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Barriers to Accessing Care (BACE) Score in Patients Attending Mental Health Services

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Abstract

Background: The World Health Organization's definition of health has stressed mental health as an important component. Terms such as access, availability, utilization and coverage have often been used interchangeably to reveal whether people are receiving the services, they need. To reduce the unmet need for treatment and it is crucial to identify barriers in mental health to reduce adverse effects associated with the absence or postponement of timely treatment. **Methods:** A cross-sectional study was performed in Mental Hospital, Lalitpur, Nepal. People suffering from mental illness who fulfilled the inclusion criteria were recruited and BACE scale was administered along with relevant details of participants. **Results:** Among the patient reported barriers related to stigma, the most reported concern was " concerned that I might be seen as weak for having a mental health problem "(33.6 %), Among the reported instrumental barriers in BACE scale , "having no one who could help me get professional care (18.2)" was the mostreported major barrier, Among the different attitudinal components in BACE scale "wanting to solve problem on my own" (21.9%) was the most reported barrier. **Conclusion:** Thus, it can be concluded that people people suffering from mental illness also experience different barriers during help seeking . This barriers is found more on people below 45 years of age and people with low socio economic status. These barriers influence the quality of life in terms of decline in physical health and environment. **Novelty:** BACE scale administered on large sample size.

Keywords: Barriers, Health, Mental, Services, utilization

Introduction

After cardiovascular disease, Mental disorders are the major cause of disability, mental disorders account for approximately 33% of time lost to disability. Life time prevalence of

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mental disorder among adult worldwide excluding neurological condition affecting the brain ranges from 12.2% to 48.6%.(Fleury et al., 2014) Despite of this fact; mental health services are often underutilized.

The problem of underutilization of mental health services may be due to: (1) barriers to initiation of mental health services and (2) barriers to persistence in treatment once it is sought. Barriers to help seeking may be of various types, Cognitive barriers to seeking mental health services involves culturally informed conceptions of mental illness.(Leong & Lau, 2001) Cognitive barriers include topics such as communication, language and health literacy. (George et al., 2018)Even after a problem is cognitively defined as psychological, culturally based affective responses may act as barriers in seeking help and these are defined as affective barriers. Value orientation barriers are cultural value orientations that govern norms for emotional management and communication that are highly relevant to mental health treatment.

Physical barriers include factors that may not be related to culture as much as to social class—the client's lack of awareness about available services and their inability to access services due to economic and geographic realities (e.g., having to work two jobs, unable to get time off to seek services, unmanageable distance to facility, lack of transportation, etc.).The major barriers in accessing and receiving care are relevant to the knowledge and attitude related barriers, In the pilot study of national mental health survey it was found that about 79.8% of the participants who did not receive treatment did so because they wanted to solve their problem on their own.

The prevalence and disease burden of mental illness are high globally, Person with severe and persistent mental illness have multiple and complex needs which are beyond the traditional mental health services. Assessment of patient severity and their problems in daily life is essential. People with a number of unmet needs are likely to experience poor quality of life as well. Any mental health service that aims to improve the quality of life of patients' needs to actively assess for these factors as early recognition can help in optimizing planning of treatment and implementation of care ensuring effectiveness of psychiatric care. It also plays a critical role in mental health rehabilitation.

About 76% and 85% of people with severe mental disorder in low and middle income countries receive no treatment.[7] The magnitude, suffering and burden of disability due to Mental disorders and the cost of care and impact on individuals, families and societies due to mental disorders are staggering in any developing countries including Nepal.

Although efficacious treatment is available there is minimal utilization of mental health services.(Sareen et al., 2007) Different models for help seeking behaviors suggest that individual progress through different stages before seeking help. These stages include experiencing symptoms, evaluatingthe severity and consequences of the symptoms, assessing whether treatment is required, assessing the feasibility of and options for treatment, and deciding whether to seek treatment.(Gater et al., 1991)

These barriers are broadly divided into individual attitudinal factors and system level factors. Attitudinal barriers include belief about and attitude towards mental illness and treatment, wishes to solve the problem on their own and thought that problem would go away, fear of

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stigmatization, feeling ashamed and embarrassed .In addition structural barriers include lack of time , financial resource problem and unavailability of treatment (Thompson, 2004).
Many people with mental disorder struggle with their symptoms and disabilities and in addition they are challenged by stereotypes and prejudice that result from misconceptions about mental illness. As a result, their opportunity that defines a good quality of life including good job ,safe housing and satisfactory health care are compromised. Delay in service utilization poses riskto the individual health whose social interactions deteriorates until they become too ill to seek help resulting in adverse pathway of care such as emergency services, social services or via the Criminal justice system.(Dockery et al., 2015) .Although study have been done in other countries in Nepal very fewstudies have been conducted to find out barriers of mental health services. In mental hospital patients from all over the country seek help and they share many similar religious, cultural myths and values. Understanding the different types of barriers for seeking mental health service will help out in developing different policies and plan for betterment of mental health service utilization. Much work is needed to understand the barriers of mental health service utilization in our country to reduce the unmet need for treatment and it is crucial to identify barriers in mental health to reduce adverse effects associated with the absence or postponementof timely treatment.

Research Objective

1) To find out the BACE Score and to identify different barriers in attending mental health services .

Literature review

In a qualitative study done by (Jack-Ide & Uys, 2013)among service users attending outpatient clinicof Rumingo Neuropsychiatry hospital,10 care givers and 10 clients were interviewed by using a semi structured interview guided open ended questions developed by authors which reflectedupon their experiences, onset of disorder, the difficulties, challenges of accessing service, sustaining treatment barriers and their perception of mental health services. Results were presented in two categories; sociodemographic and thematic analysis. In sociodemographic analysis 60 % were with mean age of 37.7%, 40% were unemployed ,15% had a regular income,10% were tertiary level students and 65% lived in rural area, Thematic analysis showed many factors such as barriers, mostly physical, which included poor knowledge of mental health service, centralized health services and prolonged waiting time. In addition cultural barriers including stigma/discrimination, feeling of shame and financial barriers including travel distance, high cost of service and loss of productive income were also present.
A cross sectional survey conducted by (Ali & Agyapong, 2016) using mixed qualitative and quantitative research methods in which 103 carers and 6 psychiatrists participated ,47% of respondents were male,53% were female ,73% were married,27% were unmarried including single, divorced and widows,18.4% of respondents were between age 30-40 years ,56.6% were above 40 years. 36% lacked any education and majority of participants said that their patients sought other types of treatment and consulting religious healers was the main alternative. They

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found stigma and finance as major barriers .Number of psychiatric hospital were not sufficient and there was poor staff motivation along with migration of staff to other countries, they suggested mobilization of health services to rural area, establishment of psychiatric departments in general hospital and providing incentives for doctors to increase the utilization of mental health services.

In a study in Chitwan district of Nepal conducted by (Luitel et al., 2018) to assess the treatment gap among adults with depressive disorder and alcohol use disorder, barriers to carewere assessed with the Barriers to Access to Care Evaluation (BACE) scale. For depressive disorder, the individual item proportion for expressing "any degree of barriers "ranged from 55%-92.8% and for alcohol use disorders it ranged from 45.2%-96.5%, The five most reportedbarriers for depressive disorder were not being able to afford the financial cost (22.5%), concern that I might be seen as "crazy" (11.0%), dislikes of talking about own feelings, emotions or thoughts (10.7%), concern that I might be seen as weak for having mental health problem (9.9%) and no one could help me get mental health care (8.3%). Major barriers for Alcohol use disorders (AUD) were not being able to afford the financial cost (22.5%), concernthat I might be seen crazy (12.2%), being unsure where to get mental health care 13.1%), harmfor applying for jobs (10.9%), concern of being seen as weak (10.3%), Treatment gap for bothdisorders was very high 91.5%-94.9%.

Methods

The cross-sectional study was done after protocol was accepted by the Institutional Review Board ofNAMS (National Academy of Medical Sciences), study was done at Mental Hospital with duration of 6 months , Sample size was calculated by using following formula , $N= z^2pq / d^2$ where prevalence ofmaximum barrier was taken from recent similar study by Adalberto Campo-Arias et.al and the total calculated sample size was 309 . Barriers to Access to Care Evaluation Scale (BACE scale) was used which is developed and validated at the health services and population researchDepartment, Institute of psychiatry, Kings College, London. BACE scale is designed to assess barriers to mental health care for people with mental health problems. It has 30 items and it includes barriers related to, and unrelated to, stigma and discrimination. Translated and validated BACE scale in the Nepali language is available, which is used for this study. A semi structured questionnaire is developed to record socio-demographic and otherrelevant data of participants. Data were collected after informed consent was taken from selected participants as per the inclusion and exclusion criteria .Participants who were stable, able to give consent and able to read BACE scale were included while participants Diagnosed with dementia, intellectual disabilities and others disorders affecting cognitive abilities ,Medical and other comorbidities known to be associated with significant stigma and delayin treatment seeking were excluded.

Results

The mean barrier as measured by BACE scale was calculated to be 33.70 ± 16.42. The mean score of BACE according to the socio demographic profile and the different types of barriers in BACE scale is shown in table . Mean weighted score was calculated by dividing the mean

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score from the total number of items.

Mean total BACE score was high among lower socioeconomic status followed by middle and upper classes ,mean score of BACE in male was slightly higher then female, mean score of patient from lumbini province was 41, sudurpaschim province is 39, karnali 37 and least BACE score was in province no 1 (25) .Mean BACE score of patient with respect to religion was Hindu(34) ,Buddhist (35) and Christian (32). Total BACE score in separated /divorced patient was38, single patients was 36 and un married was 32, score across occupation was same for variousservices , viz farmers and others (35) , business (29)and unemployed 34 .

Attitudinal barrier score, stigma and instrumental mean barrier score was calculated according to different socio-demographic profile like sex, socioeconomic status, religion, province, occupation and marital status .

BACE score and scores on its domains of participants

Total BACE Demographics		**score** Mean	**Attitudinal Barrier score** Mean	**Stigma Barrier score** Mean	**Instrumental Barrier score** Mean
Socio-economic status (kuppuswamy)	Lower	40	14	13	7
	Middle	33	11	11	6
	Upper	31	10	11	5
Sex of respondents	Male	34	11	12	6
	Female	33	11	11	6
	Others	.	.	.	.
Province number	1	25	8	9	5
	2	31	10	10	5
	Bagmati	35	12	12	6
	Gandaki	32	11	11	5
	Lumbini	41	14	14	7
	Karnali	37	11	13	9
	Sudhur Paschim	39	14	13	7
Religion	Hindu	34	11	12	6
	Buddhist	35	12	12	6

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respondents	Christian	32	10	12	5
	Others	29	9	8	4
Hospitalization	Yes	36	12	12	7
ever	No	33	11	11	5
Suicidal	Yes	35	12	12	6
attempts ever	No	34	11	12	6
	Married	33	11	11	6
Marital Status	Single	36	13	13	6
Separated/ Divorced		38	11	12	9

Stigma related barriers:

Among the patient reported barriers related to stigma ,the most reported concern was " concerned that I might be seen as weak for having a mental health problem "(33.6 %),followed by "concern that I might be seen as crazy " (26.4%) ,followed by "Concern that my children may be taken into care or that I may lose access or custody without my agreement " (22.6%) and " feeling embarrassed or ashamed " (21.6 %) .Mean stigma related barrier score among male /female and religion was similar, It was higher in Lumbini, Karnali and Sudurpaschim province and lowest in province no.1.

Instrumental barriers:

Among the reported instrumental barriers in BACE scale , "having no one who could help me get professional care (18.2)" was the most reported major barrier followed by " being unsure where to get professional care "(17.8)" followed by being too unwell to ask for help " (14.4%).

Attitudinal barrier:

Among the different attitudinal components in BACE scale "wanting to solve problem on my own" (21.9%) was the most reported barrier followed by "dislikes of talking about my feelings, emotions or thought "(19.5%) and "thinking that I don't have problem"(17.8%).

Discussion

More than half of the patient expressed barriers as either some degree or as major barriers with mean score of 35. The most reported stigma related barrier was "concern that I might be seen as weak as having mental health problem " and this is consistent with the item reported barrier in similar study by Luitel et.al. (Luitel et al., 2017) at Chitwan . Likewise the stigma discrimination related barrier affected majority of participants which suggests lack of common knowledge in societyabout cause and treatment for mental disorders which leads the generation of stigma and discrimination .

Most reported attitudinal barrier item in this study "wanting to solve problem on my own " is the major barrier item reported in recent mental health survey and similar to study by Dockery et.al ,(Mojtabai et al., 2011) , Reason for this may be difficulties of getting help from the person

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in family and consequences of structural stigma which may limit resources given to mental healthservices ,similarly treatment stigma has a negative effect on service user's help seeking particularly in regards to disclosure and confidentiality .

This study found higher total BACE score in Divorced/Widowed as compared with married and unmarried participants, this could possibly point towards the perception of divorce by society and stigmatization towards their marital status which could have confounded the findings. People with prior suicidal attempts and patient with previous hospital admission have more score on BACE scale which may be due to stigmatization regarding their attempts, hospital admission and fear that mental illness if present would be known to others which would add up more stigma and attitude of patients may be affected by the perception of their Friends and family. In a study by Daniel .Goldstone et .al (Goldstone et al., 2018)regarding perceptions of barrier tosuicide prevention , structural barrier ,stigma ,poverty were the major reason .

In our study regarding, age of participants was significantly high BACE score was seen among those in age group <45 years ,This findings is consistent with other similar studies which shows that younger people find more barriers and therefore find more difficulties in seeking help in mental health care . Older people may have more contact with mental health professionals and, with it ,a lower barrier of attitudinal access (Campo Arias et.al,Dockery et.al).

In our study we also found that socioeconomic status is associated with BACE score ,higher barriers was seen in those with lower socioeconomic status which may be becacuse of low level of occupation or unemployment ,lower knowledge and not being exposed to such services making them more susceptible to erroneous traditional beliefs regarding mental health which they may hold strongly and this may have contributed to higherlevel of barriers to service utilization . Interestingly, individuals reporting a low family incomehad a high probability of reporting psychiatric symptoms, which could be related to more exposure to stress and deprivation circumstances, but it could also be due to difficulty of individuals with mental disorders to obtain and maintain good jobs .

Over all most of the findings in this study is is consistent with the findings of previous studies by Luitel et.al, Dockery et.al and Bustamate et .al.

Strength and Limitations

This is the study to report on barriers to care utilizing BACE in Mental hospital, which is the only central hospital for mental health. As compared to another similar study (Dockery et.al, clement et.al) this study has large sample size. As this scale is self-administered scale, patient were free to rate their score in attitudinal ,stigma related and instrumental score .

As this study was hospital based results cannot be generalized to community samples, this may include to those patient who are severe during the time of their first service utilization .The BACE scale is only to be filled by the those who are able to read and write ,this could not include to those who are illiterate . In addition, although the patient may be stable during the time of interview there may be unnoticed psychopathology that may interfere with the total BACE score.

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As this is a cross sectional study ,based on hospital setting there may be bias in terms of case selection, Although maximum precautions was taken to avoid any errors while entering the raw data and analyzing it, chances of human errors are still possible.

Clinical Implication:

Barriers to care are prevalent in our community, As identified the most commonly reported items were “Concern that I might be seen as weak for having a mental health problem “followed by "Concern that I might be seen as crazy".Incorporating stigma reducing programs at least during inpatient management of patients can do a great deal in reducing affiliate stigma, In a hospital-based setting, stigma reduction approach by education and contact is suggested, Approach by education increases knowledgeabout mental illness and thus leads people to be less likely to endorse stigma and discrimination. This education intervention could be by group sessions, flyers, posters, pamphlets, audio and visual aids during visits to hospital. Approach by contact facilitates stigmatized people to interact, people with mental illness and their affiliates. Being in contact with them will lead to realization, of negative aspects of their prejudice thus decreasing chancesof endorsing and internalizing, with the end product being less affiliate stigma.

As this study has measured the instrumental barriers and attitudinal barriers, policy to increase the mental health service utilization and to make service more accessible can be considered. Identifying barriers not only measures the gap for help seeking behavior, considering the possible barrier can help clinician to maintain uninterrupted compliance, regular follow-up and improve social support. All these changes will ultimately lead to better prognosis,shortened course of illness, decrease cost and burden of frequent admission and prevent cognitive decline and disability.

Conclusion

It can be concluded that barriers to mental health service utilization is endorsed by the participants of this study.

Among the patient reported barriers related to stigma ,the most reported concern was “ concerned that I might be seen as weak for having a mental health problem “(33.6 %),followed by “concern that I might be seen as crazy “ (26.4%) ,followed by “Concern that my children may be taken into care or that I may lose access or custody without my agreement “ (22.6%) and ” feeling embarrassed or ashamed “ (21.6 %) . Among the reported instrumental barriers in BACE scale , “having no one who could help me get professional care (18.2)“ was the most reported major barrier followed by “ being unsure where to get professional care “(17.8)“ followed by being too unwell to ask for help “ (14.4%). Among the different attitudinal components in BACE scale “wanting to solve problem on my own” (21.9%) was the most reported barrier followed by “dislikes of talking about my feelings, emotions or thought “(19.5%) and “thinking that I don’t have problem”(17.8%).

Recommendations

Future studies must be conducted to elicit the reliability of these findings. Inclusion of the severity of illness, variables measuring other burdens and other factors experienced by

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participants canbe useful in eliminating possible confounders. Validation of the tool measuring barriers in the context of Nepal is also recommended.

Author Contribution: Rationale of study, literature review, topic selection, data collection and analysis**.**

Conflict of interest: No conflict of interest

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