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Socio-economic variations in the mental health treatment gap for people with anxiety, mood, and substance use disorders: Results from the WHO World Mental Health (WMH) Surveys

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160

161 A complete list of all within-country and cross-national WMH publications can be found at
162 <http://www.hcp.med.harvard.edu/wmh/>.

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164

Abstract

165 **Background:** The treatment gap between the number of people with mental disorders and the
166 number treated represents a major public health challenge. We examine this gap by socio-
167 economic status (SES; indicated by family income and respondent education) and service sector
168 in a cross-national analysis of community epidemiological survey data.

169 **Methods:** Data come from 16,753 respondents with 12-month DSM-IV disorders from
170 community surveys in 25 countries in the WHO World Mental Health Survey Initiative. DSM-IV
171 anxiety, mood, or substance disorders and treatment of these disorders were assessed with the
172 WHO Composite International Diagnostic Interview (CIDI).

173 **Results:** Only 13.7% of 12-month DSM-IV/CIDI cases in lower-middle-income countries,
174 22.0% in upper-middle-income countries, and 36.8% in high-income countries received
175 treatment. Highest-SES respondents were somewhat more likely to receive treatment, but this
176 was true mostly for specialty mental health treatment, where the association was positive with
177 education (highest treatment among respondents with highest education and a weak association
178 of education with treatment among other respondents) but non-monotonic with income
179 (somewhat lower treatment rates among middle-income respondents and equivalent among those
180 with high and low incomes).

181 **Conclusions:** The modest, but nonetheless stronger, association of education than income with
182 treatment raises questions about a financial barriers interpretation of the inverse association of
183 SES with treatment, although future within-country analyses that consider contextual factors
184 might document other important specifications. While beyond the scope of this report, such an
185 expanded analysis could have important implications for designing interventions aimed at
186 increasing mental disorder treatment among socio-economically disadvantaged people.

187

188 **Key words:** Mental disorders, mental health service use, inequalities, education, income,
189 occupation, WMH surveys, population studies

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Background

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The discrepancy between the number of people needing treatment for mental disorders and the number receiving treatment, known as the mental health treatment gap, represents a major public health challenge. Although mental disorders are a leading cause of disability (World Health Organization, 2012; Whiteford *et al.* 2015; Vigo *et al.* 2016), only a minority of people with these disorders receives treatment (Wang *et al.* 2007). This gap is even greater for people with low socio-economic status (SES) and those living in low-income countries (Steele *et al.* 2007; Ormel *et al.* 2008) even adjusting for disorder severity (Mojtabai, 2010; Andrade *et al.* 2014).

It is less clear, though, whether these disparities are equally large across all service sectors and all levels of disorder severity. We know that cross-national differences in treatment rates are strongly influenced by healthcare spending (Lewer *et al.* 2015) and that probability of receiving treatment is influenced by illness severity (Wang *et al.* 2007). We also know that specialist mental health (SMH) treatment resources are scarcer than general medical and nonmedical resources and that access to SMH treatment is often restricted through gatekeepers to the most severe-complex cases (Thornicroft & Tansella, 2013). It is less clear, though, how much the association of SES with treatment varies with these other factors. SES might be more weakly associated with treatment among severe cases or in the SMH sector due to access being driven more by need than ability to pay. Alternatively, it might be that the association of SES with treatment is stronger in these cases due to more stringent barriers associated with low-SES. Research on more general patterns of healthcare utilization suggests that the latter is the case: that is, that under-representation of low-SES individuals is more pronounced in the specialty sector than general medical sector (Devaux & De Looper, 2012), but this pattern might not hold

214 for mental disorders. Nor do we know how stable such a pattern is across countries, although
215 there is some evidence of cross-national differences in the association of SES with mental
216 disorder treatment (Kessler *et al.* 1997; Van Doorslaer & Masseria, 2004; Devaux & De Looper,
217 2012).

218 The World Mental Health (WMH) Surveys (Kessler *et al.* 2009), a series of cross-
219 sectional population surveys of common mental disorders, provide an unprecedented opportunity
220 to investigate the SES gradient in treatment of mental disorders at the level of the individual
221 survey respondent as a joint function of disorder severity, service sector, and country income
222 level. We do this here focusing on mental disorders in the 12 months before interview. It is
223 noteworthy that the cross-national interactions we consider are at the level of the country income
224 group rather than individual country in order to maintain precision in estimating individual-level
225 coefficients. It might be that future analyses could gain more insight by investigating contextual
226 factors other than country income level, but we considered this the most interesting broad factor
227 discriminating WMH countries the current analysis.

228 **Methods**

229 **Sample**

230 Data come from the 16,753 respondents across 28 WMH surveys with 12-month DSM-
231 IV disorders. The surveys were administered to representative samples of adult household
232 residents in 25 countries. These include 7 surveys from countries classified by the World bank as
233 lower-middle-income (Colombia, Iraq, Nigeria, Peoples Republic of China, Peru, Ukraine), 7
234 upper-middle-income (Brazil, Bulgaria, Medellin Colombia [carried out at a later date than the
235 national Colombian survey, at which time the income level of the country had increased],
236 Lebanon, Mexico, Romania, South Africa), and 14 high-income (Belgium, France, Germany,

237 Israel, Italy, Japan, Netherlands, New Zealand, Northern Ireland, Poland, Portugal, Spain [both a
238 national survey and regional survey in Murcia], USA) (World Bank, 2009). There were no low-
239 income countries in the sample.

240 The samples were based on a multi-stage clustered area probability household design.
241 Samples were nationally representative in 19 surveys, representative of all urbanized areas in 3
242 others (Colombia, Mexico, Peru), and representative of selected regions (Nigeria) or
243 Metropolitan areas (Sao Paulo in Brazil, Medellin in Colombia, a series of cities in Japan,
244 Beijing/Shanghai and Shenzhen in the Peoples Republic of China) in the others. More details on
245 sample designs are presented in Appendix Table 1. Interviews were carried out face-to-face in
246 respondents' homes by trained lay interviewers. The respondents considered here were aged 18
247 and over other than in Medellin (age 19), Japan (age 20), and Israel (age 21). Response rates
248 were 45.9-97.2% across surveys with a weighted (by sample size) average of 70.1% using the
249 American Association for Public Opinion research RR1w definition (AAPOR, 2016).

250 To reduce respondent burden, interviews were divided into two parts. Part I assessed core
251 mental disorders and was administered to all respondents. Part II assessed additional disorders
252 and correlates and was administered to all Part I respondents with any Part I disorder plus a
253 probability subsample of other Part I respondents. Part II data were weighted to adjust for the
254 under-sampling of Part I non-cases, making weighted Part II prevalence estimates identical to
255 Part I estimates. Treatment was assessed in Part II. 71,239 Part II respondents were interviewed
256 across all surveys, 16,753 of whom met criteria for any 12-month disorders. These 12-month
257 cases are the focus of analysis here. Further details about WMH weighting are available
258 elsewhere (Heeringa *et al.* 2008).

259 **Measures**

260 **Mental disorders:** Mental disorders were assessed with the WHO Composite
261 International Diagnostic Interview (CIDI) Version 3.0 (Kessler & Ustun, 2004), a fully-
262 structured interview generating lifetime and 12-month prevalence estimates of common DSM-IV
263 disorders. The 12 disorders considered here include 7 anxiety disorders (adult separation anxiety
264 disorder, agoraphobia, generalized anxiety disorder, panic disorder, post-traumatic stress
265 disorder, social phobia, specific phobia), 3 mood disorders (bipolar disorder including bipolar I,
266 II and sub-threshold; dysthymic disorder; major depressive episode [MDE]), and 2 substance use
267 disorders (abuse or dependence on alcohol or illicit drugs). As detailed elsewhere (Merikangas *et*
268 *al.* 2011), our definition of sub-threshold bipolar disorder includes both hypomania without
269 history of major depressive episode and sub-threshold hypomania with history of major
270 depressive episode. Our definition of substance dependence is limited to cases with a history of
271 abuse. The CIDI interview translation, back-translation, adaptation, and harmonization protocol
272 required culturally competent bilingual clinicians to review, modify, and approve key phrases
273 describing symptoms (Harkness *et al.* 2008). Blinded clinical reappraisal interviews with the
274 Structured Clinical Interview for DSM-IV (First *et al.* 2002) in a number of WMH surveys found
275 generally good concordance with diagnoses based on the CIDI (Haro *et al.* 2006).

276 We focus here on disorders present in the 12 months before interview. Respondents were
277 classified as having a severe 12-month disorder if at least one of their DSM-IV/CIDI disorders
278 included either bipolar I disorder, substance dependence with a physiological dependence
279 syndrome, any disorder associated with making a 12-month suicide attempt, or any disorder
280 associated with severe impairment in any domain of the expanded-revised Sheehan Disability
281 scales (SDS) (Leon *et al.* 1997). Respondents not classified severe were classified moderate if at
282 least one of their 12-month disorders included substance dependence without a physiological

283 dependence syndrome or at least one disorder with moderate interference in any SDS domain.
284 All other respondents with 12-month disorders were classified as mild (Ten Have *et al.* 2013).

285 **Mental Health Treatment:** Part II respondents were asked if they ever obtained
286 professional treatment for “problems with emotions, nerves, mental health, or use of alcohol or
287 drugs” and, if so, whether they received such treatment at any time during the 12 months before
288 interview. Importantly, this question was not disorder-specific, which means that we have no way
289 of knowing which disorders respondents sought treatment for. Respondents who reported 12-
290 month treatment were asked whether they received this treatment during the past 12 months from
291 each of a wide range of treatment providers that were subsequently classified into four
292 categories: (1) *specialist mental health* (SMH; psychiatrist, psychologist, other mental health
293 professional in any setting, social worker or counselor in a mental health specialist treatment
294 setting, used a mental health hotline); (2) *general medical* (GM; primary care doctor, other
295 medical doctor, any other healthcare professional seen in a GM setting); (3) *human services* (HS;
296 religious or spiritual advisor, social worker, or counsellor in any setting other than SMH); and
297 (4) *complementary alternative medicine* (CAM; any other type of healer such as chiropractors or
298 participation in self-help groups). Further details on the treatment variables are presented
299 elsewhere (Wang *et al.* 2007).

300 **Socio-economic status:** Two indicators of SES were considered: respondent education
301 and family income in the 12 months before interview. As educational levels and systems varied
302 across countries, education was defined in terms of four groups based on country-specific
303 distributions of *high* (which, in high-income countries, corresponded to a college degree with or
304 without further education), *high-average* (some post-secondary education without a college
305 degree), *low-average* (secondary school graduation), and *low* (less than secondary education,

306 including no education). More details on the education coding scheme are presented elsewhere
307 (Scott *et al.* 2014). Family income was also divided into four categories using the within-country
308 approach adopted in international studies of welfare economics (Levinson *et al.* 2010), which
309 defines *high income* as greater than three times the within-country median per capita family
310 income (i.e., income divided by number of family members), *high-average* income as between
311 one and three times median per capita family income, *low-average* income as 50-100% of
312 median per capita family income, and *low* income as less than or equal to 50% of median per
313 capita family income.

314 **Control variables:** Our models controlled for respondent age, sex, and marital status.
315 Age was considered in four groups of 18-34, 35-49, 50-64, and 65+. Marital status was divided
316 into three groups of never married, previously married (separated, divorced, widowed), and
317 currently married or cohabiting.

318 **Statistical analysis**

319 Weights adjusted for under-sampling Part I respondents without disorders, differences in
320 within-household probabilities of selection (due to the selection of only one respondent per
321 household no matter the number of eligible residents), and residual discrepancies between
322 sample and population distributions on Census demographic-geographic variables. All
323 multivariable regression models in these weighted data were estimated in pooled cross-national
324 analyses with dummy control variables included for surveys, yielding coefficients representing
325 pooled within-survey associations. Controls were also included for respondent age, sex, and
326 marital status.

327 The multivariate associations of type, number, and severity of mental disorders with
328 treatment were specified in a relatively complex model, both because these disorder

329 characteristics are known to predict treatment (Andrade *et al.* 2014) and because SES is known
330 to be inversely related to these disorder characteristics (Scott *et al.* 2014), making it important to
331 control adequately for these characteristics to obtain accurate estimates of effects of SES on
332 treatment. Expanded models then examined both main effects of SES and interactions of SES
333 with disorder severity and country income level. All models were estimated using a logistic link
334 function.

335 The multivariable associations of mental disorders with treatment in these models were
336 necessarily constrained because the number of logically possible disorder combinations ($2^{12} =$
337 4,096) is far greater than the number of predictors we could include in the models. As a result,
338 our models included 12 separate disorder-specific dummy variables along with dummy variables
339 for exactly 3 and 4+ disorders. Given that all respondents had at least one disorder and that the
340 model included dummy variables for people with 3+ disorders, the disorder-specific ORs
341 represent the adjusted (for the control variables) incremental predicted odds of treatment (versus
342 not-treatment) among respondents with exactly one disorder. The incremental predictive effects
343 of individual disorders among people with 2 disorders were then assumed to be multiplicative;
344 that is, if the OR associated with Disorder X was 1.5, we would expect respondents with exactly
345 1 other disorder would have a 1.5 increased odds of obtaining treatment in the presence versus
346 absence of Disorder X. This specification imposed parsimony on the data by constraining the OR
347 of Disorder X to be the same across all 11 combinations of Disorder X with exactly 1 other
348 disorder (i.e., reducing the $12 \times 12 = 144$ logically possible main effects and 2-way interactions
349 between pairs of disorders to 12 coefficients). The dummy variables for 3 and 4+ disorders
350 imposed additional constraints by assuming that the 3-way and higher-order interactions among
351 disorders predicting treatment were subject to a constant multiplier that could be 1.0 (i.e., the

352 interactions were strictly multiplicative) or different from 1.0. Models of this form have been
353 shown to be useful in a number of prior WMH analyses (e.g., Stein *et al.* 2016; McGrath *et al.*
354 2016).

355 Logistic regression coefficients and standard errors were exponentiated to generate odds-
356 ratios (ORs) and 95% confidence intervals (95% CIs). Confidence intervals for prevalence
357 estimates and ORs were estimated using the Taylor series linearization method (Wolter, 1985)
358 implemented in the SUDAAN software system (Research Triangle Institute, 2002) to adjust for
359 weighting and geographic clustering of data. We used design-based F tests to evaluate between
360 country differences in means and design-based Wald χ^2 tests to evaluate the multivariable
361 significance of predictor sets to decide when individually significant coefficients should be
362 interpreted. Significance was consistently evaluated using .05-level two-sided tests. Even with
363 these global tests, though, over-fitting was possible due to the large number of tests, making it
364 important to consider results only exploratory.

365 Results

366 Twelve-month treatment of DSM-IV/CIDI disorders

367 A weighted 14.9% of Part II respondents across surveys met criteria for at least one 12-
368 month DSM-IV/CIDI disorder. More details about between-survey differences and prevalence
369 estimates of individual disorders are reported elsewhere (Scott *et al.* In press). 29.0% of
370 respondents with 12-month disorders received 12-month treatment. The treatment rate was
371 highest in high-income countries (36.8%), lower in upper-middle-income countries (22.0%), and
372 lowest in lower-middle-income countries (13.7%; $F_{2,5366}=221.1, p<.001$). (Table 1) The highest
373 treatment rate across surveys was in Murcia, Spain (49.6%) and the lowest in Shenzhen in the
374 People's Republic of China (PRC; 6.7%).

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(Table 1 about here)

The GM sector had the highest treatment rate (17.8%). The SMH sector had the second highest treatment rate (13.5%). The treatment rates were much lower in the human services sector (3.7%) and CAM sector (3.7%). The sum of sector-specific treatment rates (38.7/100 respondents) exceeded the 29.0% of individuals with any treatment due to some patients being treated in multiple sectors. Although there was a consistent trend for treatment rates to decrease with country income level within each sector (($F_{2,5366}=132.7$, $p<.001$ for SMH; $F_{2,5366}=231.4$, $p<.001$ for GM; $F_{2,5366}=6.0$, $p=.003$ for HS; $F_{2,5366}=33.2$, $p<.001$ for CAM) as well as overall ($F_{2,5366}=221.1$, $p<.001$), treatment was consistently most common in the GM sector followed by the SMH sector and much lower in the human services and CAM sectors.

Clinical predictors of treatment

Disorder type was significant in predicting treatment in the base multivariate model predicting overall treatment ($\chi^2_{12}=506.1$, $p<.001$) as well as treatment in each service sector ($\chi^2_{12}=36.4-315.1$, $p<.001$). (Table 2) The significant disorder-specific ORs were overwhelmingly greater than 1.0, indicating that comorbidity was associated with increased odds of treatment. Generalized anxiety disorder and PTSD had significantly elevated ORs in all 5 equations (OR=1.4-2.0). Major depressive episodes had significantly elevated ORs in 4 equations (OR=1.5-2.4), the exception being human services treatment. Two disorders had significantly elevated ORs predicting any treatment and treatment in the SMH and GM sectors: panic disorders (OR=2.4-3.4) and agoraphobia (OR=1.6-1.9). Drug use disorder had significantly elevated ORs predicting any treatment and treatment in the SMH and CAM sectors (OR=1.6-1.8). And two disorders, social phobia and bipolar spectrum disorder, had significant ORs predicting treatment in the SMH sector (OR=1.2-1.3). Alcohol use disorder was the only disorder

398 associated with multiple significantly decreased ORs, which involved any treatment and
399 treatment in the GM and human services sectors (OR=0.6-0.7) indicating that respondents with
400 any other disorder profiles were significantly less likely to obtain treatment in these sectors in the
401 presence than absence of comorbid alcohol use disorder.

402 **(Table 2 about here)**

403 Disorder number was significantly associated with each type of treatment ($\chi^2_2=9.4-11.7$,
404 $p=.003-.009$) due to significantly decreased ORs for 4+ disorders (OR=0.6-0.7). These
405 decreased ORs indicate that the elevated odds of treatment due to comorbidity (i.e., the generally
406 positive sign pattern of disorder-specific ORs) increase at a decreasing rate as comorbidity
407 becomes more complex. Disorder severity, finally, had a significant monotonic relationship with
408 Each treatment outcome ($\chi^2_2=21.3-186.0$, $p<.001$), with severe disorders having highest relative-
409 odds (OR=2.0-2.9) followed by moderate disorders (OR=1.3-1.5) compared to mild disorders.

410 **SES differences in treatment**

411 The 4-category measures of respondent education and income were significantly
412 correlated with each other (polychoric correlation = 0.295, $p = <.001$; see Appendix Table 2 for
413 within-survey distributions and associations). Controlling income, respondent education was
414 significantly and positively associated with treatment overall ($\chi^2_3=17.0$, $p<.001$) and in three
415 service sectors ($\chi^2_3=8.9-32.2$, $p=.030-<.001$), the exception being the GM sector. These
416 significant associations were due to reduced ORs of 0.4-0.8 for respondents in each of the three
417 lower education categories relative to high-education respondents.

418 **(Table 3 about here)**

419 Family income, in comparison, while not significant overall in predicting any treatment
420 in a model that controlled for education ($\chi^2_3=4.3$, $p=.233$), was significantly and positively

421 associated with SMH treatment ($\chi^2_3=8.0$, $p=.045$) due to an OR of 0.8 for respondents in each of
422 the three lower income categories relative to the highest income category. In addition, income
423 had a significant inverse association with HS treatment ($\chi^2_3=9.4$, $p=.024$) due to elevated ORs
424 for respondents in each of the two lowest income categories (OR=1.5-1.7) relative to the highest
425 income category.

426 **Interactions of SES with disorder severity, respondent SES, and country income level**

427 **Significance of interactions:** We estimated interactions of SES with disorder severity
428 and country income level in predicting any treatment and treatment in the SMH and GM sectors.
429 We lacked the statistical power to carry out parallel analyses of interactions predicting HS and
430 CAM treatment. The 3-way interactions were significant for both education and income
431 predicting any treatment ($\chi^2_{12}=22.9-29.8$, $p=.029-.003$) and for income predicting GM treatment
432 ($\chi^2_{12}=26.8$, $p=.008$). The 2-way interactions of income with severity and with country income
433 level were significant in a model that excluded the 3-way interactions in predicting SMH
434 treatment ($\chi^2_6=12.9-13.6$, $p=.045-.035$).

435 **(Table 4 about here)**

436 **Education:** Subgroup analysis showed that the significant association of education with
437 any treatment in the total sample was limited to severe and moderate cases in high-income
438 countries ($\chi^2_3=9.9-17.2$, $p=.019-.001$). Significant ORs among respondents with lower levels of
439 education were in the range 0.5-0.8. (Table 4) The significant association of education with SMH
440 treatment in the total sample varied by disorder severity and country income, with significant
441 ORs among respondents of lower education were in the range 0.6-0.7. The non-significant
442 association of education with GM treatment found in the total sample was found not to vary
443 significantly by disorder severity or country income.

444 (Table 5 about here)

445 **Income:** Subgroup analysis showed that the non-significant association of income with
446 any treatment in the total sample masked a significantly positive association among severe cases
447 in lower-middle income countries (significant ORs of 0.2-0.4 among respondents in lower
448 income subgroups; $\chi^2_3=20.1$, $p<.001$) and a significantly negative association among mild cases
449 in upper-middle-income countries (a significant OR=1.8 for low-income respondents; $\chi^2_3=14.9$,
450 $p=.002$). (Table 5) The significant association of income with SMH treatment in the total sample
451 was consistent across country income groups due to especially low odds of treatment in
452 intermediate income groups within each severity subsample (OR=0.3-0.5) rather than in the
453 lowest income group (OR=0.7-0.9). The non-significant association of income with GM
454 treatment in the total sample, finally, was found to mask a significantly positive association
455 among moderately severe cases in lower-middle income countries and mild cases in both lower-
456 middle and high income countries (significant ORs of 0.2-0.7; $\chi^2_3=8.8-18.3$, $p=.032-<.001$) and
457 significantly negative associations among mild cases in upper-middle-income countries and
458 severe cases in high income countries (significant ORs of 1.5-2.0; $\chi^2_3=15.1-44.3$, $p=.002-$
459 $<.001$).

460 **Discussion**

461 These results represent the most comprehensive examination ever undertaken of the
462 associations of SES with mental disorder treatment. Consistent with previous research (Kohn *et*
463 *al.* 2004; Wang *et al.* 2007; Ormel *et al.* 2008), only a minority of people with the 12-month
464 disorders considered here received any treatment, the highest proportion of people receiving
465 treatment was in the general medical sector followed by the specialty mental health sector, and
466 treatment was much less common in lower- than higher-income countries. However, the two

467 SES indicators considered here, respondent education and family income, were much less
468 consistently associated with 12-month treatment than we had anticipated.

469 As noted in the introduction, we had expected to find the association of SES with
470 specialty treatment to increase with disorder severity to the extent that the restrictions on access
471 to specialty care were related to income but to decrease with disorder severity to the extent that
472 the restrictions were related to need for treatment. We found neither pattern, as the lowest odds
473 of SMH treatment were among respondents having intermediate income levels across all levels
474 of disorder severity and country income groups. This could be due to lowest-income people, but
475 not people with intermediate income levels, having free access to specialty care, resulting in
476 highest financial barriers existing among people with intermediate incomes.

477 The association of education with SMH treatment was stable across all levels of disorder
478 severity and country income groups, with the significant association due to a comparatively high
479 odds of treatment among people at the highest education level (ORs of 0.6-0.7 for lower
480 education levels equivalent to 1.4-1.7 higher odds at highest versus lower levels). These
481 associations are presumably not due to financial barriers given that they were obtained after
482 controlling income. Other possible explanatory variables (e.g., recognition of need, perceived
483 stigma, perceived efficacy of treatment) need to be explored in future studies to interpret these
484 associations.

485 Subgroup analysis found no significant association of income with overall treatment in
486 the total sample and only inconsistent opposite-sign associations in subsamples. However, the
487 significant positive association with specialty mental health treatment and the significant inverse
488 association with human services treatment in the total sample showed that even though people of
489 different financial means were equally likely to receive some type of treatment, a significant

490 discrepancy existed in the sector in which treatment was received. This discrepancy was small,
491 though, as cases in the highest income category (roughly one-fourth of the population) had only
492 about 25% higher odds of specialty mental health treatment than those in lower income
493 categories and, as noted in the prior paragraph, there were no differences in odds of receiving
494 specialty treatment across the lower three income categories.

495 Although the association of income with GM treatment was non-significant in the total
496 sample, a significant 3-way interaction was found due to a series of opposite-sign subgroup
497 associations that had no apparent patterning. Perhaps the clearest observation about this
498 specification is that it showed that lowest income was for the most part not associated with
499 lowest odds of GM treatment. Education, in comparison, was most consistently associated with
500 SMH treatment, as the associations of education with treatment in other service sectors were
501 relatively weak (significant ORs in the range 0.6-0.8).

502 Why did we find weaker and less consistent associations of income and education with
503 treatment than previous studies (Rossi *et al.* 2005; Tello *et al.* 2005; Steele *et al.* 2007)? One
504 possibility is that we included two indicators of SES in the models, income and education. Given
505 that these two indicators are significantly correlated with each other, the strength of each as a
506 predictor of treatment was reduced by including both in the equations. We considered it
507 appropriate to include both, though, as the mechanisms involved in the two are presumably
508 different. As we saw, both indicators were statistically significant, albeit not large in substantive
509 terms

510 **Limitations**

511 The study had a number of limitations. First, the sample was limited in that the sample of
512 countries was non-representative and the response rate varied widely across countries. Although

513 we attempted to control for differential response through post-stratification adjustments, survey
514 response might have been related to social status, presence and severity of mental disorders or
515 treatment in ways that were uncorrected.

516 Second, the disorder measures were limited in that some severe disorders, such as
517 schizophrenia, were not assessed, duration was not measured for the disorders that were
518 assessed, and validity, although good in the WMH surveys where it was assessed (Haro *et al.*
519 2006), was not assessed in all surveys and might have varied with SES.

520 Third, the treatment measures were limited to self-reports, which have been found to
521 over-estimate treatment compared to administrative records (Rhodes & Fung, 2004). In addition,
522 these self-reports only assessed number of visits rather than treatment quality. The small amount
523 of research that exists on mental disorder treatment quality finds that low-SES patients are
524 significantly more likely than other patients to receive lower-quality treatment (Amaddeo &
525 Jones, 2007; Young & Rabiner, 2015).

526 Fourth, the only contextual variable considered was a simple 3-category measure of
527 country income level. Many other potentially important contextual variables exist at both the
528 country level (e.g., access to universal healthcare) and within countries (e.g., number of
529 treatment providers per capita within the access area of the respondent). However, as the number
530 of countries was small ($n = 25$) and no information was available about within-country
531 geographic characteristics in most surveys, we had too few geographic units of analysis to carry
532 out quantitative analyses of other contextual factors. It might be that future analyses could gain
533 more insight by estimating within-country models that treated each country as a case study and
534 considering contextual factors qualitatively.

535

536 **Conclusions**

537 Within the context of these limitations, our findings are consistent with previous research
538 in showing that only a minority of people with common mental disorders receive treatment, even
539 in high income countries, and that treatment rates are lower in lower income countries. We also
540 broadly confirmed previous evidence that people with low SES have an especially low rate of
541 treatment, although in the total sample this was true only for SMH treatment and income was
542 inversely related to HS treatment, resulting in income being related more to sector of treatment
543 than to whether or not treatment was received. The significant associations of SES with
544 treatment were most consistent in predicting SMH treatment, but they were less strong than
545 anticipated. Direct investigation of reports about barriers to treatment would be needed to delve
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547

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644

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References

- 666
667
- 668 **Amaddeo F, Jones J** (2007). What is the impact of socio-economic inequalities on the use of
669 mental health services? *Epidemiologia e Psichiatria Sociale* **16**, 16-9.
- 670 **American Association for Public Opinion Research (AAPOR). 2016.** *Standard Definitions:*
671 *Final Dispositions of Case Codes and Outcome Rates for Surveys. 9th edition.* AAPOR.
672 ([http://www.aapor.org/AAPOR_Main/media/publications/Standard-](http://www.aapor.org/AAPOR_Main/media/publications/Standard-Definitions20169theditionfinal.pdf)
673 [Definitions20169theditionfinal.pdf](http://www.aapor.org/AAPOR_Main/media/publications/Standard-Definitions20169theditionfinal.pdf)). Accessed 31 August 2017.
- 674 **Andrade LH, Alonso J, Mneimneh Z, Wells JE, Al-Hamzawi A, Borges G, Bromet E,**
675 **Bruffaerts R, de Girolamo G, de Graaf R, Florescu S, Gureje O, Hinkov HR, Hu C, Huang**
676 **Y, Hwang I, Jin R, Karam EG, Kovess-Masfety V, Levinson D, Matschinger H, O'Neill S,**
677 **Posada-Villa J, Sagar R, Sampson NA, Sasu C, Stein DJ, Takeshima T, Viana MC, Xavier**
678 **M, Kessler RC** (2014). Barriers to mental health treatment: results from the WHO World Mental
679 Health surveys. *Psychological Medicine* **44**, 1303-17.
- 680 **Chen H, Cohen P, Chen S** (2010). How big is a big odds ratio? Interpreting the magnitudes of
681 odds ratios in epidemiological studies. *Communications in Statistics—Simulation and*
682 *Computation*® **39**, 860-864.
- 683 **Devaux M, De Looper M** (2012). Income-related inequalities in health service utilisation in 19
684 OECD countries, 2008-2009, OECD Health Working Papers, No. 58. OECD Publishing: Paris,
685 France. (DOI: 10.1787/5k95xd6stnxt-en). Accessed 31 May 2017.

686 **First MB, Spitzer RL, Gibbon M, Williams JBW** (2002). *Structured Clinical Interview for*
687 *DSM-IV-TR Axis I Disorders, Research Version, Non-patient Edition. (SCID-I/NP)*. Biometrics
688 Research, New York State Psychiatric Institute: New York.

689 **Harkness J, Pennell B-E, Villar A, Gebler N, Aguilar-Gaxiola S, Bilgen I** (2008). Translation
690 procedures and translation assessment in the World Mental Health Survey Initiative. In *The*
691 *WHO World Mental Health Surveys: Global Perspectives on the Epidemiology of Mental*
692 *Disorders* (ed. R. C. Kessler and T. B. Üstün), pp. 91-113. Cambridge University Press: New
693 York, NY.

694 **Haro JM, Arbabzadeh-Bouchez S, Brugha TS, de Girolamo G, Guyer ME, Jin R, Lepine**
695 **JP, Mazzi F, Reneses B, Vilagut G, Sampson NA, Kessler RC** (2006). Concordance of the
696 Composite International Diagnostic Interview Version 3.0 (CIDI 3.0) with standardized clinical
697 assessments in the WHO World Mental Health surveys. *International Journal of Methods in*
698 *Psychiatric Research* **15**, 167-80.

699 **Heeringa SG, Wells JE, Hubbard F, Mneimneh ZN, Chiu WT, Sampson NA, Berglund PA**
700 (2008). Sample designs and sampling procedures. In *The WHO World Mental Health Surveys:*
701 *Global Perspectives on the Epidemiology of Mental Disorders* (ed. R. C. Kessler and T. B.
702 Üstün), pp. 14-32. Cambridge University Press: New York, NY.

703 **Kessler RC, Aguilar-Gaxiola S, Alonso J, Chatterji S, Lee S, Ustun TB** (2009). The WHO
704 World Mental Health (WMH) Surveys. *Die Psychiatrie : Grundlagen und Perspektiven* **6**, 5-9.

705 **Kessler RC, Frank RG, Edlund M, Katz SJ, Lin E, Leaf P** (1997). Differences in the use of
706 psychiatric outpatient services between the United States and Ontario. *New England Journal of*
707 *Medicine* **336**, 551-7.

708 **Kessler RC, Ustun TB** (2004). The World Mental Health (WMH) Survey Initiative Version of
709 the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI).
710 *International Journal of Methods in Psychiatric Research* **13**, 93-121.

711 **Kohn R, Saxena S, Levav I, Saraceno B** (2004). The treatment gap in mental health care.
712 *Bulletin of the World Health Organization* **82**, 858-66.

713 **Leon AC, Olfson M, Portera L, Farber L, Sheehan DV** (1997). Assessing psychiatric
714 impairment in primary care with the Sheehan Disability Scale. *International Journal of*
715 *Psychiatry in Medicine* **27**, 93-105.

716 **Levinson D, Lakoma MD, Petukhova M, Schoenbaum M, Zaslavsky AM, Angermeyer M,**
717 **Borges G, Bruffaerts R, de Girolamo G, de Graaf R, Gureje O, Haro JM, Hu C, Karam**
718 **AN, Kawakami N, Lee S, Lepine JP, Browne MO, Okoliyski M, Posada-Villa J, Sagar R,**
719 **Viana MC, Williams DR, Kessler RC** (2010). Associations of serious mental illness with
720 earnings: results from the WHO World Mental Health surveys. *British Journal of Psychiatry*
721 **197**, 114-21.

722 **Lewer D, O'Reilly C, Mojtabai R, Evans-Lacko S** (2015). Antidepressant use in 27 European
723 countries: associations with sociodemographic, cultural and economic factors. *British Journal of*
724 *Psychiatry* **207**, 221-6.

725 **McGrath JJ, Saha S, Al-Hamzawi A, Andrade L, Benjet C, Bromet EJ, Browne MO,**
726 **Caldas de Almeida JM, Chiu WT, Demyttenaere K, Fayyad J, Florescu S, de Girolamo G,**
727 **Gureje O, Haro JM, Ten Have M, Hu C, Kovess-Masfety V, Lim CC, Navarro-Mateu F,**
728 **Sampson N, Posada-Villa J, Kendler KS, Kessler RC** (2016). The bidirectional associations
729 between psychotic experiences and DSM-IV mental disorders. *American Journal of Psychiatry*
730 **10**, 997-1006.

731 **Merikangas KR, Jin R, He JP, Kessler RC, Lee S, Sampson NA, Viana MC, Andrade LH,**
732 **Hu C, Karam EG, Ladea M, Medina-Mora ME, Ono Y, Posada-Villa J, Sagar R, Wells JE,**
733 **Zarkov Z** (2011). Prevalence and correlates of bipolar spectrum disorder in the world mental
734 health survey initiative. *Archives of General Psychiatry* **68**, 241-51.

735 **Mojtabai R** (2010). Mental illness stigma and willingness to seek mental health care in the
736 European Union. *Social Psychiatry and Psychiatric Epidemiology* **45**, 705-12.

737 **Ormel J, Petukhova M, Chatterji S, Aguilar-Gaxiola S, Alonso J, Angermeyer MC, Bromet**
738 **EJ, Burger H, Demyttenaere K, de Girolamo G, Haro JM, Hwang I, Karam E, Kawakami**
739 **N, Lepine JP, Medina-Mora ME, Posada-Villa J, Sampson N, Scott K, Ustun TB, Von**
740 **Korff M, Williams DR, Zhang M, Kessler RC** (2008). Disability and treatment of specific
741 mental and physical disorders across the world. *British Journal of Psychiatry* **192**, 368-75.

742 **Rhodes AE, Fung K** (2004). Self-reported use of mental health services versus administrative
743 records: care to recall? *International Journal of Methods in Psychiatric Research* **13**, 165-75.

744 **Rossi A, Amaddeo F, Sandri M, Tansella M** (2005). Determinants of once-only contact in a
745 community-based psychiatric service. *Social Psychiatry and Psychiatric Epidemiology* **40**, 50-6.

746 **Scott KM, Al-Hamzawi AO, Andrade LH, Borges G, Caldas-de-Almeida JM, Fiestas F,**
747 **Gureje O, Hu C, Karam EG, Kawakami N, Lee S, Levinson D, Lim CC, Navarro-Mateu F,**
748 **Okoliyski M, Posada-Villa J, Torres Y, Williams DR, Zakhosha V, Kessler RC** (2014).
749 Associations between subjective social status and DSM-IV mental disorders: results from the
750 World Mental Health surveys. *JAMA Psychiatry* **71**, 1400-8.

751 **Research Triangle Institute** (2002). *SUDAAN: Professional Software for Survey Data Analysis*
752 [computer program]. Research Triangle Institute: Research Triangle Park, NC.

753 **Scott KM, de Jonge P, Stein DJ, Kessler RC** eds. (In press). *Mental Disorders Around the*
754 *World: Facts and Figures from the World Mental Health Surveys*. Cambridge University Press:
755 New York, NY.

756 **Steele L, Dewa C, Lee K** (2007). Socioeconomic status and self-reported barriers to mental
757 health service use. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie* **52**, 201-6.

758 **Stein DJ, Karam EG, Shahly V, Hill ED, King A, Petukhova M, Atwoli L, Bromet EJ,**
759 **Florescu S, Haro JM, Hinkov H, Karam A, Medina-Mora ME, Navarro-Mateu F, Piazza**
760 **M, Shalev A, Torres Y, Zaslavsky AM, Kessler RC.** (2016). Post-traumatic stress disorder
761 associated with life-threatening motor vehicle collisions in the WHO World Mental Health
762 Surveys. *BMC Psychiatry*. **16**, 257-71.

763 **Tello JE, Mazzi M, Tansella M, Bonizzato P, Jones J, Amaddeo F** (2005). Does
764 socioeconomic status affect the use of community-based psychiatric services? A South Verona
765 case register study. *Acta Psychiatrica Scandinavica* **112**, 215-23.

766 **Ten Have M, Nuyen J, Beekman A, de Graaf R** (2013). Common mental disorder severity and
767 its association with treatment contact and treatment intensity for mental health problems.
768 *Psychological Medicine* **43**, 2203-13.

769 **Thornicroft G, Tansella M** (2013). The balanced care model for global mental health.
770 *Psychological Medicine* **43**, 849-63.

771 **Van Doorslaer E, Masseria C** (2004). OECD health working paper NO. 14, Income-related
772 inequality in the use of medical care in 21 OECD countries. OECD Publishing: Paris, France.
773 (<https://www.oecd.org/els/health-systems/31743034.pdf>). Accessed 31 May 2017.

774 **Vigo D, Thornicroft G, Atun R** (2016). Estimating the true global burden of mental illness.
775 *Lancet Psychiatry* **3**, 171-8.

776 **Wang PS, Aguilar-Gaxiola S, Alonso J, Angermeyer MC, Borges G, Bromet EJ, Bruffaerts**
777 **R, de Girolamo G, de Graaf R, Gureje O, Haro JM, Karam EG, Kessler RC, Kovess V,**
778 **Lane MC, Lee S, Levinson D, Ono Y, Petukhova M, Posada-Villa J, Seedat S, Wells JE**
779 (2007). Use of mental health services for anxiety, mood, and substance disorders in 17 countries
780 in the WHO world mental health surveys. *Lancet* **370**, 841-50.

781 **Whiteford HA, Ferrari AJ, Degenhardt L, Feigin V, Vos T** (2015). The global burden of
782 mental, neurological and substance use disorders: an analysis from the Global Burden of Disease
783 Study 2010. *PloS One* **10**, e0116820.

784 **Wolter KM** (1985). *Introduction to Variance Estimation*. Springer-Verlag: New York, NY.

785 **World Bank** (2009). World Bank list of economies (July 2009). The World Bank: Washington,
786 D.C. (http://www.iqla.org/joining/World-Bank_Classification-List_2009.pdf). Accessed 31 May
787 2017.

788 **World Health Organization** (2012). Global burden of mental disorders and the need for a
789 comprehensive, coordinated response from health and social sectors at the country level.
790 Document EB130.R8. World Health Organization: Geneva, Switzerland.
791 (http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_R8-en.pdf). Accessed 31 May 2017.

792 **Young AS, Rabiner D** (2015). Racial/ethnic differences in parent-reported barriers to accessing
793 children's health services. *Psychological Services* **12**, 267-73.

Table 1. Twelve-month treatment of mental disorders overall and within separate service sectors among WMH respondents with 12-month DSM-IV/CIDI disorders by survey

	Any treatment		Specialty mental health		General medical		Human services		CAM		Number of respondents with any disorder (n)
	%	(SE)	%	(SE)	%	(SE)	%	(SE)	%	(SE)	
I. Lower-middle income countries											
Colombia	13.5	(1.6)	7.4	(1.2)	5.8	(1.0)	1.1	(0.6)	0.5	(0.3)	(789)
Iraq	11.7	(2.3)	3.6	(1.6)	4.1	(1.4)	4.6	(1.5)	0.5	(0.4)	(469)
Nigeria	11.7	(2.5)	1.5	(0.8)	10.3	(2.5)	1.3	(0.7)	0.0	(0.0)	(204)
PRC-Beijing/Shanghai	12.1	(4.5)	3.7	(1.5)	8.5	(4.4)	0.3	(0.3)	4.8	(4.0)	(206)
PRC-Shenzhen	6.7	(1.6)	2.4	(1.0)	2.6	(0.9)	1.1	(0.7)	2.4	(0.8)	(404)
Peru	19.1	(2.6)	10.3	(1.4)	5.4	(1.4)	2.7	(0.8)	2.9	(0.9)	(360)
Ukraine	18.1	(2.3)	4.0	(1.0)	11.1	(1.9)	3.8	(1.0)	1.5	(0.5)	(643)
Overall	13.7	(0.9)	5.1	(0.6)	6.4	(0.6)	2.6	(0.5)	1.3	(0.3)	(3,075)
II. Upper-middle income countries											
Brazil-Sao Paulo	24.1	(1.0)	15.5	(1.1)	8.8	(0.8)	3.5	(0.7)	3.4	(0.6)	(1,177)
Bulgaria	20.7	(2.7)	6.4	(1.2)	16.8	(2.5)	0.9	(0.8)	0.05	(0.05)	(400)
Colombia-Medellin	18.7	(2.1)	11.7	(1.5)	6.9	(1.4)	1.4	(0.6)	1.6	(0.6)	(514)
Lebanon	11.0	(1.8)	3.4	(1.1)	7.2	(1.4)	1.2	(0.6)	0.0	(0.0)	(309)
Mexico	18.0	(1.8)	10.3	(1.5)	6.1	(1.0)	0.6	(0.3)	3.1	(1.0)	(655)
Romania	23.4	(3.0)	11.2	(2.3)	13.5	(2.7)	0.8	(0.5)	0.0	(0.0)	(175)
South Africa	25.7	(2.5)	5.8	(1.3)	16.9	(1.9)	6.4	(1.4)	5.8	(1.0)	(700)
Overall	22.0	(0.9)	10.0	(0.6)	11.3	(0.7)	3.2	(0.5)	3.1	(0.3)	(3,930)
III. High income countries											
Belgium	38.3	(4.2)	20.2	(2.8)	30.7	(4.9)	0.9	(0.7)	1.2	(0.6)	(227)
France	30.5	(2.9)	11.9	(1.6)	23.1	(2.6)	1.5	(0.7)	1.1	(0.6)	(394)
Germany	25.8	(3.3)	13.5	(2.4)	17.5	(2.7)	1.9	(0.8)	1.2	(0.5)	(268)
Israel	34.9	(2.3)	17.5	(1.8)	17.3	(1.9)	5.7	(1.1)	3.1	(0.8)	(483)
Italy	26.7	(2.7)	8.5	(2.2)	22.7	(2.5)	1.2	(0.5)	0.6	(0.4)	(280)
Japan	22.9	(3.3)	15.3	(2.5)	11.2	(2.1)	1.3	(0.7)	5.5	(2.2)	(237)
Netherlands	30.5	(4.4)	16.2	(2.9)	24.3	(4.2)	1.7	(0.7)	2.3	(0.8)	(273)
New Zealand	38.4	(1.2)	16.1	(1.0)	28.4	(1.0)	4.9	(0.5)	6.5	(0.7)	(2,734)
Northern Ireland	42.5	(3.0)	14.8	(1.8)	38.1	(2.8)	2.7	(0.7)	6.2	(1.4)	(533)
Poland	21.5	(2.0)	13.5	(1.4)	10.1	(1.2)	2.6	(0.8)	3.7	(0.9)	(622)
Portugal	36.2	(2.0)	17.6	(1.7)	24.0	(1.7)	2.1	(0.6)	1.7	(0.4)	(726)
Spain	34.4	(3.1)	20.5	(2.3)	23.1	(2.4)	1.0	(0.5)	1.6	(0.6)	(407)
Spain-Murcia	49.6	(3.4)	28.0	(4.2)	26.9	(2.6)	0.0	(0.0)	1.0	(0.6)	(361)
USA	41.6	(0.9)	22.0	(0.9)	23.1	(0.8)	8.1	(0.8)	6.9	(0.6)	(2,203)
Overall	36.8	(0.6)	17.7	(0.5)	24.2	(0.5)	4.3	(0.3)	4.6	(0.3)	(9,748)
IV. Total											
	29.0	(0.5)	13.5	(0.3)	17.8	(0.4)	3.7	(0.2)	3.7	(0.2)	(16,753)
$F_{2,5366}$	221.1*		132.7*		231.4*		6.0*		33.2*		

794 *Significant difference across the three country income groups at the .05 level, two-sided test

Table 2. Multivariable associations of clinical characteristics (disorder type, number, and severity) with 12-month treatment of mental disorders overall and within separate service sectors among WMH respondents with 12-month DSM-IV/CIDI disorders (n=16,753)¹

	Any treatment		Specialty mental health		General medical		Human services		CAM	
	OR	(95% CI)	OR	(95% CI)	OR	(95% CI)	OR	(95% CI)	OR	(95% CI)
I. Type of disorder										
a. Anxiety										
Adult separation anxiety disorder	1.1	(0.8-1.4)	1.2	(0.9-1.6)	0.9	(0.7-1.2)	1.2	(0.7-2.0)	1.1	(0.7-1.7)
Agoraphobia (w/o panic disorder)	1.8*	(1.4-2.2)	1.6*	(1.2-2.1)	1.9*	(1.5-2.5)	0.8	(0.5-1.4)	1.0	(0.7-1.5)
Generalized anxiety disorder	1.8*	(1.5-2.0)	1.6*	(1.3-1.9)	1.7*	(1.4-2.0)	1.5*	(1.1-2.0)	1.4*	(1.1-1.9)
Panic disorder	3.4*	(2.8-4.0)	2.4*	(1.9-2.9)	3.2*	(2.6-3.8)	1.4	(1.0-2.0)	1.4	(0.9-2.0)
Posttraumatic stress disorder	2.0*	(1.7-2.4)	1.7*	(1.4-2.1)	1.7*	(1.5-2.1)	1.4*	(1.0-2.0)	1.7*	(1.2-2.3)
Social phobia	1.1	(1.0-1.3)	1.2*	(1.0-1.5)	1.1	(1.0-1.3)	1.1	(0.8-1.6)	1.1	(0.9-1.5)
Specific phobia	0.9*	(0.7-1.0)	0.8	(0.7-1.0)	0.9	(0.8-1.1)	0.8	(0.6-1.1)	1.0	(0.8-1.3)
b. Mood										
Bipolar spectrum disorder	1.2	(0.9-1.4)	1.3*	(1.1-1.7)	1.2	(0.9-1.5)	1.2	(0.9-1.7)	0.9	(0.6-1.3)
Dysthymic disorder	1.3*	(1.1-1.6)	1.1	(0.9-1.4)	1.2	(1.0-1.5)	1.1	(0.8-1.6)	0.7	(0.5-1.1)
Major depressive episode	2.2*	(1.9-2.5)	2.4*	(2.0-2.8)	1.9*	(1.7-2.3)	1.2	(0.9-1.7)	1.5*	(1.1-2.1)
c. Substance										
Alcohol abuse or dependence	0.7*	(0.6-0.9)	1.0	(0.8-1.3)	0.6*	(0.5-0.8)	0.7*	(0.4-1.0)	0.9	(0.6-1.4)
Drug abuse or dependence	1.6*	(1.2-2.2)	1.6*	(1.2-2.1)	1.4	(0.9-2.0)	1.0	(0.6-1.8)	1.8*	(1.1-3.0)
χ^2_{12}	506.1*		275.1*		315.1*		39.4*		36.4*	
II. Number of disorders										
4+	0.7*	(0.5-1.0)	0.6*	(0.4-0.9)	0.6*	(0.4-0.9)	1.1	(0.5-2.1)	1.1	(0.6-2.1)
3	1.1	(0.9-1.3)	1.0	(0.8-1.3)	1.0	(0.8-1.2)	1.1	(0.7-1.7)	1.3	(0.9-1.9)
2	1.0	--	1.0	--	1.0	--	1.0	--	1.0	--
χ^2_2	11.0*		11.7*		9.4*		0.1		1.9	
III. Severity of disorders										
Severe	2.4*	(2.1-2.8)	2.9*	(2.4-3.4)	2.1*	(1.8-2.5)	2.0*	(1.5-2.7)	2.4*	(1.8-3.3)
Moderate	1.3*	(1.2-1.5)	1.3*	(1.1-1.6)	1.4*	(1.2-1.6)	1.3	(1.0-1.8)	1.5*	(1.1-2.0)
Mild	1.0	--	1.0	--	1.0	--	1.0	--	1.0	--
χ^2_2	179.6*		186.0*		90.6*		21.3*		36.6*	

*Significant at the .05 level, two-sided test

¹Results are based on multivariable logistic regression models with dummy variables for survey. See the section on Analysis Methods in the text for a discussion of the logic of the models and interpretation of coefficients.

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Table 3. Multivariable associations of socio-demographic characteristics with 12-month treatment of mental disorders overall and within separate service sectors controlling for clinical characteristics among WMH respondents with 12-month DSM-IV/CIDI disorders (n=16,753)¹

	Level of education								χ^2_3	Level of family income								χ^2_3
	Low OR	(95% CI)	Low average OR	(95% CI)	High average OR	(95% CI)	High OR	(95% CI)		Low OR	(95% CI)	Low average OR	(95% CI)	High average OR	(95% CI)	High OR	(95% CI)	
I. Any treatment	0.8*	(0.7-0.9)	0.8*	(0.7-0.9)	0.8*	(0.7-1.0)	1.0	--	17.0*	0.9	(0.8-1.1)	0.9	(0.8-1.0)	0.9	(0.8-1.0)	1.0	--	4.3
II. Specialty mental health care	0.6*	(0.5-0.8)	0.6*	(0.5-0.7)	0.7*	(0.6-0.9)	1.0	--	32.2*	0.8*	(0.7-1.0)	0.8*	(0.7-0.9)	0.8*	(0.7-1.0)	1.0	--	8.0*
III. General medical	1.0	(0.8-1.2)	0.9	(0.8-1.1)	1.0	(0.8-1.2)	1.0	--	0.6	1.0	(0.8-1.1)	0.9	(0.8-1.1)	0.9	(0.8-1.1)	1.0	--	1.3
IV. Human services	0.6*	(0.4-0.8)	0.8	(0.6-1.1)	0.8	(0.6-1.1)	1.0	--	8.9*	1.5*	(1.0-2.1)	1.7*	(1.2-2.4)	1.3	(0.9-1.9)	1.0	--	9.4*
V. CAM	0.4*	(0.3-0.7)	0.7*	(0.5-0.9)	0.7*	(0.5-0.9)	1.0	--	19.7*	1.2	(0.9-1.7)	1.1	(0.8-1.5)	1.1	(0.8-1.6)	1.0	--	1.8

Significant at the .05 level, two-sided test

¹Results are based on multivariable logistic regression models with dummy variables for survey and controls for the clinical variables in Table 2 as well as for respondent age, sex, and marital status. All respondents in the French survey were coded at the mean of education because education was not assessed in the French survey

Table 4. Subgroup associations of respondent education with 12-month treatment of mental disorders overall and in the specialty mental health and general medical sectors based on multivariable models that allowed for interactions of education with disorder severity and country income level controlling for clinical characteristics among WMH respondents with 12-month DSM-IV/CIDI disorders (n=16,753)¹

	Level of education								χ^2_3
	Low		Low-average		High-average		High		
	OR	(95% CI)	OR	(95% CI)	OR	(95% CI)	OR	(95% CI)	
I. Any treatment									
A. Lower-middle-income countries									
Severe	2.0	(1.0-4.1)	1.2	(0.6-2.3)	1.4	(0.7-2.9)	1.0	--	4.1
Moderate	0.9	(0.5-1.9)	1.4	(0.8-2.8)	0.8	(0.4-1.5)	1.0	--	4.0
Mild	0.5	(0.2-1.1)	0.7	(0.3-1.6)	0.6	(0.3-1.3)	1.0	--	3.1
B. Upper-middle-income countries									
Severe	0.7	(0.4-1.4)	0.7	(0.4-1.2)	0.9	(0.6-1.6)	1.0	--	2.2
Moderate	0.8	(0.4-1.5)	0.7	(0.4-1.2)	0.7	(0.4-1.3)	1.0	--	2.3
Mild	0.7	(0.4-1.4)	0.8	(0.4-1.4)	0.9	(0.6-1.5)	1.0	--	1.5
C. High-income countries									
Severe	0.5*	(0.4-0.7)	0.7*	(0.5-1.0)	0.9	(0.7-1.2)	1.0	--	17.2*
Moderate	0.7*	(0.5-0.9)	0.8*	(0.6-1.0)	0.8*	(0.6-1.0)	1.0	--	9.9*
Mild	1.4	(1.0-1.9)	0.8	(0.6-1.1)	0.9	(0.7-1.2)	1.0	--	9.2*
II. Specialty mental health treatment									
Total	0.6*	(0.5-0.8)	0.6*	(0.5-0.8)	0.7*	(0.6-0.9)	1.0	--	31.7*
III. General medical treatment									
Total	1.0	(0.8-1.2)	1.0	(0.8-1.1)	1.0	(0.9-1.2)	1.0	--	0.4

¹Significant at the .05 level, two-sided test

¹Results are based on three multivariable logistic regression models, one for each type of treatment. In each model, subgroup coding was used to estimate associations of education with the outcome in subgroups where the education-treatment outcome was found to be statistically different from in other subgroups. All models included dummy variables for survey, controls for the clinical variables in Table 2, and controls for respondent age, sex, marital status, and family income along with any significant interactions of income with disorder severity and country income level. All respondents in the French survey were coded at the mean of education because education was not assessed in the French survey.

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Table 5. Subgroup associations of respondent family income with 12-month treatment of mental disorders overall and in the specialty mental health and general medical sectors based on multivariable models that allowed for interactions of education with disorder severity and country income level controlling for clinical characteristics among WMH respondents with 12-month DSM-IV/CIDI disorders (n=16,753)¹

	Level of family income				χ^2_3
	Low OR (95% CI)	Low-average OR (95% CI)	High-average OR (95% CI)	High OR (95% CI)	
I. Any treatment					
A. Lower-middle-income countries					
Severe	0.4* (0.2-0.8)	0.2* (0.1-0.4)	0.4* (0.2-0.7)	1.0 --	20.1*
Moderate	0.5* (0.2-0.9)	0.8 (0.4-1.6)	1.0 (0.5-1.9)	1.0 --	7.4
Mild	1.6 (0.7-3.6)	1.0 (0.4-2.1)	0.8 (0.4-1.9)	1.0 --	2.5
B. Upper-middle-income countries					
Severe	0.7 (0.4-1.1)	1.0 (0.6-1.6)	1.0 (0.6-1.6)	1.0 --	4.0
Moderate	0.9 (0.5-1.5)	1.0 (0.6-1.7)	0.8 (0.5-1.3)	1.0 --	1.9
Mild	1.8* (1.1-3.0)	0.7 (0.4-1.2)	1.3 (0.8-2.3)	1.0 --	14.9*
C. High-income countries					
Severe	1.0 (0.7-1.4)	1.2 (0.8-1.6)	0.8 (0.6-1.1)	1.0 --	6.4
Moderate	0.9 (0.7-1.2)	0.9 (0.7-1.2)	1.0 (0.8-1.3)	1.0 --	1.7
Mild	1.0 (0.7-1.4)	0.8 (0.6-1.1)	0.8 (0.6-1.1)	1.0 --	4.5
II. Specialty mental health (by severity regardless of country income level)					
Severe	0.7 (0.3-1.4)	0.5* (0.3-0.8)	0.4* (0.2-0.7)	1.0 --	10.9*
Moderate	0.7 (0.4-1.4)	0.4* (0.3-0.8)	0.5* (0.3-0.8)	1.0 --	11.2*
Mild	0.9 (0.4-1.9)	0.3* (0.2-0.5)	0.4* (0.2-0.7)	1.0 --	20.2*
III. General medical treatment					
A. Lower-middle-income countries					
Severe	0.6 (0.3-1.3)	0.5 (0.2-1.0)	0.9 (0.3-2.6)	1.0 --	4.5
Moderate	0.4* (0.2-0.8)	0.5 (0.3-1.0)	0.8 (0.4-1.7)	1.0 --	8.8*
Mild	0.4* (0.2-0.9)	0.2* (0.1-0.8)	0.3* (0.1-0.9)	1.0 --	11.0*
B. Upper-middle-income countries					
Severe	0.6 (0.4-1.1)	1.4 (0.8-2.6)	0.8 (0.5-1.5)	1.0 --	4.8
Moderate	0.8 (0.5-1.3)	1.4 (0.8-2.2)	0.6 (0.4-1.1)	1.0 --	6.7
Mild	1.7* (1.1-2.5)	0.5 (0.3-1.0)	0.9 (0.5-1.5)	1.0 --	15.1*
C. High-income countries					
Severe	1.8* (1.4-2.3)	2.0* (1.6-2.6)	1.5* (1.2-2.0)	1.0 --	44.3*
Moderate	1.0 (0.8-1.3)	1.0 (0.8-1.2)	1.1 (0.9-1.3)	1.0 --	1.0
Mild	0.8 (0.6-1.1)	0.6* (0.5-0.8)	0.7* (0.5-0.9)	1.0 --	18.3*

¹Significant at the .05 level, two-sided test

¹Results are based on three multivariable logistic regression models, one for each type of treatment. In each model, subgroup coding was used to estimate associations of family income with the outcome in subgroups where the income-treatment outcome was found to be statistically different from in other subgroups. All models included dummy variables for survey, controls for the clinical variables in Table 2, and controls for respondent age, sex, marital status, and respondent education along with any significant interactions of education with disorder severity and country income level. All respondents in the French survey were coded at the mean of education because education was not assessed in the French survey

Appendix Table 1. WMH sample characteristics by World Bank income categories^a

Country by income category	Survey ^b	Sample characteristics ^c	Field dates	Age range	Sample size			Response rate ^e
					Part I	Part II	Part II and age ≤ 44 ^d	
I. Low and lower middle income countries								
Colombia	NSMH	All urban areas of the country (approximately 73% of the total national population)	2003	18-65	4,426	2,381	1,731	87.7
Iraq	IMHS	Nationally representative.	2006-7	18-96	4,332	4,332	--	95.2
Nigeria	NSMHW	21 of the 36 states in the country, representing 57% of the national population. The surveys were conducted in Yoruba, Igbo, Hausa and Efik languages.	2002-3	18-100	6,752	2,143	1,203	79.3
PRC ^f - Beijing/Shanghai	B-WMH/S-WMH	Beijing and Shanghai metropolitan areas.	2002-3	18-70	5,201	1,628	570	74.7
PRC ^f - Shenzhen ^g	Shenzhen	Shenzhen metropolitan area. Included temporary residents as well as household residents.	2006-7	18-88	7,132	2,475	--	80.0
Peru	EMSMP	Five urban areas of the country (approximately 38% of the total national population).	2004-5	18-65	3,930	1,801	1,287	90.2
Ukraine	CMDPSD	Nationally representative.	2002	18-91	4,725	1,720	541	78.3
TOTAL					(36,498)	(16,480)	(5,332)	82.2
II. Upper-middle income countries								
Brazil - São Paulo	São Paulo Megacity	São Paulo metropolitan area.	2005-7	18-93	5,037	2,942	--	81.3
Bulgaria	NSHS	Nationally representative.	2003-7	18-98	5,318	2,233	741	72.0
Colombia - Medellín ^h	MMHHS	Medellin metropolitan area	2011-12	19-65	3,261	1,673		97.2
Lebanon	LEBANON	Nationally representative.	2002-3	18-94	2,857	1,031	595	70.0
Mexico	M-NCS	All urban areas of the country (approximately 75% of the total national population).	2001-2	18-65	5,782	2,362	1,736	76.6
Romania	RMHS	Nationally representative.	2005-6	18-96	2,357	2,357	--	70.9
South Africa ^g	SASH	Nationally representative.	2003-4	18-92	4,315	4,315	--	87.1
TOTAL					(28,927)	(16,913)	(3,072)	78.5
III. High-income countries								
Belgium	ESEMeD	Nationally representative. The sample was selected from a national register of Belgium residents	2001-2	18-95	2,419	1,043	486	50.6
France	ESEMeD	Nationally representative. The sample was selected from a national list of households with listed telephone numbers.	2001-2	18-97	2,894	1,436	727	45.9
Germany	ESEMeD	Nationally representative.	2002-3	19-95	3,555	1,323	621	57.8
Israel	NHS	Nationally representative.	2002-4	21-98	4,859	4,859	--	72.6
Italy	ESEMeD	Nationally representative. The sample was selected from municipality resident registries.	2001-2	18-100	4,712	1,779	853	71.3
Japan	WMHJ 2002-2006	Eleven metropolitan areas.	2002-6	20-98	4,129	1,682	--	55.1
Netherlands	ESEMeD	Nationally representative. The sample was selected from municipal postal registries.	2002-3	18-95	2,372	1,094	516	56.4
New Zealand ^g	NZMHS	Nationally representative.	2003-4	18-98	12,790	7,312	--	73.3
N. Ireland	NISHS	Nationally representative.	2004-7	18-97	4,340	1,986	--	68.4
Poland	EZOP	Nationally representative	2010-11	18-65	10,081	4,000	2,276	50.4

Portugal	NMHS	Nationally representative.	2008-9	18-81	3,849	2,060	1,070	57.3
Spain	ESEMeD	Nationally representative.	2001-2	18-98	5,473	2,121	960	78.6
Spain - Murcia	PEGASUS- Murcia	Murcia region. Regionally representative.	2010-12	18-96	2,621	1,459	--	67.4
United States	NCS-R	Nationally representative.	2002-3	18-99	9,282	5,692	3,197	70.9
TOTAL					(73,376)	(37,846)	(10,706)	62.9
IV. TOTAL					(138,801)	(71,239)	(19,110)	70.1

Appendix Table 2. Within-survey distributions and associations (polychoric correlations) between level of education and level of family income among WMH respondents with 12-month DSM-IV/CIDI disorders (n = 16,753) 818

	Level of education ¹				Level of family income ²				r ³
	Low % (SE)	Low- average % (SE)	High % (SE)	High- average % (SE)	Low % (SE)	Low- average % (SE)	High % (SE)	High- average % (SE)	
I. Lower-middle income countries									
Colombia	30.0 (2.5)	29.3 (2.6)	19.5 (1.6)	21.2 (2.5)	35.2 (2.9)	24.8 (2.8)	16.6 (1.9)	23.3 (2.7)	0.405*
Iraq	20.6 (3.2)	36.9 (3.8)	32.5 (3.2)	10.1 (1.8)	27.0 (3.0)	24.8 (2.8)	23.1 (2.7)	22.7 (3.9)	0.269*
Nigeria	19.5 (3.7)	21.3 (4.6)	43.1 (4.6)	16.1 (4.5)	39.7 (5.4)	15.7 (3.5)	18.6 (4.5)	26.0 (4.2)	0.284*
PRC-Beijing/Shanghai	16.4 (5.6)	21.1 (3.8)	39.7 (5.3)	22.8 (5.0)	21.4 (4.4)	33.9 (6.0)	27.4 (5.2)	17.3 (4.5)	0.328*
PRC-Shenzhen	1.9 (0.8)	19.6 (3.0)	40.6 (3.9)	37.9 (3.1)	29.9 (2.9)	18.8 (2.4)	21.6 (2.9)	29.7 (3.9)	0.389*
Peru	13.4 (1.8)	11.0 (2.0)	58.9 (3.1)	16.6 (2.8)	37.3 (2.6)	21.1 (2.4)	20.0 (2.4)	21.5 (3.8)	0.519*
Ukraine	17.3 (2.4)	52.9 (2.7)	14.6 (2.7)	15.2 (2.3)	18.2 (2.3)	35.2 (2.9)	34.5 (2.8)	12.1 (2.5)	0.192*
Overall	19.4 (1.2)	31.3 (1.3)	31.0 (1.3)	18.3 (1.0)	29.5 (1.2)	26.1 (1.2)	22.9 (1.1)	21.5 (1.4)	0.324*
II. Upper-middle income countries									
Brazil-Sao Paulo	24.2 (1.6)	24.7 (1.5)	35.4 (1.8)	15.6 (2.0)	25.3 (1.8)	27.3 (2.0)	23.8 (1.7)	23.6 (2.6)	0.419*
Bulgaria	10.3 (2.1)	23.0 (3.0)	41.8 (4.0)	25.0 (4.3)	16.9 (2.1)	30.2 (3.3)	27.6 (3.1)	25.3 (4.4)	0.389*
Colombia-Medellin	2.1 (0.6)	22.2 (2.4)	48.0 (3.0)	27.8 (2.9)	41.7 (3.0)	18.1 (2.3)	20.8 (2.4)	19.5 (2.5)	0.211*
Lebanon	21.2 (4.8)	33.4 (3.9)	28.7 (5.0)	16.7 (3.3)	29.0 (4.2)	21.7 (4.2)	17.1 (4.8)	32.2 (4.5)	0.240*
Mexico	20.7 (2.3)	23.0 (2.2)	29.5 (2.4)	26.7 (2.8)	29.9 (2.8)	27.3 (2.2)	19.4 (1.8)	23.4 (2.0)	0.393*
Romania	10.9 (2.2)	21.1 (2.6)	51.9 (3.1)	16.1 (2.9)	32.0 (4.5)	17.0 (3.7)	20.9 (3.3)	30.1 (4.5)	0.234*
South Africa	6.1 (1.1)	23.1 (2.1)	54.7 (2.4)	16.2 (2.0)	41.7 (3.2)	10.2 (1.3)	11.6 (1.7)	36.4 (3.3)	0.329*
Overall	14.4 (0.8)	24.0 (0.8)	42.3 (1.1)	19.3 (0.9)	31.8 (1.0)	21.1 (0.8)	19.5 (0.9)	27.7 (1.1)	0.313*
III. High income countries									
Belgium	10.0 (2.3)	13.1 (2.8)	49.4 (5.3)	27.4 (4.3)	22.5 (4.6)	25.7 (3.4)	36.4 (5.1)	15.4 (2.6)	0.127*
France	-- --	-- --	-- --	-- --	30.0 (4.4)	31.5 (3.7)	24.1 (2.7)	14.4 (2.9)	--
Germany	23.5 (4.2)	32.1 (4.8)	39.5 (6.4)	4.9 (2.4)	26.1 (3.9)	28.5 (4.0)	30.7 (3.6)	14.8 (2.6)	-0.030
Israel	27.4 (2.1)	40.6 (2.4)	12.6 (1.6)	19.4 (1.9)	32.4 (2.3)	27.9 (2.2)	27.9 (2.1)	11.9 (1.5)	0.399*
Italy	31.9 (4.3)	17.1 (2.7)	33.6 (3.5)	17.4 (3.4)	22.6 (3.4)	25.6 (2.7)	32.8 (3.8)	19.0 (4.2)	0.184*
Japan	15.4 (2.4)	29.9 (3.5)	28.2 (3.7)	26.5 (4.1)	31.1 (3.9)	24.1 (3.3)	31.1 (3.5)	13.7 (2.1)	-0.023
Netherlands	23.8 (3.9)	41.4 (4.5)	9.7 (1.8)	25.1 (3.4)	30.8 (5.6)	25.0 (3.3)	30.6 (3.6)	13.5 (2.5)	0.366*
New Zealand	19.7 (1.1)	22.7 (1.0)	29.5 (1.3)	28.1 (1.4)	26.2 (1.4)	30.5 (1.2)	28.2 (1.3)	15.1 (1.0)	0.261*
Northern Ireland	4.7 (1.0)	9.5 (1.6)	70.9 (2.7)	14.8 (2.1)	28.6 (2.8)	25.2 (2.9)	25.4 (1.9)	20.9 (3.0)	0.153**
Poland	10.9 (1.6)	3.5 (1.1)	67.7 (2.2)	17.9 (2.0)	41.5 (2.6)	12.9 (1.6)	24.1 (2.0)	21.6 (2.0)	0.217**
Portugal	20.9 (1.6)	33.0 (2.0)	26.7 (2.2)	19.5 (1.7)	31.3 (2.4)	16.8 (1.8)	25.5 (2.7)	26.5 (2.3)	0.357**
Spain	22.0 (3.1)	34.1 (4.4)	16.8 (2.7)	27.1 (4.6)	24.5 (4.5)	26.0 (4.6)	30.9 (3.9)	18.6 (3.2)	0.219**
Spain-Murcia	23.0 (3.3)	35.2 (4.0)	21.5 (2.8)	20.3 (3.8)	31.2 (4.2)	32.3 (3.1)	25.0 (2.8)	11.5 (2.4)	0.198**
USA	18.4 (1.3)	32.9 (2.3)	29.0 (1.3)	19.7 (1.5)	30.3 (1.7)	25.4 (1.2)	26.0 (1.4)	18.3 (1.4)	0.434**
Overall	18.0 (0.5)	25.5 (0.7)	35.7 (0.7)	20.7 (0.6)	29.5 (0.7)	26.0 (0.6)	27.3 (0.7)	17.2 (0.5)	0.280**
Total	17.4 (0.4)	26.1 (0.5)	36.6 (0.6)	19.9 (0.5)	30.1 (0.5)	24.8 (0.5)	24.5 (0.5)	20.6 (0.5)	0.295**

*Significant at the .05 level, two-sided test

¹See the text for a description of the coding rules for the categorical measures of education and income.

²Polychoric correlations

³All respondents in the French survey were coded at the mean value of the education distribution across other surveys because education was not assessed in the French survey.