

Who seeks help? Factors associated with utilisation of primary care mental health services in Singapore

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Dear Editor,

Mental health screening in primary care aims to identify depression and anxiety early, but its effectiveness depends on whether patients accept follow-up services.¹ Despite the increasing accessibility of integrated mental health care in Singapore through the expansion of community and primary care mental health services, there are few studies that have evaluated the uptake of follow-up mental health services after mental health screening in primary care settings in Singapore. We examined the proportion of patients who attended the Health and Mind Service (HMS)—a multidisciplinary primary care mental health service—after a positive screen for depression or anxiety, and compared the characteristics of those who attended with those who did not.

This secondary analysis drew on data from a cross-sectional study of patients aged 21 years and above who attended NHG Polyclinics (NHGP) between December 2021 and April 2022.² Using systematic sampling, participants completed sociodemographic and validated screening questionnaires, i.e. the Patient Health Questionnaire-9 (PHQ-9) and Generalised Anxiety Disorder-7 (GAD-7). Those with scores ≥ 10 on either scale were considered screen-positive.^{3–5} These patients were offered a referral to the HMS by their attending family physician, and any attendance at HMS within 3 months was tracked. Multivariable logistic regression was performed to identify socio-demographic and clinical correlates of HMS attendance. Exemption approval was granted from the NHG Domain Specific Review Board (reference number 2024/00066).

Among the 3330 respondents, 353 screened positive. Among the 353 respondents, 12.7% ($n=45$) attended HMS. HMS attendees were predominantly young adults aged 21 to 36 years, and most had co-existing clinically significant depression and anxiety of moderate severity as well as at least 1 chronic condition. Regression analysis showed that unemployment (odds ratio [OR]

2.50, 95% confidence interval [CI] 1.08–5.77, $P=0.03$) and chronic disease burden (1–2 chronic conditions [OR 4.22, 95% CI 1.34–13.27, $P=0.01$]; ≥ 3 chronic conditions [OR 4.80, 95% CI: 1.29–17.86, $P=0.02$]) were significantly associated with higher odds of HMS attendance (Table 1).

Our findings highlight that despite the ready availability of services, most primary care patients who screened positive for depression or anxiety did not use mental health services within the primary care setting. This low uptake mirrors international trends. For instance, Hacker et al. reported that 9.4% of clients who screened positive completed a face-to-face mental health visit within 180 days,⁶ while Geyti et al. found a 29% mental healthcare initiation rate in Denmark within one year of a population-based screening.⁷ Whitton et al. reported a 36.8% uptake of at least 1 form of mental health treatment, including digital interventions, for patients who screened positive via a primary care-based screening programme in Australia within 18 weeks.⁸ While differences in healthcare models, follow-up periods, and mental health services complicate direct comparisons, all studies point to suboptimal engagement or preference for other forms of follow-up.

Our data also shows that HMS at NHGP is reaching more individuals with multiple chronic diseases and those who are unemployed—populations consistently cited in the literature as more vulnerable to adverse mental health outcomes. Patients with multimorbidity often face complex care needs and higher psychological burden,⁹ while unemployment is strongly associated with psychosocial stressors that compromise well-being.¹⁰ By supporting these vulnerable populations within a primary care setting, HMS fulfils its role as an accessible and integrated service addressing both medical and psychosocial needs.

These findings also reinforce that improving mental health support must extend beyond screening. Without adequate uptake of follow-up services, the

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Table 1. Factors associated with attendance at the Health and Mind Service (HMS) among respondents screening positive for depression or anxiety (PHQ-9 or GAD-7 ≥ 10 ; n=353).

Independent variables	Odds ratio (95% CI)	P value
Age (as of 2022)	1.00 (0.96–1.03)	0.82
Sex		
Male	Ref	
Female	1.41 (0.68–2.93)	0.36
Ethnicity		
Chinese	Ref	
Malay	0.69 (0.28–1.74)	0.44
Indian	1.38 (0.52–3.68)	0.52
Others	1.47 (0.38–5.62)	0.57
Current marital status		
Currently married	Ref	
Never married / single	1.29 (0.49–3.39)	0.60
Separated / divorced / widowed / others	1.83 (0.54–6.13)	0.33
Highest level of education attained		
Lower secondary & below	Ref	
Upper secondary / pre-university	1.88 (0.49–7.24)	0.36
Diploma and professional qualification	3.62 (0.88–14.78)	0.07
Degree & above	2.66 (0.65–10.80)	0.17
Main work status, over the last 12 months		
Employed	Ref	
Unemployed	2.50 (1.08–5.77)	0.03
Type of dwelling		
HDB 1-room / 2-room apartment	Ref	
Others	1.60 (0.39–6.54)	0.51
Overall social support (mMOS-SS)	1.00 (0.99–1.02)	0.89
Number of chronic diseases		
None	Ref	
1–2	4.22 (1.34–13.27)	0.01
≥ 3	4.80 (1.29–17.86)	0.02
PHQ-9, GAD-7 category		
PHQ-9 & GAD-7 ≥ 10	Ref	
PHQ-9 ≥ 10 & GAD-7 <10	1.22 (0.35–4.30)	0.75
PHQ-9 <10 & GAD-7 ≥ 10	0.40 (0.08–1.89)	0.25
PHQ-9 score	1.04 (0.94–1.16)	0.43
GAD-7 score	1.03 (0.91–1.17)	0.62

CI: confidence interval; GAD-7: Generalised Anxiety Disorder-7; HDB: Housing & Development Board; mMOS-SS: Modified Medical Outcomes Study Social Support Survey; OR: odds ratio; PHQ-9: Patient Health Questionnaire-9

P values in bold denote significance.

value of screening is diminished. Efforts should focus on addressing barriers to seeking mental health support, reducing stigma, improving mental health literacy, and developing services in the community.

This secondary analysis has several limitations. The single-service follow-up option may underestimate help-seeking behaviour if patients accessed community-based, private, hospital-based, or digital services. The three-month observation period may have missed delayed uptake, such as patients who accessed the HMS beyond this period. In addition, our quantitative analysis cannot fully capture patient decision-making, underscoring the need for qualitative studies to explore barriers to engagement. Furthermore, the relatively small number of participants who attended HMS may result in wider confidence intervals and greater uncertainty in the estimated associations, and therefore, these findings should be interpreted with caution.

Despite these constraints, this study provides important real-world insights from a large primary care population across multiple sites in Singapore. It is among the first to examine actual service uptake following routine mental health screening in this setting. The findings can guide allocation of resources, inform further study on patient preferences for mental health support, and strengthen the case for HMS for people with chronic conditions.

While only a minority of individuals who screened positive proceeded to attend HMS, our findings show that those who did—particularly unemployed persons and those with multimorbidity—belong to groups consistently identified in the literature as being at high risk of poor mental health outcomes. This demonstrates that HMS is reaching populations with psychosocial and health-related vulnerabilities. In addition to HMS, other mental health interventions should be developed to address patient needs and sustain and strengthen support for these groups, ensuring equitable access to timely and affordable mental health care within the community.

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Ethics statement

Waiver of patient consent for this study was approved by National Healthcare Group Domain Specific Review Board (2024/00066)

Declaration

No funding was received for this study. The authors declare they have no affiliations or financial involvement with any commercial organisation with a direct financial interest in the subject or materials discussed in the manuscript.

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