Care service use for mental health problems in the general population
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Summary

My aim in this thesis was to discover why some adults with mental health problems receive professional care while others receive none, and to determine whether undesirable inequalities exist in the utilisation of care services in the Netherlands. My most important finding was that non-illness-related determinants, such as educational background and personality, play significant roles in whether or not care is received. The three parts of my thesis addressed several specific questions that derived from my broader research question.

Trends in service use

The central focus in part 1 was on household-level trends in the use of social work and outpatient specialised mental health care (through the Regional Institutes for Ambulatory Mental Health Care, or RIAGGs). I explored whether the relative differences between household categories in the use of the two types of services shifted in the course of recent decades. I based these analyses on data from the Amenities and Services Utilisation Surveys (AVOs), a series of Dutch nationwide population studies conducted by the Social and Cultural Planning Office (SCP). The studies are based on large samples of households and have been carried out every four years since 1979, using the same research methods.

Analysis of the AVOs data showed that the percentage of households using one or both of the ambulatory care services doubled during the 1979-1995 period. The steepest rise occurred during the 1980s, after which service use stabilised. Whereas 3.4% of the Dutch households received outpatient (RIAGG) specialised mental health care in 1979, this percentage had risen to 5.7% by 1995. Utilisation of social work services grew even more sharply in the 1980s, from 2.0% in 1979 to 5.6% in 1995.

Households using both types of care to a greater extent than the average household were one-parent families, low-income households, benefit-dependent households and younger families. Households with lower levels of education were less likely than average to use specialised mental health care, but more likely to use social work.

The relative inequalities in service use between different household categories barely changed over the years, despite significant trends in care provision and in society as a whole – including an expansion of the available care options and a wider public familiarity with mental health problems and therapies. To illustrate, one-parent families in 1979 were almost three times as likely as the average household to receive outpatient specialised mental health care, and the same was true 17 years later.

How to interpret the sharp rise in service use remains an intriguing question. One conceivable explanation might have been that the increases were attributable to changes over time in the prevalence rates of service use by various household categories. This explanation proved untenable when it emerged that the relative differences in
service use did not systematically alter during the period studied. A second possibility might have been to attribute the increases in service use to changes in the population structure, for instance through a disproportionate growth in the size of particular categories that made more use of professional care services. This explanation also proved untenable. A third explanation, for which I found the strongest support, is that all categories of households, without exception, began using more care services in the period between 1979 and 1995.

Strictly speaking, my trend data on households did not permit conclusions about whether more individuals found their way to outpatient specialised mental health care. However, probabilistic linkage of a psychiatric case register makes it possible to link service contacts to specific individuals. Analysis of such data by Kooi and colleagues (2000) for Maastricht showed that it was not the treated incidence that increased during the 1981-1997 period, but the treated prevalence. In other words, individuals who were already known to the mental health services sought increasing amounts of help. These and other findings from long-existing case registers in Maastricht, Drenthe and Rotterdam suggest the possibility that new households did not find their way to outpatient specialised mental health care in greater numbers. This could also be a reason why the help-seeking and referral patterns I identified here for this type of care remained stable during the period studied.

Mental illness-related characteristics associated with service use

Part 2 of my thesis focused on adults who had experienced a mood disorder at some time in their lives. Chapter 4 involved people with lifetime bipolar disorder, and chapter 5 those with lifetime clinical (major) or subclinical (minor) depression. Data from the Netherlands Mental Health Survey and Incidence Study (NEMESIS) enabled me to analyse in more detail how mental illness-related characteristics were associated with the use of services. NEMESIS was a nationwide three-wave population study conducted by the Netherlands Institute of Mental Health and Addiction (Trimbos-instituut). It recorded in detail mental disorders, other mental illness-related characteristics, and service use in a cohort of adults who were followed from 1996 to 1999.

Analysis of the NEMESIS data showed that nearly half of all adults with lifetime depression or lifetime bipolar disorder had never received any specialised mental health care for these problems. Those with major or minor depression were less likely than those with bipolar disorder to have used specialised mental health services (55% vs 43% had no contact). Had service use been assessed over a shorter period, as is customary in the literature, that would have surely resulted in an even higher percentage of people with such clinical or subclinical mood disorders who received no care.

It was reassuring to ascertain that, amongst the people with these mood disorders, it was those with the more severe (e.g. bipolar I disorder or vegetative symptoms), more complex (e.g. anxiety-comorbid) or more dangerous (e.g. suicidal ideation) forms of illness who had a greater likelihood of receiving specialised mental health care. Thus, both the specific symptoms of the illness and the concomitant
disorders evidently help to determine whether a person will receive professional care. However, it also emerged that people with lifetime depression and alcohol dependence were no more likely than those with lifetime depression but without alcohol dependence to receive specialised mental health care, or even primary care alone, for their problems – and that was not because they reported less serious or less complex symptoms. It thus seems that (1) people with depression and comorbid alcohol dependence prefer not to discuss their problems with someone in their immediate environment like their GP; and (2) although treatment of substance dependence requires more specialised care than is available in the primary sector, primary care providers have few referral options for this patient group. A double diagnosis (comorbid mood and substance use disorder) is often a contraindication for treatment for both mental health services and addiction services.

To fully determine whether people with mood disorders are making sufficient use of the existing treatment methods, more research is needed on the content of the treatment received. Although that was not the subject of this thesis, I believe I can infer from two of my findings that the provision of care to people with bipolar disorder is in serious need of improvement. First, almost 20% of respondents with lifetime bipolar disorder who had ever received specialised mental health care reported that they had never spoken to a health care provider about one of their manic or hypomanic episodes. This seems to indicate that their decision to seek help was prompted by other symptoms or problems, and that the bipolar disorder went unrecognised. Second, nearly 40% of those who did happen to speak to a care provider about their bipolar disorder reported in the NEMESIS interview either that they had had no recent specialised mental health service contact or that they were not taking any medication, despite the often chronic nature of the disorder. This seems to confirm that a relatively large percentage of the people with lifetime bipolar disorder have never received any treatment for it from a doctor or other mental health care provider, even though safe and effective treatment methods are available (Goodwin and Jamison, 1990).

Resources and functional impairment as explanations for service use variations

In part 3 of my thesis I focused on all adults, both with and without mental disorders, in an attempt to explain variations in service use. To address these questions, I developed a research model, based partly on the literature and on the findings from part 2, which incorporated three main groups of determinants (see figure): the mental illness-related characteristics themselves; the functional impairments that people experience from their illness; and the resources they have available or can mobilise when they encounter problems. I distinguished here three types of resources: social resources such as social support, socioeconomic resources such as educational background, and psychological resources such as emotional stability. I tested the model step by step in successive chapters.
Chapters 6 to 8 each closely analysed the association between one type of resource and the use of services. In chapter 6 I studied two indicators of social support: a respondent’s living arrangements, intended to reflect the extent of social relationships; and the social support perceived by the respondent, which expressed the quality of social relationships. I first investigated whether mental disorders were associated with service use as a consequence of the functional impairments they cause – proposition 1 from the research model. People with mental disorders indeed had significantly greater probabilities either of receiving primary care alone for their mental health problems or of receiving specialised mental health care. To a considerable extent, both these higher probabilities were associated with the functional impairments the respondents experienced from their disorders. This seems to confirm that the impairments brought on by mental disorders constitute an additional explanation for variations in service use.

I then went on to investigate whether the extent to which people could cope with their functional impairments by themselves was dependent on the amount of resources they had – proposition 2 of the research model. It emerged that persons who reported functional impairments from their mental health problems, and who also reported living alone or perceiving low social support, were disproportionately more likely to receive specialised mental health care. Hence, people with fewer social resources (in this case, those living alone and those perceiving less social support) indeed appeared less capable of dealing with their impairments on their own, and therefore sought professional care. This tendency was especially strong for older women (aged 45-64). They seemed to have particular difficulty in mobilising social support in their immediate environment, or perhaps sought compensation for a lack of social support, and therefore turned to specialised mental health services. The finding that people living alone and those perceiving less social support were more likely to receive specialised mental health care was not explained by higher risks of mental disorder or functional impairment. This seems to support the conclusion that people with fewer social resources are less capable of resolving their problems on their own.

My primary focus in chapter 7 was on the interrelationships between educational background, emotional and substance use disorders, social and emotional role
impairments, and service use. These analyses provided only partial confirmation of my first research proposition that mental disorders would be associated with service use as a consequence of the impairments they caused. This relationship was confirmed for emotional disorders (mood or anxiety disorders), but not for substance use disorders. After adjustment for the influence of emotional disorders, substance use disorders were not associated with higher use either of primary care only or of specialised mental health care. My second proposition – that the extent to which people can cope with their functional impairments by themselves would be dependent on the amount of resources they have – also received only partial confirmation. People who were impaired in their social role functioning by their mental health problems, and who also had little education, were indeed disproportionately more likely to receive primary care only, but not to receive specialised mental health care. Thus, although those with lower education did appear less capable of dealing with their social role impairments by themselves, they tended to receive only primary care for their problems. I had expected that specialised mental health care would be even more likely in cases where low resources and greater functional impairment coincided. Evidently this does not apply to all types of resources.

Consistent with the literature, and still worrisome, was the finding that people with less education were more likely to experience emotional disorders than those with more education, but were less likely to receive specialised mental health care. A conceivable explanation might have been that lesser educated people are already more likely to be receiving GP treatment for somatic conditions, and might simply remain in treatment there when mental health problems arise. I found no evidence for this, however. It therefore seems plausible that people with less education are less likely to receive specialised mental health care either because they have less positive attitudes towards mental health treatment (Jorm et al., 2000), or possibly because their GPs consider them less suited for that kind of treatment.

Chapter 8 focused on the interrelationships between neuroticism, emotional disorders and service use. The notion of neuroticism reflects a lack of psychological resources. Individuals with high neuroticism scores can be described as emotionally unstable, inclined to complain and less capable of coping with problems. Chapter 8 asked not only why some people with mental health problems receive professional care and others do not, and but also why some service users have far more contacts with care professionals than others. In these analyses, I did find confirmation for my second proposition on the role of resources – people who had both an emotional disorder and a high neuroticism score had a far greater probability of using specialised mental health care. It thus seems plausible that people with high neuroticism are less able to resolve their problems on their own, and are therefore more likely to use specialised mental health care. Two more findings seem to back up this conclusion. First, people with high neuroticism were more likely to use specialised mental health care, even after adjustment for emotional disorder. Second, users of specialised mental health care who tested high on neuroticism had far higher numbers of service contacts than those with low neuroticism, also after adjustment for emotional disorder. Briefly, then, the levels of social and psychological resources that people have available seem to partially determine
how successful they are at coping with their mental health problems or functional impairments.

Chapter 10 assessed the interrelationships between all three of the resource indicators studied (social support, education level, neuroticism), emotional disorders, social and emotional role impairments, and service use. One purpose of this chapter was to test more thoroughly my first research proposition that mental disorders would be associated with service use as a consequence of the functional impairments they bring about. A further aim was to ascertain which resource would show the strongest association with service use when all other determinants in the model were held constant.

Both types of functional impairments proved to further explain variations in the exclusive use of primary care for mental health problems, but not in the use of specialised mental health care. Although disorders did result in impairments, the impairments did not increase the likelihood of specialised mental health care; that is, the associations between the two types of role impairments and service use were no longer present once neuroticism and emotional disorder were held constant.

This contrasts with my findings in chapters 6 and 7, where I concluded that the greater likelihood of the use of specialised mental health services by people with emotional disorders was explained to a considerable extent by the functional impairments they experienced from their problems. The discrepancy between these two findings can probably be attributed to neuroticism. Consistent with customary usage (Eysenck, 1953; Costa and McCrae, 1985; Hofstee, 1963), I described people with high neuroticism scores as emotionally unstable, inclined to complain, and less capable of coping with problems. As authors such as Ormel (1983), Duncan-Jones and colleagues (1990) and Kempen and colleagues (1999) have also argued, such aspects were strongly associated with psychological distress and with chronic, subclinical emotional symptoms. This makes it unclear precisely which aspects of neuroticism were responsible for the strong associations between it and both functional impairment and service use, which nullified the independent effects of impairments on the use of specialised mental health services.

The analyses in chapter 10 showed no independent effects of the two measures of social support (living alone, perceived social support) on the use of either primary care alone or specialised mental health care. Here, too, the probable reason is that a lack of social support was mainly attributable to high neuroticism. People with more education, nevertheless, remained more likely to receive specialised mental health care even when neuroticism, mental disorder and functional impairment were held constant. Unfortunately, I was unable to test possible explanations that have been suggested in the literature.

The research model as depicted in the figure, and supplemented with independent effects of resources on service use, seems to offer a viable framework for better understanding variations in the receipt and nonreceipt of professional care for mental health problems. When I tested the model, it became apparent that the presumed relationships between these determinants and service use were dependent on
the types of disorders, impairments, resources and service modalities that could be
distinguished.

Implications

Ultimately, what people think about the accessibility of care comes down to a moral
issue. My own view is that the most seriously ill patients are the ones most entitled to
care—provided that either they or society can benefit from their treatment. The data I
had available only allowed me to investigate whether or not adults with mental health
problems came into contact with care services and whether the most seriously ill patients
had the greatest likelihood of receiving specialised mental health care—but I could not
assess whether or not that care actually helped them. Bearing this limitation in mind,
one could argue that care in the Netherlands is readily accessible to people with lifetime
depression. Viewed over a longer period of time, some 73% of them ultimately came
into contact with either primary care or specialised mental health care for their
problems, albeit sometimes with unnecessary delays. Moreover, those with more severe
or complex symptoms were the ones most likely to receive specialised mental health care
rather than primary care alone. In some respects, one might be tempted to think that the
Dutch mental health care sector is too easily accessible. Some 28% of those with lifetime
subclinical depression, for example, reported having ever received specialised mental
health care, even though primary care might well have sufficed for some of them.
Notwithstanding the adequate accessibility of care in the Netherlands, at least three
groups of adults appear to remain unnecessarily out of reach of the care services. These
are the lesser educated people with mental disorders, the people with concurrent
depression and alcohol dependence, and those with bipolar disorder.

To reach better-founded conclusions about how accessible the Dutch mental
health care sector really is, one focus of future research should be on whether patients
receive the treatment they should be receiving according to the current guidelines. We
still know far too little about which patients do receive adequate treatment and which do
not—and hence about the potentials for improving mental health care to people who
are currently not getting the treatment they need.