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Help-Seeking Behavior and Related Mental Health Promotion Programs in Southeast Asian Youth: A Systematic Literature Review

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Abstract

Mental health issues are a prominent burden among adolescents and young adults in Southeast Asia, compounded by reluctance to seek help and low treatment rates. This mixed-method systematic review analyzed help-seeking profiles (preference, facilitators, and barriers) and evaluated implemented help-seeking programs. Data were sourced from electronic databases, hand-searched local databases, conference proceedings, and grey literature. Study selection followed PRISMA 2020 guidelines, focusing on 1) adolescents (10–19 years) and young adults (18–26 years) in Southeast Asia who were not receiving mental health care, 2) assessing help-seeking behavior, and 3) evaluating programs to increase help-seeking. A total of 16 articles were identified. Help-seeking behavior in Southeast Asian youth was shaped by mental health literacy and stigma (including attitudes from family, peers, and the wider community). Program effectiveness was mixed, with improvement often lacking significant differences from control groups or failing to persist at follow-up. These findings emphasized the need for more community-level and upstream policy interventions alongside individual-level interventions to improve mental health literacy and stigma. Developing interventions requires methodological improvements in help-seeking research, and ultimately, accessible and trustworthy mental health services are crucial to sustaining progress.

Keywords: adolescents, help-seeking, mental health, Southeast Asia, young adults

Introduction

The 2022 World Mental Health Report by the World Health Organization (WHO) revealed that nearly one billion people worldwide live with mental health conditions. This prevalence has remained steady at 13% since the first report in 2001.¹ Furthermore, by 2030, direct costs of care, economic productivity losses, and increased social costs due to mental health conditions are predicted to reach USD 6 trillion globally, surpassing the costs of diabetes, chronic respiratory diseases, and cancer combined.² The COVID-19 pandemic exacerbated mental health conditions, particularly for younger individuals who are more vulnerable and disproportionately affected by social and economic impacts, placing them at higher risk for adverse mental health outcomes.¹ In the first half of 2021, the United Nations Children's Fund (UNICEF) reported that a median of 19% of individuals aged 15–24 years across 21 countries felt depressed or disinterested in activities.³ The proportion of years lived with disability due to mental disorders, such as depression and anxiety, is highest globally among those aged 15–29 years (23.7–25.6%), compared to less than 10% in younger children (0–4 years) and older adults (≥60 years).¹

In 2024, the Southeast Asia (SEA) accounts for approximately 8.52% of the global population.⁴ Adolescents (10–19 years) represent a significant demographic in the region, as the WHO-SEA's 2024 Declaration on Adolescent-Responsive Health Systems highlights that approximately 360 million adolescents constitute 27% of the global adolescent population, the largest share for any region.⁵ Within the SEA, the mental health burden among adolescents and young adults is also prominent. A 2021 systematic review of university students in six SEA countries (Cambodia, Laos, Malaysia, Myanmar, Thailand, and Vietnam) reported median point prevalences of 42.4% for anxiety, 29.4% for depression, 16.4% for stress, and 13.9% for eating disorders, with suicidality present in 7–8% of students.⁶ Despite the high prevalence of these issues, treatment rates remain low, and reluctance to seek professional help is widespread.⁶ Similarly, the 2023 Indonesian Health Survey revealed that depression is most prevalent among young people (15–24 years), yet only 10.4% receive treatment.⁷

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Despite efforts to raise awareness about mental health issues, significant gaps remain in improving mental health help-seeking behavior.⁸ Mental health is yet to be prioritized in many SEA countries,⁸ and interventions must consider the region's unique cultural norms and resource limitations.⁹ A major barrier to intervention development is the scarcity of reliable data, stemming from inadequate systematic data collection processes and proficient data collection authorities.⁹ Given these challenges and the lack of literature review on this topic, a systematic evaluation of mental health help-seeking behavior among adolescents and young adults in the SEA is essential. This systematic literature review (SLR) aimed to assess published evidence on help-seeking behaviors, including assessing preferences, barriers and facilitators, and the effectiveness of mental health promotion programs implemented for the SEA youth.

Method

A mixed-method SLR was selected to comprehensively capture the diverse components and outcomes associated with help-seeking behaviors and interventions. This SLR employed the Population, Intervention, Comparison, and Outcome (PICO) framework to construct the final research question and eligibility criteria. The target population included adolescents (10–19 years) and young adults (18–26 years),^{10,11} who were not receiving mental health care. Studies focusing solely on adults without a specific sub-analysis for adolescents or young adults, as well as those involving children under 10 years old, were excluded. Any mental health help-seeking screening, assessment, program, or intervention aimed at improving help-seeking behavior was reviewed without requiring a specific comparator. Eligible outcomes encompassed mental health help-seeking, including facilitators, barriers, and preferences, as well as attitudes or behaviors related to seeking mental health support.

Studies focused on health-seeking behaviors outside of mental health (e.g., physical health or academic help) were excluded. All study designs were eligible, and only articles published in English or Indonesian language were considered. Studies conducted within Southeast Asian countries (Indonesia, Singapore, Malaysia, Thailand, Vietnam, Laos, Myanmar, Cambodia, Brunei Darussalam, the Philippines, and Timor-Leste) were included. Only original research articles, including brief reports, were included. Review articles, theoretical articles, study protocols, as well as editorials, opinion pieces, and perspective articles were excluded. There were no restrictions on the publication date.

Systematic searches through major electronic databases and manual hand-searching of local databases, conference proceedings, and grey literature were conducted in October 2024. Four electronic databases (MEDLINE, EMBASE, PsycINFO, and PsycEXTRA) were searched using keywords encompassed five main themes: 1) mental-health promotion programs, 2) help-seeking profiles, 3) help-seeking behavior, 4) adolescents and young adults, and 5) Southeast Asia. Supplementary Material 2 lists all keywords used, and Supplementary Material 3 details the manual hand-searching sources. Search results were exported to EndNote 21 (institutional license provided by the London School of Hygiene and Tropical Medicine), where duplicates were removed before screening. The study selection process followed the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) 2020 flow diagram for systematic reviews, including searches of databases, registers, and other sources.¹²

Data were systematically extracted into a pre-specified grid, tailored to accommodate variations based on the aim of each study (either on help-seeking behavior profile or program) and design. For help-seeking behavior profile studies, extracted data included publication year, participant characteristics (country, setting, age range, sampling method, and sample size), study methods (study design, data collection, and analysis), and outcomes (mental health scales used and results for quantitative studies, or themes and concepts for qualitative studies). For help-seeking behavior program studies, data extraction included publication year, participant characteristics, study methods, intervention, comparison in the control group (if applicable), and outcome (measured behavior, mental health scales used, assessment time points, and results). Different Joanna Briggs Institute (JBI) critical appraisal tools were used based on study design: 1) randomized controlled trial (RCT), 2) quasi-experimental, 3) cross-sectional, and 4) qualitative.¹³ Scoring and grading followed a previous SLR.¹⁴

The data synthesis process was organized by study aims, categorizing them as describing the overall help-seeking behavior profile or evaluating help-seeking interventions. Within these categories, the synthesis was further detailed as follows: 1) Profile (mental health scales used, facilitators and barriers to help-seeking, and preferences for support), and 2) Program (intervention delivery and effectiveness). Quantitative data were narratively analyzed following the Synthesis Without Meta-analysis (SWiM) guidelines.¹⁵ Qualitative data were inductively analyzed through thematic synthesis, following the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) reporting

guideline.¹⁶ Themes were manually extracted from the “results” and “conclusions” sections to form overarching concepts without computer software. Data reporting followed the PRISMA 2020 checklist.¹²

Results

Database searches initially yielded 511 results, of which 106 duplicates were removed (Figure 1). Title and abstract screening excluded 367 articles, leaving 33 for full-text review. Manual hand-searching identified 13 studies, 12 of which were retrieved and reviewed. At full-text stage, 24 articles (Supplementary Material 4) were excluded for reasons listed in Figure 1. This review included 16 studies (11 from database searches and five from manual hand-searching).

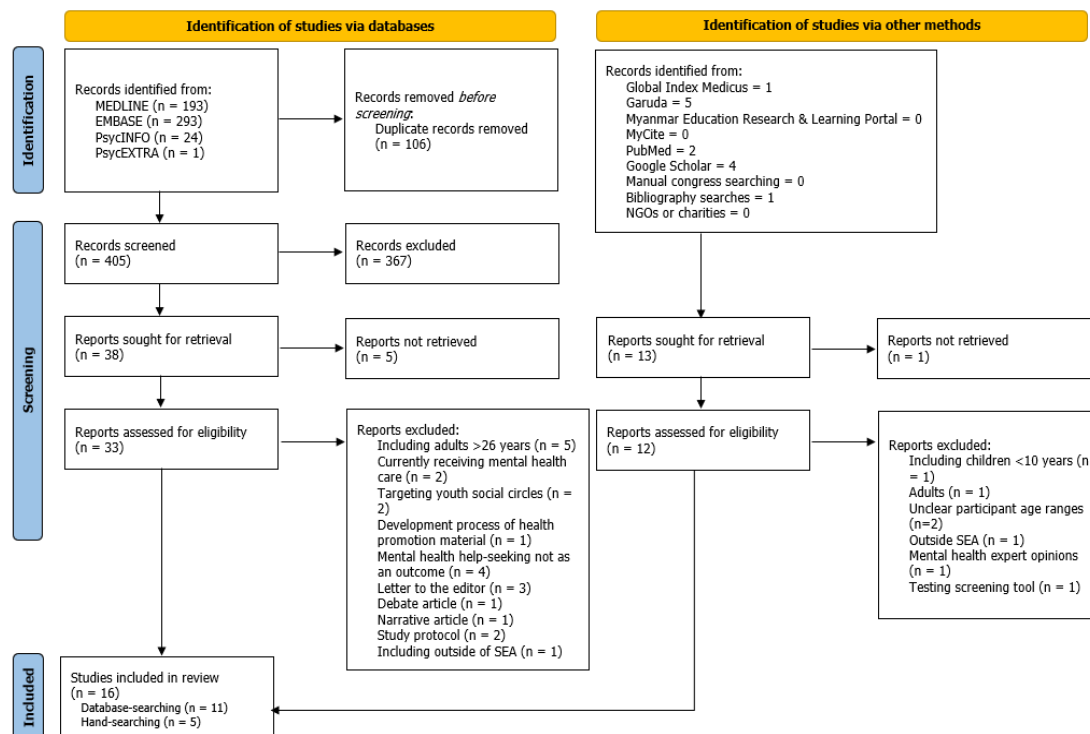


Figure 1. PRISMA 2020 Flow Diagram

The majority (68.8%) of included studies were published from 2020 onwards. Five studies originated from Malaysia, five from Indonesia, four from Vietnam, and two from Singapore. Most studies (81.3%) were conducted in educational facilities (schools or universities). More than half of the studies (56.3%) were conducted in adolescents aged 10–19 years. The remaining seven (43.8%) included both adolescents and young adults, with the broadest age range being 13–25 years. Twelve studies (two qualitative and 10 cross-sectional) assessed help-seeking behavior profiles (Table 1), while four studies (two RCTs, one quasi-experimental, and one cross-sectional) evaluated interventions aimed to facilitate or increase help-seeking behavior (Table 2). Critical appraisal results showed seven high-quality studies (43.8%), two medium-quality (12.5%), and seven low-quality studies (43.8%).

Table 1. Summary of Study Characteristics (Profile)

| Author (Year) | Country | Study Design | Participants' Characteristic | Sample Size | Data Method | Collection | Help-seeking Profile | Critical Appraisal Grading |
|--|-----------|-----------------|--|-------------|-----------------------|------------|---|----------------------------|
| Goh DH et al. (2007) ¹⁷ | Singapore | Cross-sectional | 12–18 years secondary school students | 448 | Custom questionnaire | | Attitude | Low |
| Aida J et al. (2010) ¹⁸ | Malaysia | Cross-sectional | 15–17 years secondary school students | 205 | Custom questionnaires | | <ul style="list-style-type: none"> • Preferences • Barriers | Low |
| Muthupalaniappen L et al. (2012) ¹⁹ | Malaysia | Cross-sectional | 13–17 years government school students | 131 | Custom questionnaires | | <ul style="list-style-type: none"> • Preferences • Barriers | Low |

| Author (Year) | Country | Study Design | Participants' Characteristic | Sample Size | Data Method | Collection | Help-seeking Profile | Critical Appraisal Grading |
|---|-----------|-----------------|---|-------------|---|------------|--|----------------------------|
| Thai QCN <i>et al.</i> (2018) ²⁰ | Vietnam | Cross-sectional | 19–26 years college students | 350 | Custom questionnaires | | <ul style="list-style-type: none"> • MHL • Preferences | Low |
| Ibrahmi N <i>et al.</i> (2019) ²¹ | Malaysia | Cross-sectional | 13–25 years secondary school and college students | 202 | <ul style="list-style-type: none"> • GHSQ • MHSAS • SSOH | | <ul style="list-style-type: none"> • Facilitators • Barriers | High |
| Prawira B <i>et al.</i> (2020) ²² | Indonesia | Cross-sectional | 18–24 years college students | 284 | <ul style="list-style-type: none"> • SOSS • GHSQ | | <ul style="list-style-type: none"> • Facilitators • Preferences | High |
| Berry C <i>et al.</i> (2020) ²³ | Malaysia | Qualitative | 16–23 years in a non-governmental education and mental health social enterprise and partner organizations | 9 | Semi-structured interview | | <ul style="list-style-type: none"> • MHL • Preferences • Facilitators • Barriers | High |
| Thai TT <i>et al.</i> (2020) ²⁴ | Vietnam | Cross-sectional | 15–18 years high school students | 1,114 | <ul style="list-style-type: none"> • MHLS • GHSQ | | <ul style="list-style-type: none"> • MHL • Preferences • Attitude | Medium |
| Brooks H <i>et al.</i> (2022) ²⁵ | Indonesia | Qualitative | 11–15 years from primary care and child and adolescent mental health services | 19 | Semi-structured interview | | <ul style="list-style-type: none"> • MHL • Preferences • Facilitators • Barriers | High |
| Siswanti DN <i>et al.</i> (2022) ²⁶ | Indonesia | Cross-sectional | 17–22 years in Makassar City | 177 | <ul style="list-style-type: none"> • MHKQ • Custom questionnaire | | <ul style="list-style-type: none"> • Preferences • Facilitators | Low |
| Syakarofath NA <i>et al.</i> (2023) ²⁷ | Indonesia | Cross-sectional | 14–19 years high school students | 300 | <ul style="list-style-type: none"> • MHSAS • MHSIS | | <ul style="list-style-type: none"> • Attitude • Intention • Preferences | Low |
| Lesmana MHS <i>et al.</i> (2024) ²⁸ | Indonesia | Cross-sectional | 16–19 years old public high school students | 760 | <ul style="list-style-type: none"> • GHSQ • MHLS | | <ul style="list-style-type: none"> • Facilitators • Barriers • MHL | High |

Notes: GHSQ = General Help-Seeking Questionnaire, MHSAS = Mental Help-Seeking Attitudes Scale, SSOH = Self-Stigma of Seeking Help, SOSS = Stigma of Suicide Scale, MHLS = Mental Health Literacy Scales, MHKQ = Mental Health Knowledge Questionnaire, MHSIS = Mental Help-seeking Intention Scale.

Table 2. Summary of Study Characteristics (Program)

| Author (Year) | Country | Study Design | Participant's Characteristic | Sample Size | Intervention | Data Collection Method | Help-seeking Outcome | Critical Appraisal Grading |
|--|-----------|--------------------|---|-------------|---|---|---|----------------------------|
| Ibrahim N <i>et al.</i> (2020) ²⁹ | Malaysia | Quasi-experimental | 12–17 years boarding school students | 101 | One-time depression literacy intervention | <ul style="list-style-type: none"> • MHSAS • SSOH | <ul style="list-style-type: none"> • Attitude • Self-stigma towards professional mental health services | High |
| Nguyen DT <i>et al.</i> (2021) ³⁰ | Vietnam | Cross-sectional | 16–20 years secondary school students | 643 | A website delivering health and mental health information | Custom questionnaires | <ul style="list-style-type: none"> • Website visit activities • User evaluation | Low |
| Tay JL (2022) ³¹ | Singapore | RCT | 18–24 years university students | 175 | Four online mental health sessions | Custom questionnaires | <ul style="list-style-type: none"> • Attitude • Intention | Medium |
| Tran TD <i>et al.</i> (2023) ³² | Vietnam | RCT | 15–16 years public high school students | 1,084 | Six 90-minute whole-class sessions | CSES | Social support seeking | High |

Notes: MHSAS: Mental Help-seeking Attitudes Scale; SSOH: Self-stigma of Seeking Help; CSES: Coping Self-efficacy Scale.

Mental Health and Help-Seeking Measurements in Southeast Asian Youth

The General Help-Seeking Questionnaire (GHSQ) was used in four studies.^{21,22,24,28} The Mental Health Literacy Scales (MHLS) were used in two studies,^{24,28} in which both observed low levels of mental health literacy (MHL). An adequate MHL of 26.3% was found only in one study.²⁰ MHL emerged as a concept in two included qualitative studies, where both authors interpreted low levels of MHL.^{23,25} MHL was shaped by personal experiences in their living environment, reflected as heavily dependent on family members and technology to access information,²⁵ and exposure to new perspectives and cultural environments.²³ The Mental Help-Seeking Attitudes Scale (MHSAS) was used in two studies.^{21,27} The Mental

Health Knowledge Questionnaire (MHKQ) and the Mental Help-Seeking Intention Scale (MHSIS) were each used in one study.^{26,27} Two studies assessed mental health-related stigma using the Self-Stigma of Seeking Help (SSOH) and the Stigma of Suicide Scale (SOSS).^{21,22}

Facilitators for Help-Seeking in Southeast Asian Youth

Mental health literacy and school climate significantly correlated with help-seeking behavior (both p-value <0.001) in one study,²⁸ with another study also found that mental health literacy significantly influenced adolescents' attitudes to seeking psychological help (p-value = 0.02).²⁶ Mental help-seeking was positively correlated with a general help-seeking attitude (p-value = 0.027). At the same time, self-stigma of seeking help was the sole predictor of mental help-seeking attitude across different academic levels (secondary school and university) (p-value <0.05).²¹ One study found suicide stigma positively associated with both non-formal (p-value <0.001) and formal (p-value ≤0.001) help-seeking intentions.²² Several themes appeared under the facilitators' code in the two included qualitative studies, including participants' knowledge,^{23,25} support from their environment,²⁵ and positive past help-seeking experience.²⁵

Barriers for Help-Seeking in Southeast Asian Youth

Four studies highlighted barriers to help-seeking, including the negative correlation with mental health literacy and perceived stigma (p-value <0.001),²⁸ particularly between mental help-seeking attitude and self-stigma of seeking help (p-value <0.001) in university students.²¹ Various self-stigma on mental health issues were presented in two studies as barriers to accessing mental health care in primary services.^{18,19} Concerns over others' perceptions, including those of friends, family, teachers, and the wider community, were also apparent. There were additional healthcare access barriers, including limited awareness of available services and logistical challenges (time constraints, transportation difficulties, and service costs). Both qualitative studies also presented negative attitudes and stigmatizing social narratives as the main barriers to seeking help.^{23,25} Additionally, one study highlighted participants' views of building relationships with therapists as a challenging endeavor,²³ and another showed a lack of confidence in sharing their story.²⁵

Preferences for Sources of Mental Health Support in Southeast Asian Youth

Informal sources were preferred for help-seeking, with friends and family members consistently ranked among the top three preferences in six studies.^{18-20,24,26,27} Two qualitative studies stated that participants mainly relied on family and friends,²⁵ perceiving informal help-seeking from these intimate, established relationships as more acceptable.²³ Additionally, participants in both studies demonstrated a lower preference for religious or spiritual activities as sources of help.^{23,25} In three cross-sectional studies,^{20,26,27} professional or formal sources of help (counselors, psychologists, or psychiatrists) were also recognized among the top preferences. Despite this, two qualitative studies revealed contrasting views: participants exhibited skepticism towards professional help while simultaneously recognizing its potential benefits and usefulness.^{23,25} Two studies also mentioned self-reliance in mental health problem-solving.^{20,26}

Mental Health Promotion Programs Targeting Help-Seeking Behavior in Southeast Asian Youth

Four different programs were captured in this review. Among the included RCTs, one trial from Vietnam delivered six weeks of in-person class sessions on depressive symptoms and mental well-being,³² while the other from Singapore involved four online sessions providing mental health knowledge.³¹ Assessment tools included the Coping Self-efficacy Scale (CSES)³² and custom questionnaires.³¹ Follow-up periods varied, with one trial conducting a six-month follow-up,³² and the other a two-month follow-up.³¹

In the six-week in-person program, the intervention group showed a higher social support-seeking component of the CSES score and a smaller decline in scores during the six-month follow-up. However, the differences with the control group were not statistically significant at any time point (p-value = 0.068 at baseline, p-value = 0.23 at post-intervention, and p-value = 0.26 at 6-month follow-up).³² The online program found no significant differences in help-seeking intentions between the intervention and control group at baseline (p-value = 0.51), post-intervention (p-value = 0.11), or follow-up (p-value = 0.24). However, within the intervention group, there was an improvement in help-seeking over time, with notable differences between baseline and post-intervention (p-value = 0.001) and follow-up (p-value = 0.03).³¹ Both RCTs had low dropout rates and applied intention-to-treat analysis.

One quasi-experimental study from Malaysia focused on adolescents with significant depression symptoms, comparing an intervention group to a control group with a cumulative drop-out rate of 12.1% at a three-month follow-

up.²⁹ Following a one-time depression literacy intervention, including small group activities, an explanatory talk, and an animated video, the intervention group saw significantly increased MHSAS scores after intervention (p-value <0.001) and at follow-up (p-value = 0.034). In contrast, the SSOH score showed a significant decrease at post-intervention (p-value = 0.001), though not maintained at follow-up (p-value = 0.242). When controlling for pretest scores, the intervention group maintained significantly higher MHSAS scores (p-value = 0.004) and lower SSOH scores (p-value <0.001) at the three-month follow-up. A cross-sectional study from Vietnam assessed the use of a health and mental health information website.³⁰ Two weeks after its launch, 17.7% of its visitors used the website for help-seeking, with significantly higher use in regular than specialized school students (p-value = 0.003). A one-year follow-up of website traffic showed that sections focused on emotions and feelings, alongside depression-related items, were the website's second and third most visited areas. The website also received positive Likert-scale feedback from users regarding its usefulness, topical relevance and suitability, accessibility, future usage, and recommendation intentions.

Discussion

This SLR analyzed the profiles of help-seeking behavior and related mental health interventions in SEA adolescents and young adults. This SLR identified a limited-sized evidence base of 16 mixed-quality studies. The majority of studies indicated that MHL in this demographic was generally low. Despite a keen interest in improving mental health understanding and acknowledging the potential benefits of seeking professional help, skepticism and a lack of trust in professional mental health services persisted. SEA youth relied on self-help and preferred informal sources, mostly family and friends, for seeking help and mental health information. The primary barriers to help-seeking were the perceived stigma of society and negative societal attitudes, with additional barriers related to accessing and utilizing mental health services. All the interventions reviewed in this paper aimed to improve help-seeking behavior by providing mental health-related knowledge, utilizing direct contact, or an online medium in educational facilities. Primary outcomes were assessed using self-reported questionnaires. This review identified mixed efficacy. While improvements in help-seeking were observed within intervention groups, some studies did not observe statistically significant differences compared to control groups, or if they existed, were not maintained at follow-up.

The findings from this review reflected two key areas to address when improving help-seeking behavior among SEA youth: individual aspects and environmental influences. First, on the individual aspect, the MHL assessed by three cross-sectional and two qualitative studies among SEA adolescents and young adults was generally low. In the cross-sectional studies, self-reported questionnaires used to measure MHL were adapted from two questionnaires originally developed outside of SEA and for the general population, including the most commonly used MHLs. The MHLs currently stands as the most reliable, validated, and comprehensive MHL instrument and has been adapted for various cultures and languages; however, reviews on its adaptations' measurement properties are still scarce, with a systematic review currently underway.³³ This highlights the need for future research to develop a methodologically rigorous and context-relevant MHL scale tailored to SEA youth.

Furthermore, MHL was identified as a significant factor correlating to help-seeking behavior in two studies. A positive correlation between MHL and help-seeking behavior was also supported by a 2023 systematic review.³⁴ In addition to its direct influence on help-seeking, MHL influences other individual-level aspects, such as self-stigma and preference for sources of help. For example, a study from Singapore emphasized the importance of improving MHL and the recognition of mental health conditions, as these were associated with reduced personal and perceived stigma and an increased likelihood of seeking professional help.³⁵ Based on these findings, this review suggests that improving MHL could address various individual barriers, including youth perceptions of professional help, scepticism, self-stigma, and preference for sources of help.

Second, exploring youth preferences and opinions leads to the other key area to address: youth's environmental influences, including informal sources of help and perceived negative stigma and attitude. Favorable preferences towards informal help sources were reported by eight studies consisting of five low- and one medium-quality cross-sectional studies and two high-quality qualitative studies. Out of these six cross-sectional studies, only two measured outcomes in valid and reliable ways,^{20,24} and four others let participants select more than one answer. Given these considerations, concluding a clear preference for youth's sources of help may be challenging, as most studies reported these preferences in a descriptive way and did not provide additional supporting statistical analysis. However, a favorable preference towards informal sources of help was also supported by two high-quality qualitative studies, and allowing multiple answers captured the complexity of SEA youth's thoughts and experiences related to help-seeking in reality. This

complexity calls for careful consideration when designing surveys or other data collection methods for future quantitative studies. It highlights the strength of employing qualitative methods to capture this data type.

Findings from this review showcase that efforts to improve help-seeking in SEA youth need to be supported by improvement in their environment. This finding is supported by a large-scale cross-national study on the mental health of children and adolescents across 13 Asian and European countries with varying income levels, which found that support from informal sources, particularly family members, friends, and educators, is particularly vital in lower-income settings.³⁶ Additionally, despite the general understanding of religion's role in SEA's sociocultural context, SEA youth show a lesser preference for religious or spiritual activities when seeking mental health help.^{23,25} This contrasts with a previous cross-sectional survey finding from a multi-ethnic Asian adult population in Singapore that found religious affiliation was associated with enhanced positive mental health components,³⁷ highlighting the need to cater to the unique differences across various population groups.

Four mixed-quality studies presented interventions to improve help-seeking behavior in SEA youth, with mixed efficacy overall. The lower quality in the two studies was mainly attributed to methodological issues affecting results and interpretation, such as insufficient reporting on the reliability and validity of exposure and outcome measurements. Similarly, the authors also reflected limitations related to measurement scales and self-reported tools in all intervention studies.²⁹⁻³² There is a need for improvements in methodological tools and standards in youth help-seeking study,³⁸ as reliance on self-reported questionnaires introduces various biases. A need for larger-scale trials was also identified, as interventions analyzed in this review came from only three SEA countries, and two studies incorporated participants from only one school or university setting.

Additionally, the need for more studies includes developing original help-seeking interventions that are relevant and tailored to the context of youth and their environment in SEA. One included study shared an interesting reflection on adapting a program from its original version to accommodate participants in their study setting.³² It included an upscaling of participant group sizes to more than double the size in the original program, and researchers faced challenges in the delivery of the program. This may also have affected the quality and effectiveness of the intervention.

Similar mixed results in effectiveness were also seen in one systematic review on interventions to increase help-seeking for mental health care in low- and middle-income countries; however, a clear trend of favorable results is seen in interventions incorporating multiple components of raising general population's awareness and promoting help-seeking among the population in need of mental health care.³⁹ Reflecting on the two areas mentioned in the previous section, all interventions analyzed in this review primarily focused on the individual aspect, specifically targeting individual's mental health literacy and self-stigma through educational facilities. Mental health education through educational facilities allows interventions to reach the overall student and teacher community, potentially addressing peer stigma. However, it is important to ensure that young people outside of educational settings are not overlooked.³⁸

Future studies are needed on more diverse and dynamic youth environments, as well as interventions on wider determinants of youth's mental health. Given that larger facilitators and barriers often involve social groups outside of youth individually, a review study on interventions targeting family and wider community or upstream policy interventions will be crucial to support evidence on individual-level interventions. Ultimately, this review also reflected the constraints of time, transport, and service costs faced by SEA youth to access mental health services. A preliminary scoping review in 2023 on mental health services access and utilization across SEA identified several barriers related to mental health services, including inadequate training of health professionals, quality of service, and poor distribution of resources.⁴⁰ The same study highlighted enablers, including outreach services, accessibility, and affordability.

This paper is the first SLR focusing on help-seeking behavior among SEA adolescents and young adults. By using a mixed-method approach, this study provided a comprehensive and interconnected analysis of the help-seeking profiles and the programs implemented to date, highlighting the existing gaps in the current evidence base. This SLR, however, had several limitations. First, it excluded individuals who, at the time of the included studies, were already receiving mental health care. Future studies should include this population to capture broader insights and experiences of what successfully prompted them to seek help. Second, this review included studies published in English and Indonesian languages only. Expanding language inclusion through collaboration with multilingual SEA researchers or using professional translation services could enhance the number of studies analyzed in future reviews. Third, most included studies were considered low-quality, underscoring the scarcity of evidence and highlighting the pressing need for more robust evidence in this topic and area. Future systematic reviews should be conducted once a stronger body of research with improved methodologies becomes available on this topic.

Conclusion

This review examines the mental health help-seeking behavior profile and implemented interventions in SEA youth. SEA youth hold significant potential as a facilitator to empower help-seeking both individually and within their communities. To maximize their potential, it is crucial to enhance the mental health literacy of youth and the wider community, particularly by actively addressing self- and perceived community stigma associated with seeking help and mental illness. Additionally, designing accessible and relevant mental health services is essential to complement improvements in literacy and stigma, thereby facilitating help-seeking behavior in this population. Ultimately, developing help-seeking interventions needs to be supported by developing objective and robust tools to record or assess help-seeking behavior.

Abbreviations

WHO: World Health Organization; SEA: Southeast Asia; SLR: Systematic Literature Review; PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-analysis; RCT: Randomised Controlled Trial; MHLS: Mental Health Literacy Scales; MHL: Mental Health Literacy; MHSAS: Mental Help-seeking Attitudes Scale; MHKQ: Mental Health Knowledge Questionnaire; MHSIS: Mental Help-seeking Intention Scale; SSOH: Self-stigma of Seeking Help; SOSS: Stigma of Suicide Scale; CSES: Coping Self-efficacy Scale.

Ethics Approval and Consent to Participate

Not applicable.

Competing Interest

The authors declared no conflict of interest.

Availability of Data and Materials

Materials were accessed through the London School of Hygiene and Tropical Medicine's library database or publicly available through sources listed in the supplementary files.

Authors' Contribution

GO conceptualized the study, performed data collection and analysis, and prepared the manuscript. JD and KC reviewed the study protocol, performed data collection and analysis, and reviewed the draft of the manuscript. All authors have read and approved the published version of the manuscript.

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