

## ORIGINAL PAPER

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**Correlates of a perceived need for mental health assistance and differences between those who do and do not seek help**

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**Abstract** *Background:* This study examined prevalence of perceived need for mental health assistance, characteristics of people with a perceived need, and how persons with a need who sought help were different from those who did not.

*Methods:* A national random phone survey ( $n = 1,394$ ) was conducted in Israel, which included questions about (1) perceived need for mental health assistance and (2) help seeking.

*Results:* Prevalence of life-time and recent perceived need for males was 21% and 10.7%, and for females 31% and 15.1%. Of those with a perceived need, 31.4% of males and 41.6% of females had gone for help. Based on logistic regression models, the variables associated with need were being female, divorced, having a chronic physical disease, and low income (for males only), while predictors of help seeking were living in a big city and not being a recent immigrant. The major sources of help in descending order were: mental health professionals (46%), family physician (25%), family or friends (19%), and other (10%).

*Conclusions:* A majority of people who feel that they need help for mental health problems do not get help.

professional help (Regier et al. 1993; Kessler et al. 1994). Need for mental health services has been operationalized as meeting diagnostic criteria for a disorder or on the basis of scales measuring perceived need. For example, using the first approach, the National Comorbidity Survey (NCS; Kessler et al. 1994) found that 42% of those with a life-time disorder (about half of all US Americans) had sought help, as had 15% of those respondents without a diagnosable disorder. Similarly, of those with a disorder in the past year, 21% (29.5% of US Americans) had sought help, as had 7% of those without a diagnosable 1-year disorder, and 13.3% of all respondents. It has recently been estimated that many more NCS respondents eventually have some professional contact (Kessler et al. 1998). Similar results were obtained in an earlier US survey, the Epidemiological Catchment Area (ECA) study (Regier et al. 1993), despite the use of different instruments, sample and diagnostic criteria. The ECA found that 28% of those with a diagnosable disorder in the year before interview had sought help from mental health services (15% of all respondents surveyed). Using yet a different methodology, the Camberwell Needs for Care Survey (Bebbington et al. 1997) found that in an area of London with high levels of deprivation there was a 12.3% 1-year prevalence rate of ICD-10 disorders. In less than half of these cases respondents received needed care. These results illustrate the discordance between receiving a diagnosis and utilizing services.

The NCS and Mental Health Supplement to the Ontario Health Survey also probed perceived need (Lin et al. 1996; Kessler et al. 1997). These studies included the following item: "Was there ever a time during the past 12 months when you felt that you might need to see a professional because of problems with your emotions or nerves or your use of alcohol or drugs?" This was combined with an item that asked whether they had sought help (excluding those who sought court mandated help). Respondents were regarded as having a need if (1) they had sought help or (2) if they answered affirmatively to the question about feeling a need for

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**Introduction**

Most people in need of mental health services, even persons in great need of such services, do not get pro-

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help. Based on this definition, they found that 17.8% of Americans and 11.1% of Ontarians needed help. Both studies also found that meeting diagnostic criteria was related to need. Around one-quarter of respondents with one 12-month disorder (US = 26.5%, Ontario = 21.4%) perceived a need for help; whereas almost twice as many respondents with two such disorders perceived a need (US = 42.5%, Ontario = 54.2%).

Of the NCS respondents, the most commonly used help source for mental health and addictive problems, in the 12 months prior to interview, were mental health specialists (5.8%), general medical physicians (3.9%), human services (5.1%), and self-help organizations (3.2%) (Kessler et al. 1997). In Ontario, the most commonly used help source was general medical (4.4%), followed by mental health specialists (3.5%), human services (2.3%), and self-help group (1.2%) (Kessler et al. 1997). The ECA (Regier et al. 1993) found a more prominent role for the general medical sector, with 6.4% seeking help from general medical physicians, 5.9% from speciality mental/addictive services, 3% from human services, 0.7% from a self-help group, and 3.5% from family and friends. The prominence of primary health care physicians as a help source is further supported by Schurman et al. (1985), who found that almost one-half of the mental illness visits done by office-based physicians are done by non-psychiatrist physicians.

Leaf et al. (1988), using data from the ECA, analyzed factors relating to the use of mental health services in the context of a paradigm of needs, predisposing factors, and enabling factors. Leaf supported the argument that only after need is established do predisposing and enabling factors become relevant. Leaf et al. (1988) found that when need was present, help seeking for mental health problems was related to age, marital status, and attitudes towards services. Using data from the Ontario Mental Health Survey, Lin et al. (1996) found that in addition to diagnosis the other predictors of service use were marital disruption, being a member of a household receiving public assistance, gender, age, and urban/rural residence.

The current study addresses the question of the relationship of perceived need and help seeking using national data from Israel, where mental health services are available through universal health care, government funded community mental health centers, and privately (Feinson et al. 1997).

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## Subjects and methods

As part of an evaluation of health care reform in Israel, a national probability sample telephone survey was conducted in September 1995. A response rate of 85% was obtained (1,394 out of 1,714; 8% refused, 5% were unable to participate due to mental or language barriers, and 2% were not located). An additional 5.3% ( $n = 75$ ) of those who responded did not answer the perceived need question ( $n = 1,319$ ). From each household one respondent over the age of 22 (the age after which most persons have completed compulsory military service and enter adult civilian life) was randomly selected

and repeated attempts were made to interview the selected individual. The interview schedule was also translated into Russian and Arabic and administered by native speaking interviewers to respondents in their native language. Sampling was carried out in two stages, simple random sample and over sampling of elderly respondents and those from the smaller health insurers to ensure that they would be represented in the sample. The sample compared favorably to the national demographic profile of the Israeli Census Bureau. [For a comparison to the national demographic profile and additional technical details of sampling procedure and methods see Berg et al. (1997)]. It should be noted that 96% of Israeli households have telephones (Bezek Telephone company, personal correspondence, 1997).

The survey included questions about perceived need for mental health assistance, help seeking, adequacy of help, and questions covering predisposing factors such as age, sex, marital status, and health status. It also included questions about enabling factors, such as whether or not respondents live in large cities where services are more available, type of insurance coverage (which will be examined in a later paper), and other background variables such as education and income.

To assess the need for mental health services, respondents were asked, similar to the perceived need item in the National Comorbidity Survey (Kessler et al. 1997) and the Mental Health Supplement to the Ontario Health Survey (Lin et al. 1996; Kessler et al. 1997), "Have you had psychological distress (depression, anxiety, tension, great sadness) in the past which you found it difficult to deal with yourself?" They were then asked whether this was during 1995 (study conducted in September, 1995) or before. Next they were asked whether they went for help, and if not why not, and if yes, to whom did they go for help, where did they go, and whether the number of sessions was sufficient. The question did not include reference to substance abuse problems, since these are rare in Israel and are treated by a separate care system.

Data were analyzed using descriptive statistics to explore frequencies, and cross tabulations to explore relationships between respondent enabling and predisposing characteristics and perceived need for services. Then respondents with a perceived need who had sought help were compared to those who had not sought help. For the descriptive and bivariate analysis, weighting was used to adjust for the over sampling of the elderly and persons from the smaller health insurers. The weighted sample size of respondents was 1,063.

The independent effects of each predictor variable were explored using logistic regression. For this purpose complete sample without weighting was used. Using logistic regression, we were able to estimate the increase in the probability of perceived need and to discriminate between those persons in need who sought help and those who did not.

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## Results

### Perceived need

A description of the sample and the bivariate relationships between perceived need and respondent characteristics are presented in Table 1 (background characteristics) and in Table 2 (current characteristics). Two sets of analyses were performed, one for recent (during the survey year, i.e., within the last 9 months) and the other for life-time perceived need (including recent need). As can be seen, a higher proportion of the females ( $n = 596$ ) than the males ( $n = 467$ ) perceived a need for help (15.1% vs 10.7% recent; 31.0% vs 21.0% lifetime). Older age was associated with greater need, as was being divorced or widowed, having less education, and being an Israeli Arab (speaking Arabic) or a recent immigrant, as reflected by speaking Russian as the pri-

**Table 1** Background characteristics associated with perceived need and seeking help

Background characteristics	Perceived need			Help seeking (life-time)	
	Recently %	Life-time %	<i>n</i>	Of those with perceived need (life-time) %	Of total sample %
Gender					
Male ( <i>n</i> = 467, 43.9%)	10.7*	21.0*	98	31.4	6.6***
Female ( <i>n</i> = 596, 56.1%)	15.1	31.0	185	41.6	12.9
Age					
22–34 ( <i>n</i> = 305, 28.7%)	12.0	21.2*	65	29.8**	6.3**
35–55 ( <i>n</i> = 471, 44.3%)	11.8	27.1	128	47.3	12.8
56+ ( <i>n</i> = 287, 27.0%)	16.6	31.6	91	31.5	10.0
Marital status					
Married ( <i>n</i> = 768, 72.7%)	11.6**	23.7**	182	36.3	8.6**
Single ( <i>n</i> = 124, 11.8%)	11.6	18.9	23	39.9	7.5
Divorced ( <i>n</i> = 67, 6.3%)	19.1	46.3	31	50.6	23.4
Widow ( <i>n</i> = 97, 9.2%)	23.6	45.8	44	34.9	16.0
Education					
No high school ( <i>n</i> = 186, 17.6%)	18.7**(a)	36.0**(a)	67	40.3	14.5
High school ( <i>n</i> = 365, 34.5%)	12.8	25.2	92	34.7	8.7
Post high school ( <i>n</i> = 506, 47.9%)	11.5	24.3	123	39.3	9.6
Spoken language					
Hebrew ( <i>n</i> = 834, 78.4%)	11.5**	24.0**	200	44.9***	10.8
Arabic ( <i>n</i> = 143, 13.5%)	18.9	31.5	45	25.0	7.9
Russian ( <i>n</i> = 86, 8.1%)	19.2	44.0	38	16.5	7.3
Year of immigration					
1909–61 ( <i>n</i> = 249, 50.9%)	14.6*	30.4	76	40.5***(a)	12.3(a)
1962–87 ( <i>n</i> = 133, 27.2%)	8.6	19.9	26	55.2	11.0
1989+ ( <i>n</i> = 107, 21.9%)	18.2	35.1	38	13.4	4.7

\*  $P < 0.05$ ; \*\*  $P < 0.01$ ; \*\*\*  $P < 0.005$ ; (a) monotonic distribution

mary language and year of immigration. The elevated need for the earliest group of immigrants is probably confounded by their older age.

Table 2 presents the association of current life situation factors with perceived need. Factors with a signi-

ficant association were being unemployed, earning a low wage, poor health and having a chronic illness. Logistic regression models of perceived need are presented in Table 3. The model presented was based on a stepwise analysis that included *all* significant variables from the

**Table 2** Current situation and perceived need and help seeking

Current characteristics	Help needing			Help seeking (life-time)	
	Recently %	Life-time %	<i>n</i>	Of those with perceived need (life-time) %	Of total sample %
Residence					
Small city or settlement ( <i>n</i> = 445, 41.8%)	13.7	25.8	115	30.2*	7.8*
Large city ( <i>n</i> = 619, 58.2%)	12.8	27.2	168	43.2	11.8
Work status (past 3 months)					
Worked ( <i>n</i> = 665, 62.8%)	10.9*	24.3*	162	39.9	9.7
Did not work ( <i>n</i> = 394, 37.2%)	17.0	30.7	121	35.8	11.0
Monthly income (in shekels)					
Less than 2,800 ( <i>n</i> = 266, 29%)	22.0** +	36.6** +	97	36.2	13.2 +
2,801–7,000 ( <i>n</i> = 425, 46.4%)	11.3	26.1	111	34.1	8.9
7,001+ ( <i>n</i> = 225, 24.6%)	7.5	16.5	37	46.1	7.6
General health status					
Very good ( <i>n</i> = 345, 32.6%)	6.2** +	15.7**	54	44.9	8.5**
Good ( <i>n</i> = 394, 37.2%)	10.2	23.5	93	43.8	10.3
Intermediate/not so good ( <i>n</i> = 244, 23%)	21.4	41.3	101	31.6	13.1
Not good ( <i>n</i> = 53, 5%)	29.1	38.3	20	31.4	12.0
Terrible ( <i>n</i> = 23, 2.2%)	45.1	57.4	13	44.0	25.3
Chronic disease					
Has chronic disease ( <i>n</i> = 337, 31.9%)	22.7**	41.2**	139	36.1	17.7**
Does not have chronic disease ( <i>n</i> = 727, 68.1%)	8.8	20.0**	144	40.1	10.3

\*  $P = 0.05$ ; \*\*  $P = 0.01$ ; \*\*\*  $P < 0.005$ ; + = monotonic distribution

bivariate analysis. For both females and males, the significant variables in the models were being divorced or widowed, having a chronic disease, age, and for males, lower income. In a model not shown combining the sexes, and including sex as a variable, being a recent Russian immigrant was a significant predictor of perceived need. In the current models it was nearly significant. The variables that were not associated with perceived need in the logistic model were education, being employed, general health status, and being an Arab speaker.

#### Help seeking among those with perceived need

Returning to Table 1, in column 5 we see that 31.4% of the 98 males *with a life-time need* sought help, as did 41.6% of the 185 females. As shown in the last column, this was 6.6% of all males and 12.9% of females. Of those respondents with a perceived need, the following variables significantly discriminated between those who did, and those who did not, seek help (Tables 1, 2): age 35–55, divorced, Hebrew speaker (not Russian or Arab speaker), not being a recent immigrant, and living in a big city. There was a trend for a higher proportion of females in need to seek help and for a higher proportion of divorced persons in need to seek help. The lack of significance for the variables showing a trend may be due to lack of power. This is suggested by the significant findings for some of the variables in the last column, which are based on the total sample (not controlling for need). It should be noted that this is not necessarily the proportion of respondents who sought mental health assistance, since only respondents who had a perceived need were asked about help seeking.

In a logistic regression model (Table 3, column 4), the major predictors of help seeking among those with a perceived need were living in a big city, and not being a recent Russian speaking immigrant. Since gender was

not significant in the logistic regression analysis, separate models were not done for each gender as had been done for perceived need where gender was associated with need.

#### Reasons for not seeking help

The respondents who noted a need for help but did not seek help were asked why. The major reasons given for not seeking help were: solved problems on their own (74%), did not feel comfortable (11%), economic reasons (6%), and other reasons relating to lack of trust of health care system (9%).

#### Sources and adequacy of help

The major sources of help in descending order were: mental health professional (46%), family doctor (25%), family or friends (19%), and other medical care (10%). The only variable relating to choice of help source was language. Of the Hebrew speakers, 13% sought help from family and friends as compared to 81% of Arab speakers and none of the Russian speakers ( $P < 0.000$ ). Differences in choice of help source were not found using other predisposing and enabling background and current variables.

About 30% of help sought was under private non-insured care, 20% under government funded facilities, and 50% through health insurance plans. There was a trend for people in the highest income bracket to prefer seeking help privately (8 out of 15) as compared to people in the middle (5 of 22) and lower (4 of 20) income brackets ( $P = 0.07$ ). As a rough gauge of adequacy of treatment, respondents were asked whether the length of treatment was adequate. Seventy-three percent ( $n = 54$ ) of respondents said that the number of sessions had been sufficient.

**Table 3** Logistic regression models of perceived need and help seeking among help needers (odds ratio, with 95% confidence interval in parentheses)

	Perceived need (life-time)		Help seeking (life-time) among those with perceived need Males & Females
	Females	Males	
Divorced or widowed	2.0 (1.4–3.0)**	2.4 (1.7–3.5)*	
Chronic disease	2.6 (1.8–3.7)**	2.6 (1.9–3.6)**	
Lowest income		1.4 (1–1.9)*	
Highest income			2.0 (0.94–4.3)?
Recent Russian speaking immigrants (CIS & Russia) (2)			0.23 (0.09–0.58)**
Lives in large city			1.8 (1.05–3.15)*
Age 35–55	1.9 (1.3–2.7)**		
Older than 56		0.60 (0.46–0.90)**	0.58 (0.32–1.06)?
Percent correct prediction of model	69%	80%	69%

<sup>a</sup> The other variable included in the model, which was not significant, was gender for help needers

<sup>b</sup> Based on year of immigration and language preference (CIS Commonwealth of Independent States)

?  $P < 0.08$ , \*  $P < 0.05$ , \*\*  $P < 0.001$

## Use of medical services

Respondents who recently perceived a need were more likely than those who had not to have visited, within the previous 3 months, primary care physicians (49.4% vs 39.1%) or specialists (78.2% vs 65.4%) and to have needed urgent health care (during the last 6 months) (38.7% vs 24.6%). After controlling for age and chronic disease in a logistic regression model, perceiving a need for help was no longer associated with primary health care physician visits. Two additional logistic regression models were run, one with visiting a specialist as the dependent variable and the other with urgent health care. After controlling for the variables significant at the bivariate level, perceived need was almost the strongest predictor of visiting specialists (OR = 1.4, 95% CI = 1–1.9), second only to chronic disease (OR = 1.5, 95% CI = 1.2–2.0). Similar results were obtained for using urgent health care (chronic disease, OR = 1.95, 95% CI = 1.5–2.6; perceived need, OR = 1.91, 95% CI = 1.3–2.7). Thus, being in need of help was associated with an increased likelihood that a person visits a specialist and uses urgent health care. In additional analysis of those with a perceived need during 1995, we found that those who had sought help were no less likely to need specialist or urgent health care. This may relate to the fact that the help seeking question reflected life-time, rather than current help seeking.

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## Discussion

Using a national probability sample of households, we found that prevalence of life-time and recent need for mental health services in Israel for males was respectively 21.0% and 10.7% and for females 31.0% and 15.1%. Among respondents reporting a lifetime need, 31.4% of males and 41.6% of females had gone for help. Predictors of perceived need were being female, being divorced, having a chronic physical disease, and low income (only for males). The major predictors of help seeking were not being a Russian immigrant and living in a big city. In descending order of use were: mental health professionals, primary health care physicians, family or friends.

Similar to the ECA (Robbins et al. 1991), the NCS (Kessler et al. 1994), the Mental Health Supplement to the Ontario Health Survey (Lin et al. 1996), and the Camberwell Needs for Care Survey in London (Bebbington et al. 1997), a majority of people in need did not get any kind of help. The variables related to help seeking were similar to those found in the Ontario survey (Lin et al. 1996). Similar to the ECA (Robbins et al. 1991) and NCS (Kessler et al. 1994) and other studies (Holzer et al. 1986; Bruce et al. 1991), lower income was related to more mental health needs. Unlike in the ECA and Ontario, the mental health practitioner's role was more substantial than the primary care physician's.

There have been no other national studies of perceived need in Israel. One study bearing on the issue of need found that 20% of a national sample of persons aged 24–33 had a diagnosable psychiatric condition (Levav et al. 1993). In that same age group we found that 12% of respondents answered “yes” to our question regarding perceived need.

The results suggest, similar to other studies, that consideration should be given to ways of facilitating people in need of help to obtain it. One of the obstacles to obtaining care may be access to care, at least for people living in smaller cities, who were less likely to seek help. Almost all of the people with a perceived need had been seen by either a primary care physician, urgent care, or specialists within the 3 months prior to the study improved recognition, treatment, or referral by medical practitioners is, therefore, likely to increase the proportion of those in need of care receiving care.

The major limitations of this study are the reliance on a single item to measure perceived need, the lack of measures of severity of need, and lack of behavioral measures of distress or symptoms. Other limitations are the lack of a similar item on service use for respondents who did not have a perceived need. This would have allowed exploring service use among people who did not perceive a need for help, but may have gone for help for other reasons. Due to these limitations, it was not possible to know what type of care would be needed for those with a perceived need or to estimate the number of persons who sought help in the absence of a sense of need. Also, need was probably underestimated, since we had no measure to detect needs that were not perceived by the respondent. Future research is being planned that will incorporate a survey of perceived needs with instruments to detect psychological distress or symptomatology. This will allow for also identifying needs that may not be perceived and to estimate severity of needs.

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