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Community perception of accessibility and barriers to utilizing mental health services

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Abstract:

BACKGROUND: The Government of India and State Government authorities are trying their best to provide adequate mental health services through various mental health policies and programs. To reduce the burden in psychiatric hospitals, Government has decentralized mental health services. Although Government has provided mental health services, the utilization has always been low due to many reasons. In the present study, an attempt was made to assess the accessibility and the barriers to utilizing mental health services with various community stakeholders.

MATERIALS AND METHODS: This is a qualitative study wherein data was collected from youth, women, geriatric groups, community key leaders, and Anganwadi workers. The primary data were collected through focused group discussions and interview methods. The collected data were analyzed using thematic coding.

RESULTS: A total of twenty-five factors have been identified in the study, which were categorized under eight themes. (a) Lack of awareness and misinformation on mental health, illness, and available services, (b) Perceived causes for mental illness, (c) Reasons for not approaching health professionals, (d) Treatment adherence-related issues, (e) No multidisciplinary team in private hospitals and lack of involvement in government sector (f) Manpower issues, (g) Quality of service issues and building confidence among community people, and (h) Belief system and stigma.

CONCLUSIONS: Inadequate mental health services, lack of awareness of mental health, and illness are still persist. The District Mental Health Program and other service providers need to reach communities, especially in remote areas. Periodical evaluation should be carried out to improve the utilization of mental health services.

Keywords:

Barriers to utilize mental health services, community perception, mental health, mental health services, mental illness

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Introduction

More than 20 million people are suffering from various forms of mental disorders in India, with over 9 million suffering from severe mental disorders.[1,2] The national mental health survey of India 2015–2016 reported that overall weighted lifetime prevalence for any mental morbidity was 13.7%, current mental morbidity was 10.6%, and the treatment gap was 70%–92% for different disorders. It is reported that 150 million Indians required active interventions, but due to limited resources, there is a huge treatment gap in the care of the mentally ill in India.[3]

To improve the mental health services, the Government of India, in collaboration with state governments has implemented National Mental Health Programme in 1982 (NMHP)[4] and the District Mental Health Program (DMHP) was added to NMHP in 1996. The primary purpose was to provide essential but sustainable mental health services to the community to

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integrate mental health services with primary health care services, early detection, and mental illness treatment in the community.[5] National Mental Health Policy of India 2014 and the Mental Health Care Act 2017 are new concrete efforts to enhance mental health services and reach the community. It shows that Government is trying to extend mental health services to all. It is evident that mental health services have been decentralized over time, and policy-level initiatives have been expanded to reach the community. Hence, there is a need to assess the community's perception of accessibility and barriers (if any) in utilizing mental health services. Therefore, the present study attempted to identify the accessibility and obstacles in utilizing mental health services among various community stakeholders. The present research was conducted in the Kalyana Karnataka Region (KKR), which includes six districts in Karnataka named Bellary, Kalaburagi, Yadgir, Bidar, Koppal, and Raichur. KKR is the most backward and underdeveloped region in the Karnataka state, India, having a total population of 11,286,343.[6]

Materials and Methods

Study design and setting

This is a qualitative study which was conducted in the community setup.

Study participants and sampling

The study participants were youth, women, geriatric groups, community key leaders, and Anganwadi workers. Two Focus Group Discussion (FGD), each with youths (N = 17, one in Kalaburagi, another one in Bellary), women (N = 17, one in Raichur, another one in Koppal), and geriatric group (N = 17, one in Yadgir, another one in Bidar) were conducted. Interviews were conducted with Anganwadi Workers (N = 12, two from each district), community key informants (N = 12, two each from each district), and the general public (N = 25, minimum of four from each district). Purposive sampling was used to recruit the study participants.

Data collection tool and technique

A standardized script for conducting the FGDs and interview guide was developed based on study's aim, enriching the literature review and discussion with research experts. In addition field notes were maintained to note down each day's observations, discussions, and feedback from the participants. The FGDs were conducted based on Varkevisser *et al*. guidelines.[7]

Data analysis

The information collected from the participant was transcribed in its natural form. There were 25 factors [appendix 1], which were categorized under the eight themes and where all the factors were provided separate codes. In addition, factors were categorized into various themes and sub-themes based on the main themes.[8] The thematic coding was given to three experts to get their opinions and suggestions. The researcher had recoded the categories or the themes based on the opinion and suggestions.

Ethical consideration

Written informed consent was obtained from the participants. Proper care was taken to establish a rapport with every participant before the interview. Approval was obtained from the Departmental ethics committee (Department of Social Work, Central University of Karnataka).

Results

The fundamental purpose of this research is to investigate the perception of the community in accessing mental health services in KKR. Table 1 illustrates the background data.

One hundred (100) respondents participated in the study. Most of them were adults, 38 were studied up to 10 + 2 and above, around half (47) of the participants were from an agricultural background, and an equal number were males and females [Table 1].

Accessibility of available mental health services

Various mental health care services are provided under DMHP and NMHP. The mental health services are extended to district hospitals by establishing the psychiatry departments by the Government of Karnataka. The secondary data show that for a total of 11.2 million population in six districts of KKR,

Table 1: Background data

Variable	Value label	*n*=100
Respondents	Youth group (20-29 years)	17
	Women group (30-50 years)	17
	Geriatric group (60 and above)	17
	Anganwadi worker (20-40 years)	12
	Community key informants (35-60 years)	12
	General public	25
	25-35 years (6)	
	36-50 years (14)	
	51 years and above (5)	
Education	Illiterate	20
	1-5th standard	20
	5th-10th standard	30
	10 + 2 and above	30
Occupation	Agriculture	47
	Self-employment	19
	House work	10
	Anganwadi workers	12
	Not working	12

approximately 25 psychiatrists, 16 Psychiatric Social Workers (PSWs), and 7 Clinical Psychologists (CPs) were available.[9] Therefore for every 448,000 people, only one Psychiatrist was available. Moreover, these psychiatrists are not proportionately distributed in 6 districts. Although the Psychiatric department was established in all the district hospitals, there were no psychiatrists in the Yadgir district and only one Psychiatrist in the Koppal district. Out of 6 districts, five of them had psychiatric services in medical colleges. Yadgir district did not have a medical college. Private medical colleges were available only in Kalaburagi District. Private psychiatric clinics were available in 5 districts except for Yadgir.[9,10]

Mental health service utilization in Kalyana Karnataka Region

In 2017–2019, 13,659 Persons with Mental Illness (PwMI) were identified and treated in Koppal. In Yagdir, 4425 and Bidar, 16,880 PwMI utilized mental health services from 2010 to 2018. In Bellary, between April 2017 and September 2018, 8606 utilized mental health services. From 2017 (April) to 2019 (March), 20,153 people utilized the services in Kalaburagi. The Raichur district data was not available (Source: Ministry of health and family welfare, Government of Karnataka, 2019)[9].

Barriers to utilize mental health services

The following barriers were identified for not utilizing the available services, as follows-

Theme I: Lack of awareness and misinformation on mental health, illness, and available services

Although several activities and awareness programs have been initiated, lacks of awareness among the participants were found. Most of them could not be able to express what normal mental health is as understood in literature. For them, normal mental health means free from mental illnesses. In addition suicide, adjustment problems, emotional issues, sleep difficulties were not mental illness. The authors explained to them about the mental illness, normality and then sought to know how many were mentally ill in their community. Initially, participants could able to identify only severe psychosis cases. After the explanation, they reported many people were required mental health services.

When it was enquired about the available mental health services under DMHP, NMHP, only Asha workers heard about these and said that few times they had meetings on the same and took some patients for treatment to district hospitals. Whereas, the community people were not aware of these services. The community people agreed that awareness is increasing gradually compared to previous years.

The following statements describe similarly.

"Compared to previous years, awareness is increased, but in remote areas, it is not reaching" (Asha worker 1)

"We do not know what mental health and mental illness is. I have never heard about adjustment issues leads to mental health problems."(2FGD R9)

Theme II: Perceived causes for mental illness

The reasons for mental health problems and illness were analyzed. It was reported that loss in business, debt, no or less income, loss or no proper cultivation, family issues such as a single partner, fights in the family, couples having problems of infertility, other emotional problems, failure in life were reported as major reasons for mental illness. This shows that participants could able to perceive the causes of mental illness.

The following statements from a community leader and a youth describe similarly:

"I had seen one of our relatives became mad because he lost son"-Community leader 1

"In our village, one person became mad because there was an ongoing fight at home"-Youth 4

Theme III: Reasons for not approaching health professionals

The participants were asked a question-why people do not approach doctors for mental health problems?

Lack of knowledge and resources were the primary cause for not availing of available services. However, the findings also revealed that the distance from their living place to the district hospital was far away. Besides, the participants were not aware that Primary Health Centres (PHCs) could treat them. Although PHC doctors were trained under DMHP to treat mental illness in the community, even though not treating or not paying attention to common mental illnesses. In case of severe mental illness, they refer patients to district hospitals.

It was found that most of the people who have mental illness were poor and depended on daily wages. If they need treatment, they need to go to a district hospital which is far away which was adding to the transport cost and denying their daily earnings. Further, the research findings were also found that in some villages, there was no PHC. Apart from the distance, it was found that transportation facilities were very limited. As a result, many patients avoid going to the hospital.

The majority of the participants showed their inability to access mental health services due to poor financial conditions. The people depending on agriculture were

financially poor. Those doctors who work in DMHP and District hospitals had a private practice and encouraged them to visit their private clinics for better treatment. Further, it was observed that there were no fixed charges for consultation in private clinics, which varied from Indian Rupees 200–500 for each consultation.

Some people had dogma in their mind that they get better treatment at private hospitals only. It has been reported that some people sold their lands for their treatment in private hospitals. However, the majority of the respondents reported a lack of money to purchase medicines, bear traveling expenditure, take care of livelihood, etc. It could be clarified through these statements.

"In our village, only in the morning and evening bus comes. If we miss the bus, we cannot go to the hospital. Hence, we avoid going"-Women 2

"In the private hospitals we have to pay more money. But it is okay. They treat better than government hospital" (1FGD R5)

"I had seen a person became mad. His family members took him to one private hospital and treatment went on for few years. They sold part of the land for seeking treatment" (CKI 4)

Theme IV: Treatment adherence related issues

Most of the people do not give importance to functionality and pay attention to the symptoms. Once the symptoms reduce, they stop medicines thinking they were cured. Psychiatric disorders require adherence to treatment. However, people feel it is like fever and other diseases, where treatment is for a limited period. It was reported that people were in a hurry for an immediate solution for their illness. Changing doctors and stopping medicines during the treatment phase creates more problems for the patients. It was reported that doctors do not provide psycho-education.

Due to the lack of supporting mental health staff, providing full treatment such as therapies, counseling to patients is not possible in Government hospitals.

"People need immediate solutions for their illness. If it is not cured, they prefer to change them. I had seen that one patient's family members changed three doctors in one month" (CKI 4)

Theme V: No multidisciplinary team in private hospitals and lack of involvement in the government sector

As per the policy of NMHP, DMHP, and MHP 2017, district hospitals and other psychiatric hospitals should have Psychiatrists and other mental health professionals such as PSWs, CPs to handle psychosocial issues. However, in most of the private hospitals, only psychiatrists are working, whereas other mental health professionals are missing. Psychiatrists are interested only in prescribing medications, so counseling and other important course of treatment are missing.

Although PSWs, CPs are working in government hospitals, lack of involvement in the treatment process was reported. The researcher inquired about the multidisciplinary team. None of them were aware of this. Only after explaining that PSWs and CPs would also be working with the psychiatrists could they understand. However, they said that they need more visibility.

"Doctors are interested only in prescribing medicines. Many times, I wanted to discuss the patient, his occupational issues, and family issues. However, he has not shown interest. I have never seen other mental health professionals doing any counseling"-Asha worker.

Theme VI: Manpower issues

After visiting a hospital, patients find a severe shortage of doctors and other supporting staff due to the lack of manpower in the mental health service system. As a result of this, patients do not get accurate information regarding mental health professionals' availability. Lack of knowledge of community health workers, ASHAs, and poor knowledge among PHC doctors regarding mental illness puts a significant barrier for community people from receiving mental health services. It was reported that some PHC doctors send the PwMI to district hospitals due to their lack of knowledge and competence in treating mental illness. Some places are very far from district hospitals. They would fail to find doctors after reaching the hospital, as there is a lack of manpower in few districts.

"Some time ago, I had taken one of my village person to the district hospital, which is 90 kilometres away. After reaching the hospital, we came to know that doctor has gone to some other place. Only one psychiatrist was available in the hospital. We had to come back and go some other day"-Asha worker 5

Theme VII: Quality of service and building confidence among community people

The quality of service is a majorly implementation barrier in providing mental health services to community people.

Some participants reported that doctors have a double yardstick for poor patients and those who have a strong influence. They firmly believe that with influence, they would get priority and fair treatment.

A long hour of waiting is also a problem. Most government hospitals are overloaded and require long hours of waiting for consultation. Most of the community people believe that they do not get proper quality treatment and services in government hospitals.

The above reasons are some of them which create low confidence among the people for Government hospitals and their services.

"*Doctors are not giving proper treatment in the government hospitals. If you have a political background, then only they will treat you properly.*" (Respondent 4)

Theme VIII: Belief system and stigma

The belief system is one of the causes which prevent people from seeking treatment. People feel that the sins from the past life cause mental illness. For example, some of the dominant religion of India, i.e., Hindu religious texts promotes and propagate about rebirth and such mentioned beliefs. Hence, first, they approach faith healers and later on to psychiatrists. There is also a stigma in the community about mental illness. People feel that if they approach a psychiatrist or mental health practitioners they would be given a tagline as "mad." Hence, at first, they try to avoid it and if they approach, prefer to keep it a secret.

Discussion

The present study was conducted in the community, and it presents the community's perception of the barriers to utilizing mental health services.

Lack of awareness and misinformation on mental health, illness, and available services

The participants reported that the level of awareness linked to mental health remains inadequate in the community, but it gradually it is increasing. It is very much important to evaluate this issue critically. The major mental health initiatives in India started in KKR. The Bellary district project in Karnataka was one of the two projects (the second was the Raipur Rani project, Haryana), which influenced India's mental health services, and Kalaburagi is one of the initial districts where the DMHP program was implemented in the country and in the Karnataka state.[11] Before DMHP, sufficient mental health services were not available in the region. At present, under DMHP each district has mental health services and the district hospital psychiatry unit. The awareness is provided regarding mental illness, and campaigns have been undertaken regularly. Even after 25 years of all the efforts and implementation taken by the DMHP, the conditions are not improved significantly. This finding supports previous studies.[10,12]

Reasons for not approaching health professionals

Multiple reasons were emerged for not approaching health professionals. It shows that lack of knowledge and resources in the region, lack of transportation, financial barriers, dogma on a particular treatment, etc., were the primary reasons. The entire region is historically backward, and India's Constitution provided special status, that is, 371J. Studies reported mental health service affordability, availability, and stigma are few perceived barriers for the mental health treatment gap in India.[6-12]

Treatment adherence related issues and manpower issues

Treatment adherence-related issues have been reported in the study. It shows that though the services are available, it is not fully functional. Unless patients and family members are educated, it cannot be addressed. This issue can be tackled by using multidisciplinary teamwork. It is the standard practice in treating PwMI that psychiatrists, CPs, PSWs, psychiatric nurses work as a team and provides comprehensive services, which was not properly practiced. Studies corroborate with the present study findings that in India, mental health professionals are not sufficient, and the tradition of teamwork has not emerged except in mental health hospitals.[2,4,13-22]

As evident in the study, the manpower issue is very significant. As discussed in the results, for the entire region, which is home to a total 1.12 crore population in six districts of KKR, approximately 25 psychiatrists, 16 PSWs, and seven CPs were available. These resources were not equally distributed. The limited manpower hinders the services, which was evident in the results. Under DMHP, all Medical Officers from PHCs had undergone a 3-day training program on psychiatry. It was expected that with this training, they might follow up with PwMI. The Ministry of Family and Child Welfare, Government of India, provides nine psychiatric drugs to all PHCs and CHCs. These drugs were supplied by the state governments once in 6 months. However, the study found out that due to certain unknown reasons drugs were not been supplied regularly. Because of this, patients were prescribed medicines and advised to buy from outside. Similar kind of studies supports the present study findings.[4,10,11,21,22]

Quality of service issues and building confidence among community people

Quality of service and building confidence among the community is another barrier that needs to be addressed effectively. As mental health services are expanded through DMHP, it is high time to use different methods to build public confidence in mental health services in the community.

Belief system and stigma

Stigma is a significant barrier in seeking treatment for mental illness. People try to hide and keep it secret due to the stigma. It is unfortunate that still many of the traditional malpractices and stigma are persisted even now. Studies corroborate with the present study.[18,20]

Limitation and recommendation

The study has been restricted only to the community setup. Further study needs to be conducted to identify the policy level and implementation barriers to provide mental health services. There is a need to make sure that the services of the government flagship program i.e., DMHP should reach every corner of society. There is a need to enhance the awareness among people living in remote areas. Another important suggestion is to increase specialists in the mental health care service system. Under DMHP, training has been provided to PHC doctors to treat. It is suggested that the training programs must be periodically conducted. There is a need to extend the services to the taluka level (Administration unit, which comes after District) by appointing mental health professionals for effective delivery of the services. It could reduce the burden on the family, and encourage in seeking treatment, which in turn may enhance the treatment-seeking behavior. This may also reduce the stigma and encourage more people to seek treatment due to increased accessibility in Government hospitals. There is a need to enhance the quality of services provided in the district hospitals. The free and subsidized medicines and services which are provided need to be supplied regularly. Improvement of transportation would enhance the treatment-seeking behavior of the community.

Conclusions

The study observed that mental health services are not adequate in the KKR region, and the community has not fully utilized the available mental health services. There are many barriers to utilizing the services. Lack of awareness of mental health and mental illness persists, and services have not yet reached the needy. The DMHP and other service providers need to reach the communities, especially the remote areas. There is a need to have proper coordination and cooperation among various mental health service providers. To improve the utilization of mental health services, a periodical evaluation must be carried out.

Ethical approval

All procedures performed in the study involving human participants were in accordance with the ethical standards of the institutional/national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent

Informed consent was obtained from all individual participants included in the study.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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Appendix 1: Barriers to utilize mental health services

In this study, participants information was analysed, in which 25 factors have emerged. They are

1. Lack of awareness about mental illness and its various symptoms and misconceptions
2. There is something evil
3. The study area is a backward region which is home to the illiterates, migrants, and poor people
4. People do not believe that mental illness is a disease
5. People losing their agricultural/agricultural crops often go into depression and become mentally ill and found to throw stones
6. Private hospitals are far costlier than government hospitals and the patients' family often have to arrange money either through hiring loans or through the sale of their personal assets including land
7. The illness is mired not only in superstitious beliefs but also attached to societal stigma
8. People often visit the locally available faith healers for solution
9. Their first preference will be a temple, God, and faith healers
10. They do not know that treatment is available at PHC level
11. Those are staying in remote areas they cannot access mental health services
12. Distance is the bigger problem
13. The district hospital is far
14. No primary health centers in villages
15. Most people often look for an immediate cure
16. If the people are not satisfied with a particular doctor in a particular hospital, they will go to other hospitals
17. They visit multiple psychiatrists all over the place
18. If the patients get side effects with a particular medicine, they stop the medicines
19. Doctors are not available in government hospitals
20. Doctors are not available in PHCs
21. No other mental health professionals in private hospitals
22. In government hospitals, other mental health professionals not visible
23. Some people prefer private clinics
24. Will not get proper quality medicines in the government hospital
25. Will get proper care and treatments in private hospitals

PHCs=Primary health centers