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Barriers to Effective Mental Health Problems Management by Family Doctors in Primary Health Care Settings

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Abstract

Barriers to effective mental health problems management by family doctors in primary health care settings often stem from systemic and structural issues. One significant barrier is the lack of time during patient consultations. Family doctors frequently have heavy caseloads, which limits their ability to conduct thorough assessments and engage in meaningful discussions about mental health. Additionally, many practitioners may feel ill-equipped to handle mental health issues due to insufficient training during their education. Despite the high prevalence of mental health conditions, primary care training programs have historically emphasized physical health, leaving physicians underprepared to identify and treat psychological disorders. Furthermore, stigma surrounding mental health can further complicate patient interactions in primary care settings. Family doctors may experience their own latent biases about mental health, which can influence the quality of care they provide. Patients, too, may be hesitant to disclose mental health concerns due to fear of being judged or misunderstood, leading to underreporting of symptoms. Financial and resource limitations also play a role; many family practices lack access to mental health specialists for referrals or collaborative care, constraining doctors' ability to offer comprehensive treatment plans. As a result, these barriers can lead to inadequate management of mental health issues, potentially exacerbating the overall health outcomes for patients in primary care environments.

Keywords: Barriers, mental health, family doctors, primary care, stigma, training.

INTRODUCTION

According to the World Health Organization (WHO), a health system is the culmination of all the institutions, organizations, and resources that work to enhance the general public's health. It should offer universal healthcare and resources of high quality, provide adequate and proper financial services, and safeguard everyone's right to health through professional or non-professional assistance [1].

According to the World Health Organization, the quality, scope, and validity of a health system's operations can be assessed by looking at its six essential components: leadership and governance; service delivery; health workforce; health information system; medical products, vaccines, and technologies; and health system financing. The World Bank categorizes countries into four distinct income groups, which are used to assess the development of healthcare systems. These groups are often further categorized in the literature into two broader classifications: low- and middle-income countries (LMICs) and high- and middle-income countries (HMICs) [2].

A state of mental health is one in which each individual achieves their full potential, manages day-to-day issues, works efficiently, and contributes to their community (Roberts, 2018). Despite the fact that mental health is an essential component of overall health, the problem has not received enough attention from healthcare organizations [3].

In low- and middle-income countries (LMICs), the majority of people with mental health conditions, including depression, bipolar affective disorder, ADHD, anxiety disorders, and behavioral and emotional disorders in children, do not receive mental health support because of both known and unknown obstacles [4].

It is estimated that by 2030, schizophrenia, depressive disorders, bipolar disorders, and health-related issues in LMICs will account for 19.1% of the

mental health disorders. However, cultural and social factors like stigmatization, discrimination, and some superstitious beliefs contribute significantly to the burden of mental health disease in the population. Mental health issues encompass anxiety, depression, and psychiatric illnesses such as schizophrenia, bipolar disorders, and substance abuse-related disorders. Our review indicates that low- and middle-income countries (LMICs) are facing a shortage of resources, and the challenges related to funding for mental health education must be addressed [5].

With many of its effects still unknown, it is an understatement to say that COVID-19 has disrupted global activities as we know them, including foreign travel, workplace ethics, food supply and distribution, and corporate norms, among others [6].

Since COVID-19 is significantly affecting our communities' mental health, it is more crucial than ever to develop and implement mental health services in primary care in LMICs. People are afraid and apprehensive about their own and their loved ones' health, and stress levels have dramatically grown. Employment problems are getting worse, which is causing more people to live in poverty and consume drugs as a result of depression and social isolation. Since studies from the 2000s are included here, this study will assist in identifying the present challenges [7].

There are a number of barriers that prevent primary care providers and family doctors from working efficiently in LMIC institutions. Although a number of hurdles have been reported in recent studies (Kamvura *et al*., 2022), little is known about them [8]. Regardless of resource constraints, these experts offer vital healthcare services to a variety of patients (Pokhrel *et al*., 2021) [9]. As recently suggested in this review, the dearth of existing literature on the mental health competencies and skills of primary care practitioners in LMICs can result in serious impairment and a substantial health burden on LMICs as a post-pandemic consequence [10].

Challenges facing primary care physicians in managing mental health:

In order to alleviate the burden on busy primary care physicians (PCPs) and to address gaps in access to high-quality mental health treatment in primary care, policymakers, providers, and researchers devised CC models. Under the guidance of a psychiatrist who helps with case reviews and challenging cases, care managers—typically nurses or certified social workers—provide monitoring (using standardized screening tools) and problem-solving treatment. They are the cornerstone of these models. The programs' ability to manage or even successfully treat the new flood of patients with mental health concerns is still up in the air. In fact, high point prevalence estimates of stress (29%-31%), depression (25%-47%), anxiety (32%-47%), sleep difficulties (34%-36%), and posttraumatic stress disorder (16%-18%) are reported in research from various nations completed in 2020 (53 studies; n = 158,000). [11].

Even before COVID-19, settings with CC programs indicated a lack of resources (such as full-time equivalents of care managers) to handle the number and complexity of prevalent mental health illnesses that are observed in actual primary care settings [12].

Despite advancements in payment models and a growing number of non-physicians, this problem still exists. Low reimbursement rates, time constraints from conflicting demands (e.g., therapy vs. coordination), low job satisfaction, and less-than-ideal relationships with PCPs—especially in large primary care settings with multiple PCPs per care manager—are some of the factors that contribute to the shortage of care managers to meet patient demand [12].

A robust, integrated primary health care system is also essential for CC outcomes, but this has historically been challenging to universally adopt [13].

Additionally, the COVID-19 pandemic's quick adoption of telemedicine has an impact on clinical responsibilities, especially for physician assistants who have historically performed depression screening but do not have pre-visit telemedicine protocols. Dispersed infrastructures for staff, patient, and provider communication have also become prevalent. The economic impact of COVID-19 has resulted in increased case-mix adjusted costs and a higher proportion of uninsured, Medicare, and Medicaid patients in various medical settings. However, there isn't much research that looks at the particular difficulties in implementing CC in environments that use fee-for-service structures that undervalue mental health services [12].

The implementation of CC also depends on provider engagement. However, PCPs are increasingly dealing with shorter, now remote visits; administrative, teaching, and telemedicine onboarding tasks; high trainee turnover; and conflicting quality improvement priorities (e.g., diabetes targets, domestic violence screening), all of which lead to burnout and exhaustion [12].

In academic settings, many providers are not physically present in clinics (e.g., have half-day sessions) and do not receive formal training in mental health or CC during residency, which leaves physicians unprepared to effectively manage the mental health conditions of their patients and provide "shared care" with a psychiatrist based on population health [14].

Furthermore, even though physician-to-physician engagement frequently creates a medical learning environment that improves the psychiatric treatment skills of PCPs, direct communication between

PCPs and psychiatrists remains rare in these models, which may explain why even successfully implemented CC programs see remission in less than half of patients. Moreover, rising rates of provider psychological distress may make it more difficult to identify and treat mental health issues in patients [15].

Stigma, fear of side effects, lack of treatment options, and a preference for physical concerns are patient-level barriers that lead to nonadherence. Chronic, resistant, psychosomatic symptoms that are frequently observed in primary care settings further exacerbate these barriers. It's unclear if the short-term care offered by CC can adequately manage the long-term physical and mental effects of COVID-19 [16].

Role Discordance: Challenges For Psychiatrists:

Psychiatrists must step back from direct patient care and work with a care manager who provides therapy and communicates with the PCP for medication management. While in an idealized CC setting, psychiatrists' limited time would be spent supervising the care manager and educating the team. For a variety of reasons, psychiatry residency, like all other medical residency training programs, offers little to no training in managing other clinicians (such as care managers) or communicating with PCPs. The combination of needless psychiatric consultations or patients staying in primary care who require referral to more specialized treatment results from the lack of concrete data to determine whether a patient would be better suited for independent care by the PCP as opposed to direct or indirect (via care manager) psychiatric consultation. Furthermore, many doctors enter psychiatry particularly to spend time providing individual treatment to patients, as is the case with the majority of other specialty residency training programs. This leads to a propensity for direct vs indirect consultation. Finding psychiatrists for these positions is difficult due to these issues as well as the shortage of general psychiatrists. The introduction of telepsychiatry has improved patient and provider access and convenience, but it has also resulted in fewer face-to-face interactions with PCPs and care managers. These interactions can present special difficulties, such as a decrease in nonverbal cues and informal interactions, which are frequently essential for elucidating clinical and process details and establishing rapport and trust within the team [17].

Barriers to mental health treatment in primary care practice in low- and middle-income countries in a post-covid era:

In our review, we concentrated on the key factors that influenced access to mental healthcare services, particularly in LMICs. The attitudes toward mental health issues, the acceptance of the problem's existence, and the credibility of the healthcare centers are among the barriers to a community's access to mental healthcare. It was also established that knowledge and skills related to mental health play a significant role; a lack of adequate knowledge about mental health issues leads to stigmatization. The main themes have been management and leadership, financial resources, and the motivation to change.

Social-cultural factors:

Community mental health knowledge, attitudes toward the mental health program, and drive to change are the primary obstacles to receiving mental healthcare treatment in the sociocultural community setting. These elements are crucial for changing behavior and have a close relationship with one another. The obstacles under the healthcare systems are also categorized as those pertaining to administration and leadership, as well as the distribution of financial resources [18].

All of the relevant studies, with the exception of one, showed community reactions about the appropriateness, acceptability, and credibility of mental health treatments in primary health clinics (PHCs) [19].

In the community context, the barriers include (a) the belief that mental illness is a punishment from God or the ancestors rather than a disease (the majority of the communities lack knowledge about mental health and do not know that people with the disorder should be taken for treatment); (b) cultural beliefs about the dangers of people with mental illness have caused stigmatization and avoidance of these people [18].

It was also proven that most people avoid seeking medication because it looks shameful, as they will be labeled as mad or crazy [20]. Additionally, the communities are not satisfied with the level of knowledge possessed by the family physicians, which discourages them from continuing to seek treatment. Furthermore, it was discovered that a major obstacle to receiving the best care possible in primary care settings in LMICs is the presence of unfavorable attitudes regarding mental health. In response, primary care physicians (PCPs) indicated a lack of understanding and poor consultation abilities by stating that mental healthcare services are not included in primary care practices [20].

Knowledge and Skills:

Barriers related to knowledge and skills were found in every study. A few of the major problems are the low rate of mental illness diagnosis and treatment due to inadequate facilities, which leads to a lot of referrals, the inability to identify antipsychotic medications, the lack of knowledge about psychosocial interventions, the lack of awareness and training regarding mental health issues, the lack of screening tools, and the lack of education and skills regarding health structures and processes in mental health management .Because they involve strength, knowledge, and abilities, these characteristics were categorized as behavioral aspects under COM-B and as "capability" in the SURE framework. These problems were evident in all LMICs

when looking at the primary care setting in terms of knowledge and abilities [21].

Motivation to Change:

The desire to change can both help and hinder access to mental health services. Only one of the eligible studies did not offer a clear explanation of why [21].

According to the review, the following are important motivation-related obstacles to receiving mental health services:

- Lack of enthusiasm for providing mental health care
- a heavy workload in a short amount of time
- Insufficient community and district-level assistance
- Insufficient resources to deliver adequate care
- The consequences of diagnosing mental health conditions or providing care for patients with mental health issues

Since they entail resources, time, cues, location, interpersonal impact, physical affordance, and social and cultural elements, all of the SURE model's barriers were classified as "opportunities" in COM-B.

Health management and leadership:

There are eight research studies that identified management and leadership-related barriers to mental healthcare services [22].

These include inadequate planning, organization, and coordination between primary healthcare providers and the government to design legislation and policies inadequate training in mental healthcare services, especially for family physicians; a lack of government support to develop knowledge and skills in PCPs; a lack of prioritization of mental healthcare issues; a lack of knowledge about system structure and work processes; the healthcare system's inability to respond to the rise in mental health issues; and a lack of interest by institutions and the government in creating responsive mental health services [23].In this study, the management and leadership barriers were identified in nine studies and they were classified as the “Opportunity” domain under the SURE model and COM-B.

Financial resources:

Five of the chosen studies highlighted the financial and resource-related obstacles that primary care settings encounter when integrating mental healthcare services. These obstacles include insufficient funding allocation, a lack of benefits and motivation for employees, the inability to hire and support staff to lower the cost of mental health at the community level, and uncertainty about funding continuation. The SURE framework classified the financial resource barriers under the “Motivation” domain [24].

COVID-19: An enhancer of barriers to mental health treatment in LMICs:

The indiscriminate global spread of COVID-19 has caused severe mental stress for many people, including food hardship, job loss, and the inability to manage pre-existing medical conditions and maintain preventive measures like social distancing and use of personal protective equipment (PPE). Those with autoimmune disorders and chronic illnesses are among the most vulnerable during the COVID-19 period. Recent research indicates that the epidemic has caused a 30% increase in stress levels [7].

In order for people and families to accept reasonably priced mental health services, it is necessary to improve primary healthcare in the community. Here, we can cite the WHO, which explicitly recognized primary healthcare as the best way to deliver all-encompassing mental health treatments in LMICs. In LMICs, this will lessen stigma, enhance primary care availability and quality, lessen the prevalence of chronic mental illness, and enhance social integration [25].

Implications and future directions:

The current mental health treatment gap is caused by stigma, a lack of human resources, fragmented service delivery models, and a lack of research capacity for implementation and policy change (Qureshi *et al*., 2021; Tausch *et al*., 2022) [26]. This review outlines how health systems in LMICs can address this mental health gap and further identify challenges and priority areas, especially after the coronavirus pandemic, for future research. Primary care is the first stop for the majority of people with mental symptoms (Goel *et al*., 2022) [27].

Consequences of stigma for access and quality care:

For instance, people's reluctance to seek help for a mental illness has been linked to anticipated stigma from healthcare providers. The consequences of these issues include compromised patient-provider relationships and early termination of treatment [28]. According to a survey conducted by the Canadian Psychiatric Association, 79% of respondents reported first-hand experiences of discrimination towards a patient, and 53% observed other medical providers discriminating against a patient from psychiatry [29].

Additionally, stigma has an impact on patient safety. A recent Canadian study found that stigma, which results from institutional culture and staff attitudes as well as the stigmatized marginalization of mental health patients, is a barrier to patient safety [30].

Another effect of stigmatization is that people with mental diseases receive worse physical care. When seeking care for non-mental health issues, those who have lived with a mental illness frequently have difficulties getting their physical care needs fulfilled, such as not having their symptoms taken seriously [29].

Research also shows that people with a history of mental illness receive lower-quality care for their physical health issues. It is thought that this is mostly caused by a process known as "diagnosis and treatment overshadowing," in which physical symptoms are mistakenly linked to a patient's mental illness, delaying diagnosis and treatment choices [31].

Additionally, stigmatization affects health professionals' own willingness to disclose a mental health issue or seek help, which can lead to an excessive reliance on self-treatment, a lack of peer support (including rejection and criticism from coworkers if disclosure does occur), and an elevated risk of suicide. It is even more crucial to take into account the effects of stigma in this setting because mental diseases are linked to presenteeism and productivity losses in the workplace. For instance, early resistance to asking for assistance could lead to lower productivity, which could then reinforce preconceptions and create stigma among coworkers, which would make people even less inclined to ask for assistance [32].

CONCLUSION

The data in this review shows that there are currently no healthcare policies that address the barriers to mental health services that have been identified. Care for people with mental illnesses will continue to be compromised if the main obstacles are not taken into account. We find that the underlying social and economic problems in these communities are reflected in barriers to accessing mental healthcare services in primary care settings. In 8 out of 14 studies, we were able to pinpoint stigma as the main social context barrier. Religious and spiritual values then influenced the decision to seek mental health care in LMICs. We discovered that healthcare organizations' lack of interest in mental health services is reflected in the poor policies and health models of LMICs without mental health services. We also draw the conclusion that corruption in LMICs neglected mental health in these communities and diverted available international monies to other health concerns. According to this study, the COVID-19 pandemic has made social determinants of health worse and has revealed that stigma in the community seriously hinders mental health care in LMICs. We come to the conclusion that family physicians' ignorance of mental health services is the reason for the low uptake of mental healthcare. We encourage more post-pandemic mental health research to uncover context-specific barriers to mental health services in primary care that LMICs face, given that the current COVID-19 pandemic has resulted in an increase in mental diseases. To enhance mental health care worldwide, appropriate interventions might be suggested.

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