Original Article

Where do People with Mental Disorders in Singapore go to for Help?

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Abstract

Introduction: This study aims to examine the pattern of services utilisation and the factors associated with help-seeking behaviour among those with mental disorders in the multi-ethnic Asian population of Singapore. Materials and Methods: A household survey was carried out on a nationally representative sample of the adult (18 years and above) resident population. The main instrument used to establish the diagnosis of mental disorders and the services sought was the Composite International Diagnostic Interview version 3.0 (CIDI 3.0). The 'services' component of the instrument contains questions, which examine service utilisation for mental health problems. Results: A total number of 6616 completed respondents constituted a representative sample of the adult resident population in Singapore. Only 31.7% of those with mental disorders had sought help: 15.7% from mental health providers, 8.4% from general practitioners, and 7.6% from religious/ spiritual advisors or other healers. Among respondents with severe disability across any disorder assessed in our survey, 50.1% had sought help from some service in the past 12 months. Individuals with moderate or mild levels had lower rates of consultation, i.e. 35.4% and 30.6% respectively. The rate of using the Internet as a source of help was low in this population. Conclusion: There is a need to engage and work collaboratively with healthcare providers (including religious and spiritual healers) in the community to detect, assess and treat those with mental illness. More general practitioners need to be involved, and the role of the Internet also requires further consideration as a source for help.

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Introduction

Not only are mental disorders prevalent in any country, it is also common that many of those with mental disorders are neither seeking nor receiving help. This is the case even in developed countries: of the 31% of the US population affected by at least one mental illness, 67% of them are not being treated[1] and in Europe where mental illness affects 27% of people yearly, 74% of them received no treatment.[2] Whether or not an individual with mental disorder seeks help is dependent on and influenced by multiple factors including demographic characteristics, culture and religion, socioeconomic factors and the geographical accessibility of services.[3-6] Understanding these factors and their interaction is important in any effort to change and inculcate appropriate help-seeking behaviour in order to improve accessibility of care.

Little is known about the use of services for people with mental illnesses in Singapore—a city-state of 274 sq miles in Southeast Asia with a 5-million multi-ethnic population. It has a high literacy rate: 98% are literate in English with 78% of the population being Internet users. An earlier study in Singapore which used the screening instrument, General Health Questionnaire–28 (GHQ-28), found that of the 16.9% of the population who attained a score high enough to merit professional mental health help, only 2.6% had used the services of any professional caregiver in the past 4 weeks. General practitioners (GPs) were the most commonly preferred caregiver and were used by 41.1% of those who sought help.[7]

The Singapore healthcare system provides services in both the public and private sectors. Of the more than 8300 doctors in Singapore, close to 40% are specialists—there are about 150 psychiatrists—while the rest are mostly primary care doctors or general practitioners. GPs provide 80% of the primary healthcare services, while an island-wide network of 18 government polyclinics provide the remaining 20%. Public hospitals (which are referred to as restructured hospitals) provide about 80% of the tertiary care in Singapore, with the remaining 20% being provided

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by private hospitals. People in public hospitals may apply for a range of subsidies from 20% to 80% of their total bill. Private acute hospitals, on the other hand, are profit-driven and derive revenues entirely through fees-for-service without any form of subsidy from the government.

The care of people with mental illness in Singapore still rests almost entirely on the specialised mental health services in both the public and private sectors, complemented and supplemented by voluntary welfare organisations (VWOs) with limited involvement of GPs. Most of these VWOs are Family Service Centres (FSCs) which are social service providers located within the community. They are staffed with professional counsellors and social workers who provide an array of services, including counselling and financial assistance.

In this study, we used a household sample and examined the pattern of services utilisation among those with mental disorders and the factors associated with help-seeking behaviour.

Materials and Methods

The Singapore Mental Health Study has been described in greater detail elsewhere.[8] In brief; this is a cross-sectional epidemiological household survey of the adult Singapore resident population (Singapore Citizens and Permanent Residents) aged 18 years and above who were randomly selected from an administrative database. A disproportionate stratified sampling was used where the 3 main ethnic groups (Chinese, Malays, and Indians) were sampled in equivalent proportion of about 30% each rather than in proportion to the ethnic distribution in the general population. Face-to-face interviews at the respondents' homes were conducted from December 2009 to December 2010 in English, Chinese or Bahasa Melayu (the official language of the Malay ethnic group). The survey was administered using laptop computer-assisted personal interview (CAPI) and paper and pencil (PAPI) methods by professional survey interviewers who had been trained and supervised by the research staff of the Institute of Mental Health (IMH).

The present analysis is based on the following sections of the interview schedule:

The CIDI 3.0 Diagnostic Section

This provided lifetime and 12-month prevalence rates of disorders according to both the ICD-10 and the DSM-IV psychiatric classification systems. In our survey, the following disorders were assessed: anxiety disorders (generalised anxiety disorder, obsessive compulsive disorder); mood disorders (major depressive disorder, dysthymia, bipolar disorder); and alcohol abuse disorders (alcohol abuse/ dependence) using rules of hierarchy.

Clinical Severity

Respondents with any DSM disorder in the past 12 months were divided into 3 groups according to the degree of severity based on Sheehan's Disability Scale that was administered at the end of each diagnostic module in CIDI 3.0.

1. Severe cases: Respondents reporting at least 2 areas of role functioning with severe role impairment due to mental disorder (scored 7 or above on a10-point severity scale on at least one of the Sheehan Disability Scales).
2. Moderate cases: Respondents who assessed the impairment due to mental disorder to be at least moderate (scored above 4 on a 10-point severity scale on at least one of the Sheehan Disability Scales).
3. Mild cases: All other respondents.

The CIDI 3.0 Services Section

Respondents were asked a key question: 'Did you ever in your lifetime go to see any of the professionals on this list for problems with your emotions, nerves, mental health or your use of alcohol or drugs?' A list of treatment providers was then presented to the participant.

This list included:

- A psychiatrist.
- A general practitioner or family physician.
- Any other medical doctor such as a cardiologist, urologist or gynaecologist.
- A psychologist.
- A social worker, youth aid worker, child welfare officer, school counsellor or teacher.
- A counsellor other than a school counsellor.
- Any other mental health professional such as a psychotherapist or psychiatric nurse.
- A general nurse, occupational therapist or other health professional.
- A religious or spiritual advisor like a minister, priest, monk or imam.
- Any other healer, like a herbalist, homeopath, naturopath, chiropractor, spiritualist or traditional healer.

The data on lifetime contacts were categorised into 4 groups:

1. Consultation with a mental health professional, including a psychiatrist, psychologist or other mental health professional.
2. Consultation with other medical professionals

including general practitioner, other medical doctor, nurse, occupational therapist or any other healthcare professional.

3. Consultation with a professional from social services sector, including a social worker or counsellor.
4. Consultation with religious or other healers.

We also assessed the use of Internet-based help-seeking by analysing responses to the question, "Did you ever use an Internet support group or chat room to get help for problems with your emotions or nerves?" The respondents were also asked for the reasons for not seeking help.

Socio-demographic variables included cohort (defined by age at interview and categorised as 18 – 34, 35 – 49, 50 – 64 and 65 years and above), gender, ethnicity (Chinese, Malay, Indian, and other), income (<20,000 SGD, 20,000 – 49,999 SGD and ≥50,000 SGD), marital status (never married, married, divorced or separated and widowed), educational level and employment (employed, economically inactive which included students and housewives and unemployed)

Statistical Analyses

All estimates were weighted to adjust for over sampling and post-stratified for age and ethnicity distributions between the survey sample and the Singapore resident population in 2007. Mean and standard deviations were calculated for continuous variables, and frequencies and percentages for categorical variables. Patterns of service use were examined by computing proportions in treatment, for different settings and according to socio-demographic variables. Data were analysed separately for those who saw providers in multiple sectors and those who saw providers in only one sector. Univariate analysis using chi-square tests followed by multiple logistic regression analysis were used to study sociodemographic predictors of receiving lifetime treatment in particular sectors among those receiving any treatment. Standard errors (SE) and significance tests were estimated using the Taylor series linearisation method. Multivariate significance was evaluated using Wald x^2 tests based on design corrected coefficient variance–covariance matrices. Statistical significance was evaluated at the 0.05 level using 2-sided tests. All statistical analyses were carried out using the Statistical Analysis Software (SAS) System version 9.2 (SAS Institute Inc. 2011. SAS/STAT 9.2 User's Guide. Cary, NC).

Results

A total number of 6616 respondents who completed the study constituted a representative sample of the adult resident population in Singapore. The proportions of males and females were equivalent and the mean (SD) age was 42 (14.5) years. Table 1 shows the socio-demographic distribution of the entire sample. The ethnic group that was classified as "Others" included only 268 respondents belonging to diverse and heterogeneous ethnic origins. As such, we could not make any meaningful inferences and will not be discussing this group.

Eight hundred and seventy-four respondents (12.0%) of the adult resident population met criteria for the common affective, anxiety, or alcohol use disorders. We found that the lifetime prevalence of major depressive disorders (MDD) to be 5.8%, bipolar disorder to be 1.2%, generalised anxiety disorder (GAD) to be 0.9%, obsessive compulsive disorder (OCD) to be 3.0% and alcohol-related disorders (abuse and dependence) to be 3.6%.[9] Of the 874 with any one mental disorder, 267 (31.7%) had sought help from one or more than one service provider for their mental health problems.

Table 2 shows the service sectors that people with mental

Table 1. Demographic Distribution of the Sample (n = 6616)

Socio-demographic characteristics		n	Unweighted %	Weighted %
Age Group (years)	18–34	2293	34.7	31.7
	35–49	2369	35.8	34.1
	50–64	1542	23.3	23.1
	65 and above	412	6.2	11.1
Gender	Women	3317	50.1	51.5
	Men	3299	49.9	48.5
Ethnicity	Chinese	2006	30.3	76.9
	Malay	2373	35.9	12.3
	Indian	1969	29.8	8.3
	Others	268	4.1	2.4
Marital Status	Never Married	1825	27.6	28.9
	Married	4290	64.9	62.4
	Divorced/ Separated	262	4.0	4.2
	Widowed	237	3.6	4.4
Education	Pre-primary	307	4.6	5.5
	Primary	929	14.0	14.7
	Secondary	1975	39.9	27.6
	Vocational	721	10.9	7.9
	Pre-U/Junior College/Diploma	1342	20.3	22.4
	University	1342	20.3	21.9
Employment	Employed	4594	71.5	71.0
	Economically inactive*	1522	23.7	24.5
	Unemployed	313	4.9	4.5

*Includes homemakers, students and retirees/pensioners

disorder have turned to for help (this includes those who sought help from multiple care-providers). The majority consulted mental health providers. Of those who sought help from non-mental health professionals, the most popular were counsellors and medical social workers, followed by other medical professionals (of whom 84.3% were GPs) and religious/spiritual advisors or other healers.

Table 3 shows the proportion of those who sought help from only one sector in their lifetime. Relatively substantial proportions of people sought help from spiritual and religious healers (16.6%), and of these only 2 (7.1%) were recommended to seek further help from a mental health specialist, clinic or programme (Table 3).

A very small proportion of people with mental illnesses used an Internet support group or chat room (3.9%) to get help for their "problems with…emotions or nerves", and only 3.6% endorsed using a Hotline for their problems with emotions or nerves.

The multiple logistic regression showed that females ($P = 0.001$, OR = 12.2) were significantly more likely to seek help from a professional in a medical setting. We found no socio-demographic factors to be significantly associated with the likelihood of seeking help from spiritual or religious healers.

Services sought for mental health treatment were clearly related to the severity of the disorders and significantly different according to the severity of the disability ($P = 0.047$ and $x^2 = 6.1$). Among respondents with severe disability across any disorder assessed in our survey, 50.1% had sought help from some service in the past 12 months. Individuals with moderate or mild levels had lower rates of consultation i.e. 35.4% and 30.6% respectively. There were significant differences between those who sought help from only one sector of services and the severity of disability: those who consulted mental health professionals had significantly higher rate of severe disability (18.0%) as compared to mild (4.8%) or moderate (4.2%) disability ($x^2 = 6.8$, $P = 0.0329$). In contrast, those who sought help from religious or other healers had significantly higher rate of mild (3.8%) disability as compared to moderate (0.2%) or severe (0.9%) disability ($x^2 = 8.8$, $P = 0.0124$).

Twelve-month data revealed that majority of those who

Table 2. Pattern of Service use by Those with Lifetime MDD, Bipolar, GAD, OCD and Alcohol Use Disorders

Diagnoses (n = Number of respondents diagnosed with Lifetime Disorders)	**Any mental health professional seen (Psychiatrist/ psychologist/other mental health professional)**	**Any other medical health professional seen (GP/other specialist/other health professional)**	**Any professional in a social support setting (Social worker/counsellor)**	**Any religious or spiritual advisor/healer**
	n (Weighted %)	n (Weighted %)	n (Weighted %)	n (Weighted %)
MDD (n = 417)	65 (18.1%)	55 (11.5%)	62 (14.9%)	33 (7.9%)
Bipolar Disorder (n = 93)	23 (38.3%)	12 (10.4%)	19 (23.4%)	13 (15.7%)
GAD (n = 71)	17 (40.0%)	12 (20.8%)	15 (26.0%)	12 (20.5%)
OCD (n = 230)	29 (14.6%)	15 (8.7%)	21 (9.2%)	13 (7.6%)
Alcohol Abuse (n = 217)	18 (7.0%)	14 (5.8%)	18 (7.2%)	9 (4.5%)
Alcohol Dependence (n = 41)	7 (23.2%)	1 (1.7%)	12 (28.0%)	3 (4.4%)
Any Mental Disorder (n = 874)	117 (15.7%)	86 (9.1%)	111 (12.7%)	59 (7.6%)

Table 3. Use of a Single Source of Help by Those with Lifetime MDD, Bipolar, GAD, OCD and Alcohol Use Disorders

Diagnoses	**Any mental health professional only**	**Any other medical health professional only**	**Any professional in a social support setting only**	**Any religious or spiritual advisor/healer only**
	n (Weighted %)	n (Weighted %)	n (Weighted %)	n (Weighted %)
MDD	30 (37.8%)	34 (26.8%)	29 (23.9%)	11(11.5%)
Bipolar Disorder	8 (49.9%)	3 (3.0%)	9 (23.4%)	8 (23.7%)
GAD	8 (24.5%)	7 (32.7%)	6 (20.5%)	7 (22.3%)
OCD	20 (38.4%)	9 (21.5%)	15 (19.3%)	7 (20.8%)
Alcohol Abuse	10 (31.1%)	6 (11.8%)	13(44.1%)	3 (13.0%)
Alcohol Dependence	2 (23.1%)	1 (11.4%)	5(42.4%)	2 (23.1%)
Any Mental Disorder	58 (36.1%)	52 (21.6%)	61 (25.7%)	28 (16.6%)

did not seek help for their mental health problems either thought that they could handle the problem on their own (55.6%) or they did not think they had a problem (31.6%) (Table 4).

Table 4. Reasons Respondent did not Want to see Professional During the Past 12 months (n = 234)

	Reasons	n	Weighted %	SE
1.	Respondent didn't think he/she had a problem	57	31.6	4.5
2.	Respondent had a problem, but thought he/she could handle it on his/her own	149	55.6	4.8
3.	Respondent thought that he/she needed help but didn't believe professional treatment would be helpful	21	8.0	2.5
4.	Other reasons	7	4.7	2.2

Discussion

More than two-thirds (68.2 %) of those with a lifetime mental disorder in Singapore had not sought help. This high rate has clinical and policy implications and understanding the behaviour underlying healthcare utilisation is crucial to address this problem. One of the often-used models is Anderson's Behavioral Model of Health Service Use[10] that identifies predictors at 3 levels: needs (perceived and evaluated needs), predisposing characteristics (including demographic characteristics like age, gender, race, marital status, and education) and enabling factors (financial resources and insurance coverage). A number of studies have found that when it comes to mental health, 'need' factors override predisposing and enabling factors in determining the patterns of mental health services utilisation.[11,12] People may tolerate many psychological symptoms for some time without seeking help until it causes distress and impairment in their relationship or work.[13-15] This seems to be the case in our study as we found a significant association between help-seeking and the severity of the disorders: those with severe disability were significantly more likely to seek help as compared to those with moderate and mild severity. From the responses of our respondents for reasons pertaining to their lack of help-seeking, it emerged that there is either a denial or tendency to deal with the problem on their own and it is only when the illness become more severe and impairing, then these individuals feel compelled to seek help.

Predisposing demographic characteristics like gender and marital status have been implicated as factors associated with mental health service utilisation in other studies.[16-18] Analyses of general help-seeking behaviour indicate a gender difference with women having a predilection to take on a more active help-seeking role.[19] The Australian National Survey of Mental Health and Wellbeing found that being female was associated with use of GP services (the largest subgroup of mental health services in this Australian study) and females were also more likely than males to use services provided by 'other health professionals' rather than mental health professionals.[18] Leaf and Bruce[20] similarly found that women were more likely to consult general practitioners, but not psychiatrists or psychologists. We found that the women in Singapore were more likely to seek help from professionals who were not in the in the mental health sector but those in the medical sector. We do not have an explanation for this but a study of immigrant Chinese-American women reported that if the problem was conceptualised in terms of a physical problem, medical services were sought. If the problem was conceptualised as a psychological one, these Chinese-American women were more likely to turn to themselves or ask family and friends for assistance. Collectively, the findings of these studies suggest that perception and attitudes may differ between the genders.[21]

Counsellors did not appear to be a significant alternative or sole source of help in our population. This finding is consistent with an UK study where only 16% of the respondents with common mental disorder had sought help from a counselor and only 14% said that they would consult a counsellor if they developed health problems that they perceived as a consequence of stress or strain.[22] Our findings suggest that counsellors and social workers were likely to be working in collaboration with mental health providers either as a referring agency and/or as part of the 'care-team'.

GPs, on the other hand, are consulted more frequently as the sole provider of mental health care than the counsellors. GPs have been reported to play a significant role in mental health care in a number of developed countries. A study in UK[23] reported that 35% of its respondents with non-psychotic disorders saw their GPs within a year for psychological problems. In the Netherlands, primary care was most frequently sought by those with psychiatric morbidity of whom, 22.4% had consulted a GP.[24] In the United States, GPs were more often sought than psychiatrists[25] and in Australia and New Zealand, GPs were consulted more often than other medical specialists[26,27] for mental health problems.

These findings are contrary to ours where the mental health professionals were the most frequent source of help. In a survey done on a representative sample of the GPs in Singapore to study the attitudes and perceptions of GPs towards managing patients with mental disorders, the common inhibiting factors cited were lack of adequate

time and support from ancillary healthcare professionals, a perceived lack of training to meet the needs of patients with more serious mental illness, and 75% of them do not stock psychotropic medications in their clinics.[28] Another possible reason is that patients receiving treatment from GPs do not receive subsidised care.

Religious and spiritual healers are also a relatively important source of help. The perception of the individual with regards to his or her problems is often influenced by the prevailing social, cultural and religious factors. These include the attitudes, values and belief systems of the family and community.[29,30] Razali and Najib observed that in Malay society where the extended family system is widely prevalent, the strength of the social support and the belief of relatives in supernatural causes of mental illness were strongly associated with the decision to seek treatment with a bomoh (spiritual healer) and usually in preference to Western psychiatric treatment which may be perceived to be ineffective in such situations.[31,32] A study of Chinese patients seeking help from a psychiatric department in a teaching hospital in Singapore found that 36% of them had consulted a spiritual or traditional healer before going to the hospital—this study also found no association between educational status and help-seeking from traditional healers).[33] Likewise, we found no socio-demographic correlates (including gender, race and educational levels) with seeking help from religious and other healers.

With more than 80% of the population being Internet users,[34] it was surprising that only a relatively small proportion had used this means of accessing help (we did not asked if they had used the Internet to obtain information). There are 2 possible explanations. The first could be the relative lack of Internet users in our study population. According to a local survey, the vast majority of Internet users were youths between 15 and 24 years old and young adults between 25 and 34 years old 33 while most of our respondents were older (mean age of 43 years) and the proportion of those from 18 to 34 years is only about 32%. The second is the lack of online counselling and psychotherapy services in Singapore.

There is currently a need for more robust evidence for the efficacy of such Internet-based interventions[35,36] as well as concerns pertaining to accuracy of information and its unregulated nature would be an issue. Nonetheless, the Internet has the advantages of privacy, anonymity and widespread availability at low or no cost.[37] The potential of using the Internet to educate and support those with mental illness for whom concern of confidentiality and fear of stigma might prevent help-seeking[38] needs to be explored and studied as this is likely to be an area of future expansion and a valuable tool for healthcare policy makers and service providers.[39]

A few limitations should be considered in considering the results of this study. The survey was household-based and we did not include those who were institutionalised at the time of the survey and certain mental disorders were also excluded. The responses were self-reported and hence subjected to various sorts of recall bias. Nevertheless, from the service provision perspective, our findings are of particular relevance in that they identified the main players in the local mental health landscape.

Conclusion

WHO has made the assertion that the more common forms of mental illness (anxiety and depression) should be treated in primary care and specialist psychiatric services should be for more severely ill patients.[40] But with more people with mental illness in Singapore being treated by specialist services than by primary care, there is, a need to engage the primary community sector to a greater extent.

In a country like Singapore where sectors of its resident population still hold deep-rooted Asian cultural and religious beliefs that have been weaved into the conception of mental wellness and disorder, the role of religious and spiritual leaders and healers in the mental health care has to be acknowledged. Challenging though it may be, a number of experts have called for the incorporation of the socio-cultural, religious and spiritual factors into mental health policies,[41] services[42] and medical education[43] to break barriers in the mental health services and to better meet the needs of the mentally ill.

Not only would it be necessary to ensure that these community healthcare providers (GPs, spiritual healers and counsellors) are equipped with the knowledge and skills to detect, manage or refer those with mental illness to the specialist carers when indicated, a collaborative care management model that uses a multidisciplinary team to screen and track mental conditions in primary care settings would probably be more effective.[44-46]

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