Help-Seeking Behaviours of Individuals With Mood Disorders

JianLi Wang, PhD[1], Scott B Patten, MD, FRCPC, PhD[2], Jeanne VA Williams, BA, MSc[3], Shawn Currie, PhD, RPsych[4], Cynthia A Beck, MD, MASc, FRCPC[5], Colleen J Maxwell, BSc, MA, PhD[6] Nady El-Guebaly, MD FRCPC[7]

Objectives: This study had the following objectives: 1) to estimate the 12-month prevalence of conventional and unconventional mental health service use by individuals with major depressive disorder (MDD) or mania in the past year, and 2) to identify factors associated with the use of conventional mental health services by individuals with MDD or mania in the past year.

Methods: We examined data from the Canadian Community Health Survey: Mental Health and Well-Being (CCHS 1.2). Respondents with MDD (n = 1563) or manic episodes (n = 393) in the past 12 months were included in this analysis.

Results: An estimated 63.9% of respondents with MDD and 59.0% of those with manic episodes reported having used some type of help in the past 12 months; 52.9% of those with MDD and 49.0% of those with manic episodes used conventional mental health services. Approximately 21% of respondents with either MDD or manic episodes used natural health products specifically for emotional, mental health, and drug or alcohol use problems. Respondents who reported comorbid anxiety disorders and long-term medical conditions were more likely to have used conventional mental health services.

Conclusions: Relative to previous Canadian literature, our analysis suggests that the frequency of conventional mental health service use among persons with MDD has not increased significantly in the past decade. Further, the rate of conventional mental health service use by persons with manic episodes is unexpectedly low. These findings may reflect the lack of national initiatives targeting mood disorders in Canada. They have important implications for planning future education, promotion, and research efforts.

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Clinical Implications

- In Canada, the frequency of conventional mental health service use by persons with MDD has not increased significantly in the past decade.
- Only 49% of individuals with manic episodes use conventional mental health services.
- Approximately 21% of individuals with mood disorders use natural health products for emotional, mental health, and drug or alcohol use problems.

Limitations

- The CCHS 1.2 was a cross-sectional study. The temporal sequence of mood disorders, comorbid physical and mental disorders, and mental health service use was not clear.
- The CCHS 1.2 relied on self-report. Therefore, reporting and recall bias was possible.
- The CCHS 1.2 did not collect data about the severity of mental disorders.

Key Words: *mental health service use, mood disorder, CCHS 1.2, bipolar disorder, natural health products, major depression*

Mood disorders are prevalent and impose a significant burden on society. Although efficacious treatments have been developed for both unipolar depressive disorder and bipolar disorder (1,2), it is well recognized that many people with MDD in the community do not use mental health services. The Edmonton Survey of Psychiatric Disorders (3) and the Mental Health Supplement to the Ontario Health Survey (the Supplement) (4) examined mental health service use in local populations. Regarding conventional mental health service use among persons with MDD, studies based on these 2 surveys reported a 12-month prevalence of 46.7% (3) and 52.5% (5), respectively. To formulate mental health policy, national-level descriptive data for mental health service use among people with mental disorders are essential (6). However, such data were not available prior to the CCHS 1.2 (7).

Mental health care is primarily provided by mainstream health care professionals. However, persons with mental disorders may also seek help from other sources, including religious advisors or healers and CAM practitioners. Services provided by these professionals for individuals with mental health problems have been broadly referred to as unconventional medicine (8–13). Although the effectiveness of unconventional medicine for the treatment of mental disorders needs to be established, individuals with mental health problems have increasingly used unconventional medical services (11–13). Data from the CCHS 1.2 provided a unique opportunity to examine help-seeking behaviours of people with mental disorders outside the mainstream health system.

Using the data from the CCHS 1.2, our objectives were, first, to estimate the frequency of conventional and unconventional mental health service use in the past 12 months for emotional, mental health, and alcohol or drug use problems among individuals with MDD or manic episodes; and second, to identify factors related to the use of conventional mental health services in individuals with MDD or mania in the past year.

Abbreviations used in this article

CAM	complementary and alternative medicine practitioners
CCHS 1.2	Canadian Community Health Survey: Mental Health and Well-Being
CI	confidence interval
CIHR	Canadian Institutes of Health Research
MDD	major depressive disorder
NCS-R	National Comorbidity Survey-Replication
OR	odds ratio
VAS	Visual Analog Scale

Methods

The CCHS 1.2

Elsewhere in this issue of the *CJP*, Ronald Gravel discusses in detail the CCHS 1.2 methodology, target population, sampling procedures, response rate, and psychiatric assessment (14).

Help-Seeking Behaviours

Health Professionals. The CCHS 1.2 asked respondents the following question: "Have you ever seen, or talked on the telephone, to any of the following professionals about your emotions, mental health or use of alcohol or drugs?" (referred to thereafter as "mental health problems"). The professionals included psychiatrists, family doctors or general practitioners, other medical doctors, psychologists, nurses, social workers, counsellors or psychotherapists, religious or spiritual advisors, and other professionals. "Other professionals" referred to acupuncturists, biofeedback teachers, chiropractors, energy healing specialists, exercise or movement therapists, herbalists, homeopaths or naturopaths, hypnotists, guided imagery specialists, massage therapists, relaxation experts, yoga or meditation experts, and dieticians.

Other Help. In addition to health professionals, the CCHS 1.2 collected information about whether respondents had used an Internet support group or chat room, a self-help group, or a telephone helpline for mental health problems.

Natural Health Products. The CCHS 1.2 respondents were presented with the following statement and question: "Many people use other health products such as herbs, minerals or homeopathic products for problems with emotions, alcohol or drug use, energy, concentration, sleep or ability to deal with stress. In the past 12 months, have you used any of these health products?" The Statistics Canada document lists in detail the names of the health products referred to (7).

Classification of Service Use. To be consistent with the previous studies (8–13), in this analysis we defined contact in the past 12 months with a psychiatrist, a psychologist, other medical doctors, a nurse, a social worker or a therapist for mental health problems as the use of conventional mental health services. The use of unconventional health services means contacts with religious advisors or CAM practitioners. The use of Internet support, self-help groups, or telephone helplines does not fit well with either type of service as described above. In this analysis, the results of using these latter types of help are presented separately. Regarding natural health products, previous studies of CAM service use for mental health problems focused mainly on the services provided by CAM

Table 1 The frequency of mental health service use by individuals with MDD and manic episodes in the past 12 months

Services	With MDD[a] *n* = 1563 Weighted % (95%CI)	With manic episodes *n* = 393 Weighted % (95%CI)
Conventional Services	52.9 (49.3 to 56.5)	49.0 (42.4 to 55.6)
Psychiatrists	17.9 (15.3 to 20.6)	23.3 (17.6 to 29.1)
Psychologists	13.6 (11.2 to16.0)	10.8 (6.6 to 15.1)[b]
Other MDs	40.8 (37.1 to 44.4)	37.6 (31.3 to 43.9)
Nurses	4.2 (2.9 to 5.4)	6.8 (4.0 to 9.6)[b]
Social Workers	14.7 (12.0 to 17.5)	17.3 (12.3, 22.3)
Unconventional Services	6.1 (4.6 to 7.5)	9.3 (5.4 to 13.2)[b]
Religious Advisors	4.5 (3.2 to 5.7)[b]	8.2 (4.4 to 12.0)[b]
CAM Practitioners	1.9 (1.0 to 2.8)[b]	
Natural Health Products	22.0 (19.1 to 24.9)	21.1 (16.1 to 26.0)
Other Services	10.5 (8.3 to 12.7)	12.5 (8.3 to 16.8)[b]
Self-help groups	7.2 (5.3 to 9.0)	7.3 (4.0 to 10.5)[b]
Internet chat rooms	1.7 (0.9 to 2.5)[b]	
Telephone helplines	2.7 (1.7 to 3.7)[b]	4.9 (2.5 to 7.3)[b]
Any Help	63.9 (60.5 to 67.4)	59.0 (52.4 to 65.7)
Any Help Excluding Natural Health Products	54.9 (51.3 to 58.5)	51.0 (44.3 to 57.6)

[a]Individuals who had had a major depressive episode in the past 12 months, excluding those with lifetime manic episodes
[b]Bootstrap coefficient of variance between 16.6% and 33.3%
Other MDs = family doctors, general practitioners, and other medical doctors

practitioners (10–13,15). For comparison, the results related to the use of natural health products are also presented separately.

Other Measures

Demographic variables are included in this analysis (specifically, sex, age, marital status, levels of family income and education, and rural or urban residence), as are clinical variables (specifically, long-term medical conditions, role interference, suicide attempts in the past 12 months, comorbid anxiety disorders, and comorbid alcohol and illicit drug dependence). The CCHS 1.2 respondents who passed the screener for depression were administered the Sheehan Disability Scale (16) to assess the extent to which a particular mental disorder interfered with functioning at work, in the household, in relationships, and in social roles in the worst month of the past year. Responses were scored with a 0-to-10 VAS. Statistics Canada defined a score of 4 or more on the scale as severe role interference or functional impairment (7).

Statistical Analysis

Respondents who had MDD, that is, those who had major depressive episode(s) without lifetime mania (*n* = 1563) and those with manic episodes (*n* = 393), were included in this analysis. To be consistent with the timeframe of mental health service use (that is, the past 12 months), the occurrence of MDD and manic episodes referred to the preceding year. We estimated the proportions using various services in the past 12 months separately for these 2 groups.

The use of conventional mental health services has direct policy and service planning implications. Therefore, we focused on identifying factors associated with conventional mental health service use. The proportions of those with mood disorders using conventional mental health services were estimated by demographic and clinical variables. Logistic

Table 2 Top 3 natural health products used for emotional and mental health problems in participants with MDD and manic episodes in the past 12 months

Products	With MDD[a] *n* = 1563 Weighted % (95%CI)	With manic episodes *n* = 393 Weighted % (95%CI)
Vitamins	12.7 (10.2 to 15.2)	9.2 (5.6 to 12.8)[b]
St John's wort	4.2 (2.8 to 5.6)[b]	4.8 (2.1 to 7.5)[b]
Ginseng	3.4 (2.2 to 4.5)[b]	4.6 (2.3 to 7.0)[b]

[a]Individuals who had had a major depressive episode in the past 12 months, excluding those with lifetime manic episodes

[b]Bootstrap coefficient of variance between 16.6% and 33.3%

regression modelling was used to identify factors associated with the use of conventional mental health services. Because the CCHS 1.2 used complex sampling procedures, we used sampling weights and bootstrap weights endorsed by Statistics Canada to estimate the proportions and to calculate associated 95%CI. This analysis was carried out using SAS 8.0 (17).

Results

Table 1 shows the proportions of respondents with MDD and manic episodes who used various services in the past 12 months for mental health problems. Among respondents with MDD, 63.9% used some help, mainly from conventional mental health care providers (52.9%). Only 6.1% reported having used services from religious advisors or CAM practitioners. Respondents who attended self-help groups or used Internet chat rooms or telephone helplines accounted for 10.5% of those with MDD. Twenty-two percent reported that they had used natural health products for their mental health problems. We observed similar patterns of health service use among respondents with manic episodes. Respondents with manic episodes did not differ from those with MDD in use of any help (59.0%), in use of conventional health services (49.0%), in use of unconventional health services (9.3%), in use of natural health products (21.1%), and in use of other services (12.5%).

We examined the natural health products frequently used for mental health problems. Table 2 lists the 3 most frequently used health products in each group. Vitamins were most frequently used, followed by St John's wort and ginseng. The use of St John's wort did not differ from that of ginseng, regardless of the disorder. Respondents with MDD were more likely to use vitamins than were those with manic episodes. Among respondents with MDD, more used vitamins than St John's wort and ginseng.

Table 3 shows the estimated frequencies of conventional mental health service use among individuals with different demographic and clinical characteristics. Among respondents with MDD, the use of conventional mental health services did not differ by sex, marital status, family income and educational levels, or rural–urban areas. Those aged 26 to 45 years were more likely to use mental health services than were the youngest group. Individuals who reported having one or more long-term medical conditions, severe role interference, suicide attempts, comorbid anxiety disorders, or any comorbid disorders in the preceding year were more likely to use conventional mental health services. Conventional mental health service use was not related to having comorbid substance use disorders.

We observed a similar pattern among those with manic episodes, except that the proportions of conventional mental health service use in the group with 13 or more years of education (60.1%) and in the group aged 46 years or older (65%) were higher than proportions in the group of respondents with less education (38.6%) and in the youngest group (36.8%). Respondents who reported suicide attempts appeared to be more likely to use conventional mental health services than those who did not report suicide attempts.

We used logistic regression modelling to identify clinical factors associated with the use of conventional mental health services, controlling for the effects of demographic and socioeconomic characteristics. In logistic regression modelling, we analyzed age as a continuous variable. In the models, preliminary analysis found large bootstrap coefficients of variance associated with family income levels, rural or urban residence, severe role interference, and suicide attempts. To be consistent with Statistics Canada guidelines, we did not include these variables in the final models. In the multivariate analysis, the association between having one or more long-term medical conditions together with comorbid anxiety disorders and conventional mental health service use persisted, regardless of having MDD or manic episodes (Table 4).

Table 3 The frequency of conventional mental health service use by demographic and clinical variables among those with MDD and manic episodes in the past 12 months

Variables	With MDD[a] % (95%CI)	With Manic Episodes % (95%CI)
Demographics		
Men	48.8 (42.3 to 55.2)	44.5 (34.9 to 54.1)
Women	55.2 (50.8 to 59.6)	53.3 (44.0 to 62.7)
Aged 15 to 25 years	41.9 (34.5 to 49.2)	36.8 (26.1 to 47.6)
Aged 26 to 45 years	58.6 (53.4 to 63.8)	50.7 (41.2 to 60.2)
Aged 46+ years	52.9 (46.3 to 59.5)	65.0 (50.8 to 79.3)
Married, common law, partnership	51.1 (45.1 to 57.2)	51.4 (40.3 to 62.4)
Single	54.7 (49.4 to 60.1)	41.5 (31.9 to 51.0)
Divorced, separated, widowed	52.2 (44.6 to 59.7)	62.0 (47.3 to 77.1)
Low family income	55.4 (50.6 to 60.1)	50.1 (40.8 to 59.4)
Middle–high income	53.2 (47.4 to 58.9)	51.4 (41.5 to 61.4)
≤ 13 years education	50.3 (45.1 to 55.4)	38.6 (29.1 to 48.0)
> 13 years education	54.8 (49.4 to 60.2)	60.1 (50.9 to 69.2)
Rural areas	47.8 (37.1 to 57.8)	38.0 (20.9 to 55.1)
Urban areas	53.8 (50.1 to 57.7)	51.0 (44.0 to 58.0)
Clinical Variables		
Long-term medical conditions		
Yes	56.5 (52.5 to 60.5)	53.5 (46.4 to 60.6)
No	32.4 (24.3 to 40.4)	19.5 (7.3 to 31.8)
Severe role interference		
Yes	55.0 (51.3 to 58.8)	48.4 (41.7 to 55.2)
No	31.9 (19.8 to 44.0)	
Suicide attempts		
Yes	71.3 (55.1 to 87.5)	62.9 (39.8 to 86.0)
No	52.3 (48.7 to 55.9)	47.3 (40.6 to 54.1)
Comorbid anxiety disorders		
Yes	66.5 (58.3 to 74.8)	60.4 (50.5 to 70.3)
No	48.8 (44.7 to 52.9)	38.1 (29.0 to 47.3)
Comorbid substance use disorders		
Yes	55.5 (43.9 to 67.1)	46.5 (33.5 to 59.5)
No	44.5 (32.9 to 56.1)	49.8 (42.0 to 57.6)
Any comorbid disorders		
Yes	65.0 (56.9 to 73.2)	55.8 (47.6 to 63.9)
No	48.8 (44.6 to 53.0)	32.5 (20.3 to 44.6)

[a]Individuals who had had a major depressive episode in the past 12 months, excluding those with lifetime manic episodes

Table 4 Results of logistic regression modelling for the use of conventional mental health services in participants with MDD or manic episodes[a]

Variables	With MDD[b] OR (95%CI)	With Manic Episodes OR (95%CI)
Long-term chronic conditions	2.91 (2.48, 3.43)	3.14 (2.69, 3.68)
Comorbid anxiety disorders	5.35 (4.43, 6.46)	6.12 (5.20, 7.22)

[a]Controlling for the effects of sex, age, marital status, and educational levels. Age was analyzed as a continuous variable.

[b]Individuals who had had a major depressive episode in the past 12 months, excluding those with lifetime manic episodes

Discussion

We found that 63.9% of respondents with MDD and 59.0% of those with manic episodes had used some type of help in the preceding year. Respectively, 52.9% and 49.0% of these 2 groups used conventional mental health services. The lower rate of conventional mental health service use among those with manic episodes was unexpected. Unlike unipolar depression, bipolar disorder is typically treated in the mental health specialty sector (18). The CCHS 1.2 data showed that help-seeking behaviours among respondents with manic episodes resembled those observed in subjects with MDD. One possible explanation is that, unlike MDD, manic symptoms are not easily recognized by the general public. Some may not consider elevated or expansive mood to be psychiatric symptoms, leading to delayed mental health service use or to no use.

Worldwide, treatment-seeking rates for major depression appear to be increasing over time (19). Compared with the findings from the Edmonton study (46.7%) (3) and from the Supplement study (52.5%) (5), the CCHS 1.2 data suggest that the frequency of conventional mental health service use in persons with MDD has not increased significantly in the past decade. This finding is consistent with a study based on data from the National Population Health Survey (20) and a recent study in the UK (21). There may be many reasons for this. The findings from the Edmonton study and the Supplement have been widely disseminated in Canada, but there have been no efforts to implement national initiatives similar to the Major Depression Screening Day in the US (22), the Defeat Depression Campaign in the UK (23), and the SPHERE project in Australia (24).

The rate of using any help reported in the CCHS 1.2 was slightly higher than that reported in the US NCS-R (57.3%) (25). The rates of using conventional mental health services in the NCS-R and in our analysis resembled each other (51.6% and. 52.9%, respectively). The rate was higher than that reported by the recent European Study of the Epidemiology of Mental Disorders project (36.5%) (26). However, the NCS-R reported a higher rate of specialty service use (31.6%) and a lower rate of general medical service use (27.2%) than our analysis.

Previous studies reported that a significant proportion of individuals with mental health problems used CAM services (12,13,15). Using a similar definition of CAM services, the CCHS 1.2 data indicated that only a small proportion of those with mood disorders used these services: only 1.9% of those with MDD used CAM practitioners, which is lower than the use of other services in this population (that is, self-help groups, Internet chat rooms, and telephone helplines). One explanation is that, in Canada, people with mood disorders do not use services provided by CAM practitioners specifically for mental health problems. Alternatively, the low rate might be due to the phrasing of the CCHS 1.2 questions. For the question "Have you ever seen, or talked on the telephone, to any of the following professionals . . ." CAM practitioners were included among other professionals at the end of the question. Because of this placing, some respondents who had actually used CAM services for their mental health problems might have ignored the choice, leading to an underestimated prevalence of unconventional service use.

Univariate analysis showed that the prevalence of conventional mental health service use did not differ by demographic and socioeconomic characteristics among respondents with MDD. Respondents aged 26 to 45 years appeared to have a higher prevalence of conventional mental health service use. These results were consistent with the findings from the Supplement study (5). Among those with manic episodes, there was a trend for the prevalence of conventional mental health services increased with age. Those with 13 or fewer years of education were less likely to have used conventional mental health services. The remaining demographic and socioeconomic variables were not associated with conventional mental health service use in respondents with manic episodes.

Respondents who reported one or more long-term medical conditions, severe role interference, suicide attempts, and comorbid anxiety disorders had a higher prevalence of

conventional mental health service use, regardless of having MDD or manic episodes. The association between long-term medical conditions together with comorbid anxiety disorders and conventional mental health service use persisted in multivariate analysis. This was consistent with clinical expectations. However, having comorbid substance use disorders was not related to conventional mental health service use in these 2 groups. It was not clear why comorbid alcohol or illicit drug dependence did not affect service use in these 2 groups. Perhaps this finding is due to regional variations in the degree to which addiction and mental health services are integrated. It may also reflect a treatment culture that manages individuals with comorbid substance use disorders in separate services.

Our analysis had several limitations. First, the CCHS 1.2 was a cross-sectional study. The temporal sequence of mood disorders, comorbid physical and mental disorders, and mental health service use was not clear. Second, the CCHS 1.2 relied on self-report. Thus reporting and recall bias was possible. Third, the CCHS 1.2 did not collect data that allowed us to assess how severity levels were related to mental health service use. Finally, we could not assess treatment quality, since data on medication dosage and treatment duration were not collected.

Within the context of these limitations, results of our study suggest that people with mood disorders seek help from various sources. Clinical factors are more strongly associated with conventional mental health service use than are demographic and socioeconomic factors. Policy-makers, mental health service planners, and clinicians should be aware that natural health products are frequently used in this population. More studies are needed to determine the risks and benefits of natural health products for treating mood disorders.

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[1]Assistant Professor, Departments of Psychiatry and Community Health Sciences, University of Calgary, Calgary, Alberta.
[2]Associate Professor, Departments of Community Health Sciences and Psychiatry, University of Calgary, Calgary, Alberta.
[3]Research Assistant, Department of Community Health Sciences, University of Calgary, Calgary, Alberta
[4]Adjunct Associate Professor, Departments of Psychology and Psychiatry, University of Calgary, Calgary, Alberta.
[5]Clinical Assistant Professor, Department of Psychiatry, University of Calgary, Calgary, Alberta
[6]Associate Professor, Departments of Community Health Sciences and Medicine, University of Calgary, Calgary, Alberta.
[7]Professor, Department of Psychiatry, University of Calgary, Calgary, Alberta
Address for correspondence: Dr JL Wang, Department of Psychiatry, Room 3645, Peter Lougheed Centre, 3500-26 Av. NE, Calgary, AB T1Y 6J4
e-mail: jianli.wang@calgaryhealthregion.ca

Résumé : Comportements de recherche d'aide des personnes souffrant de troubles de l'humeur

Objectifs : Cette étude avait les objectifs suivants : 1) estimer la prévalence de 12 mois de l'utilisation des services de santé mentale conventionnels et non conventionnels par les personnes ayant souffert de trouble dépressif majeur (TDM) ou de manie dans l'année écoulée et 2) identifier les facteurs associés à l'utilisation des services de santé mentale conventionnels chez les personnes ayant souffert de TDM ou de manie dans l'année écoulée

Méthodes : Nous avons examiné les données du volet Santé mentale et bien-être de l'Enquête sur la santé dans les collectivités canadiennes (ESCC 1.2). Les répondants ayant souffert de TDM (n = 1 563) ou d'épisodes maniaques (n = 393) dans les 12 derniers mois étaient inclus dans cette analyse.

Résultats : Selon une estimation, 63,9 % des répondants souffrant de TDM et 59,0 % de ceux ayant des épisodes maniaques ont déclaré avoir eu recours à un type d'aide quelconque au cours des 12 derniers mois; 52,9 % de ceux souffrant de TDM et 49,0 % de ceux ayant des épisodes maniaques ont utilisé des services de santé mentale conventionnels. Quelque 21 % des répondants souffrant soit de TDM, soit d'épisodes maniaques ont utilisé des produits de santé naturels spécifiquement pour des problèmes émotionnels, de santé mentale ou de consommation d'alcool et de drogues. Les répondants qui déclaraient des troubles anxieux comorbides et des affections médicales de longue durée étaient plus susceptibles d'avoir utilisé des services de santé mentale conventionnels.

Conclusions : Relativement à la documentation canadienne antérieure, notre analyse suggère que la fréquence de l'utilisation des services de santé mentale conventionnels chez les personnes souffrant de TDM n'a pas augmenté significativement dans les dix dernières années. En outre, le taux d'utilisation des services de santé mentale conventionnels chez les personnes ayant des épisodes maniaques est étonnamment faible. Ces résultats peuvent refléter l'absence d'initiatives nationales qui cibleraient les troubles de l'humeur au Canada. Ils ont des implications importantes pour la planification des futurs projets d'éducation, de promotion et de recherche.