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Breaking the Silence: The Interplay of Literacy, Attitudes, and Mental Health Access among Malaysian Adolescents

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Abstract

Purpose: This study aimed to explore the interplay between mental health knowledge, attitudes, perceived barriers, and facilitating factors regarding access to mental health services among Malaysian government secondary school students. **Methods:** A total of 6735 adolescents (mean age 14.91 ± 1.36 years) across six states completed a validated, self-administered online questionnaire. Data were analyzed using descriptive statistics, independent samples t-tests, one-way ANOVA, Pearson correlations, and multiple linear regression to identify predictors of perceived barriers to care. **Results:** Participants demonstrated relatively high mental health knowledge and positive attitudes, yet reported substantial internal and sociocultural barriers to accessing care. Female and urban students exhibited significantly higher knowledge and more positive attitudes than their male and rural counterparts. Notably, perceived barriers remained uniformly high across all geographic locations. Correlation analysis revealed that while knowledge positively correlated with attitudes and facilitators ($P < 0.001$), it had no significant relationship with perceived barriers. Furthermore, regression analysis revealed that being male and, surprisingly, having a highly positive attitude toward mental health were both strongly linked to reporting greater barriers to accessing care ($P < 0.001$). **Discussion:** High mental health literacy and positive attitudes do not inherently diminish the systemic and cultural obstacles Malaysian adolescents face when seeking professional help. Enhancing service utilization requires moving beyond awareness campaigns to implement culturally sensitive, school-based interventions that foster professional trust and reduce internal stigma.

Keywords

Barriers, Facilitators, Mental Health Services, Help-Seeking Behaviour, Adolescents, Malaysia

1. Introduction

Adolescence is a highly vulnerable period for mental health; nearly one-third of psychiatric disorders emerge before age 14 [1] [2], and the World Health Organization estimates that one in seven adolescents globally experiences a mental health disorder, constituting 15% of their worldwide disease burden [3]. Left untreated, conditions like depression severely impair long-term educational attainment [4] and escalate the risk of suicide, now a leading cause of adolescent mortality globally [5]. This public health crisis is acutely evident in Malaysia, where the 2022 National Health and Morbidity Survey (NHMS) revealed that 26.9% of secondary students (aged 13 - 17) exhibited depressive symptoms, with prevalence among females doubling that of males. Furthermore, longitudinal data illustrates a distressing decade-long escalation in Malaysian adolescent suicidal ideation, climbing from 7.9% in 2012 to 10%, before reaching 13.1% in 2022 [6].

Despite the prevalence and importance of addressing mental health issues among this young population, there are various challenges faced in accessing mental health services. Adolescents often delay or avoid seeking mental health services due to social stigma and lack of mental health literacy which are consistently identified as key barriers to professional help-seeking [7] [8]. This included fear of being judged by peers or labelled, as well as negative expectations about treatment which discourage disclosure and contacting services [7] [8]. Cultural values also have influence in that, in collectivist Asian contexts for instance, seeking professional mental health services may be avoided due to face concern and familial stigma by fearing that acknowledging mental health issues will bring shame upon both self and family which could lead to reliance on informal support networks rather than professional care [9]-[11].

Furthermore, adolescent help-seeking is highly contingent on adult facilitation, with parents and school personnel acting as critical gatekeepers who can either enable or impede access to care [12] [13]. However, this dependency often creates a paradox: fears of privacy breaches and a lack of trust that professionals will keep information confidential from parents frequently drive youth to delay or avoid treatment [8] [14]. Beyond these interpersonal dynamics, structural barriers further obstruct care. Financial constraints, such as prohibitive treatment costs and inadequate insurance coverage, disproportionately exclude low-income adolescents [8] [15]. These financial burdens are compounded by logistical hurdles, including geographic isolation, transportation limitations, and inflexible clinic hours that clash with rigid school schedules [16] [17]. Ultimately, adolescent access to mental health services is hindered by a complex interplay of interpersonal

dependencies, privacy anxieties, and systemic practical challenges.

Although extensive literature documents barriers to adolescent mental health care, the predominance of non-local evidence limits its transferability [7] [8] [12] [16] [18]. This limitation is particularly salient in Malaysia, where a uniquely multiracial and multireligious landscape shapes distinct cultural attitudes and beliefs toward professional help-seeking [19] [20]. Current domestic research remains fragmented, focusing largely on localized mental health literacy or targeted regional interventions [21]-[23]. Furthermore, the country's primary nationwide surveillance, the NHMS Adolescent Health Survey [6], tracks risk behaviours and broad mental health indicators without capturing the students' perceived barriers or facilitators to accessing care. To address this critical nationwide evidence gap, this study investigates the factors influencing Malaysian government secondary school students' access to mental health services. Specifically, we aim to assess students' baseline mental health knowledge, evaluate their attitudes toward professional care, and quantify the perceived barriers and facilitators shaping their help-seeking behaviours.

2. Methods

2.1. Study Design and Participants

This quantitative, cross-sectional study utilized online survey to assess the perceived barriers and facilitators to mental health service access among Malaysian adolescents. A multi-stage stratified cluster sampling design was employed to capture a diverse, multi-regional sample. First, six states (Perak, Selangor, Johor, Pahang, Sabah, and Sarawak) were selected via simple random sampling.

The target sample size was calculated at 6258 students, based on a 16.2% estimated prevalence of poor mental health among adolescents [6], a 95% confidence level, a design effect of 1.5, and an anticipated 40% response rate. To ensure proportionate representation, the required 6258 respondents were distributed equally across the six regions, requiring 1044 respondents per state. Within each state, the sample was further stratified equally into urban (n = 522) and rural (n = 522) strata.

To achieve this sample allocation, 63 government secondary schools were selected across urban and rural strata using probability proportional to size (PPS) sampling to account for enrolment and demographics. The 63 schools were distributed across the states as follows: Perak, Johor, and Sarawak were allocated 11 schools each (6 urban, 5 rural); while Selangor, Pahang, and Sabah were allocated 10 schools each (5 urban, 5 rural).

Depending on the number of schools in a given stratum, the target number of participants per school was mathematically adjusted to meet the required 522 students per stratum. For strata containing five schools, the target was 105 students per school; for strata containing six schools, the target was 87 students per school. Within each school, systematic random sampling identified four to six classes. Eligible students within these sampled classes were recruited using quota sampling

to meet the respective school targets (87 or 105 students). This deliberate selection at the classroom level ensured a representative demographic mix of ages (13 to 18 years), genders, and races across the final sample.

Eligibility for study participation was restricted to adolescents aged 13 to 18 years who were currently enrolled in Malaysian government secondary schools and demonstrated proficiency in reading and writing in either Malay or English. Potential participants were excluded if they were unable to comprehend the study requirements to provide informed assent, or if their respective parental or guardian consent could not be obtained.

2.2. Data Collection Procedure

Following formal approval from the Ministry of Education (MOE), district education offices, and school principals, data were collected between September and October 2024. Designated school coordinators distributed the self-administered Google Forms survey link to eligible students and their parents via class teachers. Access to the survey instrument was strictly contingent upon the provision of both parental consent and student assent. The questionnaire required approximately 10 to 15 minutes to complete, and participation was entirely voluntary with no financial compensation provided.

To ensure data integrity, the system was configured to accept only fully completed forms. Participants retained the right to withdraw from the study at any juncture by exiting the browser; partial responses were automatically discarded and permanently destroyed to protect participant privacy. Upon the conclusion of the collection period, the survey link was deactivated. All primary data were securely stored with access restricted exclusively to the core research team, and no follow-up procedures were conducted.

2.3. Measure

A structured 48-item questionnaire was adapted from established measures and underwent a rigorous, three-phase validation process specifically for the Malaysian adolescent context. First, content validity was evaluated by a multidisciplinary panel of 10 experts. The instrument demonstrated outstanding content validity, with all items achieving an Item-Level Content Validity Index (I-CVI) of ≥0.90 and a Content Validity Ratio (CVR) of ≥0.80, resulting in an excellent Scale-Level Content Validity Index (S-CVI/Ave) of 0.98. Second, face validity was established via cognitive debriefing with 30 target-demographic adolescents who confirmed the items were culturally relevant and highly comprehensible, requiring no item attrition. Finally, a pilot test involving 200 adolescents confirmed robust internal consistency, yielding Cronbach's alpha coefficients ranging from 0.805 to 0.938 across all domains.

The survey consisted of seven demographic items capturing background variables, including religion, which literature identifies as a significant predictor of mental health beliefs [24]. Mental health knowledge was measured using 10 items adapted from the Mental Health Knowledge Questionnaire [22]. Attitude towards

mental health was assessed using seven items derived from Lee *et al.* [22] and the Self-Stigma of Seeking Help Scale [25]. Furthermore, perceived barriers to accessing mental health services were quantified using 15 items adapted from the Barriers to Seeking Psychological Help Scale [26]. Finally, facilitating factors for help-seeking were measured using nine items adapted from the Facilitators Questionnaire [27]. All items for attitude, perceived barriers, and facilitating factors were rated on a five-point Likert scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree). Meanwhile, mental health knowledge was measured using a five-point Likert scale ranging from 1 = very not sure to 5 = very sure.

Composite scores for each of the four core domains were calculated for analysis. For mental health knowledge (10 items), scores range from 10 to 50, with higher scores indicating greater mental health knowledge. The attitude towards mental health domain (7 items) yields scores ranging from 7 to 35, where higher scores reflect a more positive and destigmatized attitude. Perceived barriers (15 items) and facilitating factors (9 items) have score ranges of 15 to 75 and 9 to 45, respectively; higher scores indicate a higher level of perceived barriers or a greater presence of facilitating factors. Prior to score calculation and analysis, all negatively worded statements within the instrument were reverse-coded.

2.4. Ethical Consideration and Informed Consent

Ethical approval for this study was granted by the National Medical Research Register (NMRR ID-24-01341-RRF [IIR]) and the Ministry of Education Malaysia via the Educational Research Application System (KPM.600-3/2/3-eras [21415]). All procedures strictly adhered to the principles of the Declaration of Helsinki and the Malaysian Guidelines for Good Clinical Practice. The study posed minimal risk to participants, and participation was strictly voluntary.

Informed consent was obtained from all participants and their legal guardians. Prior to enrolment, comprehensive information sheets and consent forms were distributed to parents/guardians by designated school personnel at least two weeks before data collection, allowing one week for review and return. Concurrently, students received an age-appropriate information sheet and assent form. On the day of data collection, a web-based information sheet was displayed prior to the online survey. Digital assent was formally captured when students clicked "Yes" to the agreement statement, which permitted them to proceed to the questionnaire. Participants were explicitly informed that they were allowed sufficient time to consider their participation and could withdraw from the study at any time without penalty. All data were kept strictly confidential.

Furthermore, informed consent was obtained from all multidisciplinary experts and target-demographic adolescents who participated in the earlier instrument validation and cognitive debriefing phases.

2.5. Statistical Analysis

All statistical analyses were performed using IBM SPSS Statistics version 29.0.

Prior to analysis, data were screened for completeness and normal distribution. Descriptive statistics, including frequencies and percentages, were summarized for all categorical demographic variables. Means and standard deviations (SD) were computed for the continuous composite scores of the four core constructs: Mental Health Knowledge, Attitude, Perceived Barriers, and Facilitators.

To assess differences in these construct scores across various demographic groups, independent samples t-tests and one-way analysis of variance (ANOVA) were conducted. Pearson correlation coefficients were utilized to evaluate the bivariate relationships and interplay among students' mental health knowledge, attitudes, perceived barriers, and facilitating factors. Prior to conducting the multiple linear regression, categorical demographic variables were coded to allow for appropriate interpretation (Gender: 1 = Male, 2 = Female; Residential Area: 1 = Urban, 2 = Rural). Finally, multiple linear regression analysis was employed to identify significant demographic and cognitive predictors of adolescents' perceived barriers and facilitators to accessing care. While the multi-stage sampling design ensured a representative nationwide sample to address existing evidence gaps, standard inferential statistics were used without cluster adjustments because the primary analytical focus was on examining individual-level relationships and behavioural predictors. Key stratification variables, such as residential area, were included as covariates in the regression models to control for demographic variations. The threshold for statistical significance was set at $P < 0.05$ for all tests.

3. Results

3.1. Sample Characteristics

A total of 7200 secondary school students were initially recruited and invited to participate in the study, distributed evenly as 1200 students per selected state. Of these, 6735 secondary school students provided full parental consent and personal assent, and successfully completed the questionnaire (Table 1). The sample was predominantly female (57.7%) and of Malay ethnicity (68.4%). Participants had a mean age of 14.91 ± 1.36 years, with the 13- to 16-year-old cohorts relatively evenly distributed, though 15-year-olds constituted the largest single proportion (22.4%). The majority of respondents identified as Muslim (79.2%) and reported that their parents were married and living together (82.2%). Geographically, the respondents were well-distributed across the six targeted states.

Table 1. Respondents' sociodemographic characteristics ($n = 6735$).

Characteristics	*n*	%
Gender		
Male	2849	42.3
Female	3886	57.7
State		
Selangor	1110	16.5

Continued

Perak	1127	16.7
Johor	1120	16.6
Pahang	1175	17.4
Sabah	1115	16.6
Sarawak	1088	16.2
Ethnicity		
Malay	4610	68.4
Chinese	593	8.8
Indian	169	2.5
Bumiputera Sabah	538	8.1
Bumiputera Sarawak	414	6.1
Others	411	6.1
Age (years old)		
13	1393	20.7
14	1332	19.8
15	1509	22.4
16	1483	22.0
17	1009	15.0
18	9	0.1
Religion		
Muslim	5336	79.2
Christian	675	10.0
Buddhist	510	7.6
Hindu	148	2.2
Others	66	1.0
Parents' marital status		
Married	5534	82.2
Married but not living together	350	5.2
Divorced	431	6.3
Separated	85	1.3
Widowed	310	4.6
Orphan	25	0.4
Residential area		
Urban	3284	48.8
Rural	3451	51.2

3.2. Descriptive Statistics of Study Variables

Overall, the sample demonstrated relatively high mental health knowledge (Mean = 39.77, SD = 6.12) and moderately positive mental health attitudes (Mean = 24.67, SD = 3.35). However, despite this strong baseline literacy, participants still reported substantial perceived barriers to accessing services (Mean = 46.62, SD = 11.16). Concurrently, respondents indicated robust facilitating factors that could potentially encourage them to seek professional help (Mean = 34.44, SD = 6.16).

3.3. Gender and Residential Differences across Study Variables

Independent samples t-tests were conducted to evaluate differences in mental health knowledge, attitude, barriers and facilitators in accessing mental health services across gender and residential location (Table 2). Gender analysis revealed highly significant differences across all four domains. Female students demonstrated significantly greater mental health knowledge ($P < 0.001$) and more positive attitudes toward care ($P < 0.001$) compared to their male counterparts. Crucially, male students reported significantly higher perceived barriers to accessing services ($P < 0.001$), although they also noted slightly higher facilitating factors ($P = 0.008$). Regarding geographical location, urban students exhibited significantly higher mental health knowledge ($P = 0.006$), better attitudes ($P = 0.005$), and stronger facilitating factors ($P = 0.015$) than rural students. Interestingly, there was no statistically significant difference in perceived barriers between urban and rural adolescents ($P = 0.262$), indicating that obstacles to accessing care are experienced uniformly regardless of residential setting.

Table 2. Independent samples t-test comparing mental health knowledge, attitudes, barriers, and facilitators across gender and residential location.

Variables	Male (n = 2849) Mean ± SD	Female (n = 3886) Mean ± SD	t-value	P	Urban (n = 3284) Mean ± SD	Rural (n = 3451) Mean ± SD	t-value	P
Knowledge	39.31 ± 6.34	40.11 ± 5.93	−5.34	**<0.001**	39.98 ± 5.79	39.57 ± 6.41	2.73	**0.006**
Attitude	24.45 ± 3.46	24.83 ± 3.26	−4.6	**<0.001**	24.79 ± 3.35	24.56 ± 3.35	2.79	**0.005**
Barriers	48.06 ± 10.72	45.56 ± 11.36	9.17	**<0.001**	46.77 ± 11.63	46.47 ± 10.69	1.12	0.262
Facilitators	34.67 ± 6.18	34.27 ± 6.14	2.67	**0.008**	34.62 ± 6.08	34.26 ± 6.23	2.43	**0.015**

SD: Standard Deviation. Bold P-values indicate statistical significance ($P < 0.05$).

3.4. Variations in Study Variables by Age

A One-Way ANOVA was conducted to examine differences across age groups regarding students' mental health knowledge, attitudes, perceived barriers, and facilitators in accessing mental health services. The analysis revealed statistically significant differences across all four domains: mental health knowledge ($F = 25.10$, $P < 0.001$), attitudes ($F = 6.73$, $P < 0.001$), perceived barriers ($F = 5.13$, $P < 0.001$), and facilitating factors ($F = 10.23$, $P < 0.001$). Post-hoc evaluations using the Tukey HSD test indicated a clear developmental trajectory among the core adolescent cohorts (aged 13 to 17). Specifically, as students advanced in age, they

demonstrated progressively higher mental health knowledge and more positive attitudes toward care, with 17-year-olds scoring the highest in both domains. Older adolescents (aged 16 and 17) also reported significantly higher facilitating factors compared to younger cohorts. However, perceived barriers did not follow a strict linear decline, remaining persistent across all age groups and peaking slightly among the 13- and 17-year-olds.

3.5. Interplay between Mental Health Knowledge, Attitudes, and Access to Mental Health Services

A Pearson correlation analysis was conducted to examine the bivariate relationships among the four variables (Table 3). The results revealed strong, highly significant positive correlations between mental health knowledge and both attitudes toward care ($r = 0.420$, $P < 0.001$) and facilitating factors ($r = 0.527$, $P < 0.001$). Similarly, positive attitudes were moderately correlated with higher facilitating factors ($r = 0.373$, $P < 0.001$).

Most notably, mental health knowledge showed no statistically significant correlation with perceived barriers ($r = 0.022$, $P = 0.073$). Furthermore, both attitude ($r = 0.072$, $P < 0.001$) and facilitating factors ($r = 0.320$, $P < 0.001$) demonstrated positive correlations with perceived barriers. This crucial finding indicates that while better knowledge and positive attitudes enhance a student's willingness to seek help (facilitators), they do not diminish the systemic or structural obstacles (barriers) the student faces in accessing that care.

Table 3. Pearson correlation coefficients among mental health knowledge, attitudes, barriers, and facilitators in accessing mental health services.

Variables	1	2	3	4
Mental Health Knowledge	1			
Mental Health Attitude	0.420***	1		
Perceived Barriers	0.022	0.072***	1	
Facilitating Factors	0.527***	0.373***	0.320***	1

*** $P < 0.001$. All tests were two-tailed.

3.6. Predictors of Perceived Barriers to Access Mental Health Services

A multiple linear regression analysis was performed to determine the extent to which sociodemographic factors (gender, residential area) and cognitive domains (mental health knowledge, attitudes) predict adolescents' perceived barriers to accessing mental health services (Table 4). The overall model was statistically significant [$F (4, 6730) = 32.20$, $P < 0.001$, Adjusted $R^2 = 0.018$]. When interpreting the unstandardized coefficients (B) to determine the direction of the associations, female (coded as 2) was associated with a significant decrease in perceived barriers compared to males (coded as 1) ($B = -2.614$, $P < 0.001$). Furthermore, mental health attitude was a significant positive predictor ($B = 0.268$, $P < 0.001$), indicat-

ing a paradoxical trend where heightened mental health awareness and more positive attitudes correlate with an increased recognition of systemic barriers.

To evaluate the relative strength of these predictors, standardized beta coefficients (β) were examined. Gender emerged as the strongest predictor in the model ($\beta = -0.116$, $P < 0.001$), confirming that male students are significantly more likely to perceive higher barriers to care when controlling for other variables. Furthermore, mental health attitude was a significant positive predictor ($\beta = 0.080$, $P < 0.001$), indicating a paradoxical trend where heightened mental health awareness and attitudes correlate with an increased recognition of systemic barriers. Conversely, mental health knowledge ($B = -0.009$, $\beta = -0.005$, $P = 0.713$) and residential area ($B = -0.333$, $\beta = -0.015$, $P = 0.217$) failed to significantly predict perceived barriers, reinforcing the finding that systemic obstacles to care remain universally persistent among adolescents, regardless of their individual literacy or geographic location.

Table 4. Multiple linear regression predicting perceived barriers to access mental health services.

Variables	*B*	SE	*Standardized β*	*t*	P	R^2	*Adjusted* R^2	VIF
Perceived Barriers (Model 1[a])						**0.019**	**0.018**	
(Constant)	**44.988**	**1.264**		**35.6**	**<0.001**			
Mental Health Knowledge	**−0.009**	**0.024**	**−0.005**	**−0.37**	**0.713**			**1.217**
Mental Health Attitude	**0.268**	**0.044**	**0.080**	**6.04**	**<0.001**			**1.216**
Gender	**−2.614**	**0.274**	**−0.116**	**−9.56**	**<0.001**			**1.006**
Residential Area	**−0.333**	**0.27**	**−0.015**	**−1.23**	**0.217**			**1.003**

[a]Model 1: Adjusted for mental health knowledge, mental health attitude, gender (1 = Male, 2 = Female), and residential area (1 = Urban, 2 = Rural). VIF: Variance inflation factor, SE: Standard error, *B*: Unstandardized coefficient, *β*: Standardized coefficient.

4. Discussion

To our knowledge, this is the first large-scale, multi-regional study exploring the interplay between mental health knowledge, attitude, perceived barriers, and facilitating factors among adolescents in accessing mental health services in Malaysia. The results indicate that while respondents possess generally high mental health knowledge and positive attitudes, they paradoxically face substantial perceived barriers to accessing care. These obstacles are predominantly internal, driven by personal shame, stigma, and difficulty disclosing distress. Conversely, trust in professionals, a positive disposition toward help-seeking, and robust institutional support emerged as the most critical facilitators.

Consistent with existing literature, our findings confirm a significant positive correlation between mental health knowledge and attitudes [28]-[30]. Enhancing mental health literacy equips adolescents to better identify symptoms, reduces stigma, and fosters a positive disposition toward psychological care [29] [30]. Furthermore, our data show that adolescents with excellent knowledge and attitudes more readily recognize facilitating factors for accessing services [31] [32]. This

suggests that psychoeducational interventions not only improve baseline literacy but also enhance an adolescent's self-efficacy in navigating available support pathways [28] [33] [34].

However, a pivotal finding of this study is that high knowledge and positive attitudes do not inherently diminish the perceived barriers to accessing care. Despite their literacy, Malaysian adolescents continue to report significant perceived obstacles. Prior global studies note that fear of peer judgment and labelling deters youth from seeking help [7] [8] [18]. In Malaysia's collectivist cultural setting, this is compounded by family-related stigma, where acknowledging psychological distress is often perceived as bringing shame or a "loss of face" to the family [9]-[11] [35]. Consequently, young people often choose to conceal their struggles or rely on informal networks rather than risking the social cost of professional disclosure.

To bridge this critical gap between literacy and actual service utilization, facilitating factors must be leveraged. Cultivating elements such as trust in mental health professionals and strong institutional support is vital, as structural availability alone is insufficient. Adolescents require a relational foundation to feel safe disclosing their issues [12] [13] [36]. Because adolescents may anticipate shame, their expectations of strict confidentiality and non-judgmental care act as pivotal determinants of whether they perceive existing services as accessible and intend to utilize them [12] [21] [22].

Overall, these findings carry significant implications for advancing the National Strategic Plan for Mental Health [37]. Interventions must evolve beyond basic awareness campaigns. Addressing these profound perceived barriers requires youth-friendly, culturally sensitive, and highly confidential service delivery frameworks [38]. Schools must serve as the primary nexus for this support by embedding mental health literacy into the curriculum and empowering teachers and school counsellors as capable, frontline responders [38] [39]. Building trust within these familiar institutional environments is essential for transforming positive attitudes into proactive help-seeking intentions [22] [40].

The primary strength of this study is its extensive multi-state scope, ensuring representation across diverse geographic regions and sociocultural backgrounds in Malaysia. The use of a robust quantitative approach to evaluate multiple domains simultaneously provides a comprehensive, multidimensional understanding of adolescent help-seeking dynamics. Collectively, these methodological strengths offer valuable baseline data to directly inform national policy.

5. Limitations

Several limitations should be considered when interpreting these findings. First, the reliance on self-reported measures may introduce response bias, as participants might underreport or overreport their experiences due to social desirability or recall inaccuracies. Second, the cross-sectional design inherently restricts the ability to infer causal relationships between mental health literacy, attitudes, and perceived access barriers. Third, while foundational content and face validity were

established prior to data collection, the psychometric evaluation of the adapted questionnaire had constraints; specifically, reliability was assessed solely through internal consistency (lacking test-retest reliability), and the structural validity via Exploratory or Confirmatory Factor Analysis was not formally tested within this study population. Finally, the sample was drawn exclusively from government secondary schools via an online platform. Consequently, the findings may not be fully generalizable to adolescents in private or international schools, out-of-school youth, or those lacking adequate internet access and digital literacy.

6. Conclusion

This study demonstrates that despite possessing strong mental health knowledge and positive attitudes, Malaysian adolescents continue to report significant perceived barriers to accessing care. To bridge the critical gap between mental health literacy and intentions to seek care, interventions must leverage key facilitating factors to enhance perceived service accessibility. Moving forward, public health strategies must prioritize culturally sensitive, school-based initiatives that normalize psychological distress and strengthen trusted referral pathways. By systematically addressing perceived obstacles and reinforcing environmental facilitators, Malaysia can foster an inclusive, empowering environment that promotes positive help-seeking intentions and psychological well-being among its youth.

Data Availability

The data that support the findings of this study are available upon reasonable request.

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AI-Assisted Tool Disclosure

ChatGPT-5.6 Thinking was utilized for language polishing and grammar correction of this manuscript. All outputs generated by the tool were reviewed and verified by the authors, who assume full responsibility for the manuscript's final content.

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Author Contributions

Conceptualization, L.K., M.P.A., N.A.J. and N.I.; methodology, L.K., M.P.A.,

N.A.J. and N.I.; validation, L.K., M.P.A., N.A.J. and N.I.; formal analysis, L.K.; investigation, L.K.; data curation, L.K.; writing-original draft preparation, L.K.; writing-review and editing, L.K., M.P.A., N.A.J. and N.I.; project administration, L.K. and M.P.A.; funding acquisition, L.K. All authors have read and agreed to the published version of the manuscript.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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