



# **Preliminary evaluation of a university-based suicide intervention project: impact on participants**

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## **Abstract**

*Suicide and associated mental health problems are a major issue for 18–25 year-olds in Australia, many of whom are studying at university. The Suicide Intervention Project (SIP) is a peer-based mental health promotion program, designed as a partnership between the University of Canberra and the YWCA of Canberra. In its first year, the SIP trained 56 participants to be better able to respond to the mental health problems of their university peers. The present study evaluated the SIP in terms of changes experienced by 42 of its first participants. Specifically, it was anticipated that there would be improvements in participants' attitudes, norms, perceived behavioural control, self-efficacy and intentions toward talking to other university students about personal feelings and mental health problems. The social connectedness and mental health literacy of participants were also expected to improve. Results indicated the SIP did have a positive effect on participants, with almost all measures changing from pre- to post-test in the expected directions. Unexpectedly, however, none of these factors correlated with the actual behaviour of talking to other students about feelings, which was measured two weeks after program completion. Results are discussed in terms of the impact of the SIP program on the wider university community.*

## **Keywords**

*suicide prevention, program evaluation, attitude theory, student mental health, mental health promotion, tertiary education*

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## **Introduction**

Suicide, whether an attempt or completed, is a major social issue for the Australian community. In Australia, suicide is one of the most common causes of death in the 15-24 year age group (National Health and Medical Research Council: NHMRC, 2000), with 350-400 people in this age group killing themselves every year. These suicide rates are probably significantly under-reported (Australian Institute of Health and Welfare, 1997). Young people aged between 18 and 24 years are one of the highest risk groups for suicide (NHMRC, 2000), and concentrations of this age group can be found at universities. Suicide intervention strategies that are inclusive and target the support systems of people with suicidal ideation are vital in reducing suicide rates. Moreover, it is important to increase the connectedness, resilience and overall mental health literacy of those who provide support to people with suicidal ideation. Educational institutions, such as universities, can be instrumental in implementing such strategies.

The involvement of community members in education about suicidal risk and mental health is vital in reducing the number of completed suicides in the community (Zubrick, Siburn, Garton et al., 1995). One of the prevalent myths surrounding suicide among young people is that only a counsellor or mental health professional can help and prevent suicide (King, 1999). However, university students, like all other members of the community, are more likely to use informal sources of social support than formal sources (Rickwood & Braithwaite, 1994; Boldero & Fallon, 1995).

It is possible to train people to recognise the signs, symptoms and behaviours associated with suicide, and effective referral and intervention strategies can be implemented by almost anyone who has an interest in helping suicidal people (Scott & Armson, 2000). While it is generally not possible to prevent individual suicides (Australian Psychological Society, 1999),

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students are able to assess potential suicidal behaviours in others, talk to the individual about their current feelings and, if necessary, refer them to professionals for more specialised help (LivingWorks, 1999).

Connectedness and resilience can be fostered by equipping young people with a range of coping, help-seeking, and problem solving skills, by facilitating interaction between peers, and by fostering partnerships between institutions where young people congregate and community support services (Blum, 1998). Peer-based interventions are particularly appropriate in university communities, and there is also broad scope for partnerships between university support services and youth outreach services in the wider community (Spirito, Overholser, Ashwort et al., 1988).

### **The Suicide Intervention Project (SIP)**

The Suicide Intervention Project (SIP) was designed as a partnership between the University of Canberra and the YWCA of Canberra. It was based on a multi-layered peer education strategy that aimed to use prevention and early intervention methods as a means of improving capacity to respond to suicide within the university community. Participants in the SIP were trained to recognise mental health problems in others, feel comfortable talking to other students about mental health issues, and have knowledge of mental health support services available to students. The SIP was not expected to reduce the already small number of suicides on campus, as this could not be reliably measured in the short-term, but rather encourage students to talk more openly about feelings, particularly around suicide, and demystify mental health problems. Participants were not expected to provide counselling advice to other students; rather, they were required to disseminate information and encourage referrals.

The University of Canberra was deemed to be an ideal pilot site for such a suicide intervention strategy. There are approximately 10,000 students who study at the University, with 60 percent of the student population aged less than 25 years (University of Canberra website, 2002). The University has several population groups at high risk of suicide, including a high number of international students, an on-campus indigenous education centre, and a large number of students between the ages of 18 and 25 years.

The components of the SIP were:

- The Applied Suicide Intervention Skills Training (ASIST) program, which is a two-day intensive workshop designed to provide caregivers with knowledge and 'suicide first aid' (LivingWorks, 2002). ASIST has been used extensively in Australia to deliver mental health knowledge and skills to identify and interact with people who are at risk of suicide.
- A short interactive presentation by Mental Illness Education Australian Capital Territory (MIEACT) on mental health awareness and education program. MIEACT makes use of people who have personal experience of living with the effects of mental illness and aims to increase mental health literacy and reduce the negative stigma associated with mental illness in the community. The MIEACT program is based on the premise that contact with people who have experienced mental illness and have an increased knowledge about mental illness will result in decreased reported social distance toward people with mental illness, and decreased stigma.
- Three short presentations by campus professionals from the Health and Counselling Centre, Student Association, and the University of Canberra Union about sources of support on campus.
- Information packs detailing crisis lines, hospitals and specialised support services available in the Canberra region were also provided to students, as well as further reading about mental health promotion and youth suicide.

Research and evaluation are critical to the advancement of mental health promotion, and evaluation components were built into the SIP from the start. For the first groups of participants, the evaluation focussed on whether the SIP changed their attitudes and behaviours related to talking to other students about mental health problems. This was an essential first step in ensuring that the program was able to meet its longer-term goal of improving the capacity of the University to respond to suicide.

Talking to someone about feelings related to mental health, whether they are of suicide, depression or other distress is not easy for many people, and some forethought usually takes place before people choose to exhibit such behaviour. The Theory of Planned Behaviour (TPB) (Fishbein & Ajzen, 1975) has been successfully applied as a conceptual framework for many health behaviours (Norman & Connor, 1997), and was used here to identify the factors that were likely to predict whether the SIP participants were better able to talk to other students about their mental health feelings after the program.

The TPB maintains that behaviour is directly predicted by the formation of an intention to undertake the behaviour, along with perceptions of control over one's ability to undertake the behaviour. In turn, intentions are predicted by attitudes toward the behaviour, subjective norms regarding the behaviour, and perceptions of behavioural control. This conceptual framework was applied in the present context to determine whether the SIP participants increased the behaviour of talking to other students about mental health issues as a result of changes in intentions, subjective norms, attitudes, and perceived control. These measures were supplemented by an indicator of mental health literacy, which was expected to also be important in encouraging the behaviour of talking to other students about mental health related feelings. Mental health literacy has been defined as 'knowledge and beliefs about mental disorders which aid their recognition' (Jorm, Korten, Jacomb et al., 1997). The Australian population, in general, has been found to be low in mental health literacy (Jorm et al., 1997; Sawyer, Arney, Baghurst et al., 2000).

Furthermore, participating in the SIP was expected to personally benefit the participants by increasing their social connectedness to other students at the University.

It was therefore predicted that students who undertook the SIP would increase in their intentions to talk to other students about their feelings, and that they would develop attitudes, subjective norms, and perceived behavioural control that were more supportive of this behaviour. Furthermore, the mental health literacy of SIP participants was expected to improve, and they were also expected to experience stronger social connectedness as an outcome of participating in the SIP.

## **Method**

### **Participants**

There were 56 participants in the first year of the SIP and 42 (30 females and 12 males) were available to take part in the evaluation (note that the first group of SIP participants was not able to take part in the evaluation as ethics approval had not been obtained). Participants' ages ranged from 17 to 48 years, with a mean age of 24.2 years ( $SD=6.24$ ). Most participants (69%) were under 25 years old, and this is similar to the age profile of the student body at the University of Canberra. The research was conducted from June to September 2002. The research complied with NHMRC ethical guidelines and approval was received from the University of Canberra Committee for Ethics in Human Research.

Recruitment of students to the SIP was undertaken by the SIP project officer, by way of flyers, inclusion of information in the campus newspaper and student diaries, and later in the year by word of mouth through students who had completed the program. The SIP project officer individually interviewed each student. The interview aimed to screen out students who may have had unresolved traumatic experiences in the recent past and who may not have been able to cope with the suicide intervention aspect of the program. Participants were selected so as to represent as wide a cross-section of the University student community as possible, favouring students who were from culturally and

linguistically diverse backgrounds, who lived on campus, and who were not undertaking studies in the 'helping professions' such as psychology and nursing (as these students were expected to be exposed to related information through their studies).

### **Design and procedure**

The research was designed as an evaluation study, and consisted of a self-report pre-test questionnaire, an identical self-report post-test questionnaire, and a follow-up self-report questionnaire. All the questionnaires were administered by the researcher. The SIP participants were asked to complete the pre-test questionnaire immediately on arriving at training on the first day of the program. The post-test questionnaire was administered immediately after completion of the SIP training. The follow-up questionnaire was administered two weeks after completion of the program. The pre- and post-test questionnaires took fifteen minutes to complete and the follow-up questionnaire took five minutes to complete.

### **Measures**

#### **Pre and post-test**

##### ***Attitude toward talking about feelings:***

The attitude measure was adapted from the Attitude Toward Professional Psychological Help Scale - Brief and Revised (Fischer & Farina, 1995) to be specific to the behaviour of talking to other students about their mental health feelings. The scale comprised six statements such as 'A person who was feeling suicidal is likely to feel better if they talked about their feelings', which were responded to on a four-point scale ranging from 'agree' to 'disagree'. A higher score indicated a more positive attitude toward talking to other students about their feelings.

##### ***Social distance:***

Social distance is also an accepted and proven measure of attitude specifically towards persons with mental illness (Trute, Tefft, & Segall, 1989). Consequently, five social distance items were included in the pre- and post-test questionnaires. The items were adapted from

Trute et al. (1989) to be appropriate for university students, and included, 'Would you be willing to have a person with a mental illness become a close friend?' Items are responded to on a four-point scale from 'very willing' to 'not at all willing'. A higher score indicated a desire for greater social distance.

##### ***Subjective norms:***

The subjective norms measure was adapted from Maher and Rickwood (1997) to be specific to the behaviour of talking to other students about their mental health feelings. Normative beliefs were measured by eight items asking whether significant others, such as 'friends' and 'parents' would approve of talking to other students about their feelings. Perceived approval was rated on a seven-point Likert-type scale from 'strongly approve' to 'strongly disapprove'. A high score indicated more supportive social norms regarding talking to other students about their mental health feelings.

##### ***Perceived behavioural control:***

The perceived behavioural control measure was adapted from Rickwood, O'Sullivan, Paponi et al. (1998) to be specific to the behaviour of talking to others about their feelings. The measure consisted of four items tapping different dimensions of perceived control, such as 'How likely is it that you would talk with someone you know about their feelings if you thought they needed help?' Each item was responded to on a seven-point scale from total lack of perceived control to complete control. A higher score indicated more perceived control over the behaviour of talking to other students about their feelings. To complement this scale, a measure of self efficacy was developed from Bandura's (1997) guide for constructing self-efficacy scales and consisted of four questions relating to perceived self efficacy, or confidence, in talking to other students about their feelings. A higher score on this scale indicated more confidence.

##### ***Intentions:***

The intentions measure was adapted from Rickwood et al. (1998) to be specific to the behaviour of talking to other students about their mental health feelings. Two items were used, including 'If a student you knew was having problems would you talk with them about their

feelings?' Each item was responded to on a seven-point scale from total lack of intention to complete intention to undertake the behaviour. The two items were summed and a higher score indicated greater behavioural intentions.

***Mental health literacy:***

This measure was designed to measure the participants' general mental health literacy, and consisted of two multiple choice and five open-ended questions that aimed to measure the participant's knowledge regarding: prevalence of mental illness and suicide ideation in Australia; the main types of mental illness and symptoms of these; factors that may lead to a person developing a mental illness; where help is available and the benefits of seeking help early for signs of mental illness. Responses to the seven questions were coded by the researcher as either right, partly right, or wrong. This yielded a total score that was converted to a percentage, with a higher percentage indicating greater mental health literacy.

***Social connectedness:***

Social connectedness was measured to determine whether the resilience of SIP participants themselves was improved as a consequence of program participation. The measure asked about connectedness with different social groups for university students, specifically: the participant's closest friends at university; other people in the participant's university course; students in other courses at the university; and other people in the

university community (Rickwood, 2001). For each social group, participants responded to statement such as, 'I feel that (people in particular group) keep their promises to me', on a seven-point Likert-type scale from 'strongly agree' to 'strongly disagree'. This yielded four scales, with higher scores on each scale indicating more social connectedness with that social group.

***Follow-up:***

The follow-up measure consisted of two questions measuring the behavioural outcome of talking to other university students about their mental health related feelings. The first question asked participants how many times in the two weeks following the suicide intervention program they had talked to other university students about their feelings. The second asked whether this was more or less than before participating in the SIP, on a five-point scale that ranged from 'much less' to 'much more' than usual.

**Results**

All analyses were undertaken using SPSS version 10.0. Descriptive statistics for all the measures at all three time points are presented in Table 1. All measures attained adequate reliability as indicated by Cronbach alpha coefficients.

**Table 1. Means and Standard Deviations of Measures at Pre- and Post-test and Follow-up**

Measures	Range	Pre-test			Post-test			Difference
		<i>M</i>	<i>SD</i>	$\alpha$	<i>M</i>	<i>SD</i>	$\alpha$	<i>p</i>
Attitude	1-4	3.48	.37	.57	3.86	.27	.66	.000 <sup>a</sup>
Subjective norms	1-7	5.49	1.05	.93	5.93	.81	.85	.002 <sup>a</sup>
Perceived behavioural control	1-7	5.35	.71	.59	5.94	.75	.59	.000 <sup>b</sup>
Self-efficacy	1-10	6.42	1.55	.85	8.05	1.57	.85	.000 <sup>b</sup>
Intentions	1-7	6.00	.91	.64	6.67	.50	.64	.000 <sup>a</sup>
Mental health literacy	0-100	68.48	14.38	-	75.51	11.45	-	.001 <sup>b</sup>
Social distance	1-4	1.42	.53	.82	1.26	.36	.76	.019 <sup>b</sup>
Connectedness								
Close friends	1-7	5.86	.83	.96	6.06	1.00	.98	.029 <sup>b</sup>
Students in own course	1-7	4.70	1.07	.92	5.05	1.28	.94	.011 <sup>b</sup>
Students in other courses	1-7	4.50	.99	.93	4.76	1.15	.92	.050 <sup>b</sup>
University community	1-7	4.76	1.15	.90	5.03	1.26	.92	.106 <sup>b</sup>
<i>Follow-up</i>	<i>Range</i>	<i>M</i>	<i>SD</i>					
Behavior (n times)	-	4.52	2.90					
Self-reported change	1-5	2.85	1.10					

<sup>a</sup> Student t-test<sup>b</sup> Wilcoxon Signed Ranks Test

A series of paired t-tests were used to determine whether there was change from pre-test to post-test on each of the measures. Non-parametric tests (Wilcoxon Signed Rank) were undertaken for the four measures that did not meet the assumptions of normality (Howell, 1999). With a Bonferroni adjustment for multiple comparisons the significance level was set at  $p < .005$ . Table 1 shows that nearly all the measures had a significant change from pre-test to post-test in the expected directions. Only changes in the measures of social distance and connectedness did not attain significance at this stringent cut-off, however, their change was also in the predicted direction.

Follow-up behavioural information was available for 27 or the 42 SIP participants. The low response rate for the follow-up was a result

of follow-up procedures not being in place for some of the earlier SIP participants. Those students for whom follow-up information was available, reported an average of 4.5 times that they had talked to other students about their mental health feelings in the two weeks after completion of the SIP. This was more often than before SIP participation in terms of self-reported change.

In order to establish which measures at post-test correlated with reported behaviour as measured at follow-up two weeks later, a correlation analysis was performed for the participants who returned the follow-up questionnaire. The results of the correlation are presented in Table 2. There were no significant correlations between any of the components of the TPB and the follow-up behavioural measures.

**Table 2. Correlations between Theory of Planned Behaviour Components and Follow-up Measures**

	Attitude	Norms	PBC	Efficacy	Distance	Intentions
Behaviour	-.08	.10	.04	-.09	-.05	-.05
Self reported change	-.09	-.01	.02	-.05	-.02	.02

PBC=Perceived behavioural control

## Discussion

The preliminary evaluation of the first year of the SIP at the University of Canberra showed promising results. At this early point in evaluating the implementation of the program, only the impact on the actual program participants was considered. Participants were shown to improve on all the factors that were predicted, by the TPB, to determine the behaviour of talking to other university students about mental health feelings.

All the TPB constructs, namely attitudes, subjective norms, perceived behavioural control, and intentions improved for participants. After taking part in the SIP, participants had more favourable attitudes and subjective norms, and reported greater feelings of control and greater intentions regarding performing the behaviour of talking to other university students about mental health feelings. Mental health literacy also increased, and most students reported an increased level of actually talking to other students about mental health feelings at the two-week follow-up.

This shows that the SIP was effective in generally improving the confidence of participants in talking to other students about mental health feelings, by changing the attitudes and the control beliefs that participants held around this behaviour. SIP participants became more comfortable in talking to other students about their feelings and it would be expected that this would make them more effective in their approach to persuading individuals with suicidal ideation to get help (Neimeyer, Forner, & Melby, 2001; LivingWorks, 1999).

The direction of change for the social distance and connectedness measures indicated

improvements in these measures also, however the level of change was not strong enough to attain significance. It should be noted that the measures of social distance and connectedness were highly skewed at both pre- and post-test, revealing that the SIP participants had very low social distance and very high levels of connectedness, even before the program. Consequently, there was very little room for improvement on these measures. Despite this, participants reported in focus groups held immediately after the SIP that they had formed strong links to other participants in the program, as expressed in the following quote:

*You guys are like family to me, I have shared things with you that I would never have had a chance to share, even with my closest friends.*

In future research, the strength of the networks formed between participants in the SIP and more sensitive measures of connectedness would better reveal the impact of the SIP on social relationships. It may also be useful for further research to focus on investigating the effects that SIP participants have in terms of their relationship and interactions with groups of students who are particularly isolated, rather than the general student body, for example international students, students in demanding courses, students who struggle academically or students living on campus. Improving the connectedness to these students is especially important because of their high level of risk.

The increased mental health literacy of participants in the SIP is consistent with other recent research showing the effectiveness of the MIEACT program. For example, Rickwood, Cavanagh, Curtis et al. (2002) demonstrated improvements in mental health literacy among high-school students who participated in the MIEACT program, and the current research

shows that the program is equally effective for university students.

The lack of correlation between any of the predictors of the TPB and either of the behavioural follow-up measures is contrary to other research predicting behaviour using the theory (Ajzen, 1991; Ajzen, 2002). Along with the relatively small number of participants who returned the follow-up survey, which reduced the power of the correlations, it is possible that the behaviour measured – talking to other university students about their feelings – was not specific enough for the conceptual framework that the TPB requires. Ajzen (1988) argues that behaviour predicted with this theoretical framework needs to be concrete and unambiguous; for example, voting in an election. Talking to someone about feelings may be interpreted in different ways by different people, and each instance may not be effectively recalled by participants when completing the follow-up questionnaire. It is also possible that a two-week period was too short a time for SIP participants to have an opportunity to carry out the behaviour of talking to other students about their feelings, particularly as they may not have come across other students who indicated any need. The SIP participants did, however, self-report that they were more likely to talk to other students about their mental health feelings after compared with before completing the SIP. The average number of times that they reported talking to people about their feelings was 4.5 over two weeks. One respondent who reported that s/he had not changed in the amount of times s/he had talked to someone about their feelings commented on the follow-up questionnaire 'but I handled the conversations differently', suggesting that behaviour had changed in qualitative as well as quantitative ways as a result of the SIP.

One of the limitations of this study was the lack of a control group to ensure that changes were due only to participation in the SIP, and further research should include a control group to eliminate other explanations for the observed changes, such as re-test effects. It is also unclear what impact the SIP participants have had on the wider university community, and an awareness study across the university community would be useful to determine its wider impact. Furthermore, it is not clear whether the SIP would be appropriate for use in its current form in other universities or educational settings in Australia, although the current evaluation suggests that it is able to attract participants and is effective in improving the confidence of students talking to other students about their feelings.

Overall the SIP program appears to be effective in promoting mental health by improving the confidence of program participants in responding to the mental distress of other students. It has the potential to increase levels of understanding and tolerance for people who may have emotional problems, as well as improve the connectedness and resilience of those who attend the SIP. As a peer-based intervention, it is expected that proceeding with the SIP in subsequent years will have a wider effect on the general student population, although further evaluation is required to demonstrate this impact.

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