

Help seeking for common mental disorders

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INTRODUCTION

The most common mental disorders in the population and in primary care settings are affective disorders and anxiety disorders. A world-wide WHO study (WHO survey consortium, 2004) shows a considerable range between countries, with a 1-year prevalence ranges of all mental disorders together varying from 4.3% in Shanghai to 26.4% in the USA. But in each of the 14 sites anxiety (2.4% - 18.2%) and affective disorder (1.7% - 9.8%) rank on the first two places. Comparable figures are replicated in the European Study of the Epidemiology of Mental Disorders (Alonso et al. 2004a), the Australian National Survey of Mental Health and Wellbeing (Andrews et al. (1999) the US National Comorbidity Study (Kessler et al. 1994) and the Dutch NEMESIS study (Bijl et al, 1997)

Many of these disorders remain untreated. In the Dutch population-wide survey of 1996 (Bijl and Ravelli, 2000) only 34% of those with at least one disorder reported some form of care (which included even informal care); 27% had been treated in primary care and 16% in ambulatory or residential mental health care. Kessler et al. (2001) report from the US that less than 40% of those with serious mental illness received treatment. In the European Study (Alonso et al. 2004b), 26% of those with a diagnosis of mental disorder did consult a formal health service for their mental health.

Women, 35-55 year old, people in cities, single people and unemployed or disabled had higher chances to use some kind of care, according to Bijl and Ravelli (1995); Bebbington et al. (2000) pointed to severity of the mental disorder as the most important predictor for help seeking. Besides, female sex, age and employment status contributed to the chances that help might have been sought. Bland et al. (1997) mention female sex, age less than 45 and comorbidity of several mental disorders as factors increasing the probability of help seeking.

The behavioural model of Andersen (Andersen, 1968, 1995), developed in the sixties but still a powerful explanatory model to explain health services use, distinguishes three kinds of determinants for the use of services. Determinants that contribute to people's disposition to use services, factors that enable the use of services and factors that determine the need for care.

Among the predisposing characteristics demographic factors are counted (age, gender, education, ethnicity); people's attitudes, beliefs and values regarding mental health care are predisposing characteristics as well. At last, personality should be mentioned: not the pathological DSM-IV axis 2 personality disorders but the normal personality dimensions as they are structured in the five factor model: neuroticism, extraversion, openness, agreeableness and conscientiousness.

Enabling factors have to do with availability of care. Classical enabling factors are the geographical (distance) and financial (insurance, income) access to institutions.

Need for care should be the main determinant for the use of health care facilities. Need for care can be divided in need for care as assessed by the clinician: the clinical need for care and need for care from the patient's perception: the perceived need for care. Clinical need for care has a number of indicators: the diagnosis, severity, presence of co-morbidity, and recurrence.

In an ideal health care systems, use of services should be determined exclusively by need determinants. Analyzing use of services within the broader context of need, predisposing and enabling factors, enables us to detect imperfections within the functioning of the mental health care system. Analysis of the several determinants, distinguished in the model, within a multivariate approach will learn us more about the relative contributions of several determinants.

Therefore, the main research question is: to what degree is use of mental health services by people, affected by depression or anxiety determined by the predisposing characteristics, enabling characteristics and need characteristics, summoned above.

SUBJECTS AND METHOD

New data on the use of health services were collected in the Netherlands Study of Depression and Anxiety (NESDA). For a fully detailed account of this study, see Penninx et al., (submitted). NESDA is a multi-centre study designed to examine the long-term course and consequences of anxiety and depressive disorders. For its purpose, patients with a DSM-IV diagnosis of mood or anxiety disorder in the past six months have been recruited in primary care (680 persons), specialized mental health care settings (806 persons) and in the open community (134 persons). The primary care sample was selected from patients, visiting their GP, irrespective of their reason for visit. The sample from specialized mental health care settings was drawn from attendants of those settings. The community sample came from two cohorts of patients, known with a psychiatric disorder in the past for themselves or their parents.

For all recruitment settings, uniform in- and exclusion criteria were used. A general inclusion criterion was an age of 18 through 65 years. As the sample should be representative of patients seen in different settings, there were few a-priori exclusion criteria. Excluded were patients with a primary diagnosis of psychotic disorder, obsessive compulsive disorder, bipolar disorder, or severe addiction disorder (requiring care in specialized addiction clinics) since the course and care-trajectories of these patients will be determined largely by the primary disorder which is not subject of NESDA. A second exclusion criterion was not being fluent in Dutch,

During the selection interview the Composite Interview Diagnostic Instrument (CIDI) – lifetime version 2.1- was administered to diagnose depressive and anxiety disorders. Besides, the respondents were interviewed about their health services use and preferences, and they completed a large battery of questionnaires and tests, to be discussed in more detail below.

As “use of mental health service (including primary care)” is our primary dependent variable, the specialized mental health sample is not fit for our purpose, as use of mental health service is the criterion according to which this sample is selected. The community sample, being a sample of ex-patients or people at risk, is strongly biased regarding use of health services. Therefore, our analysis is confined to the 680 patients with a mood or anxiety disorder, selected from patients visiting their GP.

Sample

Primary care patients were recruited from practices of 65 general practitioners (GPs) in the vicinity of the field sites (Amsterdam, Groningen, Leiden). In the Netherlands all patients are enlisted at a general practice. For the selection of respondents, a three-stage screening procedure was used. Screening questionnaires were sent to a random sample of GP patients aged 18-65 years who consulted the GP in the last 4 months irrespective of reason for consultation. The screening questionnaire consisted of the Kessler-10 (K-10, Kessler et al., 2003). The K-10 has shown to have good screening characteristics for affective disorders.(Furukawa et al., 2003;Kessler et al. 2003). A screen-positive score on the

extended K-10 was defined as a validated K-10 score of ≥ 20 , (Furukawa et al., 2003) or a positive score on any of the added anxiety questions. Screen-positives were approached for a short telephone screening interview, consisting of the CIDI-short form sections for anxiety and depressive disorders. Those who fulfilled criteria for a current depressive or anxiety disorder during the telephone screening interview, were fluent in Dutch, and did not report to have been treated in a mental health care organization in the past for other psychiatric disorders were invited to participate in the NESDA study. In addition, a random selection of the screen-negatives were also invited to participate. A total of 23750 screening questionnaires were sent out by primary care physicians, of which 10774 (45%) were returned. Those returning the screener were more likely to be female (59.3% versus 50.0%, $p < .001$) and older (44.4 versus 39.0 years, $p < .001$) compared to those not returning the screener. Using the subsequent three-stage screening procedure, 680 participants with a current depressive or anxiety disorder were recruited.

Measures

Dependent variable: use of mental health services.

Mental health care seeking was measured by means of the Perceived Need for Care Questionnaire, PNCQ (Meadows et al. 2000). The PNCQ is a structured interview in which among others the use of health care services during the past 6 months is carefully assessed. The respondents report if they had any contacts during the past six months with a general practitioner, a medical specialist or a company doctor, all because of mental health problems and/or if they had any contacts with social work, a primary care psychologist (a psychologist working in primary care, using a limited number of sessions, treating clients with relatively uncomplicated mental health problems), a psychiatrist, a psychotherapist, an institution for ambulatory mental health care or an institution for addiction problems. General practitioner, social work and primary care psychologist are considered primary care, company doctor and medical specialist medical care and the last four possibilities are categorized among specialized mental health care.

Predisposing characteristics

Detailed socio-demographic data were collected, including age, sex and ethnicity. Socioeconomic information was collected by asking for education. Personality is measured by the NEO personality questionnaire, a 60-item questionnaire which measures five personality domains, including neuroticism, extraversion, agreeableness, conscientiousness, and openness to experience. (Costa, Jr. and McCrae, 1995). Patient's trust in mental health care, considered to be a relevant belief, was measured with items measuring "trust in professional help" (Cronbach's $\alpha = .78$), items measuring "trust in lay-help" (Cronbach's $\alpha = .46$) and one item: "psychological problems are best kept to yourself".

Enabling resources

Income of the respondent, the respondent's partner, and the respondent's parents was assessed during the interview. A large degree of urbanization is considered an enabling resource because the supply of institutions and providers is higher. NESDA includes the Quote instrument to measure the evaluation of received care for depression and anxiety (Sixma, Kerssens et al., 1998). The 19-item questionnaire consists of evaluations of accessibility, GP's emotional support, information and advice received, patient centeredness, self help, and quality of care received. We use the evaluation of accessibility as an enabling resource.

Need

The NESDA baseline assessment includes various indicators of the presence, symptoms, severity, and history of depressive and anxiety disorders. The diagnoses of depression and anxiety disorders (Generalized anxiety disorder, Social Phobia, Agoraphobia and panic disorder) were established with the CIDI psychiatric interview (WHO version 2.1) which classifies diagnoses according to the DSM-IV criteria. (American Psychiatric Association, 2001). Specially trained clinical research staff conducted the CIDI interview. The life-time CIDI allows for the determination of the history, recency, duration and age of onset of episodes. Severity of depressive symptoms was measured with the 30-item Inventory of Depressive Symptoms self-report version (IDS-SR). Severity of generalized anxiety and panic symptoms was measured using the validated Beck Anxiety Inventory, a 21-item scale (Beck, Epstein et al., 1988).

Perceived need according to the patient was measured during the PNCQ interview (see above), as the patient expressed in the initial question if he or she had experienced any psychological problem during the past 6 months.

Analytic strategy

Our study sample consists of the 680 persons from the primary care sample who fulfilled criteria for a DSM-IV of anxiety or mood disorder. Based on self-report in the PNCQ this sample is divided in persons who discussed psychological problems with any caretaker during the last 6 months versus persons who did not discuss psychological problems with anybody and univariate tests (X-square and t-test for independent samples) were performed on each of the predisposing, enabling and need determinants, described above. The same procedure was followed for persons discussing their psychological problems within primary care versus who did not and persons discussing their psychological problems within secondary care versus who did not.

As a second step, multivariate logistic regression was performed, involving all determinants with a significant effect in the univariate tests.

RESULTS

Table 1

Table 1 shows the composition of psychopathology in the study sample. More than 70% of the persons suffered from anxiety disorder and a slightly smaller proportion of 65% had one or more affective disorders. About one third of the sample showed comorbidity of affective and anxiety disorder.

Table 2

Table 2 gives the use of services for the mental health problems as reported by the respondents.

About half of the study sample had contacts within primary care concerning psychological problems in the past 6 months, especially with their GPs (44%). About 15 % had contacts with specialized mental health care. Also 15% had contacts with more specialised medical doctors, especially company doctors. 40% indicated to have no contact at all during which mental health problems were discussed.

Table 3

Table 3 shows the characteristics of patients who received or did not receive any treatment, primary care treatment or specialized mental health treatment.

Patients who discussed psychological problems with any kind of caretaker were younger, believed more in professional help for mental health problems and scored higher on the neuroticism scale of the NEO personality questionnaire than persons who did not ($p < .05$). There were no differences between the two groups regarding any of the enabling factors and there were outspoken differences on all the determinants, indicating need: the presence of affective disorder, severity of both anxiety and depressive disorder and the number of DSM-IV diagnoses all made significant differences between the two groups ($p < .000$). The effect of perceived need is clear as well: Among those who did not discuss any psychological problem about one quarter denied to have any psychological problems.

The same trends can be seen when differences between those discussing problems in primary care are compared with those not doing so and between those discussing problems in specialised mental health care compared with those who do not. In this latter respect, some other determinants make a significant difference: patients who discuss problems with a mental health specialist have a lower score on the personality trait “consciousness”, have more often an anxiety disorder and have less faith in help from relatives or friends when mental problems are at stake.

Table 4a-b-c

At last, the significant differences between no treatment and any treatment were tested in a multi-variate logistic regression analysis. See table 4a. The same tests were done for the significant differences between primary care treatment vs no primary care treatment (table 4b) and specialized mental health treatment vs no specialized mental health treatment.

Regarding receiving any help and primary care help most of the significant effects from the bilateral comparisons remained, after controlling for other variables. Among those, indicating “need” the presence of affective disorders and patient’s own perception of having a mental health problem appeared to be dominant over severity and number of psychiatric diagnoses. The effect of neuroticism disappeared after controlling for need variables.

However, when considering the odds of discussing problems in specialist mental health care, all significant effects, except that of “belief in professional help”, disappeared when all variables are entered in the equation.

CONCLUSION

Summary

Forty percent of patients with a diagnosis of anxiety or depression, who recently visited their GP, did not have any professional contact about their mental distress. Fifty percent of these patients did discuss their problems with a professional in primary care, mostly with their GP. 15 percent of them contacted a specialist mental health care professional and also 15 percent reported to have discussed their mental problems with another kind of medical doctor, mostly a company doctor.

Several predisposing characteristics of patients proved to be predictive for help seeking. Younger patients, patients who expressed confidence in the help of psychologists or psychiatrists and patients with a higher score on neuroticism, had better chances to discuss their mental health problem with any professional and within primary care. The impact of neuroticism disappears after controlling for indicators of a higher clinical need, especially the presence of an affective disorder and the self-awareness of the patient of being in need.

Remarkably, the odds of consulting a mental health specialist is not predicted by any “need-characteristic” nor by age or neuroticism, but only by “belief in psychologists or psychiatrists”. The odds of getting specialised mental health care appear to be more or less at random.

Another remarkable result to be mentioned, is the lack of any effect of enabling factors. Neither income of the patients, perceived accessibility of services nor factual presence of services, as indicated by the degree of urbanisation made any difference between respondents receiving treatment and respondents who did not.

Contribution to existing knowledge

The results largely fit within earlier reported knowledge about predictors for help seeking: patients who are more in need, expressed by severity and co-morbidity (number of mental disorders) received more treatment in primary care as well as in specialised mental health care. However, after controlling for other influences, the presence of an affective disorder and patient’s own perception of having a mental problem proved to be the decisive factors.

Regarding the age effect our study agrees with other studies that the oldest age categories are disadvantaged. However, our results point to an even younger category (26 – 35) with the highest chances of receiving treatment than Bland et al. or Bijl et al.

Although we find slight overrepresentation of women and employed people among those who received any or primary care treatment, these differences were not significant in our study. As far as specialised mental health care is concerned unemployed people receive even (unsignificantly) more treatment.

New is the slight but consistent effect of belief, expressed by the respondents in professional help for mental health problems which distinguishes those who receive treatment from those who do not. Also new is the consistent qualification of those who receive treatment as more neurotic than those who do not. This however, seems to be explained by the larger need of the former, because the effect disappears after introducing the need factors.

Methodological considerations

Receiving treatment for mental health problems was measured by the respondent’s affirmative answer on the question “if he/she had discussed their problems with a GP, a psychiatrist, a psychologist etc.” It is the patient’s perception of having got any treatment. Comparable indicators for treatment have been used in the studies, cited in the introduction (Alonso et al. 2004, Bijl et al. 2000, Kessler et al., 2001). The measurement of treatment might be cross-validated by taking into account the registered patient files of the health care professionals. As far as GP files are concerned, we are prepared to do so in the near future within the NESDA study.

Mental health status of the respondents was established by a CIDI interview. In this respect the methodology is comparable with the earlier studies as well.

One disadvantage in the NESDA study, regarding the sampling is the geographic emphasis of the three study centres in the Netherlands. For reasons of budget, GP practices around the three participating university centres (three large cities in urbanized areas) were invited to supply the sampling frames. As a result, patients from strongly urbanized areas are heavily overrepresented.

Discussion

As was explained in the method section, NESDA also obtained data from three other samples, recruited in specialized mental health care settings and in the population. Both population samples showed comparable proportions of help seeking in general and in

primary care. They received help from specialized care to a somewhat higher degree, which might be explained by their history (respondents in the population sample were detected ten years ago as patients with a psychiatric diagnosis). Respondents from the specialized mental health sample all had had professional contacts about their mental health problems in specialist mental health care, but 80% of them had also discussed their mental health problem with their GP, which is a considerably larger proportion than the primary care sample showed.

From this we conclude that our results are not only applicable to patients with a mental disorder who visited their GP the past few months, but to any patient with a mental disorder as well.

Furthermore, the receiving of any kind of treatment does not only depend from the need of the patient, although patients with more disorders and more severe disorders have better chances for being treated. Very important in that respect is patient's own recognition of his problems as being a mental health problem. Another important factor is patient's belief in professional help in case of mental problems. Both factors point to the "imago" mental health problems and mental health care have for the patient. In this respect the caretaker who is firstly seen by the patient, with a request for mental help or another medical request – mostly the GP - has a large responsibility.

Another important observation, especially again for those firstly contacted caretaker, is the result that especially older patients are likely to be overlooked.

A last observation, regarding these results, can be made regarding the so called "enabling factors". At least in our study sample, factors like income, urbanization and perceived accessibility of services do not make any difference between those who receive treatment and those who don't. We may conclude that financial and geographical access is equal for all patients within our study sample. Of course we should keep in mind of what has been said before about the representativity of this sample,

Conclusions and recommendations

Still a relatively large part of patients with a mental disorder does not receive any kind of treatment for this disorder. For a certain part of these, their problems will recover spontaneously, for another part, this neglect might have more serious consequences in the future. As NESDA is a longitudinal study and we have the opportunity to follow these people for another six years, we certainly will analyze these follow-ups in order to answer the question which characteristics predict a negative outcome after not receiving any help.

We have learned more about the characteristics of people with mental disorder that facilitate their reception of treatment. In this respect professionals should be aware bias, regarding age, and for the imago of mental health care, constructed by the patients. The same professionals might play an important role in this image building.

LITERATURE

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TABLES

Table 1: DSM-IV diagnoses of included patients

	All psychopathology
N	680
GAD	18.8%
Soc.Fob.	33.1%
Panic without Agorafobia	12.2%
Panic with Agorafobia	21.3%
Agorafobia without panic	8.2%
At least 1 anxiety disorder	71.0%
Major Depression single	27.4%
Major Depression recurrent	33.4%
Dysthymia	3.4%
At least 1 affective disorder	64.7%
Mean N of DSM-IV diagnoses	1.6
Anxiety without affective disorder	37%
Affective disorder without anxiety	29%
Comorbid affective disorder and anxiety	34%

I: screening questionnaire among GP-patients (18-65 yr) with GP-contact past 4 months

II: Phone screen among screen positives

III: T-0 of NESDA (among which: CIDI)

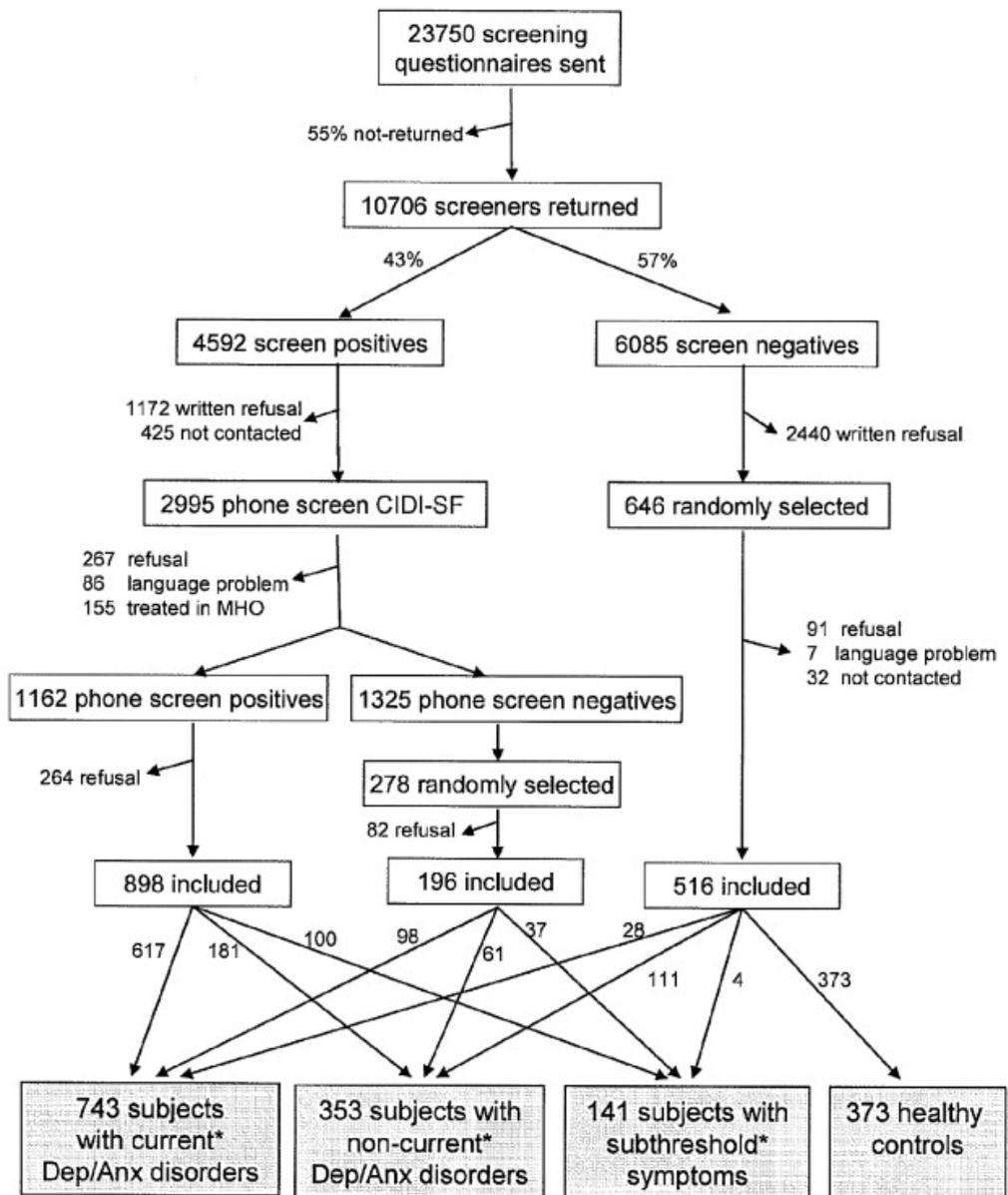


Table 2: Professional Help Received by included patients

N	680
Primary Care	52.7%
- General Practitioner	44.6%
- Social Work	9.7%
- Primary care psychologist	15.0%
- Psychiatric nurse	1.0%
Specialist mental health care	14.6%
- Ambulatory mental health care	5.7%
- psychiatry	5.4%
- psychotherapist	4.3%
- Alcohol/drugs department	0.9%
Medical care	14.6%
- Medical specialist	2.6%
- Company doctor	12.4%
No treatment at all	39.6%

Table 3: Characteristics of patients with a mental disorder who received any treatment versus no treatment, primary care treatment vs no primary care treatment and specialized treatment versus no specialized treatment.

	No Treatment	Received any treatment	Received no primary care treatment	Received primary care treatment	Received no specialized mental health treatment	Received any specialized mental health treatment
N	269	411	321	359	581	99
Predisposing characteristics						
male	31%	28%	31%	27%	29%	30%
Age (average)	46.5*	43.9*	46.3*	43.6*	45.2	43.4
Born in the Netherlands	86%	90%	85%	91%	89%	82%
Unemployed	41%	39%	42%	38%	39%	47%
low education	41%	35%	38%	36%	39%	29%

middle education	28%	32%	30%	31%	30%	35%
high education	31%	33%	32%	33%	31%	35%
Belief in professional help (average)	3.7*	3.9*	3.8*	3.9*	3.8*	4.0*
Belief in lay help (average)	3.0	2.9	3.0	2.9	3.0*	2.7*
Belief in self help (average)	2.1	2.0	2.1	2.0	2.1	2.0
Personality: Neuroticism (average)	39.2*	41.3*	39.8*	41.1*	40.1*	42.8*
Personality: Extraversion (average)	35	34.8	34.8	35.0	35.0	34.4
Personality: Agreeableness (average)	43.0	42.6	42.8	42.8	42.8	42.6
Personality: Openness (average)	30.9	31.1	31.3	30.8	31.0	31.1
Personality; Conciousness (average)	36.7	36.6	36.5	36.7	36.8*	35.5*
Enabling characteristics						
Income: Low	56%	56%	55%	57%	56%	56%
Evaluation of accessibility (average)	2.6	2.6	2.5	2.6	2.5	2.7
% very urban	73%	77%	73%	78%	76%	75%
Need						
At least one affective disorder	49%**	72%**	53%**	72%**	61%*	75%*
At least one anxiety disorder	75%	68%	75%	68%	70%*	79%*
Severity depression (average)	24.7**	30.0**	25.7**	30.0**	27.1**	32.4**
Severity anxiety (average)	14.3**	18.0**	15.1**	17.8**	16.0**	19.7**
N of diagnoses (average)	1.43**	1.69**	1.49**	1.67**	1.53**	1.89**
% of patients perceiving a mental health problem themselves	77%**	97%**	80%**	97%**	87%**	98%**

Table 4a: Logistic regression on receiving any treatment

	Step 1		Step 2	
	Odds	95% interval	Odds	95% interval
N				
Predisposing characteristics				
Age: 18 – 25	0.88	0.37 – 2.13	0.97	0.38 – 2.48
26 – 35	1.71	0.95 – 3.10	1.93	1.02 – 3.65
36 – 45	1.32	0.76 – 2.30	1.33	0.73 – 2.41
46 – 55	1.45	0.88 – 2.40	1.35	0.79 – 2.32
56 – 65 (ref)	1.00			
Belief in professional help	1.50	1.16 – 1.96	1.73	1.30 – 2.29
Personality: Neuroticism	1.06	1.03 – 1.09	0.99	0.96 – 1.03
Need				
At least one affective disorder (no = ref)			1.73	1.10 – 2.72
Severity depression			1.28	0.94 – 1.75
Severity anxiety			1.48	0.92 – 2.36
N of diagnoses			1.11	0.81 – 1.53
% of patients perceiving a mental health problem themselves (no = ref)			5.62	2.56 – 12.31

¹⁾ figure in bold: $p < .05$

Table 4b: Logistic regression on receiving primary care treatment

	Step 1		Step 2	
	Odds	95% interval	Odds	95% interval
N				
Predisposing characteristics				
Age: 18 – 25	1.47	0.62 – 3.50	1.67	0.67 – 4.13
26 – 35	1.85 ¹⁾	1.05 – 3.26	2.05	1.13 – 3.72
36 – 45	1.09	0.63 – 1.86	1.05	0.60 – 1.85
46 – 55	1.50	0.92 – 2.44	1.44	0.87 – 2.41
56 – 65 (ref)	1.00			
Belief in professional help	1.22	0.95 – 1.57	1.33	1.02 – 1.73
Personality: Neuroticism	1.03	1.00 - 1.06	0.98	0.94 – 1.01
Need				
At least one affective disorder (no = ref)			1.54	1.00 – 2.37
Severity depression			1.30	0.97 – 1.73
Severity anxiety			1.14	0.76 – 1.71
N of diagnoses			1.07	0.80 – 1.42
% of patients perceiving a mental health problem themselves (no = ref)			4.76	2.13 – 10.63



¹⁾ figure in bold: $p < .05$

Table 4c: Logistic regression on receiving specialised mental health care treatment

	Step 1		Step 2	
	Odds	95% interval	Odds	95% interval
N				
Predisposing characteristics				
Age: 18 – 25	0.59	0.15 – 2.30	0.59	0.14 – 2.34
26 – 35	0.71	0.30 – 1.70	0.74	0.30 – 1.80
36 – 45	2.11¹	1.03 – 4.34	2.09	0.99 – 4.39
46 – 55	1.02	0.49 – 2.09	0.94	0.45 – 1.98
56 – 65 (ref)	1.00			
Belief in professional help	1.49	1.01 – 2.20	1.57	1.06 – 2.32
Belief in lay help	0.73	0.55 – 0.98	0.77	0.57 – 1.05
Personality: Neuroticism	1.07	1.02 – 1.11	1.02	0.97 – 1.08
Personality: Conciousness	0.98	0.94 – 1.02	0.97	0.93 – 1.01
Need				
At least one affective disorder (no = ref)			1.56	0.67 – 3.58
At least one anxiety disorder (no = ref)			0.98	0.66 – 4.68
Severity depression			1.57	0.75 – 1.60
Severity anxiety			1.09	0.97 – 2.56
N of diagnoses			0.98	0.75 – 1.60
% of patients perceiving a mental health problem themselves (no = ref)			6.99	0.90 – 54.4

¹⁾ figure in bold: $p < .05$