



Review Article

Barriers to Mental Health Treatment for Children and Adolescent: A Systematic Review

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ABSTRACT

Background: Despite the higher prevalence of mental health problem among children and adolescent, the rate of mental health services utilization among this group is still low. Among small number of children and adolescents attended mental health treatment, many of them tend to prematurely terminate the treatment offered.

Objective: This systematic review aims to provide an overview reported barriers to mental health treatment for children and adolescents from the perspectives of parents or caregivers.

Methods: Quantitative studies published between 2005 to March 2015 were identified through electronic searching via four selected databases, PsycINFO, Psychology and Behavioural Sciences Collection, CINAHL and ProQuest. Studies which involved parents or caregiver of targeted children aged between 2 to 18 years were included. Relevant data were extracted and barriers to mental health treatment were reviewed.

Results: Five studies were identified met the inclusion criteria included for this review. The most prominent barriers reported by parents or caregivers of children and adolescent aged between 2 to 18 were attitudinal barriers that include beliefs that nothing could help, seeking help is a sign of weakness or failure, reluctance to admit to having mental health problems, denial of problems, too embarrassed to seek help and barriers related to stigma.

Conclusions: Attitudinal barrier especially believed that nothing could help is one of the main barriers to mental health treatment for children and adolescent. School-based program could improve children's and adolescent's mental health status by reducing the barriers.

Key Words: Barriers, Mental Health, Treatment, Children, Adolescent.

INTRODUCTION

Prevalence of mental health problem in children was high, however, many children with mental health problem remain unidentified, untreated and low utilization rate of mental health services. This could be due to some barriers, for examples, low social support, lack of transport, competing financial priorities, perception on mental

illness and treatment, parental stressors and lack of knowledge about how to access services. ⁽¹⁾

Moreover, among children who were attended for treatment, many of the children tend to disengage from treatment prematurely and fail to respond to the treatment offered. ⁽²⁾ Surprisingly, a large proportion, 28% up to 75%, of the

treatments in adolescent mental health care also results in premature termination (dropout).⁽³⁾ Predictors of dropout for Cognitive Behavioural Therapy (CBT)-based mental health treatment among children in community clinic were low child and parent rated treatment credibility and high parent self-rated internalizing symptoms.⁽⁴⁾ Whereas, in adolescent, the main predictors for anxiety treatment dropout was comorbid depression symptom.⁽⁵⁾ If left untreated, negative outcomes associated with children mental health problems such as depression were lead to poor academic performance, family and social dysfunction, physical ill health, suicide attempts and completed suicide.⁽⁶⁾

The rate of mental health services utilization was not only low among children and adolescent but also adult and elderly. For example, in United State, only approximately one third of the estimated 46 million adults in this country with mental illness receiving treatment,⁽⁷⁾ whereas, in Netherland, 65.5% of young adult with serious internalizing or externalizing problems did not seek professional help.⁽⁸⁾ In Australia, among Chinese immigrant showed that the average length of the delay for mental health treatment was 7.04 years and the average time to mental health problem recognition was 8.07 years.⁽⁹⁾

Barriers to mental health treatment among adult were varied, such as, i) Perceived Problems as Self-Limiting and Perceived Help-Seeking Negatively. Perceived Problem as Self-Limiting, for example, they believed that problems were not serious,⁽⁸⁾ low perceived need or desire to handle the problem on one's own,^(10,11) beliefs that the illness will pass by itself.⁽¹²⁾ Perceived Help-Seeking Negatively, for example, they believed that treatment would not help⁽⁸⁾ or doubt whether treatment works.⁽¹²⁾ A part from that, other barriers reported by adults were related to stigma,^(11,13-15) denied having problems,⁽⁸⁾ having problem

with transportation to access the service,^(9,16) lack of knowledge about available treatment,^(9,12) lack of knowledge of their own illness and its treatability,⁽¹²⁾ feelings of shame,⁽¹²⁾ lack of time,⁽¹¹⁾ treatment fearfulness,⁽¹⁷⁾ as well as financial constraints.^(9,14) In older adult, gender also influenced intentions to seek professional psychological help, women exhibited more favourable intentions to seek help from mental health professionals than men, likely due to their positive attitudes concerning psychological openness.⁽¹⁸⁾

Barriers are typically categorised as either structural (for example transportation, time) or attitudinal (for example the relevance of treatment, barrier related to perceptions of mental health problems, perception of mental health services).⁽¹⁹⁾ Other researchers further divided attitudinal barriers into two separate categories, perceptions about mental health problems and perceptions about mental health services, such as Owens et al (2002)⁽²⁰⁾ that categorised barrier into three categories: i) structural (practical) barriers; ii) perceptions about mental health problems and iii) perceptions about mental health services. Baker et al, (2005)⁽²¹⁾ classified barriers into individual factor such as personal beliefs, coping skills, self-efficacy and perceived stigma and these factor interact with structural factors including the accessibility and affordability of services. This review were categorised barriers based on Kerkorian et al, (2006)⁽¹⁹⁾ Proposed barrier to mental health treatment were low social support, lack of transport and child care options, competing financial priorities (food or accommodation, for example), parental stressors, perceptions of mental illness and treatment, lack of knowledge about how to access services and overburdened service providers.⁽²⁰⁾

A large number of studies and reviews were conducted to examine the barriers for mental health in adult aged 18

years and above. Moreover, research on youth help-seeking has focused on adolescents, few studies have examined this in regard to children. ⁽²²⁾ Little is known about the barriers to mental health in children and adolescents. Parents are usually the individuals responsible for children's use of mental health services. ⁽¹⁹⁾ Therefore, this review was conducted in order to provide an overview of parental reports on the barriers to mental health treatment for children and adolescents. In this paper 'children' refers to those aged between 2 and 12 years and 'adolescents' refers to those aged between 12 and 17 years. This systematic review was guided by a research question: What are the barriers to mental health treatment for children and adolescents?

METHODOLOGY

Four databases i) PsycINFO, ii) Psychology and Behavioural Sciences Collection, iii) CINAHL and iv) ProQuest were electronically searched for articles published between 2005 and March 2015, with the key search terms i) Barrier OR Obstruct OR Cause OR Treat, ii) Mental Health OR Mental Disorders and iii) help seek OR seek help OR seek treatment OR Help Seeking Behaviour. Based on the initial screening, completely irrelevant articles that were unrelated to the topic of this review were excluded at this stage, while relevant studies were retained and the selected full-text articles were examined for the second-stage screening. By using the full-text, a second-stage screening was performed to determine their eligibility for this review based on inclusion and exclusion criteria.

The inclusion criteria for this systematic review were i) the study was published in a English language journal, ii) study was accessible for the full text in databases subscribed, iii) study describing what parents or caregivers reported the barriers to mental health treatment for their

children and adolescents, iv) studies involved parents or caregiver of targeted children aged between 2 to 18 years (this criterion was considered met if more than 75% of the targeted children or adolescent were aged between 2-18 years age range, the sample mean age was 17 year or below). Exclusion criteria for this review were i) study was a review, ii) qualitative study and iii) Study participants were not members of the general community (e.g., studies of groups with restricted access to a range of help-seeking opportunities such as prisoners and members of the military).

A standardized electronic form was used as references in order to assist data extraction process. Data extracted from selected studies include: i) reference item such as, journal, title, author and year of publication, ii) study design, iii) number of participants, iv) study instruments or questionnaire used to measure barriers for mental health treatment in children and adolescent, v) children's age range or mean age and vi) main finding of the study.

Study methodological quality was assessed based on 22 criteria of '*Strengthening the Reporting of Observational studies in Epidemiology*' (STROBE) checklist. This checklist was developed by an international collaboration of epidemiologists, statisticians and journal editors. Although not a tool for assessing the quality of primary studies, they provide a useful indication of the essential information needed to appraise the conduct of such studies. ⁽²³⁾ The 22 criteria covered all the components in an observational epidemiological study such as cross-sectional, the components includes i) title and abstract, ii) introduction, iii) methods, iv) participants, v) results, vi) discussion and vii) other information, for example, funding.

Selected studies for this systematic review were analysed descriptively. Characteristic of the study were describe based on authors and year of publication,

age range of study participants, the total number of study participants, main finding of study and the study methodological quality rating. Measure, for instance, only significant percentage being considered in the result of this review.

RESULTS

The total of 97 relevant published paper were identified from the searching process through four databases (PsycINFO, Psychology and Behavioural Sciences Collection, CINAHL and ProQuest). The title and abstracts of these relevant articles were screened by the primary author at the first screening stage. 88 studies were excluded with reasons for exclusions at the first stage and the reasons were stated clearly in a flow diagram (Figure 1). For the second stage of screening, 9 of the remaining studies were screen for eligibility by using their full-text of articles and the screening process was based on inclusion criteria. Two studies were excluded with reasons whereas, five studies that met the inclusion criteria were eligible and included for this systematic review.

Study Included and Quality Assessment: The characteristics of each of the included studies on barriers to mental health treatment are detailed in Table 1. An overview of these characteristics includes the year and location of the study, the

methodologies employed, sample size, the measurement tool used to measure barriers to mental health treatment and the age of targeted children or adolescents.

The studies were published between 2006 to 2013, with most conducted in the United States (n=4) and theremainder conducted in Australia (n=1). In term of study design, two of studies employed cross-sectional study, one study conducted by using mixed-method, one study was autopsy and another one was a survey. The number of participants or sample size in the studies ranged from 163 to 3746. Data reported on the age of targeted children or adolescent also varied. Two studies provided an age range in years 13-21 and 12-25. One study with median age of 10 and another one study reported mean age of children and adolescent, 14. The remaining study reported the lowest mean age of the targeted children, 5.48 years (kindergarteners).

Two studies scored 17 and 18, whereas another three studies scored below 17 out of 22. Studies with low scores were related to lack of information describing efforts to address potential sources of bias, how the study size was obtained and statistical methods used to control for confounding and make clear which confounders were adjusted for and why they were included.

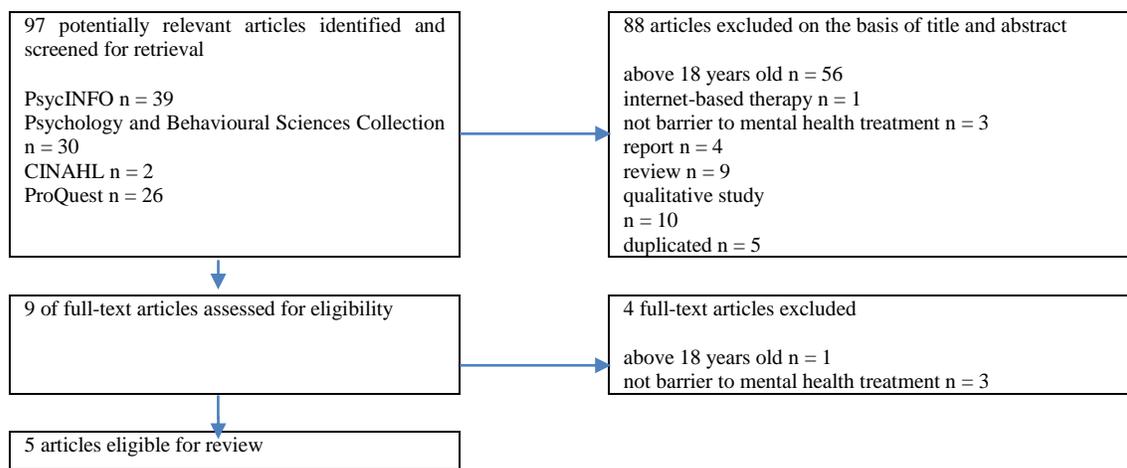


Figure 1: Flow Diagram of Study Selection Process

Table 1: The characteristic of included studies.

Title (Authors, year, country)	Study design	N	Tool	Children's age (median, mean or range) (year)	Study Quality
Seeking Help a Second Time: Parents'/Caregivers' Characterizations of Previous Experiences With Mental Health Services for Their Children and Perceptions of Barriers to Future Use (Kerkorian et al, 2006, United States)	Cross-sectional	253	Child and Adolescent Services Assessment ⁽²⁴⁾	10.2	18/22
Utah Youth Suicide Study : Barriers to Mental Health Treatment for Adolescents (Moskos et al, 2007, United States)	Psychological autopsy	270	Name of questionnaire used was not mention	13-21	13/22
Where to seek help for a mental disorder? National survey of the beliefs of Australian youth and their parents (Jorm et al, 2007, Australia)	Survey	3746	Name of questionnaire used was not mention	12-25	14/22
Examining Perceptions About Mental Health Care and Help-Seeking Among Rural African American Families of Adolescents (Murry et al, 2011, United States)	Mixed-method	163	The Perceived Help-Seeking Behavior Scale ⁽²⁵⁾	14	13/22
Perceived Barriers to Help-Seeking Among Parents of At-Risk Kindergarteners in Rural Communities (Girio-Herrera et al, 2013, United States)	Cross-sectional	693	Barriers to Participation Scale ⁽²⁶⁾	5.48	17/22

Table 2: Barriers to Mental Health Treatment for Children and Adolescent

Authors (year)	Barriers to Mental Health Treatment
Kerkorian et al. (2006) ⁽¹⁹⁾	Doubt about the utility of treatment as a possible barrier to their children's use of future services (p<0.05)
Moskos et al. (2007) ⁽²⁷⁾	Belief that nothing could help (73%) Seeking help is a sign of weakness or failure (71%) Reluctance to admit to having mental health problems (58%) Denial of problems (54%) Too embarrassed to seek help (52%) Couldn't afford help (31%) Insurance wouldn't cover help (27%) Did not know where to go (25%) Nothing available in community (23%) Had bad experience seeking help before (23%) Waiting list for services (20%) Parents fear, dislike, or distrust professionals (10%) Transportation problems (6%)
Jorm et al. (2007) ⁽²⁸⁾	Resistance from child (14%) Cost of seeing specialist (8%)
Murry et al. (2011) ⁽²⁹⁾	Related to stigma (49.4%) Services would be too expensive (43%) Would "make everything worse" (17.9%)
Girio-Herrera et al. (2013) ⁽³⁰⁾	Treatment would cost too much (14.7%) Treatment is not necessary (12.5%)

Barrier to Mental Health Treatment: The list of barriers reported by parents or caregivers varied across studies. The top rated barriers were those endorsed by the greatest percentage of respondents were presented in Table 2. One study included in this review was not using percentage of respondents in reporting the most prominent barrier to mental health treatment, however, the result showed the significant association between endorsement of doubt about the utility of treatment as potential barrier to children's use of services in the future and the number of barrier parents endorsed. ⁽¹⁹⁾

Top rated barriers (based on the greatest percentage of respondents) from the remaining four included studies were believed that nothing could help (73%), seeking help is a sign of weakness or failure (71%), reluctance to admit to having mental health problems (58%), denial of problems (54%), too embarrassed to seek help (52%), related to stigma (49.4%) and services would be too expensive (43%). Majority of these prominent barriers are attitudinal barriers that related to perception on mental health problem and mental health services. The structural (practical) barrier to mental

health treatment such as transportation problem (6%), was less prominent reported by parents or caregivers as barriers to mental health treatment for children and adolescent.

DISCUSSION

This review focuses on barriers to mental health treatment for children and adolescent that was reported by parents or caregivers. The barriers in this studies were categorised into two based on Kerkorian et al, (2006);⁽¹⁹⁾ i) structural and ii) attitudinal barriers. The present review identified the most prominent barriers were attitudinal barriers.

Attitudinal barriers

The recent review were group the attitudinal barrier by Kerkorian et al, (2006)⁽¹⁹⁾ and Baker et al, (2005)⁽²¹⁾ into same type of barrier which is attitudinal barriers.

Belief that nothing could help and seeking help is a sign of weakness or failure

In this review, belief that nothing could help and seeking help is a sign of weakness or failure were rated as the most prominent barriers to mental health treatment for children and adolescent. Belief of nothing could help and seeking help is a sign of weakness or failure were barrier related to stigma.⁽²⁷⁾ Similarly, the most prominent barriers to mental health treatment reported by Murry et al. (2011)⁽²⁵⁾ and Gulliver et al. (2010)⁽³¹⁾ was also barriers related to stigma.

In addition, belief of seeking help is a sign of weakness or failure was also may be related to lack of knowledge on effectiveness of mental health treatment.⁽²⁷⁾ Insufficient knowledge on available mental health treatment also one of the commonest barriers reported by Garcia-Soriano et al, (2014),⁽³⁰⁾ therefore, parents or caregiver of children did not know where to go to find help (25%).⁽²⁷⁾

Reluctance to admit to having mental health problems and denial of problems

Reluctance to admit to having mental health problem and denial of problems were also considered barriers related to stigma. Stigma-related barriers to mental health treatment may cause parents or caregivers concerns about what others might think of them and their children if they were seek help.⁽³¹⁾

Too embarrassed

In line with a review conducted to examine the factors associated with non-treatment among Obsessive-compulsive disorder (OCD) sufferers, common barriers to seeking treatment were shame about the symptoms or about asking for treatment.⁽³⁰⁾ Parents or caregivers may concern about the confidentiality with respect to the person who offers help for example mental health professional or psychiatrist breach in confidentiality and embarrassment, peers or family may find out who had receive mental health treatment.⁽³¹⁾

Doubt about utility of treatment

One included study found doubt about the utility of treatment as a possible barrier to their children's use of future services ($p < 0.05$).⁽¹⁹⁾ This could be related to having bad experience seeking help before and parents fear, dislike, or distrust professionals as reported by parents or caregivers as barriers to mental health treatment.⁽²⁷⁾ In line with finding from a qualitative study that found fear of parental was identified as a barrier to mental health treatment.⁽³²⁾

Structural barriers

Accessibility: Treatment would cost too much and transportation problem

Four of included studies showed parents' reports on barriers to mental health treatment were related to treatment cost. Barriers related to treatment cost were; i) services would be too expensive (43%),⁽²⁹⁾ ii) couldn't afford help (31%),⁽²⁷⁾ iii) treatment would cost too much (14.7%)⁽³¹⁾ and Cost of seeing specialist (8%).⁽²⁸⁾ Two of the above studies were conducted in rural

communities. ^(29,31) In rural communities, parents or caregivers may experience this barrier because of financial priorities. This finding is consistent with previous review, where, lack of affordability such as cost was a prominent barrier in the studies of rural communities. ⁽³¹⁾ The less common barrier reported by parents or caregiver was also structural barrier which was transportation problems (6%). ⁽²⁷⁾

Recommendation

Mental health literacy interventions are a promising method for promoting positive help-seeking attitudes, but there is no evidence that it leads to help-seeking behavior. ⁽³³⁾ Therefore, there is a need for early school mental health screening and interventions to increase parent engagement in mental health service utilization. ⁽³⁴⁾ School-based intervention program can reduce common barriers to treatment in the community, both attitudinal and structural barriers, such as time, location, stigmatization, transportation and cost by offering low-cost and non-threatening alternative intervention program. ⁽³⁵⁾

Limitation

This study has several limitations, including only focused on studies published between 2005 and 2015, full-text, English-language journal and limited to four selected databases. Studies published earlier than 2005, full-text is not accessible, other languages and retrieved from other databases might be missed because of this limitation. A part from that, small numbers of included studies and all included studies were implemented in developed countries with majority in United States limited the generalizability of the finding to other countries and interpretation of this review's result should be made with caution.

CONCLUSION

The most prominent barriers to mental health for children and adolescent reported by parent or caregivers were related

to attitudinal barriers. These include belief that nothing could help, seeking help is a sign of weakness or failure, reluctance to admit to having mental health problems, denial of problems, too embarrassed to seek help and barriers related to stigma. A reasonable solution to reduce barrier to mental health treatment could be through school-based program. School-based program could minimize the barriers by reducing both attitudinal barriers and structural barriers. School-based mental health program could reduce stigmatising effect, cost, time as well as transportation problem.

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