Impact of Integrated Care and Co-Location of Care on Mental Help-Seeking Perceptions

Joseph H. Hammer

University of Kentucky

Paul B. Perrin

Virginia Commonwealth University

Douglas A. Spiker

University of Kentucky

Author Notes

Joseph H. Hammer, Department of Educational, School, and Counseling Psychology, University of Kentucky; Paul. B. Perrin, Psychology Department, Virginia Commonwealth University; Douglas A. Spiker, Department of Educational, School, and Counseling Psychology, University of Kentucky.

Correspondence concerning this article should be addressed to Joseph H. Hammer, PhD, Department of Educational, School, and Counseling Psychology, University of Kentucky, 243 Dickey Hall, Lexington, KY 40506. E-mail: jhhammer@gmail.com

Abstract

Background. Integrated care may offer a solution to subpar mental health referral adherence, but people's openness to receiving psychological treatment in this setting is understudied.

Aims. The present study examined the influence of the integrated care context and co-location of care on people's help-seeking perceptions.

Method. This study (N = 397) used an experimental vignette design to compare the impact of treatment type (integrated care vs. traditional psychotherapy) and distance (close vs. far) on help-seeking perceptions.

Results. The integrated care environment (significant effect on perceived behavioral control) and closer proximity of the psychologist (significant effect on intention, attitudes, perceived effectiveness of treatment, self-stigma) only improved help-seeking perceptions among those with prior experience with mental health treatment. In the overall sample, treatment type and distance only demonstrated an effect among women, but not men.

Conclusion. Pending replication with samples from diverse populations, these findings provide a cautionary tale about lay perceptions of integrated care's anticipated utility. However, co-location and, to a lesser degree, the common attributes of the integrated care format (e.g., team approach, flexible scheduling) may represent a potential pathway for reducing resistance to help seeking that can accompany traditional psychotherapy referrals among those with past exposure to behavioral healthcare.

Declaration of Interest. None.

Keywords: help seeking; integrated care; attitudes; intention; treatment utilization; health care services; co-located care

Impact of Integrated Care and Co-Location of Care on Mental Help-Seeking Perceptions

In the United States, mental health services are increasingly performed in integrated healthcare clinics rather than traditional psychotherapy offices (de Voursney & Huang, 2016). Integrated care involves close collaboration in primary care settings between medical and behavioral health providers to provide systematic, population-based care (Olfson, 2016). Integrated care lowers health care costs (Lee, Rothbard, & Choi, 2016; Katon et al., 2012) and is effective in treating mental health problems such as depression (Sadock, Perrin, Grinnell, Rybarczyk, & Auerbach, 2017). Unlike traditional psychotherapy, integrated care tends to involve shorter and fewer sessions, "warm handoffs" of clients from the primary care physician (PCP) to the behavioral health provider for instant clinical attention, and closer treatment and medical records coordination (APA, 2015). Research has extensively investigated people's attitudes toward seeking traditional psychotherapy services, but has not yet examined how the integrated care context may influence these help-seeking perceptions.

The goal of the present study was to use an experimental vignette design to determine the potential impact of treatment type (traditional psychotherapy vs. integrated care) and distance (far vs. close) on people's perceptions related to seeking help for depression symptoms from a psychologist when referred by a PCP. Given that treatment type is typically confounded with distance (i.e., integrated healthcare offering behavioral health services in the same office), explicitly accounting for distance helped determine whether the potential attraction of integrated care is about more than just ease of access due to co-location. Some argue that people are more positively predisposed toward seeking psychological help in the context of an integrated healthcare environment (Funderburk, Fielder, DeMartini, & Flynn, 2012; Maassen, Schrevel, Dedding, Broerse, & Regeer, 2017). Thus, Hypothesis 1 was that participants in the integrated

healthcare condition would endorse more favorable help seeking perceptions than those in the traditional psychotherapy condition. Likewise, extant research suggests that geographic distance can be a significant barrier to behavioral healthcare seeking (Mohr et al., 2010). Thus, Hypothesis 2 was that participants in the close condition (i.e., psychologist office across the hall) would report more favorable help seeking perceptions than those in the far condition (i.e., psychologist has an office 45 minutes away).

Method

Design

Interested participants were directed to a Qualtrics online survey that began with an informed consent page. Next, participants were randomly assigned to view one of four vignettes. After reading the vignette, participants completed the dependent variable and demographic instruments, and then had the option of entering a drawing for a $25 Amazon.com gift card. The final $N = 397$ dataset was derived from an initial $N = 437$ dataset by excluding 23 cases with inaccurate responses on more than one of the two attention check questions and another 17 cases with >20% item-level missingness on a given scale.

The vignettes (see Supplemental Material for vignette text) all began by asking participants to imagine that they were experiencing depression symptoms (e.g., depressed mood) causing distress and impairment and that they sought help from a PCP. The PCP tells them that an examination and blood work did not identify a physical cause and suggests that the participant might be experiencing depression symptoms and should see a psychologist. This wording was adapted from Schomerus, Matschinger, and Angermeyer's (2009) vignettes, which were verified by five psychopathology experts as accurately describing a person with major depression.

The final paragraph of the vignette was worded differently, depending on which of the four conditions the participant was assigned to (i.e., traditional psychotherapy far, traditional psychotherapy close, integrated care far, integrated care close). The descriptions of traditional psychotherapy and integrated care were generated by the authors, on the basis of published descriptions of these types of care (Rybarczyk, Stewart, Perrin, & Radcliff, 2017) and clinical experience, and vetted by four graduate-level psychology clinicians working in both traditional psychotherapy and integrated care settings. The clinicians' feedback was used to revise the vignettes to best capture typical differences between traditional psychotherapy and integrated care. Typical differences built into these vignettes included: the relationship of the psychologist to the medical team (i.e., psychologist is part of the team working closely with the other providers in the PCP's clinic vs. not part of the team and working separately), appointment description (i.e., "behavioral health" vs. "psychotherapy"), scheduling (i.e., "30 vs. 50-minute appointment; immediate vs. delayed appointment; weekly vs. flexible frequency), and ease of medical record sharing (i.e., share records without additional work on participants' part vs. share records via a release of information). The manipulations of far (i.e., psychologist has an office 45 minutes away) and close (i.e., psychologist has an office across the hall) were also incorporated into the vignettes.

Method of Recruitment

Participants were recruited via ResearchMatch (RM), a national health volunteer registry created by several academic institutions and supported by the U.S. National Institutes of Health as part of the Clinical Translational Science Award (CTSA) program. The University of Kentucky Office of Research Integrity approved the study. RM participants were contacted via the registry regarding the study, advertised as a survey about healthcare and personal well-being.

Participants

Participants were 397 (75 men, 320 women, 2 other gender identity) U.S. adults ranging in age from 19 to 92 (M = 52.80, SD = 14.65). Approximately 92% of the sample identified as White, 2% as Black, 1.5% as Multiracial, 1% as Latino/a, 1% as Asian American/Pacific Islander, 1.5 % as Other, and 1% prefer not to answer. Approximately 2% earned a high school diploma or GED, 8% earned an associate's degree or attended vocational school, 11% had some college experience, 26% earned a bachelor's degree, and 53% earned a graduate or professional degree. Approximately 34% of participants reported they had been diagnosed with a mental health condition and treated with medication and psychotherapy, 44% indicated they had never been diagnosed or treated for a mental health condition, 10% reported a diagnosis with medication treatment, 9% reported a diagnosis with psychotherapy treatment, 1% reported a diagnosis with no treatment, and 2% reported other. Regarding U.S. residence region, approximately 2% reported living in New England, 10% in Middle Atlantic, 19% in East North Central, 14% in West North Central, 16% in South Atlantic, 18% in East South Central, 5% in West South Central, 3% in Mountain, 12% in Pacific, and 1% reported not residing in U.S.

Measures

Help seeking perceptions was operationalized using variables drawn from the Theory of Planned Behavior (TPB; Ajzen, 1991) and extant help seeking research. In line with past help-seeking research utilizing the TPB (e.g., Hess & Tracey, 2013), we followed the recommendations of Ajzen (2002) for adapting intention, attitudes, subjective norms, and perceived behavioral control instruments to be compatible on the four TPB elements of target (e.g., psychologist), action (e.g., going to see the psychologist), context (e.g., PCP referral), and time (e.g., now or next few weeks).

Intention. The three-item Mental Help Seeking Intention Scale (MHSIS; Hammer & Spiker, 2018) was adapted to measure participants' intention to seek help from the psychologist described in the vignette (e.g., "I would intend to go see the psychologist."). Participants rated their degree of intention using a 7-point Likert scale from 1 (e.g., definitely false) to 7 (e.g., definitely true), with higher scores indicating greater intention. Different versions of the MHSIS have been used by help-seeking researchers for diverse study contexts. These versions' scores have demonstrated internal consistency (α's > .87) and convergent evidence of validity (Hess & Tracey, 2013). Hammer and Spiker (2018) provided initial support for conceptualizing the MHSIS as a unidimensional instrument that produces an internally consistent total score with appropriate construct replicability and predictive evidence of validity (i.e., prediction of future help seeking behavior). Internal consistency was .95 [95% CI of .939, .957] in the present study.

Attitudes. The nine-item Mental Help Seeking Attitudes Scale (MHSAS; Hammer, Parent, & Spiker, 2018) was adapted to measure participants' evaluation (unfavorable vs. favorable) of their seeking help from the psychologist (e.g., "For me, going to see the psychologist would be…"). Participants responded using a 7-point semantic differential scale anchored by bipolar adjectives at either end (e.g., *bad* vs. *good*), with higher scores indicating more positive attitudes. Hammer et al. (2018) provided initial support for the internal consistency, four-week test-retest reliability, and unidimensionality of the MHSAS. Convergent, incremental, and known-group evidence of validity was also demonstrated when the MHSAS score demonstrated hypothesized relationships with subjective norms, perceived behavioral control, public stigma, self-stigma, anticipated risks and benefits, intention, gender, and past help-seeking behavior. Internal consistency was .93 [95% CI of .921, .941] in the present study.

Subjective Norms. Subjective norms were assessed with a 3-item subjective norms instrument (e.g., "The people in my life whose opinions I value would ___ of my going to see the psychologist"). Participants responded using a 7-point Likert scale from 1 (e.g., *disapprove*) to 7 (e.g., *approve*), with higher scores indicating more positive subjective norms. Help-seeking subjective norms instruments that follow Azjen's (2002) recommendations have previously demonstrated evidence of reliability ($\alpha \geq .81$; Hammer et al., 2018) and validity (e.g., significant positive association between subjective norms and intention to seek help; Schomerus et al., 2009). Internal consistency was .69 [95% CI of .634, .740] in the present study.

Perceived Behavioral Control. Perceived behavioral control was assessed with a 4-item perceived behavioral control instrument (e.g., "If I wanted to, I could go see the psychologist"). Participants responded using a 7-point Likert scale from 1 (e.g., *definitely false*) to 7 (e.g., *definitely true*), with higher scores indicating greater perceived behavioral control. Help-seeking perceived behavioral control instruments that follow Azjen's (2002) recommendations have previously demonstrated evidence of reliability ($\alpha \geq .69$; Hammer et al., 2018; Hess & Tracey, 2013) and validity (e.g., significant positive association between perceived behavioral control and intention to seek help; Hammer et al., in 2018; Hess & Tracey, 2013). Internal consistency was .70 [95% CI of .645, .748] in the present study.

Self-Stigma of Seeking Help. The 10-item Self-Stigma of Seeking Help Scale (SSOSH; Vogel et al., 2006) assessed perceived self-stigma for seeking psychological help. An example item included "I would feel inadequate if I went to the psychologist for psychological help." Participants rated each item from 1 (*strongly disagree*) to 5 (*strongly agree*) with higher scores indicating greater self-stigma. The internal consistency of this instrument was found to be .86 [95% CI of .840, .881] in the current sample. The SSOSH has demonstrated convergent evidence

of validity (Vogel, Wade, & Haake, 2006). The SSOSH has demonstrated test-retest reliability over a period of 2 months (α = .72) and internal consistency (α = .89).

Perceived Effectiveness. Perceived effectiveness of treatment was assessed with a single item adapted (i.e., changed "Counseling…" to "Working with this psychologist…") from the Treatment Effectiveness subscale of the Patient Attitudes Toward and Ratings of Care for Depression (PARC-D) questionnaire (Cooper et al., 2000). This PAR-D item was rated in the scale development study as capturing one of the most important attributes of depression treatment among 126 possible attributes generated from patient focus groups.

Statistical Analysis

A 2 (treatment type: traditional psychotherapy vs. integrated care) X 2 (distance: far vs. close) mixed factorial multivariate analysis of variance (MANOVA) was conducted to examine group differences on the six dependent variables. We repeated this analysis for key subgroups including men versus women, and those who had obtained prior professional mental health treatment (medicine and/or psychotherapy) versus those who had not. We also took the latter group and repeated this analysis for those within this group who had graduate degrees versus those with less education. We conducted independent samples t-tests to examine differences on the six dependent variables between those who obtained prior professional mental health treatment versus those who had not. Means, standard deviations, Cronbach's alphas, and intercorrelations for the dependent variables are provided in Table 1.

Results

Results did not suggest the presence of a treatment type X distance interaction on the combined dependent variables (p = .19). There was a multivariate effect of treatment type on the combined dependent variables, Pillai's Trace = .05, Wilk's Lambda = .95, $F(6, 388) = 3.38$, p

= .003, η_p^2 = .05. Follow-up analysis of variance (ANOVA) tests with Bonferonni-adjusted confidence intervals for mean difference indicated that participants in the integrated care condition reported greater intention and perceived behavioral control than participants in the traditional psychotherapy condition (see Table 2 for pairwise comparisons). There was also a multivariate effect of distance on the combined dependent variables, Pillai's Trace = .063, Wilk's Lambda = .94, $F(6, 388) = 4.37$, $p < .001$, $\eta_p^2 = .06$. Participants in the close condition reported greater intention, more positive attitudes, greater perceived behavioral control, less self-stigma, and greater perceived effectiveness than participants in the far condition.

Among men, there was no interaction or main effects (*p's* > .22). Among women (see Table 3), there was no interaction effect ($p = .29$) but both main effects were significant. There was a multivariate effect of treatment type on the combined dependent variables (Pillai's Trace = .05, Wilk's Lambda = .95, $F(6, 311) = 2.99$, $p = .008$, $\eta_p^2 = .054$) such that participants in the integrated care condition reported greater intention and perceived behavioral control than participants in the traditional psychotherapy condition. There was a multivariate effect of distance on the combined dependent variables (Pillai's Trace = .063, Wilk's Lambda = .94, $F(6, 311) = 4.37$, $p < .001$, $\eta_p^2 = .06$) such that participants in the close condition reported greater intention, more positive attitudes, greater perceived behavioral control, less self-stigma, and greater perceived effectiveness than participants in the far condition.

Independent sample t-tests indicated that those who sought treatment reported greater intention ($t(395) = 2.60$, $p = .01$, $M_{difference} = .41$), more positive attitudes ($t(395) = 2.51$, $p = .01$, $M_{difference} = .30$), and less self-stigma ($t(395) = -2.55$, $p = .01$, $M_{difference} = -.16$) than those who had never sought treatment. Among those who had sought treatment (see Table 4), there was no interaction effect ($p = .30$) but both main effects were significant. There was a multivariate

effect of treatment type on the combined dependent variables (Pillai's Trace = .06, Wilk's Lambda = .94, $F(6, 210) = 2.11$, $p = .05$, $\eta_p^2 = .06$) such that participants in the integrated care condition reported greater perceived behavioral control than participants in the traditional psychotherapy condition. There was a multivariate effect of distance on the combined dependent variables (Pillai's Trace = .063, Wilk's Lambda = .94, $F(6, 210) = 4.37$, $p < .001$, $\eta_p^2 = .06$) such that participants in the close condition reported greater intention, more positive attitudes, greater perceived behavioral control, and greater perceived effectiveness than participants in the far condition.

Among those who never sought treatment, there was no interaction or main effects (*p's* > .13). Among those who never sought treatment and had graduate degrees, there were no interaction or main effects (*p*'s > .39). Among those who never sought treatment and had less than a graduate degree, there were no main effects (*p*'s > .17) but there was an interaction effect (Pillai's Trace = .20, Wilk's Lambda = .80, $F(6, 70) = 2.90$, $p = .01$, $\eta_p^2 = .20$) such that participants in the condition combining integrated care plus close distance ($M = 5.63$, $SD = .92$, $SE = .34$) reported more positive subjective norms ($F(1) = 4.28$, $p = .04$, $\eta_p^2 = .05$) than participants in the condition combining integrated care plus far distance ($M = 4.47$, $SD = 1.82$, $SE = .33$). The other five dependent variables demonstrated no such effect.

Discussion

The present study examined the impact of treatment type and distance on people's perceptions related to seeking help from a psychologist when referred by a PCP. The most important finding is that the integrated care environment and closer proximity of the psychologist only improved help-seeking perceptions (e.g., intention, attitudes, stigma) among those with prior experience with mental health treatment, a group our data showed already tend

to have more positive help-seeking perceptions than those who have no prior experience. Because those who have never sought mental health treatment are the primary target of advocacy efforts related to the integration of behavioral healthcare into primary care settings, these findings provide a cautionary tale about lay perceptions of integrated care's anticipated utility, particularly if these findings are replicated in future investigations. Subgroup analyses also indicated that treatment type and distance only demonstrated an effect among women. This suggests that men may find a shorter distance and the attributes of integrated care (e.g., team approach) to be less compelling than they are to women.

Whereas improving help-seeking perceptions among those who have never sought mental healthcare is certainly a priority, negative past experiences with mental healthcare can decrease one's willingness to seek it in the future (Czyz, Horwitz, Eisenberg, Kramer, & King, 2013), so there is still utility in identifying factors that can improve the perceptions of those who have accessed mental healthcare in the past. Those with prior mental healthcare experience did report more positive attitudes, enhanced sense of control, stronger intention to seek help, decreased self-stigma, and greater perceived effectiveness when the psychologist's office was across the hall from the PCP, rather than 45 minutes away. Consistent with the finding that clients are more likely to pursue referral if the mental health provider is co-located in the primary care setting (Gallo et al., 2004), these results indicate that closer proximity enhances one's perceived ability to access treatment, but also has a halo effect such that more proximal services are seen as more effective and less stigmatizing. This aligns with literature identifying distance as a significant barrier to psychological treatment (Mohr et al., 2010), and with literature that found patients were more likely to follow up with a mental health referral if the mental health provider was co-located in the primary care setting (Gallo et al., 2004).

Addressing Limitations Through Future Research

Most of our sample was composed of White, educated, insured women with prior experience with mental health treatment. Thus, future research focused on other populations of interest (e.g., People of Color) is necessary to investigate the generalizability of these findings. Furthermore, while the vignette design allowed for greater control in the experimental manipulation, there are also advantages to field studies that would allow the tracking of behavioral health referral follow-through rates among people seeking help in primary care clinics. Future research should also seek to systematically manipulate each of the characteristics that tend to distinguish integrated care from traditional psychotherapy (e.g., team approach, faster scheduling) to determine which of these characteristics primarily drive the main effect. This could provide empirical evidence leading to targeted recommendations regarding optimal implementation of behavioral healthcare pathways that can minimize barriers to care. In conclusion, the primary clinical implication of these preliminary results is that the integrated care format, not just co-location of services, may represent a potential pathway for minimizing some of the resistance to help seeking that may occur for traditional psychotherapy referrals.

References

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, *50*, 179-211. doi:10.1016/0749-5978(91)90020-t

Ajzen, I. (2002). Constructing a TPB questionnaire: Conceptual and methodological considerations. Retrieved from http://chuang.epage.au.edu.tw/ezfiles/168/1168/attach/20/pta_41176_7688352_57138.pdf

American Psychological Association (2015). *Competencies for psychology practice in primary care*. Retrieved from http://www.apa.org/ed/resources/competencies-practice.pdf

Cooper, L. A., Brown, C., Vu, H. T., Palenchar, D. R., Gonzales, J. J., Ford, D. E., & Powe, N. R. (2000). Primary care patients' opinions regarding the importance of various aspects of care for depression. *General Hospital Psychiatry*, *22*, 163-173. doi: 10.1016/S0163-8343(00)00073-6

Crzyz, E. K., Horwitz, A. G., Eisenberg, D., Kramer, A., & King, C. A. (2013). Self-reported barriers to professional help-seeking among college students at elevated risk for suicide. *Journal of American College Health, 61*, 398-406.

de Voursney, D., & Huang, L. N. (2016). Meeting the mental health needs of children and youth through integrated care: A systems and policy perspective. *Psychological Services, 13*, 77-91. doi:10.1037/ser0000045

Funderburk, J. S., Fielder, R. L., DeMartini, K. S., & Flynn, C. A. (2012). Integrating behavioral health services into a university health center: Patient and provider satisfaction. *Families, Systems & Health: The Journal of Collaborative Family Healthcare, 30*, 130-140. doi:10.1037/a0028378

Gallo, J. J., Zubritsky, C., Maxwell, J., Nazar, M., Bagner, H. R., Quitano, L. M., … Levkoff, S. E. (2004). Primary care clinicians evaluate integrated and referral models of behavioral health care for older adults: Results from a multisite effectiveness trial (PRISM-E). *Annals of Family Medicine*, *2*, 305–309. doi: 10.1370/afm.116

Hammer, J. H., & Parent, M. C., & Spiker, D. A. (2018). Mental Help Seeking Attitudes Scale (MHSAS): Development, reliability, validity, and comparison with the ATSSPH-SF and IASMHS-PO. *Journal of Counseling Psychology, 65*, 74-85. doi:10.1037/cou0000248

Hammer, J. H., & Spiker, D. A.* (2018). Dimensionality, reliability, and predictive evidence of validity for three help seeking intention instruments: ISCI, GHSQ, and MHSIS. *Journal of Counseling Psychology, 65*, 394-401. doi: 10.1037/cou0000256

Hess, T. R., & Tracey, T. G. (2013). Psychological help-seeking intention among college students across three problem areas. *Journal of Counseling & Development*, *91*, 321-330. doi:10.1002/j.1556-6676.2013.00100.x

Katon, W., Russo, J., Lin, E. H., Schmittdiel, J., Ciechanowski, P., Ludman, E., ... & Von Korff, M. (2012). Cost-effectiveness of a multicondition collaborative care intervention: A randomized controlled trial. *Archives of General Psychiatry*, *69*, 506-514. doi:10.1001/archgenpsychiatry.2011.1548

Lee, S., Rothbard, A., & Choi, S. (2016). Effects of comorbid health conditions on healthcare expenditures among people with severe mental illness. *Journal of Mental Health*, *25*, 291-296. doi: 10.3109/09638237.2015.1101420

Maassen, E. F., Schrevel, S. J., Dedding, C. W., Broerse, J. E., & Regeer, B. J. (2017). Comparing patients' perspectives of "good care" in Dutch outpatient psychiatric services

with academic perspectives of patient-centred care. *Journal of Mental Health*, *26*, 84-94. doi: 10.3109/09638237.2016.1167848

Mohr, D. C., Ho, J., Duffecy, J., Baron, K. G., Lehman, K. A., Jin, L., & Reifler, D. (2010). Perceived barriers to psychological treatments and their relationship to depression. *Journal of Clinical Psychology*, *66*, 394-409. doi: 10.1002/jclp.20659

Olfson, M. (2016). The rise of primary care physicians in the provision of US mental health care. *Journal of Health Politics, Policy and Law, 41*, 559-583. doi: 10.1215/03616878-3620821

Rybarczyk, B., Stewart, K. E., Perrin, P. B., & Radcliff, Z. (2017). The Virginia Commonwealth University primary care psychology training network. In M. E. Maruish (Ed.), *Handbook of psychological assessment in primary care settings, second edition* (pp. 733-762). Abingdon, UK: Taylor & Francis.

Sadock, E., Perrin, P. B., Grinnell, R. M., Rybarczyk, B., & Auerbach, S. M. (2017). Initial and follow-up evaluations of integrated psychological services for anxiety and depression in a safety net primary care clinic. *Journal of Clinical Psychology, 73*, 1462-1481. doi:10.1002/jclp.22459

Schomerus, G., Matschinger, H., & Angermeyer, M. C. (2009). The stigma of psychiatric treatment and help-seeking intentions for depression. *European Archives of Psychiatry and Clinical Neuroscience*, *259*, 298-306. doi:10.1007/s00406-009-0870-y

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology*, *53*, 325-337. doi:10.1037/0022-0167.53.3.325

Table 1.

Means, Standard Deviations, and Intercorrelations among Dependent Measures (N = 397)

Dependent Variables	α	*M*	*SD*	1	2	3	4	5
1. Intention	.95	5.38	1.20					
2. Attitudes	.93	5.50	1.19	.68**				
3. Subjective Norms	.69	6.15	1.00	.56**	.45**			
4. Perceived Behavioral Control	.70	5.39	1.58	.54**	.33**	.38**		
5. Self-Stigma of Seeking Help	.86	1.95	.62	-.33**	-.33**	-.25**	-.33**	
6. Perceived Effectiveness of Treatment	N/A	3.29	.85	.58**	0.6**	.34**	.23**	-.08

Note: ** $p < .01$

Table 2.

Pairwise Comparisons of Help Seeking Perception Variables for Treatment Type and Distance

Dependent Variable	*M (SD, SE)*	*M (SD, SE)*	Mean difference (95% CI)	*d*	*p*
Treatment Type	Integrated Care	Traditional Psychotherapy			
1. Intention	5.60 (1.54, .11)	5.17 (1.61, .12)	0.43 (-.73, -.12)	.27	.006
2. Attitudes	5.37 (1.26, .09)	5.39 (1.14, .08)	-0.01 (-.22, .25)	.02	.88
3. Subjective Norms	5.57 (1.23, .09)	5.43 (1.14, .08)	0.14 (-.36, .11)	.12	.29
4. Perceived Behavioral Control	6.28 (.93, .07)	6.01 (1.06, .08)	0.27 (-.47, -.08)	.27	.005
5. Self-Stigma of Seeking Help	1.95 (.65, .05)	1.94 (.59, .04)	0.01 (-.14, .11)	.02	.84
6. Perceived Effectiveness of Treatment	3.29 (.87, .06)	3.30 (.83, .06)	-0.01 (-.16, .17)	.01	.94
Distance	Near	Far			
1. Intention	5.68 (1.46, .10)	5.09 (1.65, .12)	0.59 (.30, .91)	.38	<.001
2. Attitudes	5.59 (1.15, 08)	5.17 (1.22, .09)	0.42 (.19, .65)	.36	<.001
3. Subjective Norms	5.61 (1.12, .08)	5.38 (1.25, .09)	0.23 (-.01, .46)	.19	.06

4. Perceived Behavioral Control	6.36 (.81, .06)	5.94 (1.13, .08)	0.42 (.24, .62)	.43	<.001
5. Self-Stigma of Seeking Help	1.87 (.58, .04)	2.02 (.66, .05)	-0.15 (-.27, -.03)	.24	.02
6. Perceived Effectiveness of Treatment	3.42 (.84, .06)	3.17 (.84, .06)	0.25 (.08, .41)	.30	.004

Table 3.

Pairwise Comparisons of Help Seeking Perception Variables among Women

Dependent Variable	*M (SD, SE)*	*M (SD, SE)*	Mean difference (95% CI)	*d*	*p*
Treatment Type	Integrated Care	Traditional Psychotherapy			
1. Intention	5.65 (1.52, .12)	5.15 (1.60, .13)	0.49 (.16, .83)	.32	<.01
2. Attitudes	5.49 (1.24, .10)	5.40 (1.15, .09)	.08 (-.18, .34)	.08	.54
3. Subjective Norms	5.59 (1.27, .10)	5.46 (1.10, .09)	0.12 (-.14, .38)	.11	.36
4. Perceived Behavioral Control	6.32 (.89, .07)	5.99 (1.07, .08)	0.32 (.11, .54)	.34	<.01
5. Self-Stigma of Seeking Help	1.93 (.63, .05)	1.96 (.60, .05)	-0.03 (-.17, .10)	.05	.65
6. Perceived Effectiveness of Treatment	3.32 (.91, .07)	3.29 (.87, .07)	0.03 (-.16, .22)	.03	.78
Distance	Near	Far			
1. Intention	5.70 (1.48, .12)	5.10 (1.63, .13)	0.59 (.26, .93)	.39	<.001
2. Attitudes	5.64 (1.18, 09)	5.24 (1.18, .09)	0.40 (.14, .65)	.34	<.01
3. Subjective Norms	5.60 (1.14, .09)	5.45 (1.23, .10)	0.14 (-.12, .41)	.13	.28

4. Perceived Behavioral Control	6.35 (.83, .07)	5.95 (1.11, .09)	0.39 (.18, .60)	.41	<.001
5. Self-Stigma of Seeking Help	1.87 (.58, .05)	2.01 (.65, .05)	-0.14 (-.28, -.01)	.23	<.05
6. Perceived Effectiveness of Treatment	3.44 (.88, .07)	3.17 (.88, .07)	0.26 (.06, .46)	.31	<.01

Table 4.

Pairwise Comparisons of Help Seeking Perception Variables among Past Treatment Seekers

Dependent Variable	*M (SD, SE)*	*M (SD, SE)*	Mean difference (95% CI)	*d*	*p*
Treatment Type	Integrated Care	Traditional Psychotherapy			
1. Intention	5.76 (1.40, .13)	5.39 (1.53, .15)	0.36 (-.02, .75)	.25	.065
2. Attitudes	5.53 (1.25, .12)	5.50 (1.13, .11)	.01 (-.30, .33)	.03	.33
3. Subjective Norms	5.63 (1.11, .11)	5.51 (1.07, .10)	0.11 (-.18, .41)	.11	.44
4. Perceived Behavioral Control	6.35 (.86, .08)	6.06 (1.10, .10)	0.30 (.05, .56)	.29	.020
5. Self-Stigma of Seeking Help	1.89 (.64, .06)	1.86 (.53, .05)	0.03 (-.12, .19)	.05	.67
6. Perceived Effectiveness of Treatment	3.29 (.90, .09)	3.37 (.82, .08)	-0.09 (-.32, .14)	.09	.42
Distance	Near	Far			
1. Intention	5.85 (1.40, .13)	5.23 (1.51, .15)	0.62 (.23, 1.00)	.43	<.01
2. Attitudes	5.72 (1.15, .10)	5.26 (1.20, .12)	0.46 (.15, .78)	.39	<.01
3. Subjective Norms	5.63 (1.07, .10)	5.50 (1.11, .11)	0.13 (-.16, .42)	.12	.38

4. Perceived Behavioral Control	6.43 (.83, .08)	5.93 (1.11, .11)	0.50 (.24, .76)	.51	<.001
5. Self-Stigma of Seeking Help	1.81 (.50, .05)	1.96 (.67, .07)	-0.15 (-.31, .01)	.25	.06
6. Perceived Effectiveness of Treatment	3.45 (.88, .08)	3.19 (.82, .08)	0.26 (.03, .49)	.31	<.05