Mental Health Awareness Phone Polling Survey: Focus on Community Knowledge, Attitude and Practice, Saudi Arabia

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Authors’ contributions

This work was carried out in collaboration among all authors. All the authors helped in designing the study and performed the statistical analysis. Author AAH wrote the protocol and author NAQ wrote the first draft of the manuscript. Authors NAQ and RAD managed the analyses of the study. Authors NAQ and AAH managed the literature searches. All authors read and approved the final manuscript.

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ABSTRACT

Background: Mental health awareness surveys that assess the broad knowledge of various stakeholders including public nationwide help in the development of relevant strategies to enhance their poor mental health literacy.

Objective: The aim of this telephone polling survey was to measure mental health awareness of general public in Saudi Arabia.

Method: The participants (n=1068) randomly selected from 13 regions of Saudi Arabia were contacted by 15 trained Saudi girl interviewers for conducting 30-minutes individual interview in Arabic language using a self-designed 15-item questionnaire.

Results: About one fourth of responders (23%) reported either personal or family member having mental disorder, and depression and anxiety disorders were the commonest problems. Stigma against mental disorders and consulting health professionals, misperceptions towards...
1. INTRODUCTION

Mental health (MH) awareness surveys of public and health professionals remain an important dynamic research agenda worldwide in order to develop strategies and policies for enhancing their mental health literacy (MHL) concerning several components of global public mental health [1-4]. Of note, the evolution of physical health literacy (PHL) and its tremendous benefits to health users and providers, and community across the globe prompted MH professionals to conduct identical research in global mental health [5-7]. Although the programs and campaigns related to MHL and PHL have invariably improved public mental and physical health awareness, contradictory results continued to be reported across the board as reflected in two studies; recognition of mental disorders (MDs) was superior in one study [8] while recognition of MH problems was poor compared to physical conditions [9] might be attributed to methodological differences. We impress that the hybrid training model of mental and physical health, i.e., comorbidities should be the best option to enhance simultaneously MH and PH literacy of public and health professionals. Like PHL, MHL research is linked with many advantages including early prevention and recognition of MH problems of variable severity and an immediate need to consult MH providers [6,7,10], provision of evidenced-based data for policy makers, training and campaign programmers, and overcoming the barriers to access MH services and at the same time increasing facilitators of MHL [11-13] and reduction in social exclusion and stigma against people with MDs [14-17].

Mental health problems afflict people irrespective of their age, gender, socioeconomic status, educational level, profession, marital status, resident status, religion affiliation, ethnicity and creed. Therefore, MH studies assessed MH awareness not only of public but also mental health professionals [18], other health practitioners [19], college students [20,21], indigenous people [22], refugees and homeless people [23] and also people with diverse individual mental disorders [24,25] including schizophrenia [26,27], depression [28-30], anxiety disorders [31,32], dementia [33,34], alcohol and other drug abuse, and technology addictions [35,36], personality disorders [37], child and adolescents disorders including suicide and child abuse/neglect [38-40], physical comorbidities [41,42], mental health organizations and their impact on MHL [43,44] and intellectual disabilities with MH problems [45]. Furthermore, mental health awareness surveys and implementation of training programs and campaigns have been carried out in several settings targeting different age groups affected by MH problems such as schools [46]. Notably, MHL and how to improve it and enhance its impact on public and professionals is a growing concern of all health stakeholders across the world. A variety of MH programs are developed for enhancing MHL that include but not limited to only training [45], engaging sufferers in specific tailored programs [47], mental health curriculum and implementation of policies and practices in schools [48,49], and whole-of-community campaigns, student-community cooperation campaigns, school-based intervention teaching help-seeking skills, MH awareness, resilience and programs directed towards individuals to better intervene in a mental health crisis [7,46], mental health first aid program [50] and programs targeting workplace people [51,52]. Overall, a brief review of individual and community MH surveys and MHL programs and campaigns in several countries suggest that there exists substantial literature especially in western world that helps in reducing stigma, early identification of MH problems and MDs and early interventions including help-seeking options by communities. Evidently, MHL enhancing
programs also help to increase MH awareness of public, mental health professionals, students and teachers in schools and other health practitioners across the world. The identical literature is scantly in the eastern world including kingdom of Saudi Arabia [3,4,30,53]. To our knowledge, probably this is the first phone MH polling survey of community in Saudi Arabia. The relevance of this survey is that there is limited information concerning MHL not only in Saudi society but also all Arabian Gulf countries. The significance of this research is that its results will identify weak areas of MHL among community members and, thereafter, those areas will be strengthened by evidence-based training programs directed towards general public and by extension to all healthcare stakeholders including health users and health providers.

1.1 Objectives

The aim of this national phone survey is to explore the mental health awareness among community members in Saudi Arabia.

2. METHODS

2.1 Setting

The two national centers in Riyadh, King Abdulaziz Center for National Dialogue (KACND) and National Center for Mental Health Promotion (NCMHP), designed this public polling telephone survey. Both National Centers actively collaborated for finalizing and conducting this national survey in 13 regions of Saudi Arabia. The KACND has well established digital call center for Public Opinion Polls.

2.2 Design

It is a cross-sectional telephone survey that included only Saudi nationals. Expatriates were not considered because this survey was conducted in Arabic language.

2.3 Sample Size

The consultant statisticians calculated sample size in accordance to the mathematical and statistical equations. The margin of errors was not more than 3% with 95% confidence level. The estimated sample was 1068 and precisely 1000 sample is enough for public polling surveys [54]. For details of how to calculate sample size and survey design, see these sources of pertinent information [54,55].

2.4 Sample Selection

The survey was comprised of Saudi citizens from different regions (n=13) of the Kingdom of Saudi Arabia. The sample was randomly selected by using a computer program designed for this purpose. The sample was selected through stratified random sampling and the community members were distributed or categorized into two strata in accordance to the two variables, 13 administrative regions and gender. A small random sample was chosen from each stratum according to proportional distribution method in which the population was withdrawn from each administrative region.

2.5 Exclusion and Inclusion Criteria

The primary inclusion criteria were both males and females having age ≥20 years and ≤65 years. Another inclusion criterion was that the participant is a Saudi citizen who speaks and writes Arabic very well. The main exclusion criteria were age below 20 and above 65 years and serious medical and psychological disease impacting adversely cognitive memory functions.

2.6 Designing the Questionnaire

First, the relevant literature was searched and retrieved important articles [56,57] were reviewed extensively by two authors. Then, the questionnaire was designed in Arabic language by three experts according to the survey objectives and concerned information in the retrieved important articles. The questionnaire was based on semi “mixed model” [57,58] in terms of closed ended questions with ‘yes’ or ‘no’ answers and open ended questions with or without Likert scale. In fact, mixed model questionnaire provides larger space to participants for expressing their knowledge, perception, attitude and practice compatible with the asked questions and take reasonable time to complete the questionnaire, which depend on total number and length of various questions, interviewer, interviewee, self- and interviewer-administered questionnaire and number of non-responders. Overall mixed model represents quantitative and qualitative dimensions; the latter method includes focus group and in-depth interviews which were not part of our survey. We simply used some open-ended probes. All the three experts agreed upon all the questions without any discrepancy. This 15-item questionnaire (1-6 items covered knowledge/practice items and 9-items about attitudes) was
also piloted on randomly selected 20 community individuals who reported minor linguistic problems which were modified and, consequently, all the items embedded in the questionnaire were clear and understandable. Finally, the self-designed, interviewer-administered questionnaire was also scientifically and linguistically reviewed by a scientific committee in consultation with a specialized healthcare team to ensure it is reliable, culturally competitive and easily useable in the community.

2.7 Data Collection

The King Abdulaziz Center for National Dialogue trained dozens of Saudi girls with adequate qualification for conducting phone and online national and regional health surveys. The trained girls use landline to collect data from the participants. For this purpose, the girls use the call center of the National Center for Public Opinion Polls situated in the KACND, Riyadh. This National Center has census of Saudi households and these girls picked up males and females randomly fitting into inclusion and exclusion criteria. All the fifteen girls were briefed about the self-designed 15-item questionnaire and semistructured sociodemographic (SD) proforma prior to collecting the data and all their queries were clarified by one of the co-investigators. These girls were assigned to collect the data for this survey by using our self-designed MH questionnaire. The 15 girl interviewers took three days (each girl took 7:00AM to 4:00Pm, one day working=8 hours, a total of 24 hours) to interview all the participants (n=1086), from 2018/9/26 to 2018/9/28. Each interviewer took approximately 20 minutes to complete one questionnaire. Each interviewer also recorded 3-5 non-responders, and the total number of refusal to participate in this survey was 52 (5200/1138=5%), and 95% response rate with 5% nonresponse bias is pretty good for small random sample selection. This response rate of public polling surveys is much higher than the response rate reported in western world ([59] attributable to multiple reasons including virtual online self-administered design surveys.

2.8 Data Management

Data was entered in computer using Statistical Package of Social Sciences (SPSS) version 21, was cleaned first and then analyzed. We calculated mainly percentage (%) frequency (f) distribution of data-responses of participants and presented in tables and bar graphs. No association and correlation statistical tests were used to analyze the data because non-probable public polling surveys mostly use descriptive statistics including graphs and charts.

Prior to interviewing, the interviewer introduced herself to the participant and told the purpose of calling him or her. Subsequently, the interviewer addressed in nontechnical language the objectives of this survey and clarified any query raised by the participant. The interviewer informed the participant that interview will not take more than 20 minutes or so and no other person except the research team will have access to the collected data. Following this, the interviewer asked the participant; are you agreeing voluntarily to participate in this survey? If the participant said ‘yes’, i.e., to take part in this survey, the interviewer proceeded further to ask questions and valid answers were recorded on the questionnaire. The participants gave verbal consent on telephone. All the participants were assured that their data will remain anonymous and their identity will not be disclosed to any third party. The participants were told that the data submitted for publication in scientific journal will also be anonymized.

3. RESULTS

3.1 Sociodemographic Variables

The participants (n=1068) drawn from 13 regions of Saudi Arabia included 58% males. About 41% of the responders were in the age group of 30 to 49 years. Majority of them (55%) had bachelor’s degree and only 5% had postgraduate education and majority of the participants (61%) were from three regions including Riyadh (25%), Mecca (21%) and Eastern province (15%) (Table 1 & Fig. 1).

3.2 Participants’ Responses on the Individual Items

3.2.1 Psychological problems

Majority of respondents (n=821, 77%) and their families had never developed any psychological problem. Conversely, only 10% of participants reported having some personal psychological problems, and another 13% indicated that some mental health problems existed in their families. A variety of psychological problems experienced by the participants (n=247, 23%) in decreasing percentages were depression (33%), anxiety disorders (30%) including generalized anxiety disorder (14%), obsessive-compulsive disorder
(13%) and social phobia (3%), insomnia and other sleep disorders (10%), schizophrenia (6%) and psychosis (6%). Further comparative percentages and frequencies calculated from total sample of these disorders are shown in Table 2. The participants perceived depression (8%) to be the commonest mental health problem in the family circle and the community, followed by anxiety disorders (3.2% anxiety and 3% OCD and 1% social phobia, (pooled anxiety disorder 7%), insomnia and other sleep disorders (2%), schizophrenia (1.4%) and other psychoses (1.3%) and other psychological problems (4%).

Table 1. Sociodemographic variables of the participants (n=1068)

<table>
<thead>
<tr>
<th>Variable</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>622(58%)</td>
</tr>
<tr>
<td>Females</td>
<td>446 (42%)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>&lt; 20 years</td>
<td>160(15%)</td>
</tr>
<tr>
<td>≥20 - ≤29 years</td>
<td>203(19%)</td>
</tr>
<tr>
<td>≥30 - ≤49 years</td>
<td>440(41%)</td>
</tr>
<tr>
<td>≥50 years</td>
<td>242(23%)</td>
</tr>
<tr>
<td>No response</td>
<td>23(2%)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>High school or less</td>
<td>418(39%)</td>
</tr>
<tr>
<td>Bachelor or diploma</td>
<td>583(55%)</td>
</tr>
<tr>
<td>Postgraduate</td>
<td>55(5%)</td>
</tr>
<tr>
<td>No response</td>
<td>12(1%)</td>
</tr>
</tbody>
</table>

3.2.2 Mental health help-seeking pathways

In case the participants or their family members experienced psychological problems, 44% of them would prefer to consult a psychiatrist, 31% would read themselves the holy Quran or supplications, and 9% of them would seek the help of well-known faith healers who recite holy Quran verses on patient and 7% would prefer to go to different health providers including psychotherapist. Finally 3% of them expressed that the psychiatric problem will improve by itself (self-remission) and, hence, they tend to pay no attention to these problems. About 6% of them informed that they tend to use a mix of modalities including religious, herbs and help from mental health professionals (Table 3). Concerning mental health professionals and hospital and clinic settings, majority of the participants (57%) prefer to go to governmental hospitals and mental health clinics while 32% prefer to consult private hospitals and clinics, and other participants (11%) expressed multitude opinions.

3.2.3 Barriers to access mental healthcare services

Concerning constraints to access specialized psychiatric services; 34% believed the high cost of various MH therapies; 28% expressed the absence of psychiatric clinics (and beds also) in public general hospitals; 17% expressed concern to the lack of hospital beds in mental hospitals for urgently needy patients. In addition, 23% cited other barriers including stigma, feeling shameful of the society, and lack of MH service awareness. On the other hand, 23% had no explanations for the constraints to having access to mental health services. Concerning possible grading of psychiatric services in the Kingdom of Saudi Arabia, 36% of participants reported the MH services in general are good. 19% of them expressed the MH services being excellent while 17% opined that MH services are poor. A proportion of 28% participants did not have a clear perception of these services (Table 4).
Table 2. Frequency and percentage of mental disorders reported by participants

<table>
<thead>
<tr>
<th>Mental disorders</th>
<th>From 247</th>
<th>From 1068</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>82 (33%)</td>
<td>82 (7.7%)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>34 (14%)</td>
<td>34 (3.2%)</td>
</tr>
<tr>
<td>OCD</td>
<td>32 (13%)</td>
<td>32 (3.0%)</td>
</tr>
<tr>
<td>Social phobia</td>
<td>7 (3%)</td>
<td>7 (0.7%)</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>15 (6%)</td>
<td>15 (1.4%)</td>
</tr>
<tr>
<td>Psychosis</td>
<td>14 (6%)</td>
<td>14 (1.3%)</td>
</tr>
<tr>
<td>Insomnia and sleeping disorder</td>
<td>24 (10%)</td>
<td>24 (2.2%)</td>
</tr>
<tr>
<td>Other</td>
<td>39 (16%)</td>
<td>39 (3.7%)</td>
</tr>
<tr>
<td>No mental disorders</td>
<td>-----</td>
<td>821 (77%)</td>
</tr>
<tr>
<td>Total</td>
<td>247 (100%)</td>
<td>1068 (100%)</td>
</tr>
</tbody>
</table>

Table 3. Participants’ help seeking pathways

<table>
<thead>
<tr>
<th>Responses</th>
<th>Frequency (%)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ignore it because it will disappear by itself</td>
<td>28 (3%)</td>
</tr>
<tr>
<td>Reading holy Quran (Ruqya) and supplications</td>
<td>331 (31%)</td>
</tr>
<tr>
<td>Islamic faith healing</td>
<td>95 (9%)</td>
</tr>
<tr>
<td>Traditional herbal remedy</td>
<td>3 (0%)</td>
</tr>
<tr>
<td>See a psychiatrist</td>
<td>468 (44%)</td>
</tr>
<tr>
<td>See a psychotherapist</td>
<td>80 (7%)</td>
</tr>
<tr>
<td>Other</td>
<td>63 (6%)</td>
</tr>
<tr>
<td>Total</td>
<td>1068 (100%)</td>
</tr>
</tbody>
</table>

*Percentages rounded up

3.2.4 Attitudes towards mental health

A proportion of 4% (strongly agreed) to 21% (agreed) participants perceived embarrassment if someone knows about family members or him/herself having a mental problem while a greater proportion of them strongly disagreed (8%) to disagreed (59%) regarding having a mental health problem. Similarly, consulting a mental health professional was also perceived as shame almost by the equal number of participants. Concerning social isolation and not acceptance mentally ill people, the participants expressed strong agreement (6%) to agreement (56%) while 17% disagreed. Inappropriate reporting about mental patients by social media negatively impacts the image of mental patients, the participants strongly agreed (7%) to agreed (38%) whereas 37% disagreed. Faith healing and mental health, 40% participant agreed that spiritual/religious improves mental condition while 22% disagreed with this therapeutic notion. About 50% of study subjects agreed that the use of psychotropic drugs cause addiction but 22% of participants disagreed and 24% were neutral in their opinion. Among those using psychotropics, the level of improvement is weak and the participants were equally divided in their opinion, 32% agreed versus 30% disagreed. Concerning accessibility of mental health professionals, 47% agreed (accessible) and 28% disagreed. With regard to availability of MH experts in public hospitals, a proportion of study subjects (34%) agreed while 17% disagreed and a greater percentage of them (43%) were remained neutral (Table 4).

4. DISCUSSION

This general community survey explored knowledge, attitude, and practice of public concerning mental health in Saudi Arabia. Regarding SD data, the proportion of male participants was more than females, and most of them were adults with bachelor degree from three largest advanced regions of Saudi Arabia. These findings support partially the results of other studies [30,53]. Alosaimi, et al. (2019) studied the public (n=416 participants) awareness, beliefs, and attitudes of bipolar disorder in Saudi Arabia and reported suboptimal awareness concerning bipolar disorder [30]. Mahmoud (2019) studied Saudi population (n=5644, 50% males) knowledge and awareness about mental health and barriers to seeking psychiatric consultation in Saudi Arabia and reported poor knowledge and awareness about mental disorders. The important implications of these findings include lifting cultural barriers to women to participate in surveys, educational level is rapidly increasing but postgraduate professional education needs scaling up, and prevention of MH problems and promotion of MH of public needs to be started prior to age 20 years in Saudi Arabia. Concerning awareness of various MDs, the participants reported the two most common disorders were depression (7.7%) and anxiety disorders (6.9%) and schizophrenia psychosis was perceived by 2.7% of responders. Overall, 23% of participants reported various
Table 4. Participants’ (n=1068) responses on the individual items

<table>
<thead>
<tr>
<th>Question concerning knowledge/practice</th>
<th>Response</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you or one of your family members ever experienced a psychological problem?</td>
<td>Yes, me and my family;</td>
<td>247 (23)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>821 (77)</td>
</tr>
<tr>
<td>2. If the answer to Q 1 is yes, then what kind of problem did you experience?</td>
<td>Depression, anxiety and OCD, sleep disorders, social phobia, schizophrenia, acute psychosis and others</td>
<td>247 (23)</td>
</tr>
<tr>
<td></td>
<td>No disorders-</td>
<td>821 (77)</td>
</tr>
<tr>
<td>3. In case you or one of your family experience psychological problem (Allah forbids), what would be your first choice to deal with the mental problem?</td>
<td>Ignore it;</td>
<td>28 (3%)</td>
</tr>
<tr>
<td></td>
<td>Reading holy Quran and supplications;</td>
<td>331 (31%)</td>
</tr>
<tr>
<td></td>
<td>Islamic faith healing;</td>
<td>95 (9%)</td>
</tr>
<tr>
<td></td>
<td>Folk herbal remedies;</td>
<td>3 (-)</td>
</tr>
<tr>
<td></td>
<td>Consult a psychiatrist;</td>
<td>468 (44%)</td>
</tr>
<tr>
<td></td>
<td>See a therapist and</td>
<td>80 (7%)</td>
</tr>
<tr>
<td></td>
<td>Others.</td>
<td>63(6%)</td>
</tr>
<tr>
<td>4. In case you or one of your family needs to see mental health professional, where would you prefer to go to?</td>
<td>Public hospitals or clinics;</td>
<td>604(57)</td>
</tr>
<tr>
<td></td>
<td>Private hospitals or clinics;</td>
<td>343(32)</td>
</tr>
<tr>
<td></td>
<td>Others; diverse responses</td>
<td>121(11)</td>
</tr>
<tr>
<td>5. In your opinion, what constrains are there for utilizing psychiatric services in mental healthcare settings?</td>
<td>No clinics in public mental hospitals;</td>
<td>298(28%)</td>
</tr>
<tr>
<td></td>
<td>Lack of enough beds for patients requiring admission;</td>
<td>182(17%)</td>
</tr>
<tr>
<td></td>
<td>High cost of therapies in private settings;</td>
<td>243(23%)</td>
</tr>
<tr>
<td></td>
<td>I do not know and others;</td>
<td>241(23%)</td>
</tr>
<tr>
<td>6. In general, how would you evaluate mental health services in the kingdom of Saudi Arabia?</td>
<td>Excellent;</td>
<td>198(19%)</td>
</tr>
<tr>
<td></td>
<td>Good;</td>
<td>384(36%)</td>
</tr>
<tr>
<td></td>
<td>Poor;</td>
<td>190(18%)</td>
</tr>
<tr>
<td></td>
<td>I do not know</td>
<td>296(28%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participants opinion concerning attitudes;</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. You feel embarrassed if someone knows that a member in your family is mentally ill.</td>
<td>43(4%)</td>
<td>222(21%)</td>
<td>91(9%)</td>
<td>628(59%)</td>
<td>84(8%)</td>
</tr>
<tr>
<td>8. It is embarrassing if someone finds that either you or one of your family members is seeing a MH professional.</td>
<td>44(4%)</td>
<td>222(21%)</td>
<td>65(6%)</td>
<td>643(60%)</td>
<td>94(9%)</td>
</tr>
<tr>
<td>9. Do you think that a mentally ill person suffers from social self-isolation and non-acceptance by society?</td>
<td>68(6%)</td>
<td>600(56%)</td>
<td>212(20%)</td>
<td>175(16%)</td>
<td>13(1%)</td>
</tr>
</tbody>
</table>
10. By inappropriate reporting, social media contributes to the bad image of mentally ill patients.  70(7%) 401(38%) 161(15%) 400(37%) 28(3%)  
11. Do you think faith healing is better therapy in mentally ill patients than other MH services?  78(7%) 429(40%) 306(29%) 236(22%) 27(3%)  
12. Do you think psychoactive drugs lead to addiction?  28(3%) 517(48%) 252(24%) 210(20%) 11(1%)  
13. The evidence level of improvement among mentally ill using medication is weak.  65(6%) 338(32%) 376(35%) 316(30%) 10(1%)  
14. Psychiatrist and psychotherapists can be accessed easily in clinical settings.  48(4%) 502(47%) 170(16%) 298(28%) 33(3%)  
15. Do you think qualified MH professional are available in public hospitals.  48(4%) 362(34%) 444(42%) 178(17%) 36(3%)
mental illnesses in this survey. This epidemiological trend also found in many studies [60-62]. However, some studies conducted in young population reported anxiety disorders more common than depression [60] attributable to methodological differences including interviewers and diagnostic tools used.

The community participants in MH surveys often report multiple diverse complex help seeking pathways [63] as also found in this cross-sectional survey, and most commonly participants tend to consult a mental health professional (44%) and religious faith healers (40%) and others including psychotherapists. Psychotherapy is not commonly used in Saudi MH care setting because most forms are westernized models which are culturally not accepted and therapist encounters some other barriers as found in some studies [64,65]. In Saudi context, a larger population with or without a MH problem and physical diseases consult religious faith healers and also auto-medicate/treat themselves using traditional herbs and roqaya and drinking ruqya-recited water, i.e., reciting holy Quran and blowing on themselves and into water [66]. Community participants perceived several barriers including high cost and unawareness of psychiatric services, no MH clinics in public general hospitals, unavailability of beds, being ashamed and stigma accessing to mental health hospitals and related services in Saudi Arabia [30,53] supporting the findings of other studies [67,68]. Overall, patients’ access to MH services is a global challenge, and 15-21% youth with single mental disorder, only 33% have access to MH services in Canada [69]. In addition, the participants’ perception of quality of MH services being negative or poor [70] tends to discourage public to go early to the MH hospitals. Although more than 50% of responders perceived MH services good to excellent, the standard of MH services needs further improvement not only in Saudi Arabia but also worldwide [70]. In this context, “hybrid model” that addresses the comorbidities of MH disorders and holistically integrate treatment interventions would be ideal holistic model for addressing co-existing complex diseases [71-73].

Evidently attitudes and perceptions of community towards MH problems constitute an important component of mental health literacy. According to this polling survey, a quarter of responders (23%) with MDs felt shame seeing a MH professional, and more than 62% (pooled) felt socially excluded from the society. These finding inform that stigma against mental illnesses and multiple stakeholders and MH settings is perceptible in Saudi society and, hence, continuing anti-stigma campaigns are needed targeting public at large [3,30,53]. It is globally accepted that stigma against public with MH problems and psychotropic drugs has wider implications and disadvantages including greater contribution to the burden of diseases to the society and exchequers, delay in contacting health professionals, and development of MH services, and poor outcome [2,16,17,30,53].

Evidently inappropriate reporting about mental patients and MH hospitals by social media negatively impacts the image of mental patients [2,30,53,69], and about 45% of the participants (versus 40%) agreed with this notion. This MHL gap need training programs targeting public and at the same time social media personnel need not to show negative images of patients suffering from mental disorders, hospitals and MH professionals [69]. At the same time, people should use suitably social media sites, which are reported to cause technology addiction, depression, low self-esteem and suicide [36, 74, 75]. Attitude of responders towards religious and spiritual therapies in terms of effect of praying, reading holy Quran and drinking Quran recited water, about 50% agreed but a quarter of them disagree concerning their therapeutic role in psychiatric disorders. Interestingly, addressing the MH needs of the Muslim community in United States, Awaad (2015) discussed the importance of connectivity between community partnerships and academcics as an effective strategy in working in a faith-based community that prefers religion-based therapies over western model of MH services [65]. In addition, the significance of academcics in enhancing MHL and wellbeing of students might be achieved if their seven suggestions including culture and communication and students societal activities are added to the stress-free environment [76]. This area further needs evidence-based campaigns and training programs and MH policies that positively modify public attitude towards religion and spiritual therapies across the board. Concerning psychotropic drugs and MH services, responders reported a couple of misperceptions and negative attitudes such as drugs are addictive and associated with weak or mild improvement, and difficult access to MH services in hospitals as also found in other studies [11-13,17]. These and other false beliefs against mental disorders influenced by multiple determinants including individual personality need to be considered.
earnestly, and awareness campaigns for mitigating such beliefs of public are needed regularly [77]. Another finding observed in the present survey was that many participants were neutral in responding to these attitudinal exploration may indicate that they were possibly not fully aware of symptoms of mental illness, help seeking standard pathways and harmful effects of stigmatization concerning different aspects of global MH. Overall according to the present survey findings and results of other surveys, MHL of general community is deficient in some areas than the other and needs further improvement across the world [77,78]. Overall, the present survey identified several deficiencies in public knowledge, attitude and practice and future studies are called for improving public MHL in Saudi Arabia.

This study has some limitations. In this public polling survey no standardized MHL questionnaire was used. However, our questionnaire was quite authenticated as all its designers agreed consistently to all included items. Nonetheless, it would have been better to assess its reliability (internal consistency) using Cronbach’s alpha test. Currently a sample size of 1000 participants is advised in public polling surveys may not apply to probability online surveys or face-to-face surveys and, hence, its results may not match with the findings of surveys of MH with larger sample, and may not generalizable to the whole population. Our community survey included selection of randomized sample proportionate to population of each region and clustered into gender and region categories, yet we impress that it may not be a probability survey. Furthermore, data analysis used only descriptive statistics because our objective was not to determine the causal factors of MHL. In polling surveys, participants declare themselves having no serious psychophysical disease and cognitive disorder and, hence, this might be a limitation of this study. The strengths of the public polling survey are diverse; completion in short time, better response rate, requirement of minimal number of human resources, substantially less expensive and production of acceptable results. The higher response rate might be attributed to the fact that this survey used official polling center, and interviewers’ gender.

5. CONCLUSION

In summary, about a quarter of community members perceived either themselves or their close relatives having mental disorders especially depression, anxiety disorders and severe mental illness. In addition, knowledge, attitude and practice were differentially deficient among community participants in this survey. Evidence-based training programs targeting public mental health components and campaigns are needed nationwide to improve their mental health literacy linked with early recognition of mental disorders together with early help seeking options and interventions resulting in better outcomes. All mental health stakeholders must develop strategies to fill the void of deficient mental health literacy among general population in Saudi Arabia.

CONSENT

As per international standard, patient’s written consent has been collected and preserved by the author(s).

ETHICAL APPROVAL

This study was approved by internal ethical committee of the National Center for Mental Health Promotion.

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COMPETING INTERESTS

Authors have declared that no competing interests exist.

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