

Global barriers to provision and utilization of mental health services: a systematic scope study

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Abstract

Background Mental Health (MH) is an important part of community well-being and a remarkable portion of global burden of diseases is related to mental disorders. Despite this fact, little attention has been given to the provision of adequate and appropriate MH services and improving equitable access to these services in some parts of the world. This review was aimed to identify main global barriers to provision and utilization of MH services.

Methods We carried out a systematic and comprehensive search on 7 important online databases for English-language literature on global barriers to provision and utilization of MH services applying Arksey and O'Malley guideline. The extracted materials were tabulated and synthesized using a content analysis approach.

Results Three main themes were developed regarding the barriers to provision of MH services including resource and administrative barriers, information and knowledge barriers, as well as policy and legislation barriers. Five frequent barriers to utilization of MH services were attitudinal barriers, structural barriers, knowledge barriers, treatment-related barriers, and family-related barriers as well.

Conclusions It is suggested that, improvement of public knowledge regarding MH, reallocation of health resources toward high-priority MH needs, developing community-based insurance, as well as integration of MH services into all levels of health-care systems and MH policy into general health policy could be considered as effective strategies to tackling the challenges especially in low- and middle-income countries. Further study is also needed for determining relative importance of the barriers and the related solutions in this regard.

Background

Mental health (MH) is a leading determinant of people's overall well-being(1). Mental disorders are founded to be among the main causes of non-fatal burden of diseases in the world(2), so that the burden of mental illnesses has become a great public health concern(3). Studies on global burden of disease show that more than 5 percent of Disability Adjusted Life Years (DALYs) and up to 15.7 percent of Years Lived with Disability (YLDs) in the world are associated with the mental disorders(4). Also economics-related health studies estimated that the global cost of mental disorders in 2010 was equal to \$2.5 trillion, and it was predicted that in 2020 the cost will increase to more than \$6 trillion(5).

Despite the increasing trend of global burden of mental illnesses, the problem has not been regarded appropriately like physical diseases and has been neglected largely in many parts of the world(6–8). This defect leads to limited, inadequate, and inequitable provision of MH services (6), and would expand treatment gap. This widening gap causes many health, social, and economic complications(9). Studies have shown that key barriers to provision of MH services include problems related to information system(10, 11), economic and resource barriers(12, 13), defects in evidence-based policy and practice, (14) as well as prevention, integration, and structural barriers(14–16).

In addition to the provision of MH services, utilization of these services has a significant effect on MH condition of the community. Utilization of MH services is influenced by several factors(17). Studies have identified several barriers to utilization of MH services, such as stigma(18–20), transportation problems(21–23), cost of services(22, 24, 25), and information barriers(13, 17, 19).

Identifying barriers to utilization and provision of MH services is essential for evidence-based planning, priority setting in resource allocation, and finally reducing burden of mental disorders(22). Although various reports including research and review studies have investigated barriers to utilization and provision of MH services, based on our searches, there is not any comprehensive study in which these two types of barriers have been investigated simultaneously. Therefore, this review scopes studies on barriers to utilization and provision of MH services in the world in order to summarize, categorize and then discuss about each of the barriers that have extracted from the reviewed reports.

Methods

The main objective of this scoping review was to map the literature about global barriers to utilization and provision of mental health services simultaneously. We have used scoping review because this method allows inclusion of literatures with heterogeneous designs and samples, and despite of the systematic review, quality assessment of each study is not considered as inclusion criteria(26).

In this regards, we used scoping review approach developed by Arksey and O'Malley(26). This methodology is consisted of five distinctive stages: 1- Identifying research question, 2- Finding the relevant studies, 3- Selecting relevant studies, 4- Charting the data, as well as 5- Collating, summarizing and reporting the results.

Identifying the question

Although research question determines scope of the study, but scoping review has an iterative process, therefore the research question of the study is developed gradually through the literature review process. Outcome of interest in our study was barriers to MH services recognized by providers and patients all around the world. In this study, general population was considered as care receivers and in the provider side, all levels from individual caregivers to policy sectors were included. Therefore, this study aimed to answer to this question: 'what are the global barriers to utilization and provision of MH services?'

Finding the relevant studies

Before carrying out a comprehensive review, we searched Cochrane database to ensure that there is no similar review. In order to find relevant studies, we conducted a systematic search on databases such as Science direct, Web of Science, ProQuest, Wiley online library, Scopus, Embase, and PubMed. We searched these databases for the studies and reviews published from 2000 to June 2018. We have

included studies which had at least an abstract in English. We determined three categories of search term through an initial literature review and then we refined and completed categories during the systematic search process. Search terms in each category were combined using logical operator 'OR' and the categories were merged applying logical operator 'AND'. The search strategy of the study is shown in table 1. Using this search strategy, we have retrieved 66833 researches and review papers. After removing duplicates, 52131 papers were entered into assessment phase. We used EndNote manager software (EndNote X7.1 version, by Thomson Reuters) to manage citations.

Selecting relevant studies

For selecting the studies that were relevant to the research question, we carried out an iterative three-step peer review process, so that in each phase we refined the search strategy, searched literature, and reviewed new papers. At the first step, title of papers were screened by two reviewers independently based on outcome of interest. In this step, 10324 papers were included for further assessment. After excluding irrelevant titles, abstract of remained papers were reviewed by two reviewers and those that did not meet the aim of the study were removed and 152 papers were selected for more scanning. Finally, 2 reviewers scanned full-text papers and 49 studies were selected for analysis. In all steps of selection phase, cases of disagreement were reviewed by a third reviewer for final inclusion. In order to get more familiar with all parts of the research process, two reviewers involved in a pilot project prior to the implementation of main study. Figure 1 shows the process of paper selection for this study in the form of a PRISMA flowchart.

Charting the data

We applied a qualitative content analysis approach for charting the data. We developed a data-charting form to extract relevant data from included papers. In this regards two reviewers carried out the charting jointly through an iterative process, so that they extracted data and updated the data-charting form continuously.

Collating and summarizing the data

We analyzed extracted data using a qualitative thematic analysis. In the first step of thematic analysis, we became familiar with the data through reading and re-reading the full-text papers. Then we identified preliminary codes based on research question and outcome of interest. In the third step, we conducted an interpretive analysis of the initial codes and organized them into wider themes. Reviewing themes was the next step. In this regards, we carried out a deeper review on the identified themes in order to combine, refine, separate, or discard initial themes if it was necessary. In the final step, we defined and labeled themes and their related subthemes in terms of relevancy of the contents then, the themes were derived from the initial codes.

Results

Table 2 indicates barriers to provision of MH services. The main categories for barriers to service provision were resource and administrative barriers, information and knowledge barriers, as well as policy and legislation barriers. The most frequent barriers to provision of MH services were insufficient resources, low level of priority regarding mental health in public policy, centralized and non-integrated services, and lack of developing evidence-based service respectively.

We tabulated barriers to utilization of MH services in two tables. Table 3 is consisted of information about barriers for utilizing MH services among adult patients. Categories represented in this table include attitudinal barriers, structural barriers, knowledge barriers, and treatment-related barriers. The most frequent barriers to utilization of MH services among adult patients were service costs, concern about social stigma, Lack of information about available services, location, distance and transportation, and lack of recognizing the problem respectively.

We have also represented information on barriers to utilization of MH services among children and adolescents in a separate table. Main categories presented in table 4 are attitudinal barriers, structural barriers, knowledge barriers, and family-related barriers. The most frequent barriers to utilization of MH services among children and adolescents were location, distance and transportation, time concerns, service costs, social and personal stigma, and lack of information about available services respectively.

Discussion

This review was carried out to determine barriers to provision and utilization of MH services. We included evidences from all over the world to provide a more comprehensive perspective on the issue. Based on our knowledge, this is the first scoping review that investigates the challenges concerning MH services utilization and provision simultaneously. About 35 percent (n: 17) of selected papers were reviews and reports of international studies. Twenty papers (62.5%) were original studies which were qualitative researches and 53.1 percent (n: 17) of them were carried out in low- and middle-income countries.

We studied barriers in both service-level and patient-level to have a better understanding of the problems recognized in MH services. We divided Patient-level barriers into two categories including adults as well as children and adolescents. Since some mental disorders occurring in adulthood come from the early decades of the life and due to the importance of preventive MH services among children and adolescents, we focused on this group separately. In this section, we discussed the findings of the study based on each category and their related sub-categories. Due to the publishing-related limitations, we focused especially on the most frequent barriers.

- Barriers to provision of MH services

A-1- Resource and administrative barriers

A-1-1- Insufficient resources

The findings of this review indicate that insufficient resources allocated to MH services was the most frequent barrier to provision of MH services (12–14). Scarcity of resources is a major problem of health systems in many countries especially in low- and middle-income ones(11). Insufficiency of resources for providing MH services is related to inadequate financial resources, shortage of medicine(15), and lack of enough staff particularly at the primary level(27). Countries that are faced with shortage of financial resources in mental health have to reallocate resources in order to meet their high priority needs in mental health(14). Furthermore, effectiveness regarding using existing financial resources should be assured for provision of sustainable MH services(28).

Human resources are the core component for provision of MH services. Insufficiency of human resources may occur at both primary and special level(27). At the primary level, delivery of MH services is focused mainly on non-specialist workers(14). Generally, Shortage of MH staff at this level is due to the limited number of educated workforces and unbalanced distribution of existing resources inside the country(29). At the special level most challenges in terms of shortage of MH workforces are related to rural-to-urban movement(27) and migration to the countries with possible higher income(30). An effective policy and planning is necessary for provision of MH human resources –especially in low-income and middle-income countries– for training adequate and qualified workforces, retaining them, and distributing the sources equitably(27).

Shortage of mental health medicines is considered as a great challenge in some countries(31). Countries that are facing with this problem have to improve management of pharmaceutical supply chain in order to provide low-cost drugs with the highest possible quality (11, 13). Moreover, in countries with severe limitation of resources, redistribution of financial resources is necessary for procurement of essential mental health medicines(11).

A-1-2- Centralized and non-integrated services

One of the leading barriers to provision of MH services in many countries is that these services are usually not integrated into Primary Health Care (PHC) and a major proportion of service facilities is located in the capital of countries and at the center of provinces(16, 32). The main challenges of integrating MH services into PHC are lack of adequate infrastructures, insufficient MH human resources, and absence of appropriate initiatives in this regard (33, 34). Multi-dimensional interventions that are aimed at integrating MH services into PHC should be implemented at three leading areas including health care organization, service delivery facilities, and society context(33).

A-1-3- Inappropriate service types

Provision of appropriate MH services is a concern for health systems. In some cases, existing services are not in accordance with the community needs(15, 35). Appropriateness of the provided services is related

to many factors such as level of services (preventive or therapeutic)(16), type of services (inpatient or outpatient)(35), target population (Adults or children)(36), and location and time of service delivery(10, 15). Health systems should provide appropriate MH services for people by allocating resources incongruence with the community needs(10).

A-2- Information and knowledge barriers

A-2-1- lack of developing evidence-based service

Lack of appropriate evidence is considered as a challenge for scale-up of MH services(16). This problem worsens the condition which is known as “mental health treatment gap”. Therefore, health systems—especially in low-income and middle-income countries— have an obligation to put the best evidence at the core of MH policy, planning, and practice in order to ensure development of adequate, appropriate, and locally relevant services(32).

A-2-2- Imperfect mental health information system

Information system is considered as a substantial building block of health care systems by World Health Organization(37), and it is obvious that evidence-based health policy and planning is dependent on an efficient information system fundamentally (38). Shortage of financial resources and lack of skillful human resources are the basic challenges regarding developing MH information system in some parts of the world(39). Governments have to increase investments in implementation and maintenance of MH information system. Involvement of all stakeholders such as clinicians, health workers, and managers is necessary for better development and adoption of the system(38).

A-3- Information and knowledge barriers

A-3-1- Low level of priority of mental health in health policy

This study indicates that low level of priority of MH in health policy is a great challenge of provision of MH services in some countries. Although high-income countries have had significant achievements in MH policy and practice,(31) but importance of MH as an integrated part of health policy has not been recognized properly yet in many poorer countries.(14) This problem necessitates the development of a comprehensive and evidence-based MH policy in Low- and middle-income countries. Formulation of MH policy should be based on real needs of the community and governments should have adequate commitment to implementation of the policy in all care levels.(13) National MH policies must be formulated according to the condition of each country and it is necessary to develop compound indicators for assessment of policy at all levels from the adoption of policy to the implementation and practice.(14)

- Barriers to utilization of MH services

B-1- Attitudinal barriers

B-1-1- Concerns about social stigma

Based on the findings of this review, the main attitudinal obstacle to utilization of MH services among both adults and children is the concern about being stigmatized by others. A large body of studies has reported that fear of being stigmatized prevented people from seeking MH services.(18, 22, 40-43) One of the effective strategies to reduce stigmatization is providing concrete information about mental disorders for people. (44) Other efficient strategy for reducing stigma is face to face contact between community individuals and people with mental disorders.(45) However, these strategies should be adapted and used according to the specific moderators of each situation.(46) Moreover, it is suggested that developing some anti-stigma campaigns would be helpful.(20)

B-1-2- Concerns about Effectiveness of services

This study indicates that the second frequent barrier to utilization of MH services, among both children and adults, is concern about effectiveness of services. Patients who think that MH service would not help them are less likely to seek and utilize these services.(19, 20, 43, 47) Undesirable experience of treatment could be considered as the main reason that patients are recognized as a concern about the effectiveness of services.(22) Furthermore, patients tendency towards alternative types of treatment may make them to become pessimistic about the specialized services.(19, 48) According to these reasons, it seems that improving the quality of mental health services and increasing public knowledge about these services can be effective in removing or modifying the barrier.

B-1-3- Personal stigma and shame

According to the findings of current review, self-stigma and embarrassment is the third attitudinal barrier to utilization of MH services. Self-stigma is related to the negative internalized perceptions and beliefs about MH status. This feeling can result in shame and accordingly reduces willingness to seek MH services.(49) Because negative personal attitudes toward mental health is regarded as the leading cause of this barrier, educating patients and specially children can be effective in alleviating the problem.(18) being supported by groups of peer who have controlled the problem successfully (50) and self-empowerment(51) are suggested as other strategies for tackling self-stigma.

B-2- Structural barriers

B–2–1- Cost of services

Results of this study indicate that cost of MH services is the most frequent structural barriers among adults and is in the second place among children and adolescents. It has been reported that in some parts of the world especially in low- and middle-income countries, cost of MH services is not affordable. (11, 48) The highest expenditures are related to medications and treatment services. (52) Cost of MH services is also related to the economic losses due to the reduced productive capacity of patients and their family(53). Some of the main reasons for this problem are lack of insurance coverage(22), imperfect coverage(54), and unaffordable insurance premium(55). In order to reduce direct costs of treatment, It is suggested that countries have to develop initiatives to introduce or improve community-based health insurance schemes(56).

B–2–2- Location, distance and transportation barriers

Location of MH care facilities and difficulties in transportation are among the most frequent structural barriers to the utilization of services. Geographical distance from service facilities, especially in rural areas, has a significant effect on the access to MH care in low- and middle-income countries(57). In addition to the limited transportation capacity, cost of transportation– as an indirect care cost– is also associated with limited access to MH services(53). It is suggested that integrating MH services into primary health care system can reduce access barriers(21).

B–3- Knowledge barriers

B–3–1- Lack of information about available services

This study indicates that lack of information about availability of services is the most important knowledge barrier to utilization of MH services. Results of MH survey conducted by WHO globally indicated that lack of knowledge about the appropriate existing services was a great barrier to utilization (22). Information about available MH services should be disseminated largely in order to help people seeking treatment(58).

B–3–2- Lack of recognition of the problem

Lack of recognition of mental problem by patients and their families is a notable deterrent against utilization of MH services. Identification of the problem is an essential prerequisite for help-seeking and accordingly utilization of MH services(40). Recognition of the problem is related to patients' knowledge about the nature of their mental disorder, symptoms of the disease, and severity of the problem(59). Therefore, it could be presumed that—in the absence of attitudinal obstacles—more severe cases of disorders are more likely to be identified and treated(60). Furthermore, lack of recognition of child's

mental problems by their parents is a substantial barrier to utilization of MH services among children and adolescents. It could be suggested that improving public awareness about MH disorders and their symptoms, especially mild and moderate types, can be a great help for alleviating the barrier.

B-4- Treatment-related barriers

B-4-1- Treatment side-effects

It was found that experiencing adverse effects of past treatment, especially related to medications, plays a role as a barrier against service utilization. Low level of awareness of patients about necessity of persistent care and adverse effects of medications are great challenges which discourage them to receive care and decrease adherence to treatment(56, 61). Educating patients about treatment choices and their potential side effects is considered as an effective strategy to solve this problem(23).

Conclusions

Provision of MH services in the world is subjected to some barriers including resource and administrative barriers, information and knowledge barriers, as well as policy and legislation barriers. These were major challenges which have been discussed in all types of the literature. Reallocation of resources, especially in low- and middle-income countries, in favor of high-priority MH services could be considered as an effective strategy. Another effective approach involves improvement of MH information system in order to provide high-quality evidences for policy and practice.

Main global barriers to utilization of MH services were also identified through reviewing the literature. The most dominant challenges include attitudinal barriers, structural barriers, knowledge barriers, treatment-related barriers, and family-related barriers. It has been discussed largely that improvement of public knowledge about MH disorders and the related symptoms, treatment choices, related side effects, and available services could be helpful to alleviate some problems. There is an obvious need for appropriate financing and developing community-based insurance with a special respect to MH in order to address the increasing MH problems in low- and middle-income countries. Integrating MH services into all levels of health-care systems and also MH policy into general health policy could be a great help in developing a comprehensive and client-oriented approach for MH care.

Study Limitations

Including papers with various types of study and different design methods makes it infeasible to appraise their quality in a meticulous and coherent way. Although the quality of studies was different, but a scoping review is not comprised of an approach regarding the quality assessment approach(26). Moreover, access to all relevant studies is dependent on spread contributors that increases potentiality of missing some evidences. However, we tried our best to review all studies in relation to challenges of

provision and utilization of MH services. Another limitation of the study is that we discussed the results according to the frequency of barriers and it does not indicate their relative importance. Therefore, further studies should be conducted in this regard.

Declarations

Abbreviations

MH: Mental Health

DALYs: Disability Adjusted Life Years

YLDs: Years Lived with Disability

PHC: Primary Health Care

Ethics approval and consent to participate

The study's proposal is approved by ethics committee affiliated with Shiraz University of Medical Sciences with the ID of SUMS-97-01-07-18586

- Consent for publication

Not applicable

Availability of data and material

All data in a form of data extraction sheets are available from the corresponding author on reasonable request.

- Competing interests

All authors declare that they have no conflict of interest regarding this study.

- Funding

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- Authors' Contributions

PB, ZK, RR, and YS designed the study. YS, MK, and PB scanned the titles, reviewed the abstracts and appraised the full-texts papers. YS and PB wrote the present paper. PB, ZK, and RR revised the manuscript critically. All authors have read and approved the manuscript for final submission.

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Tables

Table 1 Search strategy for barriers to provision and utilization of MH Services

#1 AND #2 AND #3	Strategy
“Mental health” OR “mental health care” OR “mental health services” OR “mental illnesses” OR “mental disorder” OR “mental diseases” OR psychiatry OR psychology OR psychiatric	#1
Delivery OR provision OR providing OR utilization OR use OR usage OR access OR accessibility	#2
Challenges OR problems OR shortcomings OR barriers OR deficits OR obstacles	#3

Table 2 Barriers to provision of MH services

Categories and sub-categories	Frequency (references)
Resource and administrative barriers	
Insufficient resources	14 (10-15, 23, 31, 35, 48, 55, 62-64)
Centralized and non-integrated services	7 (10, 12-14, 16, 18, 64)
Inappropriate service types	5 (10, 13, 15, 35, 36)
Geographical imbalance in resource allocation	5 (10-13, 48)
Insufficient preventive services	4 (14, 16, 36, 64)
Lack of administrative coordination	4 (10, 11, 18, 55)
Weakness of quality assurance schemes	3 (11, 23, 36)
Information and knowledge barriers	
lack of evidence-based service development	6 (10, 11, 13, 16, 36, 62)
Imperfect mental health information system	4 (11, 13, 18, 38)
Inappropriate training of providers	3 (23, 31, 62)
Lack of cross-cultural understanding between patients and care givers	1 (23)
Policy and legislation barriers	
Low priority of mental health in health policy	9 (10-14, 31, 62-64)
Lack of evidence-based policy making	4 (11, 13, 31, 64)
Imperfect insurance legislation	4 (15, 18, 36, 62)
Inappropriate legislation regarding the mental health	1 (64)
Lack of core indicators for mental health	1 (14)

Table 3 Adults' barriers to utilization of MH services

Categories and sub-categories	Frequency (references)
Attitudinal barriers	
Concern about social stigma	16 (18-25, 48, 54-56, 58, 63, 65, 66)
Concerns about effectiveness of services	9 (19-22, 24, 25, 54, 65, 67)
Personal stigma/ Shame	7 (18-21, 54, 58, 68)
Patients' Self-Reliance	7 (19-22, 54, 66, 68)
Preference for getting alternative forms of care	6 (19, 20, 23, 48, 55, 59)
Cultural beliefs against treatment	5 (23, 59, 63, 67, 68)
Patients' concerns about attitudes, beliefs, and behaviors of care providers	5 (17-19, 23, 65)
Lack of confidence in professionals	2 (21, 66)
Concern about confidentiality	1 (54)
Structural barriers	
Cost of services	17 (13, 19-22, 24, 25, 48, 55, 56, 58, 59, 61, 63, 66-68)
Location, distance and transportation barriers	13 (13, 19-24, 40, 54, 58, 59, 66, 67)
Lack of family or social support	8 (19, 20, 22, 55, 56, 59, 63, 68)
Inappropriate and inflexible services	8 (19, 20, 56, 59, 66-69)
Waiting time/time concerns barriers	7 (19, 21, 22, 54, 58, 66, 68)
lack of adequate services	5 (18, 23, 24, 40, 68)
Insurance-related limitations	4 (18, 22, 54, 55)
Separation of services and lack of integration	3 (40, 58, 68)
Inappropriate communication between providers and patients	2 (23, 65)
Vague administrative processes	2 (22, 40)
Knowledge barriers	
Lack of information about available services	15 (13, 19-24, 54, 56, 58, 59, 63, 66-68)
Lack of recognition of the problem	10 (19, 20, 22, 24, 40, 54, 56, 59, 63, 66)
Incapability of patients to seek treatment	5 (19, 20, 56, 61, 68)
Treatment-related barriers	
Treatment side-effects	4 (19, 23, 56, 61)
Long-term nature of treatment	2 (56, 59)

Table 4 Children and adolescents' barriers to utilization of MH services

Categories and sub-categories	Frequency (references)
Attitudinal barriers	
Concern about social stigma	5 (41-43, 47, 70)
Concern about effectiveness of services	5 (41-43, 47, 71)
Personal stigma/Shame	5 (41-43, 47, 70)
Lack of confidence in professionals	3 (41, 43, 70)
Concern about confidentiality	3 (41-43)
Fear of nature of treatment	3 (41, 43, 47)
Patients' Self-Reliance	3 (43, 47, 70)
Patients' concerns about attitudes, beliefs, and behaviors of care providers	3 (42, 43, 47)
Structural barriers	
Location, distance, and transportation barriers	9 (41-43, 47, 70-72)
Cost of services	6 (41-43, 47, 70, 73)
Waiting time/time concerns barriers	6 (41-43, 47, 70, 71)
Vague administrative processes	5 (41, 42, 47, 71, 72)
Inappropriate and inflexible services	5 (41, 42, 47, 70, 71)
lack of adequate services	3 (41-43, 47, 58, 71)
Insurance-related limitations	2 (41, 47)
Barriers related to legal requirements	1 (72)
Limited children involvement	1 (72)
Lack of child-friendly environment	1 (72)
Knowledge barriers	
Lack of information about available services	5 (42, 43, 47, 70, 71)
Lack of recognition of the problem	4 (41, 43, 47, 70)
Lack of willingness to seek help	2 (41, 47)
Family-related barriers	
Lack of recognition of the problem by the Family	3 (41, 47, 73)
Parental concern about stigma	2 (42, 47)
Parental education/employment status	1 (73)
Family income status	1 (73)
Parental concern about treatment side effects	1 (47)

Figures

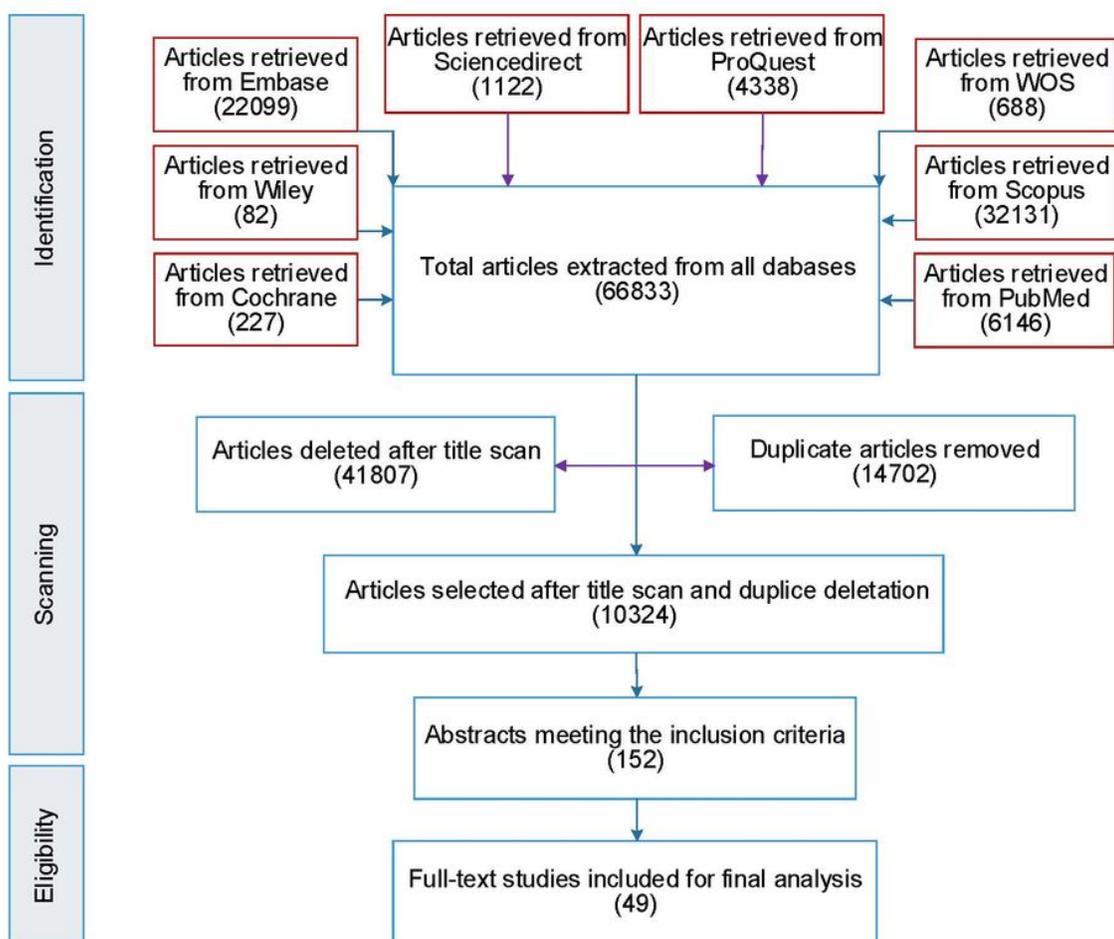


Figure 1

PRISMA flowchart for the article selection process

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