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Barriers in the treatment of psychiatric disorders

Abstract

Psychiatric illnesses are very common in prevalence. But not everyone who has a mental illness gets a psychiatric consultation. The causes are many. First, many time people don't recognise and accept mental illnesses in them as a result of lack of insight and awareness. Secondly, even if they know they have a mental illness, they don't feel comfortable in disclosing it. Third, after knowing that they have some problems which require help from a doctor, they don't know whom to consult, where to consult, and how to consult. Fourth, in spite of all possible awareness, there may not be psychiatric facilities nearby. Thus, it becomes utmost necessary to discuss those factors which stop people with psychiatric illnesses to get adequate help so that remedial steps could be taken.

Keywords: Stigma. Myths. Burden. World Health Organization.

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Burden of psychiatric disorders

Health is defined as *a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity.* There can be no health without mental health.[1] Mental illnesses are very common in occurrence. Four hundred and fifty million people suffer from a mental or behavioural disorder worldwide, i.e. one in four families have at least one member with a mental disorder. In India, prevalence rate of psychiatric illnesses in general population ranges from 0.95-13%.[2] Mental illnesses are significant cause of disability and constitute four of the top ten leading causes of years lived with disability. These disorders are- depression, alcohol use disorders, schizophrenia, and bipolar disorders.[3] As per an estimation of World Health Organization (WHO), by 2020, mental disorders will constitute 15% of the disability-adjusted life-years (DALYs), a significant increase from ten per cent in 1990 and 12% in 2000.[4] Nearly one million people commit suicide every year worldwide; that is roughly equal to one in every 40 seconds. In other words, suicides constitute 1.8% of all deaths worldwide.[5]

However, the burden is not the only problem because every illness has its own associated morbidity and mortality. What is most disheartening is that people are not getting the help which they can avail. Mental healthcare services are often not available or are underutilised. While the treatment gap in developed countries ranges from 44 to 70%, it rises to as high as 90% in developing countries.[6] According to a study, only 46% of respondents, who met their criteria for a 12-month serious mental illness, received professional treatment for their emotional problems in the prior 12 months.[7] Similarly, another study reported that almost three-fifths of persons with a severe mental illness did not receive any specialty mental healthcare.[8]

Barriers can be defined as obstacles that prevent access to something. In psychiatry, it means that the people, who need mental healthcare the most, may never get it. There are different dimensions of barriers such as: clinical barriers, patient barriers, financial barriers, policy barriers, and organisational barriers. There can be considerable overlap between these barriers. Just enumerating the different barriers is not sufficient. It is equally important to know the top/priority treatment barriers because, based on that, it can be decided which barrier needs immediate and more attention. Stigma which is commonly considered as top barrier in the treatment of mental illnesses is surprisingly found to be the fourth biggest barrier in a study which reflects the growing awareness about psychiatric illnesses and effectiveness of awareness programs.[9] "Self-sufficiency", i.e. wanting to handle the problem on one's own and simply feeling that one doesn't need treatment for the issue is now considered the top barrier. Gaining access to treatment in a timely and affordable manner is another barrier which needs urgent attention.[9]

Clinical barriers

This barrier is discussed first, because problem identification should always start from self. In India, primary care physicians serve as the first contact for the patients for all

kind of illnesses including psychiatric disorders. However, when it comes to managing mental illnesses, these primary care providers lack adequate knowledge and training about psychiatric disorders. It is partly because psychiatric disorders are not given due importance in undergraduate medical education and also partly because these primary care physicians don't show much interest in treating psychiatric illnesses or they themselves have some kind of stigma.[10] Next clinical barrier is treatment non-adherence because of compliance issues and adverse effects of drugs. There are numerous side-effects of drugs; some in short term and some in long-term, but weight gain[11,12] and sexual dysfunction[13,14] due to psychotropic medications have been studied most, as potential factors for discontinuation of medicines. Other causes of treatment non-adherence are: duration and complexity of treatment regimen, few perceived benefits, stigma of taking medications, concerns about cost, availability and dependence, non-intentional slips and lapses, poorly understood instructions, poor empathy from the clinician, poor doctor-patient relationships, severe illness,[15] presence of psychosis, and cognitive impairment. The doctor-patient relationship plays a central factor for adherence.[16] Patients with more positive beliefs about the treatment are more likely to attend for follow-up and are more satisfied with treatment after attempting medication use.[17]

Patient barriers

The common patient barriers are: myths and stigma related to psychiatric disorders, certain socio-cultural and religious beliefs, lack of awareness, expression of psychological distress in physical terms and poor economic status.[18] Myths and stigma related to psychiatric illnesses are prevalent from centuries. Mentally ill are thought to be possessed by demons, spirits, etc., leading to practice of witchcraft and torturing of mentally ill. People generally consider mentally ill to be wicked; their illness as a result of early life sinful deeds, "karma". Many among the general public assume that persons with psychotic disorders are unpredictable and incapable of being managed, even by the best efforts of the healthcare system, and therefore are considered a threat to the social order and to public safety. Patients of substance abuse or personality disorders are additionally criticised for their lack of willpower, and society stigmatise them for bringing the affliction upon themselves and their weak character strength. The film and print media reinforces the stigma by dramatising, magnifying, and overemphasising the disparity between normative behaviour and the aberrant actions of the mentally ill. Stigmatisation hampers the care of mentally ill by preventing them from seeking help as they fear of being labelled as socially unproductive and hence to be out-casted.[19]

Socio-cultural and religious beliefs about mental illnesses also act as a significant barrier. Hinduism believes in "karma", while other major religions in India like Buddhism, Islam, and Christianity also believe in noble deeds and sufferings from evil deeds, leading to a mindset that one is to be blamed for his own sufferings. Also prevalent is the belief in "upri", "ginn", "aatma", or spirits as the causative factor in mental illness.[20] This problem is compounded by lack of education in general and poor awareness of mental illnesses in particular. In developing countries, a significant number of mentally ill patients seek help from traditional faith healers. They are easily accessible to people, are acceptable, affordable, and have sufficient knowledge about local beliefs, customs, and psychological mindset of the population. In India, parallel systems of medicine (Unani, Ayurveda, etc.) also offer wide range of acceptable and affordable mental health services. The majority of individual with an untreated severe mental illness don't seek care because they believe they did not have a condition that required treatment and they can "solve the problem on their own".[7]

Organisational barriers

The organisational barriers are: poor doctor-patient ratio, inadequate services and difficulties with communication and consultation across physical and behavioural health providers. According to a study, the required manpower in the field of mental health is as follows: Psychiatrists – 11,500, Clinical Psychologists – 17,250, Psychiatric Social Worker – 23,000, and Psychiatric Nurses – 3000. However, the current manpower is: Psychiatrists. 301/100000 population, Clinical Psychologists .047/100000, Psychiatric Social Workers .033/100000, and Psychiatric nurses .166/100000 population.[10] If we talk about the beds available for the mentally ill patients in India, it is seen that they are meagre and are mostly concentrated in the mental hospitals. Around 17835 beds in mental hospitals and 10000 beds in general psychiatric hospitals are catering to the needs of this world's second most populous country.[10]

Policy barriers

According to a report of WHO, nearly one-third of all countries, and almost half of all African nations, have no comprehensive mental healthcare policy or plan, which are crucial for implementing and coordinating mental healthcare services. Among countries with mental healthcare policies in place, approximately 40% have not been revised since a long time to meet the ever changing and ever increasing demands of mental healthcare. Furthermore, 22% of countries do not have relevant laws that offer legal protection of the human and civil rights of people with mental illnesses. In India till mid of 2014, there was no officially approved mental health policy and mental health was specifically mentioned in the general health policy. However, a mental health plan do existed which was revised in 2009. The mental health plan components include: timelines for the implementation of the mental health plan, fund allocation for the implementation of half or more of the items in the mental health plan, shift of services and resources from mental hospitals to community mental health facilities and integration of mental health services into primary care. Dedicated mental health legislation in the form of 'Mental Health Act' was enacted in 1987. However, this act didn't focus much on rights of the patients. A new updated legislation focusing more on the human rights of the patients, 'Mental Health Care Bill' is under the process of parliamentary approval. Legal provisions concerning mental health are also covered in other laws (e.g. welfare, disability, general health legislation, etc.).[10]

Financial barriers

In this barrier, there are issues related to the alignment of incentives and funds. In many low- and middle-income countries, funds are not adequately assigned for health sector and out of which, mental healthcare funding is excessively neglected. Even if funds are allotted, they are directed mainly to large institutes and cities.[21] The cost of psychotropic medicines, which have to be taken for longer period, is a significant barrier in countries where psychological disorders are not covered by insurance policies. Twenty five per cent of all countries do not provide disability benefits to patients with mental disorders and one-third of the world's population lives in countries that allocate less than one per cent of their health budget to mental health.[22] In India, the Government spends only 0.06% of total health budget on mental health and most of the funds are allocated to medical disorders.[10]

Dealing with barriers

WHO has made some recommendations for dealing with barriers: 1) Providing treatment in primary care; 2) Making psychotropic medications available; 3) Giving care in the community; 4) Educating the public; 5) Involving communities, families, and consumers; 6) Establishing national policies and legislations; 7) Developing human resources; 8) Linking with other relevant sectors; 9) Monitoring community mental health; and 10) Supporting more research.[23]

India is the first country in the world to devise and implement a National Mental Health Programme (NMHP) in 1982 with three strategies: 1) Integration of mental health with primary care, 2) Provision of tertiary care institutions for treatment of mental disorders, and 3) Eradicating stigmatisation of mentally ill patients and protecting their rights through regulatory institutions like Central Mental Health Authority (CMHA) and State Mental Health Authority (SMHA). The components of this programme according to 11th five-year plan are: District Mental Health Programme; manpower development; information, education, and communication; research and training; support for central and state mental health authorities; non-governmental organisation (NGO) support and public-private partnership; modernisation of state-run mental hospitals; up-gradation of psychiatry wings in government medical colleges/general hospitals; mainstreaming NMHP into National Health Mission (NHM); and monitoring and evaluation.[24]

Government of India on 10 October, 2014 launched its first National Mental Health Policy with a goal to provide "Universal access to mental healthcare". Provisions will be made to expand the existing hospital network, as well as primary care centres. The policy is backed by a "Mental Health Action Plan 365", which assigns specific roles to the concerned authorities ranging from the centre, states, local bodies, and civil societies. In order to ensure smooth functioning and collaboration, this policy will be articulated into the National Health Policy and National Health Assurance Mission (NHAM). It has also been decided to observe October 10, as National Mental Health day like World Mental Health day.[25]

In summary, government and mental health professionals are taking different steps to bring mentally ill patients into the mainstream of medical care. According to a recent report of evaluation of NMHP, the number of mental health professionals has greatly increased, the funds have increased, more districts are covered by psychiatric care, but the final results are far from reaching.

References

1. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
2. Reddy VM, Chandrashekar CR. Prevalence of mental and behavioural disorders in India: a meta-analysis. Indian J Psychiatry. 1998;40:149-57.
3. Murthy RS. Mental Health Programme in the 11th Five Year Plan. Indian J Med Res. 2007;125:707-11.
4. World Health Organization. The World health report: 2001: Mental health: new understanding, new hope [Internet]. Geneva: World Health Organization; 2001 [cited 2015 Sep 1]. Available from: http://www.who.int/whr/2001/en/whr01_en.pdf
5. World Health Organization. Mental health: Suicide data [Internet]. 2015 [cited 2015 Sep 1]. Available from: http://www.who.int/mental_health/prevention/suicide/suicideprevent/en
6. Kohn R, Saxena S, Levav I, Saraceno B. The treatment gap in mental health care. Bull World Health Organ. 2004;82:858-66.
7. Kessler RC, Berglund PA, Bruce ML, Koch JR, Laska EM, Leaf PJ, *et al*. The prevalence and correlates of untreated serious mental illness. Health Serv Res. 2001;36:987-1007.
8. McAlpine DD, Mechanic D. Utilization of specialty mental health care among persons with severe mental illness: the roles of demographics, need, insurance, and risk. Health Serv Res. 2000;35:277-92.
9. Clement S, Schauman O, Graham T, Maggioni F, Evans-Lacko S, Bezborodovs N, *et al*. What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. Psychol Med. 2015;45:11-27.
10. World Health Organization. Mental health atlas-2011 country profiles: India [Internet]. 2015 [cited 2015 Sep 1]. Available from: http://www.who.int/mental_health/evidence/atlas/profiles/en
11. Fakhoury WK, Wright D, Wallace M. Prevalence and extent of distress of adverse effects of antipsychotics among callers to a United Kingdom National Mental Health Helpline. Int Clin Psychopharmacol. 2001;16:153-62.
12. Weiden PJ, Kozma C, Grogg A, Locklear J. Partial compliance and risk of rehospitalization among California Medicaid patients with schizophrenia. Psychiatr Serv. 2004;55:886-91.
13. Olfson M, Uttaro T, Carson WH, Tafesse E. Male sexual dysfunction and quality of life in schizophrenia. J Clin Psychiatry. 2005;66:331-8.
14. Rosenberg KP, Bleiberg KL, Koscis J, Gross C. A survey of sexual side effects among severely mentally ill patients taking psychotropic medications: impact on compliance. J Sex Marital Ther. 2003;29:289-96.
15. Hazarika S, Roy D, Talukdar SK. A study of medication nonadherence in schizophrenia. Dysphrenia. 2013;4:123-6.
16. Stevenson FA, Cox K, Britten N, Dundar Y. A systematic review of the research on communication between patients and health care professionals about medicines: the consequences for concordance. Health Expect. 2004;7:235-45.
17. Bultman DC, Svarstad BL. Effects of physician communication style on client medication beliefs and adherence with antidepressant treatment. Patient Educ Couns. 2000;40:173-85.
18. Saxena S, Thornicroft G, Knapp M, Whiteford H. Resources for mental health: scarcity, inequity, and inefficiency. Lancet. 2007;370:878-89.
19. Dinos S, Stevens S, Serfaty M, Weich S, King M. Stigma: the feelings and experiences of 46 people with mental illness. Qualitative study. Br J Psychiatry. 2004;184:176-81.
20. Tiwari SC, Pandey NM. The Indian concepts of lifestyle and mental health in old age. Indian J Psychiatry. 2013;55(Suppl 2):S288-92.
21. Saraceno B, van Ommeren M, Batniji R, Cohen A, Gureje O,

Mahoney J, *et al*. Barriers to improvement of mental health services in low-income and middle-income countries. Lancet. 2007;370:1164-74.
22. World Health Organization. Investing in mental health: evidence for action [Internet]. 2013 [cited 2015 Sep 1]. Available from: http://apps.who.int/iris/bitstream/10665/87232/1/9789241564618_eng.pdf
23. Unite for Sight. Module 8: Improving mental health care: Goals, strategies and considerations [Internet]. 2015 [cited 2015 Sep 1]. Available from: http://www.uniteforsight.org/mental-health/module8
24. Sinha SK, Kaur J. National mental health programme: Manpower development scheme of eleventh five-year plan. Indian J Psychiatry. 2011;53:261-5.
25. Government of India. Ministry of Health & Family Welfare. India. National Mental Health Policy [Internet]. 2015 [cited 2015 Sept 1]. Available from: http://www.mohfw.nic.in/index1.php?lang=1&level=2&sublinkid=4723&lid=2964

Kumar A, Phookun HR. Barriers in the treatment of psychiatric disorders. Open J Psychiatry Allied Sci. 2016;7:99-102. doi: 10.5958/2394-2061.2016.00015.X. Epub 2015 Dec 24.

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