchers would improve this research so that it may be utilized as a database to evaluate teen mental health support programs.

## Conclusion

This study focuses on adolescent mental health service-seeking behaviour. The significant finding is that adolescents have poor self-efficacy but high action cues. Adolescents believe the barriers to coming to MHS are too high, but they do not rule out accessing them if they require the assistance of professional health providers.

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