Demand for Mental Health Care and Changes in Service Use Patterns in the Netherlands, 1979 to 1995

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Objective: Mental health services appear increasingly incapable of satisfying the demand for care, which may cause some segments of the population to be less effectively reached. This study investigated the rates of use of mental health services in the Netherlands from 1979 to 1995 and examined whether particular sociodemographic groups made greater or lesser relative use of these services over time. Methods: Data were derived from the Facilities Use Surveys, a series of Dutch cross-sectional population studies that have recorded household characteristics and service use since 1979. More than 28,000 households were included in the analyses. Results: The overall use of mental health services virtually doubled from 1979 to 1995; a particularly steep rise was seen in the first half of the 1980s. Households that had one parent, that had low income, that were dependent on benefits, and that were younger all had greater odds of using both specialized mental health care (for example, prevention programs for mental health problems and psychotherapeutic and social psychiatric treatment offered by psychologists, psychotherapists, or psychiatrists) and social work services (for example, psychosocial counselling and practical support offered by social workers to people with social problems, such as housing, finances, and psychosocial issues). Households with low education were less likely to use specialized mental health care but were more likely to use social work services. Nonreligious households and urban households were more likely to use specialized mental health care and were equally likely to use social work services. Overall, these relative use patterns did not change over time. Conclusions: Despite greater pressures on mental health services and the many changes in service delivery in recent decades, relative patterns of help seeking and referral to mental health services have not varied systematically over time. (Psychiatric Services 56:1409–1415, 2005)

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he demand for mental health care is rising in many places throughout the world (1). Reasons for this trend include increased recognition of mental disorders by the general public and by primary care providers, the development of effective treatments for common mental disorders, declines in social support and other coping resources in the community, and possibly a rising overall prevalence of major depression (2–4). Given the limited resources available, a growing demand for services may lead to shifts in which segments of the population are being reached. Knowledge about long-term trends in service use patterns can help to identify any such shifts and plan an adequate allocation of scarce resources.

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ly younger ones aged 18 to 29 years, made increasing use of alcohol-relat-
ed treatment from 1979 to 1990, but they concluded that the overall treat-
ment patterns of specific groups changed little.

To our knowledge, few countries exist in which reliable longer-term data on service use by the general public have been charted by using consistent research designs and in-
struments. In the Netherlands such data are available from the Facilities
Use Surveys (FUS) of the Social and Cultural Planning Office, a series of
cross-sectional population studies conducted periodically since 1979
that are representative of the general population. This article is based on
that data.

This study addresses two research questions: Did an increase occur in
the use of mental health services in the Netherlands from 1979 to 1995?
Did particular sociodemographic groups make greater or less relative
use of these services over time? We addressed these questions separately
for two important types of mental health care provision—specialized
mental health care (represented here by services provided by regional insti-
tutes for ambulatory mental health care—for example, prevention pro-
grams for mental health problems and psychotherapeutic and social psy-
chiatric treatment; programs and treatment offered by psychologists,
psychotherapists, or psychiatrists) (8) and social work services (for example,
psychosocial counselling and practi-
cial support offered by social workers to people with social problems, such as
housing, finances, and psychosocial issues). Dividing mental health care
in this way enabled us to examine
whether trends and variations in use patterns varied according to the sec-
tor in which help was sought.

Social work services, as well as serv-
ices provided by general practitioners,
are major sources of primary mental
health care in the Netherlands. Clients may contact them directly. Re-
gional ambulatory mental health care
institutes are major sources of second-
ary care. Clients may contact them
only after referral by a general practi-
tioner. Both types of services are pub-
licly funded, and virtually no financial
barriers exist to obtaining access to ei-
ther type of care (9).

Methods
Sample
The FUS periodically investigate the
use of social, cultural, and health fa-
cilities in the Netherlands. The sur-
veys are based on nationwide house-
hold samples and contain informa-
tion on all household members. FUS
have been conducted every four
years since 1979. The data analyzed
in our study included all household
members aged 16 to 74 years cov-
ered by the five FUS conducted be-
tween 1979 and 1995 (10). All FUS
had comparable research designs.
About 6,000 households were inter-
viewed each time, with responses
just over 40 percent in 1991; around
60 percent in 1979, 1983, and 1987;
and 70 percent in 1995. The samples
were representative of households of
the noninstitutionalized population
in terms of household composition
(gender, age, and marital status) and
urbanicity of residence. In 1987 one-
person households and families with
grown children were slightly under-
represented (11). Despite the vary-
ning response rates between surveys,
these variations showed no associa-
tion with any of the trends found in
service use or help seeking. It there-
fore seems unlikely that nonre-
response compromised our results.

All the FUS applied a relatively
straightforward, random sampling
procedure. A sample of private
households (addresses) was drawn
from postal registers in proportion to
the population of each municipality
included. The households were sent
a letter of introduction with an ex-
planatory leaflet. Shortly afterwards,
they were contacted by the inter-
viewers. If necessary, interviewers
made several calls or visits to a given
address at different times to make
contact. If they succeeded, they in-
terviewed one member of each par-
ticipating household at home, gener-
ally the head of household. They also
left behind extensive questionnaires
for each household member aged six
or older, returning to collect these
later. At addresses with multiple
households (which were rare), up to
three families were interviewed. Re-
spondents received no remunera-
tion. Informed consent was obtained
under prevailing Dutch regulations,
and review board approval was se-
cured from the Central Commission
for Statistics (12).

Measures
Mental health service use. Service use
was determined by the question “In
the past 24 months, have you been to
any of the following organizations for
problems of your own or of any of
your household members?” The list
included organizations that provided
specialized mental health and social
work services. The question was
posed to all household members aged
16 years and older. We dichotomized
answers into 0, no use, and 1, use by
at least one member. Service use was
assessed at the household level, be-
cause it was not known within house-
holds who had mental health prob-
lems and who received help for them.

Household characteristics. House-
hold composition was divided into
five categories: two partners living
with children, two partners living
without children, one person without
a partner living with children, one
person living alone, and other.

Household income refers to the net
income of the primary breadwinner
and partner (if any), excluding child
allowance (that is, regular payment by
the state to the parents of a child up
to a certain age) and income from
working children. We recoded house-
hold income into four ordinal cate-
gories, low to high (categories were
created by placing 25 percent of the
households in each income group).
Missing answers were relatively fre-
quent (21 percent). To avoid a serious
reduction of the effective sample size,
we treated these missing data as a
separate category in the analyses.

Social position of primary breadwin-
er and partner (if any) was broken
down into seven household categories
on the basis of principal daily activities:
employed, student, retired, dependent
on benefits, housewife or househus-
band, employed breadwinner with a
partner who was a housewife or house-
husband, and other.

Education of primary breadwinner
and partner (if any) refers to the high-
est educational attainment. Cate-
gories ranged from primary school to higher professional or university education. Couples whose education levels differed by more than 1 point on this 4-point scale were defined as heterogamous couples (37 percent).

Religious identification of primary breadwinner and partner (if any) was determined by the question “What church or what religious group do you mainly feel part of?” and was dichotomized in terms of identifying with (1) or not identifying with (0) a religious group. Couples who differed were classified as heterogamous (9 percent).

Other characteristics included the mean age of primary breadwinner and partner (if any) and the urbanicity of household location. Urbanicity ranged from rural, score of 1, to highly urbanized, score of 5.

Statistical analysis
After deleting cases with missing values on relevant items, we performed separate analyses for the two types of services—specialized mental health care and social work services—comparing the households that used the type of service with those that did not.

The aim of our study was to show a trend of service use from 1979 to 1995. For this analysis, we used as the reference category the (weighted) average service use of all households over the entire period. The analyses for mental health care used data for 28,264 households, and the analyses for social work services used data for 28,274 households. This approach, which is commonly used in demographic research (13), is unusual in the study of service use. Therefore, a more detailed description of our methods will be given.

First, we constructed contingency tables to calculate the percentage of households that used the two types of services in each of the five years that the survey was given. We then calculated whether these percentages differed from the overall mean percentages of all households that used the services over the entire study period. These analyses addressed whether service use increased over time. A trial use of weighting in the calculations did not result in a different conclusion.

Second, we pooled the data and performed seven stepwise multiple logistic regression analyses for both types of service use. For each of the seven household characteristics (for example, household composition) we explored whether its particular household categories (for example, two partners living with children) made greater or less relative use of these services over time. In addressing this question, we used interaction terms in our stepwise multiple logistic regression analyses (in particular, a household characteristic with its particular household categories multiplied the study years). In the first step of our multiple logistic regression analyses we entered two variables: a certain household characteristic and the study year. In the second step we entered interaction terms between these two variables by using forward selection: the particular household categories multiplied by the study years. As the reference category we used the weighted average service use of all household categories over the entire study period (14).

For each of the seven household characteristics we performed two multiple logistic regression analyses. In each analysis for a particular household characteristic—for example, household composition—we explored the presence of interaction effects (that is whether the odds of using a service varied for the particular household categories over time) and reported only the significant interaction effects.

If there was no significant interaction term between one of the particular household categories and a study year, we presented the odds ratios for each of the household categories while controlling for the effect of study year.

If there was a significant interaction term between a household category and study year, we calculated the particular odds ratio for that household category in that particular year. We present this odds ratio as well as the one in the other years for the particular household categories. In this way it becomes clear to what extent the odds of making use of the services can fluctuate over time for household categories compared with the average household.

Finally, we performed one stepwise multiple logistic regression analysis for both types of service use, using the method described above. We adjusted not only for the study year but also for other household characteristics. In the first step of our multiple logistic regression analysis we entered all household characteristics and study year simultaneously. In the second step we entered interaction terms between these variables by using forward selection: all household categories by study years. As a reference category we again used the weighted average service use of all household categories over the entire study period. Results of these analyses were not tabulated here, because they did not differ substantially from those presented.

All statistical analyses were performed with SPSS version 12.0 for Windows.

No results were weighted, as we were seeking to explain, rather than describe, the interrelationships between determinants and service use. The necessity of adjusting for sampling characteristics in analytic studies is the subject of ongoing debate. Most of the time overall conclusions do not substantially change when sample weights are used (15,16).

Results
Trends in the use of mental health services
Figure 1 shows the general increases in the use of specialized mental health care and social work services over time. In 1979 household use of specialized mental health was 3.4 percent for all households; this percentage rose to 5.7 percent by 1995. The trend was significant from 1979 to 1983 in particular (two-tailed testing procedures with .05 alpha levels). The use of social work services more than doubled until the mid-1980s, from 2.0 percent in 1979 to 5.5 percent in 1987, but subsequently remained stable around 5.6 percent.

Household characteristics and use of mental health services
Table 1 shows the correlates of each household characteristic with service use, after adjustment for study year and any interactions between that
household characteristic and the study year. The numbers indicate that households that had one parent, that had the lowest income, and that were dependent on benefits were more likely than the average household to have used some type of mental health service in the study period. For example, households with one parent were approximately three times as likely as the average household to use specialized mental health care and social work services. Couples not living with children, households in which one member of a couple worked and the other kept house, and older households were less likely than the average household to use either type of care. Education had contrasting effects on specialized care and social work services. Households whose primary breadwinner and partner (if any) had primary school education only were less likely to use specialized care but were more likely to use social work services, compared with the average household. Households identified as nonreligious and households in highly urbanized areas were more likely than average to use specialized care but were equally likely to use social work services.

**Change in use of mental health services**

Some household categories showed significant fluctuations in their likelihood of service use, as seen in the interactions of some household characteristics with particular study years. However, none of these variations reflected consistent shifts over time. For example, in 1991 households in the third income category were less likely than the average household to use specialized mental health care, but they were equally likely to use it in other years. In 1987 and 1991 the effect of benefit dependence was significantly weaker than in other years. That is, compared with average households, benefit-dependent households had 1.56 times greater odds of using specialized care in 1987 and 1.47 greater odds in 1991; however, these households had an odds ratio of 2.58 for all other survey years. Households headed by students were another category that was less likely to use specialized care in 1987 than in other years. Employed households and households in which one member of a couple worked and the other kept house had elevated use of specialized care in a single study year. Other fluctuations in the relative service use of particular household categories were seen for social work services, but only for 1983 (Table 1).

These results seem to indicate that no major overall shifts occurred in the relative service use of particular sociodemographic groups, or in the existing inequalities between them, during the 17 years examined here.

**Discussion**

Data on trends and patterns of the use of mental health services are of vital importance for both public health and for the adequate allocation of mental health resources. Few representative data are available that enable a long-term analysis of trends. We made use of large-scale surveys that have been conducted in the Netherlands every four years since 1979 and that are representative of the population at large.

**Increased pressure on mental health services**

The overall use of mental health services by Dutch households virtually doubled from 1979 to 1995, with a particularly steep rise in the first half of the 1980s. In absolute terms, service use grew even more sharply, by virtue of a 32 percent increase in the total number of households in that period (from 4,911,000 to 6,469,000). Client registry data confirm the increasing pressure on both primary and secondary mental health provisions (17). In the first half of the 1980s a major change in the provision of specialized mental health care took place: within each region different institutes for ambulatory mental health care merged to create one regional institute for ambulatory mental health care, which offered various types of ambulatory care. This change made mental health care more available and accessible.

**Relative changes in households using services**

Greater pressures on mental health services and changes in their delivery—including stepped-care strategies in primary care, more efficient procedures for diagnosing mental dis-

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* Significant difference from the percentage of average households during the study period, which was 4.84 for specialized mental health care and 4.23 for social work services (p=.05, two-tailed).
Multiple logistic regression analyses of determinants of the use of specialized mental health care and social work services in households in the Netherlands, 1979 to 1995\(^a\)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Specialized mental health care(^b)</th>
<th>Social work services(^b)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adjusted OR 95% CI</td>
<td>Adjusted OR 95% CI</td>
</tr>
<tr>
<td>Household composition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two partners living with children</td>
<td>1.17</td>
<td>1.10–1.25(^c)</td>
</tr>
<tr>
<td>Two partners living without children</td>
<td>.61</td>
<td>.55–.67(^c)</td>
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<tr>
<td>One person without a partner living with children</td>
<td>2.72</td>
<td>2.29–3.24(^c)</td>
</tr>
<tr>
<td>One person living alone</td>
<td>1.13</td>
<td>1.01–1.26(^c)</td>
</tr>
<tr>
<td>Other household composition</td>
<td>1.22</td>
<td>.83–1.81</td>
</tr>
<tr>
<td>Household income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lowest</td>
<td>1.3</td>
<td>1.17–1.44(^c)</td>
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<tr>
<td>Second</td>
<td>1.06</td>
<td>.93–1.20</td>
</tr>
<tr>
<td>Third</td>
<td>1.08</td>
<td>.96–1.22</td>
</tr>
<tr>
<td>Highest</td>
<td>.91</td>
<td>.79–1.05</td>
</tr>
<tr>
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<td>.63–.82</td>
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<td>1.68</td>
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<tr>
<td>Second</td>
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<td>.63</td>
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<tr>
<td>Third</td>
<td>—</td>
<td>1.52</td>
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<tr>
<td>Highest</td>
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<td>.75</td>
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<td>Household income in 1991</td>
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<td></td>
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<tr>
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<td>.86–1.34</td>
</tr>
<tr>
<td>Second</td>
<td>1.19</td>
<td>.95–1.50</td>
</tr>
<tr>
<td>Third</td>
<td>.73</td>
<td>.54–.99(^c)</td>
</tr>
<tr>
<td>Highest</td>
<td>1.07</td>
<td>.85–1.35</td>
</tr>
<tr>
<td>Missing</td>
<td>.92</td>
<td>.70–1.21</td>
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<tr>
<td>Yes</td>
<td>.86</td>
<td>.83–.90(^c)</td>
</tr>
<tr>
<td>No</td>
<td>1.29</td>
<td>1.19–1.40(^c)</td>
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<tr>
<td>Different identification between breadwinner and partner</td>
<td>1.28</td>
<td>1.09–1.50(^c)</td>
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<td></td>
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<tr>
<td>Yes</td>
<td>—</td>
<td>1.23</td>
</tr>
<tr>
<td>No</td>
<td>—</td>
<td>.62</td>
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<tr>
<td>Different identification between breadwinner and partner</td>
<td>—</td>
<td>.96</td>
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<tr>
<td>Mean age of breadwinner and partner (if any)(^f)</td>
<td>.98</td>
<td>.97–.98(^c)</td>
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<tr>
<td>Urbanicity of household</td>
<td>1.18</td>
<td>1.13–1.23(^c)</td>
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<tr>
<td>Social position of breadwinner and partner (if any)</td>
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</tr>
<tr>
<td>Employed</td>
<td>1.11</td>
<td>1.00–1.24(^c)</td>
</tr>
<tr>
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<td>1.87</td>
<td>1.27–2.76(^c)</td>
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<tr>
<td>Retired</td>
<td>.39</td>
<td>.26–.57(^c)</td>
</tr>
<tr>
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<td>2.38</td>
<td>2.08–3.19(^c)</td>
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<td>Housewife or househusband</td>
<td>1.50</td>
<td>1.15–1.96(^c)</td>
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<td>.79</td>
<td>.71–.88(^c)</td>
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<td>1.46</td>
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<tr>
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<tr>
<td>Employed</td>
<td>1.45</td>
<td>1.22–1.73(^c)</td>
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<tr>
<td>Student</td>
<td>.81</td>
<td>.38–1.69(^d)</td>
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<tr>
<td>Retired</td>
<td>.15</td>
<td>.06–.41(^c)</td>
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<tr>
<td>Dependent on benefits</td>
<td>1.56</td>
<td>1.07–2.28(^c)</td>
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<td>Housewife or househusband</td>
<td>1.44</td>
<td>.80–2.57</td>
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<td>Breadwinner is employed and the partner is a housewife or househusband</td>
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<td>.73–1.14</td>
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<td>Social position of breadwinner and partner (if any) in 1991</td>
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<td></td>
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<tr>
<td>Employed</td>
<td>1.16</td>
<td>1.00–1.36</td>
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<tr>
<td>Student</td>
<td>1.05</td>
<td>.52–2.13</td>
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<tr>
<td>Retired</td>
<td>.24</td>
<td>.11–.55</td>
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<tr>
<td>Dependent on benefits</td>
<td>1.47</td>
<td>1.02–2.12(^d)</td>
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<tr>
<td>Housewife or househusband</td>
<td>.99</td>
<td>.49–1.99</td>
</tr>
<tr>
<td>Breadwinner is employed and the partner is a housewife or househusband</td>
<td>1.04</td>
<td>.83–1.32(^d)</td>
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<td>Other social position</td>
<td>1.07</td>
<td>.78–1.47</td>
</tr>
<tr>
<td>Education of breadwinner and partner (if any)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary education</td>
<td>.76</td>
<td>.66–.87(^c)</td>
</tr>
</tbody>
</table>

Continues on next page
orders, and a greater use of medications (1) and behavior therapies in specialized care—did not alter the relative pattern of help seeking or referral to mental health services. Any year-to-year variations in the relative service use by particular household categories during the 17 years studied were neither substantial nor sustained. Such fluctuations might even be chance outcomes of the many tests we carried out. Our conclusion that all households equally took advantage of the increased availability of specialized mental health care services concurs with several previous international studies (4,5,7).

**Reasons for use of mental health services**

Households that had one parent, that had low income, and that were dependent on benefits all had greater odds of using specialized mental health care and social work services during the study period. This finding seems consistent with several previous individual-level studies that investigated the effects of single motherhood, social support, or income sources on the use of primary care or mental health care (18–23). Households in these categories may have more emotional disorders than the average household, less access to various types of support, or less capability of solving problems or avoiding economic distress. Mental health care may then serve as a partial substitute for social or personal resources.

Households whose primary breadwinner and partner (if any) had completed no more than primary school were less likely than the average household to use specialized mental health care but were more likely to use social work services. Badawi and colleagues (24) found less service use by people aged 65 years or older and higher service use by those aged 30 to 44 years, after adjustment for mental disorder, other individual characteristics, and household type.

**Strengths and limitations**

We believe that a major strength of this study is its long-term perspective. Large samples of households, representative of the population, were surveyed by using comparable methods. Some potential limitations may also be noted. First, there was considerable nonresponse in all surveys, although the samples still remained

### Table 1

Continued from previous page

<table>
<thead>
<tr>
<th>Variable</th>
<th>Specialized mental health care&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Social work services&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adjusted OR  95% CI</td>
<td>Adjusted OR  95% CI</td>
</tr>
<tr>
<td>Lower secondary vocational education, middle-level secondary education, or middle-level vocational education</td>
<td>1.03  0.93–1.15</td>
<td>1.33  1.19–1.49&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Higher secondary education or preuniversity secondary education</td>
<td>1.27  1.12–1.44&lt;sup&gt;c&lt;/sup&gt;</td>
<td>1  0.85–1.16</td>
</tr>
<tr>
<td>Higher professional education or university</td>
<td>1.33  1.15–1.54&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.52  0.41–0.66&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Partner has a higher education than breadwinner&lt;sup&gt;f&lt;/sup&gt;</td>
<td>1.17  1.02–1.35&lt;sup&gt;e&lt;/sup&gt;</td>
<td>0.93  0.79–1.11</td>
</tr>
<tr>
<td>Breadwinner has a higher education than partner&lt;sup&gt;f&lt;/sup&gt;</td>
<td>0.87  0.78–0.95&lt;sup&gt;e&lt;/sup&gt;</td>
<td>0.8  0.71–0.90&lt;sup&gt;e&lt;/sup&gt;</td>
</tr>
<tr>
<td>Education of breadwinner and partner (if any) in 1983</td>
<td></td>
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<tr>
<td>Primary education</td>
<td>—</td>
<td>0.9  0.64–1.28&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Lower secondary vocational education, middle-level secondary education, or middle-level vocational education</td>
<td>—</td>
<td>1.26  0.93–1.71</td>
</tr>
<tr>
<td>Higher secondary education or preuniversity secondary education</td>
<td>—</td>
<td>1.54  1.07–2.22&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Higher professional education or university</td>
<td>—</td>
<td>0.55  0.26–1.17</td>
</tr>
<tr>
<td>Partner has a higher education than breadwinner&lt;sup&gt;f&lt;/sup&gt;</td>
<td>—</td>
<td>0.97  0.60–1.57</td>
</tr>
<tr>
<td>Breadwinner has a higher education than partner&lt;sup&gt;f&lt;/sup&gt;</td>
<td>—</td>
<td>0.88  0.66–1.18</td>
</tr>
</tbody>
</table>

<sup>a</sup> The analyses for mental health care used data for 28,264 households, and the analyses for social work services used data for 28,274 households. The effects of each household characteristic are adjusted for the influence of study year and, if applicable, the interaction between the household characteristic and study year. The reference group is the weighted average household of the pooled data set. To compute the deviation of a particular household category from the average household in the use of specialized mental health care or social work services (and thereby the odds ratio), the method devised by Sweeney and Ulveling (12) was used. Data for individual study years are shown only if significant differences were found between the average of all study years and the particular study year (that is, if one or more interaction terms were present).

<sup>b</sup> Compared with no such services used

<sup>c</sup> Odds ratio significantly different from odds ratio in other years (p=.05, two-tailed)

<sup>d</sup> Odds ratio significantly different from odds ratio in other years (p=.05, two-tailed)

<sup>e</sup> Age ranged from 16 to 74 years

<sup>f</sup> More than one degree of difference between breadwinner and partner
representative of the population at the household level. Response rates varied between surveys, but they showed no association with any of the trends found in service use or help seeking. It therefore seems unlikely that nonresponse compromised our results.

Second, recall problems could have affected household members’ estimations of service use in the previous two years, although it is difficult to gauge what effect that might have had on our results. Conceivably, people might have underreported service use for mild mental problems, in which case the trends we identify would underrepresent the situation.

Third, no data were available on the use of Dutch mental health services other than from the regional institutes for ambulatory mental health care and social work agencies, such as psychiatric clinics, private practices, and general practitioners. However, because these regional institutes and social agencies are major sources of secondary and primary mental health care, we believe that our results are generalizable to other such services.

Conclusions
Notwithstanding these potential limitations, we conclude that although mental health service use increased sharply during the 17-year period, no relative changes occurred in the help-seeking patterns among the sociodemographic groups examined. Service output statistics also indicate higher workloads for professionals (17). The number of client contacts per staff position (expressed in full-time equivalents) increased by 17 percent in specialized mental health from 1983 to 1995 and by 16 percent in social work services from 1987 to 1995. Thus, although care services became more heavily burdened, referral patterns and intake criteria remained relatively unchanged. Apparently, considerations related to substantive care weighed more heavily in the provision and use of services than professional workloads, which seems to indicate stable patterns of help seeking and referral to mental health services.

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References