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Functioning mediates help-seeking for mental problems in the general population

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ABSTRACT

Aims: Absent or delayed help-seeking is considered to aggravate the immense personal and societal burden caused by mental disorders. Therefore, we cross-sectionally examined rates and clinical and sociodemographic moderators of early help-seeking for current clinician-assessed non-psychotic mental problems/disorders in the community.
Methods: Altogether, 2683 individuals of the Swiss Canton Bern (16–40 years old, response rate 63.4%) were interviewed by telephone for current axis-I problems/disorders using the Mini-International Neuropsychiatric Interview, for psychosocial functioning using the Social and Occupational Functioning Assessment Scale, and for help-seeking for mental problems.
Results: In total, 1122 (41.8%) reported mental problems. Of these, 769 (68.5%) affirmed any one screening question and 353 (31.5%) fulfilled criteria for any current axis-I disorder, and 396 (35.3%) reported any lifetime help-seeking (28.3% sought help in the past and 7.0% were in current treatment). In path analyses, current help-seeking was associated mainly by type and number of mental problems/disorders mediated by functional impairment, in addition to older age, no current partner, and past treatment.
Conclusion: Our cross-sectional data indicate a gap in help-seeking for mental problems/disorders. The relationship between number of mental problems/disorders and help-seeking mediated by functional impairment confirm that individuals commonly do not seek help until problems are severe enough to cause problems in occupational and psychosocial functioning, driving the already immense costs of mental disorders. Thus, campaigns promoting early help-seeking, including early diagnostic clarification of and support for subthreshold mental problems in terms of an indicated prevention, should focus on psychosocial functioning, aside from signs of mental illness.

1. Introduction

In 2010, approximately 38% of the European population suffered from a mental disorder [1]. Mental disorders commonly have their onset in late adolescence and early adulthood [2–4], and contributed most to the overall morbidity, already in 10- to 14-year-olds [5], and annual costs in Europe in general [6] and Switzerland in particular [7].

Absent or delayed help-seeking for mental problems, and the resulting high rates of chronic or recurrent courses are considered the main reasons for the high long-term burden caused by mental disorders [8]. Consequently, treatment for early incipient cases and an indicated prevention of mental illness, through the detection and treatment of early symptoms, are considered the most important aspects of both reducing severity-persistence of primary disorders and preventing secondary disorders and, thus, of reducing the overall burden [2–4,9]. Yet, despite increasing mental health service use in recent decades, the majority of individuals with mental problems do not seek professional help in terms of both diagnostic clarification and treatment [10–12]. Thus, the rate of the so called 'treatment gap' for people with mental problems exceeds 50% around the world [13–16] (note: henceforth 'treatment gap' is used for the absence of any kind of help-seeking

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in persons with mental problems/disorders incl. seeking diagnostic clarification and temporary support).

To promote mental health by early help-seeking for mental problems in terms of both early treatment of manifest disorders and indicated prevention of incipient disorders, and to reduce long-term burden of mental disorders, a good understanding of detaining and promoting factors of help-seeking and their interplay is important. Among sociodemographic factors, previous studies found lower rates of help-seeking in men [17–20] and in younger age groups [21]. In contrast, obtaining a higher education, living alone, and being unemployed, disabled, or a single parent seemed to promote help-seeking [15,21,22]. An important clinical factor associated with more likely help-seeking is the presence of a manifest mental disorder, specifically a mood disorder [15,23], that commonly is leading to severe distress if not functional impairment. Previous studies, however, have not assessed the symptom-independent role of psychosocial functioning in help-seeking for mental disorders. In addition, they did not consider the role of satisfaction with possible earlier help-seeking attempts.

Thus, using semi-structured interviews conducted by clinical psychologists, we examined help-seeking for current mental disorders and problems possibly indicating an incipient disorder and, thus, a need for diagnostic clarification or mental health promotive actions. Moreover, advancing previous studies, we analysed the association of sociodemographic and clinical factors, including psychosocial functioning, and satisfaction with past or current treatment, to better understand the possible reasons for help-seeking.

2. Material and methods

2.1. Sample

The sample consisted of 2683 participants of the 'Bern Epidemiological At-Risk' (BEAR) study [24], a representative sample of the Bernese general population recruited using a stratified sampling method. Of the initial sample (N = 7370), 4471 were considered eligible [24]. The contact rate was 94.8%, the response rate 63.4% and the refusal rate 30.2%.

In addition to being between 16 and 40 years-of-age and a main resident of Canton Bern (i.e. having a valid address and not being abroad during the assessment period), an available telephone number was required for eligibility [24]. We called participants up to 100 times over several months at various times and days, including Saturdays. Potential participants that were not reached within this time were considered as unknown eligible. Moreover, interviews were aborted prematurely when respondents had (i) a lifetime diagnosis of psychosis (n = 41) or (ii) insufficient language skills in German, French, or English (n = 125). The former was done for the study's focus on clinical high risk for psychosis symptoms and criteria [24]. Of the 41 psychosis cases, 19 (46%) had never been diagnosed and treated at the time of the interview (these cases are described in detail in [25]). Only eight participants prematurely aborted the interview on their own account. The semi-structured interviews lasted 43 min on average (SD: 20 min; range: 20–225 min).

The BEAR study was carried out in accordance with the latest version of the Declaration of Helsinki. The ethics committee of the University of Bern approved this study. Further details on recruitment and sample are provided in Schultze-Lutter et al. [24].

2.2. Assessments

2.2.1. Axis-I disorders

Present DSM-IV non-substance-related axis-I disorders were assessed using the Mini-International Neuropsychiatric Interview (M.I.N.I.) [26], which was successfully applied in telephone surveys before [27], and was shown to be a reliable measure with good concurrent and predictive validity for assessing axis-I disorders [28] with satisfying reliability of telephone assessments compared with face-to-face assessments [29]. In line with the findings on the Modified Mini Screen (MMS) [30], which is based on the M.I.N.I., the presence of any subthreshold mental problem that signals a need of professional assessment and, consequently, a need for help-seeking was assumed when at least one screening question of the M.I.N.I. (eMaterial 1) was confirmed [30,31]. Yet, when diagnostic criteria of the respective disorder were additionally affirmed in the clinical interview, instead, we assumed presence of a current mental disorder. In an open question, we asked about any known neurological disorders to exclude mental problems/disorders caused by them. Broadly in line with the M.I.N.I., current substance misuse (incl. dependence) was estimated predominately by frequency and quantity of consumption supplemented by questions on negative consequences or problems resulting from the substance use.

2.2.2. Help-seeking

Lifetime and current help-seeking as well as regular or sporadic current treatment for mental problems were assessed using a modified version of the WHO Pathway-to-Care questionnaire [32], which has previously been used successfully in international studies of help-seeking for mental disorders [32–34]. Except when stated otherwise, 'any help-seeking contact' included any reported point-of-call to a person other than a family member or friend, irrespective of his/her professional background. When a distinction was made, professional mental healthcare was assumed when provided by psychiatrists, psychologists, and counselling services staffed with psychologists, while semi-professional mental healthcare was assumed when provided by general practitioners or other medical specialists. Only when provided by (semi-)professionals, the term 'treatment' was used.

'Satisfaction with the effectiveness of treatment' (henceforth: treatment satisfaction) was assessed using an optional item of the Brief Multidimensional Life Satisfaction Scale (BLMSS) [35], which was rated on a seven-point Likert scale, ranging from 'horrible' = 0 to 'very happy' = 6. The BLMSS has good psychometric properties and can be regarded as a brief, reliable and valid measure of life satisfaction [35].

2.2.3. Psychosocial functioning

The level of psychosocial functioning was estimated using the Social and Occupational Functioning Assessment Scale (SOFAS), a rating scale for Axis-V, the clinician's judgment of overall level of functioning, of DSM-IV [36]. The SOFAS is a global rating of current functioning ranging from 0 to 100, with lower scores representing lower functioning, and is focusing on functioning independent of the overall severity of the individual's psychological symptoms [36]. It has good psychometric properties incl. good interrater-reliability and construct validity [37,38]. A SOFAS-score between 31 and 70 refers to manifest disabilities of various degrees and a score below 30 reflects poor functioning making intensive support or supervision necessary [39]. Therefore, a score of $\leq$70 was regarded as indicative of a presence of a functional deficit [39,40].

2.2.4. Quality assurance

To achieve a $\geq$95% concordance rate with the trainers (F.S.-L. and C.M.), interviewers (all clinical psychologists) received intensive 3-month training, especially in the semi-structured, context-dependent assessment of mental disorders. Additionally, weekly supervision of all psychopathological ratings with the interviewers was performed by the trainers to further ensure excellent, valid and reliable data quality.