Help-Seeking for Psychiatric Disorders

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Objective: To examine demographic and clinical determinants of seeking help for mental or emotional problems. To determine the proportion of those people with a disorder who sought help. To determine what categories of professionals are sought by those who get care.

Method: A 2-stage random sample of 3956 adult residents of Edmonton, Alberta, Canada was interviewed by trained lay interviewers using the Diagnostic Interview Schedule (DIS) (73% completion rate). An average of 2.8 years later, a systematic random sample of 1964 subjects was reinterviewed (an 86% completion rate) using the DIS and a health care utilization questionnaire. After adjusting for age and sex, the reinterview sample was representative of those with and without a diagnosis at the first interview.

Results: Of the 1964 subjects, 570 (31%) met criteria for a DIS/DSM-III diagnosis in the year preceding the interview (one-year prevalence rate). These diagnoses included generalized anxiety disorder (GAD) and posttraumatic stress disorder (PTSD). For those with a diagnosis, sex, age, marital status, education, employment, and income were examined as determinants of help-seeking. Only sex (female) and age (under 45) were significant predictors. Comorbidity was highly significant: the help-seeking rate for those with one diagnosis was 20.3%; for those with more than one diagnosis, the rate was 42.8% (OR = 2.94, \( \chi^2 = 31.4, df = 1, P < 0.001 \)). Just over 28% of those with a diagnosis saw any health care professional, and 7.7% of those without a diagnosis sought help for a mental or emotional problem. A specific diagnosis made a difference: 46.7% of those with a major depressive episode sought help, but only 16.0% of those with alcohol abuse or dependence sought care.

Conclusion: Major determinants of help-seeking are sex (female), age (under 45), severity of the illness, and comorbidity. A surprisingly high proportion of those with a disorder (72%) do not seek help, and over one-third of those seeking help do not have a current DIS/DSM-III disorder.

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Key Words: epidemiology, help-seeking, primary care, filters to care

The study of how and why individuals in the population seek care for mental or emotional problems has received limited attention in North America, with much of the existing research coming from Britain and Europe. Goldberg and Huxley (1) conceptualized the pathway to psychiatric care (Figure 1) as a progression through a series of levels, each separated by variably permeable filters. Thus the first level is the prevalence of psychiatric disorders in the community, and the first filter is the decision to seek help. The second level is the proportion of those with a disorder who seek help, and the second filter is the recognition of a psychiatric disorder by the primary care provider. Further levels consider referral to specialized care and admission to hospital. This model fits well with a hierarchical system of care in which the only access to specialized care is by referral from a primary care physician. This does not necessarily pertain to the Canadian or American system where there may be direct access to specialized care.

Shepherd and others (2) in London found that general practitioners detected a psychiatric disorder in 14% of the population each year. Regier and others (3) determined that about 15% of the American population receives a mental health service each year, and in an earlier study, we found 12.9% of the Edmonton population received such a service (4). These are all comparable figures, yet somewhat higher than the 9.4% reported from the Netherlands (5), and the reported 8.1% of urban Ontario residents and 5.5% of rural...
Ontario residents aged 15 to 64 years who used a service for mental health reasons (6). The same study reports that in Toronto, the major urban centre in Ontario, the service use rate was 14.4%, which is more comparable to the Edmonton figure.

The British and Dutch studies were particularly interested in determinants of the second filter: primary care physician recognition of psychiatric disorder and the difference between the primary care consultation and recognition rates. This has led to significant progress in improving skills in this area. The starting point for such studies is usually a representative group of general practitioners whose work and patients become the subjects of the research.

Our starting point is somewhat different and more comparable to that reported from the Epidemiologic Catchment Area (ECA) (7,8). Our study involved data derived from a random sample of the population, which was interviewed using psychiatric diagnostic instruments and questioned about use of health care services. Thus we were primarily interested in the proportions of those with and without diagnosed mental disorders who sought help for mental or emotional problems and the demographic and clinical determinants of help-seeking in those with a disorder (Goldberg’s first filter).

### Methods

The study was conducted in the city of Edmonton, Alberta, Canada, which has a population of about 400,000 people over the age of 18. An initial sample of 3956 adult household residents in Edmonton was interviewed by trained lay interviewers between December 1984 and February 1989 using the DIS (9,10). Interview subjects were selected by a 2-stage process: first, a systematic sampling of household addresses for the city was used, and second, one respondent per household was chosen using 6 successive versions of a respondent selection grid (11).


diagram

**Figure 1.** The pathway to psychiatric care.

DIS data were analyzed by computer using the Washington University (St. Louis, MO) program, which yields DSM-III diagnoses with or without exclusion criteria. We report diagnoses without the use of exclusion criteria. The later version of the DIS, which includes GAD and PTSD, was used for the reinterview sample. The proportion of the sample with a one-year prevalence was used in this report, that is, all subjects who had ever met criteria for a diagnosis and who had symptoms within the year preceding the interview. Comorbid subjects were those who had a disorder in the year preceding the interview and had one or more other lifetime disorders (which may or may not have been in the preceding year).

For data analysis, the sample was poststratified by age and sex to 1986 census data for Edmonton and weighted for household size. Health care utilization included the subjects’ reports of what type of health care professionals had been seen in the preceding year, how many times they had been seen, and whether the visits were for “mental or emotional problems,” a phrase that was left to the respondents to interpret. We had previously verified that subject reports of this kind are quite accurate with regard to a visit being made, and that the health care provider verified that the purpose of the visit included a mental or emotional problem. Far less accurate were the subjects’ reports of how many visits had been made (4). Data were analyzed using the SAS program (12) and SESUDAAN (13). EGRET (14) was used for logistic regression analysis of single main effects and for building a model incorporating sex, age, marital status, education, employment, income, and comorbidity.

### Results

The first sample of 3956 subjects had a 73% completion rate for those with whom contact was made. The second (reinterview) sample of 1964 subjects (the basis for this report) was 86% of a systematic sample of the original subjects with whom contact was attempted. The second sample was somewhat older than the first sample, but after adjusting for age and sex, it was representative of the first on the proportional representation of those with and without a lifetime diagnosis at the first interview.

#### Prevalence

An average of 2.8 years later, a systematic random sample of 1964 of the original 3956 subjects was reinterviewed, again using the DIS and a previously tested health care utilization questionnaire (4). This latter sample forms the basis of this paper.

Five hundred and seventy of the 1964 subjects met diagnostic criteria for a DIS/DSM-III diagnosis in the year preceding the interview. The one-year prevalence from the weighted data was 31.2%, with less than 1% difference between men and women. This prevalence is higher than we have previously reported (15), but includes GAD and PTSD.
Help-Seeking

Table 1 shows that 14.1% (weighted) of the adult population reported seeking help for a mental or emotional problem during the year preceding the interview. This represents 28.1% of those with a diagnosis and 7.7% of those who did not have a diagnosis. The table shows the percentages of subjects seeing various types of professionals. The proportions are not mutually exclusive; any individual may have seen one or more category of professional, but under “any professional,” all subjects who reported seeking help are recorded.

Fully 71.9% of those with a disorder did not seek help in the year before the interview. It should also be noted that the 7.7% of those without a DIS/DSM-III diagnosis who sought help for a mental or emotional problem represent 37.6% of those who sought such help.

Determinants of Help-Seeking

Sex, age, marital status, education, employment, and income were examined as demographic and social variables that might affect help-seeking behaviour. For the 570 people who had a diagnosis (one-year prevalence), these variables were analyzed for whether or not help was sought using main effects logistic regression. So the time period of one year is the same for the prevalence and the help-seeking behaviour. The results of the single main effect logistic regression analyses are shown in Table 2, where it can be seen that being female, widowed, separated, divorced, or unemployed all significantly increased the odds of seeking help, whereas education and income level made little difference. There was a clear trend for younger people to be more likely to seek help, but this was not significant for the age groups 18 to 44, 45 to 64, and 65 and older as shown in Table 2.

Diagnosis

Two psychiatric factors were also examined: diagnosis and comorbidity. It may be expected that the more severe the psychiatric disorder, the more likely those with the disorder will seek help. As stated above, 28.1% of all those with any disorder (DIS/DSM-III) sought help in the preceding year. Three disorders with large numbers of cases were examined: major depression (MDE), GAD, and alcohol abuse or dependence. Intuitively, one may expect that a higher proportion of those with major depression would seek help compared with the other 2 disorders and that those with alcohol abuse or dependence would be least likely to seek help. We found that 46.7% of MDE cases sought help, 36.0% of GAD cases, and 16.0% of alcohol abuse or dependence cases. Thus the specific psychiatric diagnosis does affect help-seeking.

Comorbidity

Many cases (52.9%) had more than one psychiatric diagnosis, and this was hypothesized to affect help-seeking. (Table 3). All cases were divided into those with a single diagnosis (not comorbid) and those with more than one diagnosis (comorbid). As shown in Table 3, comorbidity more than doubled the rate of help-seeking from 20.3% of those with a single diagnosis to 42.8% (OR = 2.94, χ² = 31.4, P < 0.001). As the table indicates, this relationship applied to MDE, GAD, and alcohol abuse or dependence: help-seeking was at a higher rate when comorbidity was present (statistically significant for “all disorders” and for alcohol abuse or dependence, but not for MDE or GAD).

A multiple logistic regression analysis was performed using the demographic and social variables above and also including comorbidity. The final model included only sex...
(female), age (under 45 years), and comorbidity (present) as main effects, with no interaction terms, the single greatest effect being related to comorbidity (Table 4).

### Professionals Seen for Help

Table 1 shows that nonpsychiatrist physicians see a higher proportion of those seeking help than any other group of professionals, but significant proportions are also seen by the other professional groups. Although those seeking help do not have to get specialist referrals from a primary care physician, most psychiatrists will only see patients on referral. For psychologists and social workers, the patterns of referral differ, and it is obvious that many people see more than one category of professional.

### Discussion

The one-year prevalence of psychiatric disorders found in this community sample using the DIS/DSM-III diagnoses was 31.2%. This is higher than we previously reported on another sample in Edmonton (15), which was 21%. The difference is largely due to the modification of the DIS to include GAD and PTSD and not to any change in the rate of psychiatric disorders in the population. The prevalence rates found in our earlier studies have proven to be reasonably consistent, but slightly higher than those found in the ECA reports using similar methods and instruments (8,16). Goldberg and Huxley (1) estimated one-year prevalence rates to be 25%, and Giel, Koeter, and Ormel (5) using Dutch investigations of population samples (17) who were administered the General Health Questionnaire, estimated an annual prevalence of psychiatric disorder of 30%.

In this study, we found that over the one-year period, 14.1% of the population reported having consulted a caregiver for a mental or emotional problem. This was slightly higher than the 12.9% we found in an earlier study (4), but very similar to that reported by Goldberg and Huxley (1) for the proportion of the population in which general practitioners detected a psychiatric disorder (14%), and considerably higher than the 9.4% detection rate reported by Regier and others (8) and the 7.8% reported recently for the province of Ontario by Lin and others (6), but the figures rise to 14.4% for Toronto. Both Goldberg and Huxley (1) and Giel and others (5) also reported that 23% and 22.4% respectively of the population consulted general practitioners and had a mental disorder, but in a proportion this was not detected (in Table 5, this is the difference between “primary care total” and “primary care conspicuous” or “detected”). Our studies report the proportion of the population who stated that they saw a caregiver for a mental or emotional problem, and thus may more closely correspond to what Goldberg and Huxley (1) called “conspicuous psychiatric morbidity”—meaning the rate at which general practitioners detected psychiatric disorder in the population. A recent report by Goldberg (18) provides a revised set of figures for Manchester, United Kingdom and also summarizes data for Seattle in the United States. These show lower figures for the “primary care conspicuous” or “detected,” but these appear to be the cases that receive an ICD-9 (or DSM-III) diagnosis. In Edmonton, we

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**Table 3. Help-seeking by those with a disorder and by comorbidity (weighted data)**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Not comorbid</th>
<th>Comorbid</th>
<th>Total</th>
<th>P</th>
<th>OR</th>
<th>Percentage of cases with comorbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any diagnosis (n = 570)</td>
<td>20.3</td>
<td>42.8</td>
<td>28.1</td>
<td>&lt; 0.001</td>
<td>2.9</td>
<td>52.9</td>
</tr>
<tr>
<td>Major depression (n = 171)</td>
<td>37.6</td>
<td>50.1</td>
<td>46.7</td>
<td>ns</td>
<td>1.7</td>
<td>78.2</td>
</tr>
<tr>
<td>Generalized anxiety (n = 143)</td>
<td>25.8</td>
<td>42.7</td>
<td>36.0</td>
<td>ns</td>
<td>2.1</td>
<td>71.9</td>
</tr>
<tr>
<td>Alcohol abuse/dependence (n = 128)</td>
<td>9.1</td>
<td>3.8</td>
<td>16.0</td>
<td>&lt; 0.001</td>
<td>4.6</td>
<td>60.1</td>
</tr>
</tbody>
</table>

P values from continuity adjusted $\chi^2$.

OR calculated from $2 \times 2$ table and are therefore not identical to those given in Table 2, which are based on logistic regression.

**Table 4. Multiple logistic regression model for help-seeking in those with a disorder**

<table>
<thead>
<tr>
<th>Variable</th>
<th>$\beta$</th>
<th>SE</th>
<th>$P$</th>
<th>OR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex female</td>
<td>0.714</td>
<td>0.209</td>
<td>&lt; 0.001</td>
<td>2.04</td>
<td>1.36 to 3.07</td>
</tr>
<tr>
<td>Age 18 to 44</td>
<td>1.005</td>
<td>0.474</td>
<td>0.34</td>
<td>2.73</td>
<td>1.08 to 6.93</td>
</tr>
<tr>
<td>Widowed, separated, divorced</td>
<td>0.437</td>
<td>0.263</td>
<td>0.96</td>
<td>1.55</td>
<td>0.93 to 2.59</td>
</tr>
<tr>
<td>Comorbidity present</td>
<td>1.025</td>
<td>0.202</td>
<td>&lt; 0.001</td>
<td>2.79</td>
<td>1.88 to 4.14</td>
</tr>
</tbody>
</table>
examined both the number who have a DIS/DSM-III diagnosis and those who state that they saw a caregiver for a mental or emotional problem, but did not have such a diagnosis. This is not an insignificant number (see Table 1). Table 6 also allows comparison of the proportions of the population with and without a “one-year disorder” who seek help and the proportion of help seekers who do not have a “one-year disorder.” In both the city of Edmonton and the province of Ontario, only about one-quarter of those with a “one-year disorder” seek help, and approximately 40% of those seeking mental health help have not had a recent disorder diagnosed according to the schemes used.

Comparisons between patterns of help-seeking in the United States and in Britain led Goldberg and Huxley (1) to coin the term “the American Bypass.” In Britain there is a clear hierarchical progression—in order to receive specialized care one must be referred by a general practitioner—whereas in the United States, patients in many settings can self-refer for specialized care. Dutch studies have, however, commented on the increasing role played by psychologists in permitting a bypass around the British model. In Canada it is possible to self-refer to specialized care, but in practice this is unusual; most psychiatrists refuse to see un-referred patients. It is not unusual, however, for the referring physician to be an emergency room physician or another specialist rather than a general practitioner. Goldberg (18) notes that in Manchester and Seattle, 80% and 81% respectively is the proportion of the population seeing a primary care physician in a one-year period. This is identical to the figure of 80% that we had found in Edmonton (4). This is despite 3 very different health care systems—both in terms of organization and means of payment or coverage. In the United States, a 6-month general practitioner consultation rate of 58% to 60% of the population was reported (7).

There are various types of psychiatric and mental health walk-in clinics in Edmonton that see self-referrals. In some instances, social work agencies may also refer their clients for psychiatric care, often through the walk-in clinic arrangement. This must be remembered when looking at Table 1, which shows what type of professional was seen. Nevertheless, it is obvious that for most people seeking help for a mental or emotional problem, the nonspecialist physician is the helper of choice, seeing 10.4% of the population. Psychiatrists see only 3.4% of the population each year, which is twice the rate in Manchester in 1980 and the same as in Groningen, Netherlands (5).

Goldberg’s first filter—the decision on the part of someone with a mental or emotional disorder to seek help—has been the subject of only limited research. Shapiro and others (7) found that women and those with schizophrenia and affective disorders were more likely to seek help and that young adults, men, substance users, and the cognitively impaired were less likely to seek help. Williams and others (19) found that women and the unemployed were more likely to seek help, and those of low social class were less likely to seek help. Verhaak (20) concluded that women and the unemployed were more likely to seek help when they had a mental disorder, and that general health status was less important when a mental disorder was present. Many studies, including our earlier report (4), show a strong link between high General Health Questionnaire scores and seeking help.

In the present study, we examined most of the demographic variables cited in previous works (sex, age, marital status, education, employment, and income) individually, and education and income were not found to be significant. When included in a logistic regression analysis model, however, only age (under 45 years) and sex (women) were significantly associated with increased help-seeking.

### Table 5. Filters to care: annual rates per 1000 population

<table>
<thead>
<tr>
<th>Filter category</th>
<th>Manchester (1)</th>
<th>Manchester (18)</th>
<th>Groningen (5)</th>
<th>Seattle (7, 18)</th>
<th>Edmonton (4)</th>
<th>Edmonton*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>250</td>
<td>250 to 310</td>
<td>303</td>
<td>221 to 281</td>
<td>210</td>
<td>312</td>
</tr>
<tr>
<td>Primary care total</td>
<td>230</td>
<td>210 to 230</td>
<td>224</td>
<td>164</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Primary care conspicuous (ie, detected)</td>
<td>—</td>
<td>—</td>
<td>94</td>
<td>—</td>
<td>129</td>
<td>141</td>
</tr>
<tr>
<td>With ICD9 or DSM-III diagnosis</td>
<td>102</td>
<td>101</td>
<td>—</td>
<td>78</td>
<td>—</td>
<td>88</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>17</td>
<td>20.8</td>
<td>34</td>
<td>58</td>
<td>18</td>
<td>34</td>
</tr>
<tr>
<td>Psychologist</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>Inpatient</td>
<td>6</td>
<td>3.4</td>
<td>10</td>
<td>9</td>
<td>—</td>
<td>7.4*</td>
</tr>
</tbody>
</table>

*This study (includes GAD and PTSD).
| Any professional in Edmonton.

### Table 6. Diagnostic status and help-seeking

<table>
<thead>
<tr>
<th>Year diagnosis present</th>
<th>No diagnosis in last year</th>
<th>Percentage seeking help without a “last year” diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edmonton*</td>
<td>28.2</td>
<td>7.7</td>
</tr>
<tr>
<td>Ontario (6)</td>
<td>24.3</td>
<td>4.0</td>
</tr>
</tbody>
</table>

*This study.
Examination of individual diagnoses showed that rates of help-seeking varied by diagnosis. Like American reports (7,8), we found that a lower rate of help-seeking was associated with alcohol abuse or dependence, and a higher rate was associated with major depression. The similarity between Edmonton and ECA data for any DIS/DSM-III disorder is quite remarkable: the use rate of any mental health service was 28.1% in Edmonton, 28.5% in the ECA, and 24.3% for Ontario (6); for major depression, the rates were 46.7% in Edmonton and 45% in the ECA (8).

Most interesting, though, is our inclusion of comorbidity, since for each disorder examined, having one or more additional psychiatric diagnosis increased the rate of help-seeking. Merikangas and others (21) recently reported similar findings from epidemiological studies. Comorbidity also remained highly significant when included in the logistic regression with the social and demographic factors described above. The attention of primary care providers could usefully be directed toward increased awareness of comorbidity in those seeking help.

Of note in our study is that 37.6% of those who reported seeking help for a mental or emotional disorder did not meet DIS/DSM-III criteria for a disorder in the past year. The comparable figure from the Ontario study (6) is 41.6% (using the Composite International Diagnostic Interview and DSM-III-R criteria). It must be remembered, though, that the DIS/DSM-III only covers a limited number of disorders, hence, individuals may have had a disorder not covered by the diagnostic instruments. Also, the DIS/DSM-III system of diagnosis establishes threshold levels of symptoms and other items for each diagnosis, and thus it may happen that an individual has multiple symptoms that do not add in such a way as to pass the diagnostic threshold for a particular disorder, but which may nevertheless be distressing. It may also be that this rather specialist-oriented diagnostic system (as well as the questionnaires based on it) does not adequately capture the nature and quality of all the individuals who present to primary caregivers with problems (22).

Our study also highlights the high rate of untreated morbidity in the community. Per 1000 population, the one-year prevalence is 312, of whom 88 seek help; a further 53 who do not have a DIS/DSM-III diagnosis also seek help for a mental or emotional problem. Thus of the 312 diagnosed in the population survey, 224 do not seek help. For some, the disorder or symptoms may have been of short duration, but 52.3% of those with major depression did not seek help, either. This is a disorder with marked morbidity (both psychiatric and social), that is potentially life threatening and for which treatment is reasonably successful. It would seem that, at least for some disorders, public health efforts could usefully be directed towards modifying help-seeking behaviour and increasing the permeability of the first filter.

Our study gives useful information about the first filter—the decision to seek help—and some about the second filter.

Eighty percent of adults consult a general practitioner each year. If the consultation rate is assumed to be the same for consultants with and without a mental health problem, then 80% of the 312 per 1000 people with a psychiatric diagnosis are seeing their physician, that is 250 per 1000, but only 88 of those people in Edmonton are seeing their doctor for a mental health problem. This is the portion that may be termed “conspicuous morbidity,” the remainder being quite inconspicuous (23). Some are likely presenting physical symptoms (somatizing) rather than presenting mental symptoms, and some will have significant somatic illness, with the psychiatric problem being seen as secondary to that. In many instances, though, the difference between detecting and not detecting a psychiatric disorder when it is not the presenting complaint will lie with the skills and acumen of the physician. This would hardly matter if the conditions caused only minor morbidity or if treatment were ineffective. There are, however, many studies demonstrating that detection of disorder by the general practitioner leads to better management and outcomes (24). If only 1 in 3 of the people with a diagnosable mental disorder who sees his or her physician presents complaints of the mental disorder, there are presumably also barriers beyond the physician’s acumen in detecting that about which the patient does not complain. These may relate to stigma, failure to recognize or attribute mental and physical symptoms to a psychiatric disorder, or failure to recognize the role of the family physician in managing mental or emotional problems. Campaigns such as those conducted in Canada as part of the Mental Illness Awareness Week and their American and British equivalents can have a major impact on public awareness, as can appropriate media information.

Physician behaviour and skills can also be modified (25) with lasting effects on treatment practices and suicide rates. Health care system changes can also make a difference in improving outcomes with the move to more community-based care (26). Similar problems of under-detection have previously been well documented. The British Health of the Nation document (27) quotes the figure of 40% of those people who complete suicide have seen a general practitioner.
in the preceding week and two-thirds in the previous month. Whether the visit was related to mental or emotional problems or to some other aspect of health is less clear, since even when suicide is mentioned by the patient and assessed, management remains a problem.

The World Health Organization (WHO) states quite clearly “that member states have agreed that the key to achieving health for all by the year 2000 is primary health care. This is care based on the needs of populations, rather than on the needs of health structures and centralized specialist facilities . . . the health sector should be structured to support these decentralized activities . . . It may at times be resisted by some medical personnel who see decentralization as a threat to their status . . . specialist personnel will assume vital leadership roles which can only enhance their status . . . [but] . . . will require the development of educational, persuasive, interpersonal and teamwork skills . . . and hence a new approach to training (28).

Pereira Gray (23) and Horder (29) describe the changes in orientation required in the health care system as a result of the Alma–Ata Declaration (Figure 2), described as “WHO’s inverted triangle.”

There should be concern about the place of mental health in the general health care system and recognition that neither primary care nor efforts to improve population health can succeed unless mental health is an integral part. It is also obvious that should primary care providers merely act as highly permeable filters—that is, becoming more expert at detection but simply referring on to the specialized secondary and tertiary level services—such services will be overloaded and quite ineffective. Primary care providers not only have unique opportunities to work with individuals and communities to promote mental health and prevent mental illness, but they can provide much of the care that is required. This requires that the role of the specialist change to increasingly become one of education, consultation, supervision, support, research, and evaluation, while retaining an important role in the diagnosis and management of the most complex and intractable problems. For such a role change to be effective, it must be reflected in training programs (28).

Clinical Implications

- Public awareness must improve in order to reduce morbidity.
- Detection and treatment in primary care need to be enhanced.
- Professional training should reflect changes in health care.

Limitations

- Our study is based on an urban area only.
- Comparisons with other jurisdictions and systems should be made cautiously.
- Diagnostic systems do not capture many people who are seeking help in primary care.

Acknowledgements

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References

Résumé

Objectif : Examiner les déterminants démographiques et cliniques des personnes qui consultent un professionnel pour des troubles mentaux ou émotionnels. Déterminer la proportion des personnes ayant un trouble qui demandent de l’aide. Déterminer à quelles catégories appartiennent les professionnels consultés.

Méthode : Un échantillon aléatoire à 2 degrés, composé de 3956 adultes vivant à Edmonton (Alberta) au Canada, a été interviewé par des intervieweurs non professionnels formés, utilisant le protocole d’interview diagnostique (DIS) (taux de réponse de 73 %). En moyenne 2,8 ans plus tard, un échantillon aléatoire systématique de 1964 sujets a été interviewé de nouveau (taux de réponse de 86 %), à l'aide du DIS et d’un questionnaire sur l’utilisation des soins de santé. Après correction en fonction de l’âge et du sexe, l’échantillon interviewé de nouveau a été représentatif des personnes avec et sans diagnostic, lors du premier interview.

Résultats : Des 1964 sujets, 570 (31 %) ont satisfait aux critères relatifs au diagnostic d’un trouble selon le DIS/DSM-III durant l’année précédant l’interview (taux de prévalence sur un an). Les diagnostics examinés incluaient le trouble anxieux généralisé et le syndrome de stress post-traumatique. Dans le cas des personnes chez qui un diagnostic a été posé, le sexe, l’âge, l’état civil, la scolarité, l’emploi et le revenu ont été examinés comme déterminants de la recherche d’aide. Seuls le sexe (femmes) et l’âge (moins de 45 ans) se sont avérés d’importants prédicteurs. La comorbidité a aussi été hautement significative; ainsi, le taux de personnes demandant de l’aide parmi celles chez qui un seul diagnostic a été posé a été de 20,3 %, comparativement à 42,8 % chez les personnes avec plus d’un diagnostic (OR = 2,94, $\chi^2 = 31,4; df = 1; P < 0,001$). Un peu plus de 28 % des personnes avec un diagnostic ont consulté un professionnel de la santé et 7,7 % des personnes sans diagnostic ont demandé de l’aide pour un problème mental ou émotionnel. Enfin, une différence a été observée dans les cas où il y a eu établissement d’un diagnostic précis : ainsi 46,7 % des personnes souffrant d’un trouble dépressif majeur ont consulté un médecin, contre seulement 16 % des personnes faisant une consommation excessive d’alcool ou souffrant d’une dépendance à l’égard de l’alcool.

Conclusion : Les principaux déterminants de la recherche d’aide sont le sexe (femmes), l’âge (moins de 45 ans), la gravité du problème et la comorbidité. Un pourcentage étonnamment élevé de personnes souffrant d’un problème (72 %) n’ont pas demandé d’aide et plus du tiers des personnes ayant consulté un professionnel ne souffraient pas d’un problème selon le DIS/DSM-III.