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Barriers to mental health care in Japan: results from the World Mental Health Japan Survey

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Abstract

Aim—The reasons for accessing and maintaining access to mental health services in Japan may be unique in those of other countries. Using the World Health Organization World Mental Health Japan survey data, this study investigated the prevalence of sociodemographic correlates of barriers for the use of, reasons for delayed access to, and reasons for dropping out from mental health care in a Japanese community-based sample.

Methods—An interview survey was conducted with a random sample of residents living in 11 communities across Japan during the years 2002–2006. Data from 4,130 participants were analyzed.

Results—The most frequently reported reason for not seeking mental health care was a low perceived need (63.9%). The most common reason for delaying access to help was the wish to handle the problem on one's own (68.8%), while the most common reason for dropping out of care was also a low perceived need (54.2%). Being a woman and of younger age were key sociodemographic barriers to the use of mental health services.

Conclusion—Low perceived need was a major reason for not seeking, delay in using, and dropout from mental health services in Japan. In addition, low perceived need and structural barriers were more frequently reported than attitudinal barriers, with the exception of a desire to handle the problem on one's own. These findings suggest that to improve therapist-patient communication and quality of mental health care, as well as mental health literacy education in the community, might improve access to care in Japan.

Keywords

Barriers to mental health care; epidemiologic study; mental health service use; sociodemographic correlates; stigma

Introduction

Although mental disorders are common,¹ many people with mental illness remain untreated,² which may result in poor outcomes. Extended periods of untreated illness³ and ceasing treatment early^{4,5} are particularly associated with worse outcomes in people with

mental illness. In addition to poor health outcomes, untreated mental conditions are also associated with societal economic loss.⁶

There are 3 types of reasons for not seeking professional help reported previously⁷: low perceived need (e.g., not feeling a need for help), structural barriers (e.g., unavailable or inaccessible treatments, personnel or transportation or the presence of other inconveniences), and attitudinal barriers (e.g., perceived stigma, low perceived efficacy of treatments, or the desire to handle the problem on one's own) (Appendix Table A1). Of these, the attitudinal barriers related to negative health beliefs and stigmas toward treatment are the most commonly reported in studies conducted in developed Western countries.^{8,9} Reports also indicate that a lack of perceived need for treatment results in less access to physical and mental health care globally.^{7,8} Furthermore, treatment dropout rates tend to be high, owing to a lack of satisfaction with the services in addition to financial barriers.¹⁰

The majority of research that has been conducted relating to barriers to mental health care access originates in Western high-income countries, and it is not known if the results can be generalized to Japan. It has been previously reported that the proportion of those who received treatment among people who had mental disorders in Japan was less than half compared with other high-income countries, despite the fact that the Japanese national health insurance provides universal coverage and also patients are free to select medical institution of their choice.² Stigmatizing attitudes towards mental disorders were reported to be more prevalent in the Japanese than in the Australian public.¹¹ Such stigma could affect their help seeking behaviors, and also their reasons of not seeking, delaying access to, and dropping out from mental health service.^{12,13} For instance, since stigma may be caused by ignorance of mental disorders, low perceived needs may be the most frequent reason of these treatment gaps in Japan. Stigmatized attitude toward mental disorders in Japan may also come from a history of mental health care dominated by the long-term hospital care¹⁴ and polypharmacy¹⁵ in this country. People may perceive that mental health treatment as ineffective or even detrimental. If it is a case, attitude barriers may be more frequently reported. It would be useful to address a country-specific pattern of reasons for not seeking treatment, delay in seeking treatment, and dropping out in a context of mental health care in each country, particularly in Japan with such unique backgrounds.

To the best of our knowledge, there has only been one study to examine the sociodemographic determinants of attitudinal barriers for the use of mental health services in Japan.¹⁶ The results were inconsistent with those in previous studies conducted in Western countries^{17,18,19}; men tended to have a greater willingness to seek professional help and felt more comfortable talking with a professional than women did. Therefore, the reasons for not seeking treatment, delaying treatment, and dropping out of treatment may be country specific. Information regarding these reasons in Japan would be useful for improving the availability and accessibility of mental health services.

Using data from the World Mental Health Japan (WMHJ) surveys,²⁰ this study investigated patterns of the barriers to mental health care access among Japanese community residents and their relationships with sociodemographic characteristics in a Japanese community-based sample.

Methods

Participants

The WMHJ survey was an epidemiological survey of Japanese-speaking community residents aged 20 years and part of the global cross-national World Health Organization (WHO) World Mental Health (WMH) survey.²¹ In Japan, the data were collected at 11 sites in 6 prefectures including 3 urban cities and 9 rural municipalities from 2002 to 2006. These sites were selected on the basis of geographic variation, availability of site investigators, and cooperation of the local government. Subjects for the WMHJ survey were randomly selected from voter registration lists or resident registries at each site. After a letter of invitation was sent, trained lay interviewers contacted the subjects and used a standardized instrument to interview those who agreed to participate in the survey. This survey was composed of 2 parts: Part 1 of the interview contained a core diagnostic assessment and basic sociodemographic data, and Part 2 of the interview collected data about potential correlates and disorders of additional interest. All respondents who consented to participate completed Part 1 of the interview (n = 4,134, response rate = 55.1%). In the present study, we analyzed data from 4,130 participants who had no missing values in the questions relating to reluctance and expectations in the use of mental health services (Figure 1).

The Ethics Committees of Okayama University, the National Institute of Mental Health Japan, and Nagasaki University approved the recruitment, consent, and field procedures. Written informed consent was obtained from each respondent. More details of the study procedures have been reported previously.²⁰

Measures

Sociodemographic predictor variables—Sociodemographic variables included sex, age, and education. Age was categorized into 20–49 years and 50 years. Education was categorized into 0–12 years and 13 years.

Barriers for the use of mental health services—The flow of the questions regarding the reasons for not seeking, delayed access to, and dropping out from mental health services is illustrated in Figure 1. First, the use of mental health care services during the previous 12 months was assessed by asking all respondents if they had consulted any of a list of professionals for problems with emotions, nerves, mental health, or the use of alcohol or drugs. The list of professionals included mental health professionals (e.g. psychiatrist, psychologist), general medical professionals (e.g. general practitioner, occupational therapist), religious counselors, and traditional healers. In this study, “mental health service use” was defined either the use of the mental health professionals or general medical professionals due to for problems with emotions, nerves, mental health, or the use of alcohol or drugs.

Reasons for not seeking mental health services—Respondents who reported no use of mental health care services were asked whether they felt they might have needed to see a professional for mental health problems in the previous 12 months. Those who had felt the

need but did not access any mental health services were asked the reason for not seeking care (multiple answers allowed; see Appendix Table A2).

Reasons for delayed access to mental health services—Respondents who reported accessing mental health care but had delayed access to it for 4 weeks after they first felt a need to see a professional for mental health problems were provided a list of potential reasons for the delay from which to choose (multiple answers allowed; see Appendix Table A2).

Reasons for dropping out of mental health services—Respondents who had accessed mental health care in the previous 12 months were asked if the treatment had ceased and, if so, if they had “quit before the provider wanted me to stop.” Those who saw a provider and “quit” were then provided a list of potential reasons for dropping out similar to the list for not seeking health care (multiple answers allowed; see Appendix Table A2).

Data analysis

Proportions of “reasons for not seeking,” “reasons for delayed access,” and “reasons for dropping out” were compared between the groups classified on the basis of sex, age, or education using Fisher's exact tests. Statistical significance was set at a 2-sided $p < 0.01$. All statistical analyses were conducted using Stata version 12 (StataCorp, College Station, TX, USA).

Results

Sample characteristics

The flow of the study respondents through the interview is shown in Figure 1. Of the 4130 respondents, 467 participants (11.3%) reported that they had ever accessed a professional for a mental health problem. In the past 12 months, 146 had consulted a professional for a mental health problem, 130 felt as if they may have needed to access a professional, 36 did not seek help, 64 delayed accessing a professional, and 24 had dropped out of care.

The characteristics of the total sample ($n = 4130$) are provided in Table 1. Approximately 60% of the respondents were 50 years old. The number of women was slightly higher (54.8%) than that of men. Approximately one-third of the respondents had education higher than high school.

Reasons for lack of access, delayed access, or ceasing mental health care (Table 2-1, Table 3-1, Table 4-1)

Reasons for not seeking mental health services—The most frequently reported reason for not seeking treatment was “The problem went away by itself, and I did not really need help” by 63.9%, followed by “I was unsure about where to go or who to see” by 19.4%, “I thought it would take too much time or be inconvenient” by 16.7%, and “I had problems with things like transportation, childcare, or scheduling that would have made it hard to get to treatment” by 16.7%.

Reasons for delay in accessing mental health services—The most common reasons reported for delayed access to mental health care were “I wanted to handle the problem on my own” by 68.8%, “I thought the problem would get better by itself” by 48.4%, and “The problem didn't bother me very much” by 46.9%.

Reasons for dropping out of mental health services—The most commonly reported reasons for ceasing care were “I didn't need help anymore” by 54.2%, “I got better” by 41.7%, “I was not getting better” by 29.2%, and “I wanted to handle the problem on my own” by 25.0%.

Demographic correlates of barriers to mental health services (Table 2-2, Table 3-2, Table 4-2)

Reasons for not seeking mental health services—The proportion of the respondents who reported, “I was unsure about where to go or who to see” was significantly higher among women than among men ($p < 0.01$).

Reasons for a delay in accessing mental health services—By age, participants aged 20–49 years represented a significantly larger proportion of the respondents who felt structural barriers, including “I was concerned about how much money it would cost” ($p < 0.01$), “I had problems with things like transportation, childcare, or scheduling that would have made it hard to get to treatment” ($p < 0.01$).

Reasons for dropping out of mental health services—There were no significant differences in the reasons for dropping out of mental health services by sociodemographic characteristics

Discussion

The present study demonstrated that low perceived need was the primary and most common reason for not seeking, delayed access to, and dropping out of mental health care services in Japan. Although attitudinal barriers are the ones most commonly reported in Western developed countries,^{8,9} in the present study, more frequently reported were low perceived need and structural barriers, such as lack of information about access to services, the presence of other inconveniences, and difficulties in finding time to access care, than attitudinal barriers. But an exception was a desire to handle the problem on one's own, which was also the major reason for delayed access to and dropout from mental health services.

Similar to previous findings,⁷ the present study demonstrated that a low perceived need for care was a particularly important barrier for seeking services. Low perceived need may be associated with a lack of awareness of mental health problems and treatment effectiveness for these problems. This is concordant with the fact that Japanese people are more likely to attribute the cause of schizophrenia and depression to personality traits, such as nervousness or weakness.²² In addition, low perceived need may be partly related to people's negative perception of mental health service in Japan.

Delayed access to and dropping out of mental health care services were also related to a desire to handle the problem on one's own (68.8% and 25%, respectively). As a reason for the delayed access, it may represent both people's ignorance and negative attitude toward mental health treatment. A similar interpretation could apply to another frequent reason of delayed access, "I didn't think treatment would work" (23.4%). Jorm also reported a similar tendency in Japan that medication was poorly recognized as an effective treatment for mental illness,²³ although we asked respondents' attitude to mental health care in general but the latter report specifically addressed pharmaceutical medication. As a reason of dropping out from treatment, a desire to handle the problem on one's own may arise from a poor therapist-patient communication, in addition to such negative attitude to treatment. In addition, the perceived improvement in one's mental health was a common reason for dropping out ("I got better", 41.7%; "I didn't need help anymore", 54.2%), which again may indicate a poor therapist-patient communication .

Moreover, although these were less frequent reasons, some reasons should be paid attention in their clinical implications: "I received treatment before and it did not work" (10.9%) for delayed access; "I was not getting better" (29.2%); and "I had bad experiences with the treatment providers" (8.3%) for dropping out. These responses may reflect poor quality of community mental health care in Japan, often referred as a tendency of polypharmacy¹⁵ and dominant long-term hospital- based care¹⁴.

Structural barriers to seeking mental health care services, such as a lack of information about access to services, the presence of other inconveniences, and difficulties in finding time, was also commonly reported as reasons for not seeking mental health care services. Structural barriers to seeking mental health care services, such as a lack of information about access to services, the presence of other inconveniences, and difficulties in finding time, were also commonly reported as reasons for not seeking mental health care services in the present study. On the other hand, the attitudinal barriers are the most commonly reported in studies conducted in Western studies.^{8,9} This discrepancy in the findings between Japan and other Western countries^{8,9} may be caused by lack of information about access to mental health care.

Being a woman and of younger age were found to be key sociodemographic factors relating to the barriers to the use of mental health services for the following reason. Women were more likely to report a lack of information about access to services than men were, and this influenced whether they sought help and how quickly they sought help. In addition, younger participants (<50 years old) reported that structural barriers delayed their access to services, including financial problems, difficulties finding time for care, lack of information about access to services, and the presence of other inconveniences. This finding is also supported by a previous report where individuals aged <50 years were more likely to report structural barriers to seeking services.⁷ Therefore, women and younger people may be target groups for disseminating information and education in terms of the use of mental health services. There were no differences in the barriers by years of education. However, dropping out of care owing to a perceived improvement in mental health was more likely among the participants aged <50 years than their older counterparts.

This study has certain limitations. First, a selection bias may affect the findings. The participants who had greater attitudinal barriers, such as stigma towards mental illness, may have been less willing to participate in the study. In addition, previous poor treatment experience may have made people reluctant to participate in the survey. Therefore, the attitudinal barriers may be underestimated in the study. In addition, people with severe mental illness may not wish to participate; more severe illness eventually facilitates problem recognition and prompts help-seeking.²⁴ Therefore, owing to the presence of less severe symptoms and problems, participants might not have felt that professional help was necessary, and this may explain the lack of a perceived need for mental health care. Second, the sample size was relatively small. The analysis of barriers for the use of health services likely suffered from low power owing to the small number of respondents. And the number of older people who did not seek care was only 9. The findings from this small number of participants may be unstable or biased. Third, the study did not know a clinical diagnosis of respondents when they felt a need to see a professional or dropped out from the treatment. It was not clear that all these respondents really needed mental health care. Fourth, responses to the survey may have been biased by the use of a retrospective self-report. Recall bias may result in either an underestimation or overestimation of symptoms and barriers. Furthermore, self-evaluation for the need for mental health services may not be concordant with the evaluation by professionals. The reasons for low perceived need could be divided into an absence of a problem (e.g., presence of subthreshold symptoms) and low expectations for care (e.g., a perceived ineffectiveness of care or disappointment in the results of care).

The present study found that low perceived need was a major reason for not seeking, delay in using, and dropout from mental health care services in Japan. Low perceived need for care and structural barriers were more frequently reported than attitudinal barriers, with the exception of a desire to handle the problem on one's own. Better recognition of mental health issues, improved understanding of the early signs and symptoms of mental health issues, and increased knowledge of the availability and location of effective care may improve access to care for people with mental health conditions. In addition, some findings indicate a need to improve therapist-patient communication and quality of care in community mental health service in Japan.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Eli Lilly and Company, Ortho-McNeil Pharmaceutical, Inc., GlaxoSmithKline, and Bristol-Myers Squibb. A complete list of WMH publications can be found at <http://www.hcp.med.harvard.edu/wmh/publications.php>.

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The flow of the interview questions regarding the reasons for not seeking, delayed access to, and dropping out from mental health services in the World Mental Health Japan Survey

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Table 1

Demographic characteristics of the total sample with perceived barriers to mental health treatment in the World Mental Health Japan Survey 2002–2006 (n = 4130)

	All respondents		Did not seek care		Delayed access to care		Dropped out of care	
	n	%	n	%	n	%	n	%
Age (years)								
18–49	1659	40.2	27	75.0	36	56.3	18	72.0
50	2471	59.8	9	25.0	28	43.8	6	24.0
Sex								
Men	1868	45.2	14	38.9	17	26.6	8	32.0
Women	2262	54.8	22	61.1	47	73.4	16	64.0
Education (years)								
0–12	2710	65.6	16	44.4	30	46.9	11	44.0
13	1416	34.3	20	55.6	34	53.1	13	52.0
Total	4130	100.0	36	100.0	64	100.0	24	100.0

Table 2-1

Reasons for not seeking mental health treatment even though they felt they might have needed professional assistance for a mental health problem (n = 36)

	n	%
1 My health insurance would not cover this type of treatment.	2	5.6
2 The problem went away by itself, and I did not really need help.	23	63.9
3 I thought the problem would get better by itself.	3	8.3
4 I was concerned about how much money it would cost.	-	-
5 I was unsure about where to go or who to see.	7	19.4
6 I didn't think treatment would work.	1	2.8
7 I was concerned about what others might think if they found out I was in treatment.	3	8.3
8 I thought it would take too much time or be inconvenient.	6	16.7
9 I wanted to handle the problem on my own.	4	11.1
10 I could not get an appointment.	-	-
11 I was scared about being put into a hospital against my will.	-	-
12 I was not satisfied with the available services.	-	-
13 I received treatment before and it did not work.	-	-
14 The problem didn't bother me very much.	3	8.3
15 I had problems with things like transportation, childcare, or scheduling that would have made it hard to get to treatment.	6	16.7

No case.

Reasons for not seeking mental health treatment even though they felt they might have needed professional assistance for a mental health problem (n = 36)

Table 2-2

	Age (years)		Sex		Education (years)	
	20-49		Men		0-12	
	%	p	%	p	%	p
1 My health insurance would not cover this type of treatment.	3	0.48	3	1.00	-	0.49
2 The problem went away by itself, and I did not really need help.	44	0.44	25	1.00	31	0.73
3 I thought the problem would get better by itself.	8	1.00	8	0.04	6	0.51
4 I was concerned about how much money it would cost.	-	-	-	-	-	-
5 I was unsure about where to go or who to see.	14	0.46	-	<0.01*	8	1.00
6 I didn't think treatment would work.	3	1.00	-	1.00	-	1.00
7 I was concerned about what others might think if they found out I was in treatment.	6	0.25	3	1.00	6	0.24
8 I thought it would take too much time or be inconvenient.	17	0.46	6	1.00	3	0.27
9 I wanted to handle the problem on my own.	11	1.00	6	1.00	3	1.00
10 I could not get an appointment.	-	-	-	-	-	-
11 I was scared about being put into a hospital against my will.	-	-	-	-	-	-
12 I was not satisfied with the available services.	-	-	-	-	-	-
13 I received treatment before and it did not work.	-	-	-	-	-	-
14 The problem didn't bother me very much.	6	0.42	6	0.51	6	0.51
15 I had problems with things like transportation, childcare, or scheduling that would have made it hard to get to treatment.	17	0.46	3	0.27	3	0.27

No case.

* p<.05, Fisher's exact test.

Table 3-1

Reasons for delayed access to mental health treatment even though they felt they might have needed professional assistance for mental health problem (n = 64)

	n	%
1 My health insurance would not cover this type of treatment.	5	7.8
2 I thought the problem would get better by itself.	31	48.4
3 The problem didn't bother me very much.	30	46.9
4 I wanted to handle the problem on my own.	44	68.8
5 I didn't think treatment would work.	15	23.4
6 I received treatment before and it did not work.	7	10.9
7 I was concerned about how much money it would cost.	9	14.1
8 I was concerned about what others might think if they found out I was in treatment.	18	28.1
9 I had problems with things like transportation, childcare, or scheduling that would have made it hard to get to treatment.	14	21.9
10 I was unsure about where to go or who to see.	26	40.6
11 I thought it would take too much time or be inconvenient.	16	25.0
12 I could not get an appointment.	2	3.1
13 I was scared about being put into a hospital against my will.	1	1.6
14 I was not satisfied with the available services.	1	1.6

Reasons for delayed access to mental health treatment even though they felt they might have needed professional assistance for mental health problem (n = 64)

Table 3-2

	Age (years)				Sex				Education (years)			
	20-49		50		Men		Women		0-12		13	
	%	%	%	%	%	p	%	%	%	p	%	%
1 My health insurance would not cover this type of treatment.	8	0	0.06	2	6	1.00	3	5	1.00			
2 I thought the problem would get better by itself.	25	23	0.62	8	41	0.09	23	25	1.00			
3 The problem didn't bother me very much.	22	25	0.21	13	34	1.00	27	20	0.21			
4 I wanted to handle the problem on my own.	38	31	0.79	11	58	<0.01*	33	36	1.00			
5 I didn't think treatment would work.	16	8	0.39	2	22	0.05	11	13	1.00			
6 I received treatment before and it did not work.	8	3	0.45	3	8	1.00	6	5	0.70			
7 I was concerned about how much money it would cost.	14	-	<0.01*	2	13	0.42	8	6	0.72			
8 I was concerned about what others might think if they found out I was in treatment.	20	8	0.16	8	20	1.00	13	16	1.00			
9 I had problems with things like transportation, childcare, or scheduling that would have made it hard to get to treatment.	20	2	<0.01*	2	20	0.09	6	16	0.14			
10 I was unsure about where to go or who to see.	30	11	0.04	13	28	0.57	14	27	0.13			
11 I thought it would take too much time or be inconvenient.	20	5	0.02	5	20	0.53	8	17	0.25			
12 I could not get an appointment.	3	-	0.50	-	3	1.00	-	3	0.49			
13 I was scared about being put into a hospital against my will.	2	-	1.00	-	2	1.00	-	2	1.00			
14 I was not satisfied with the available services.	-	2	0.50	-	2	1.00	2	-	0.49			

No case.

* p<0.01, Fisher's exact test.

Table 4-1

Reasons for dropping out of mental health treatment before the professional wanted them to stop (n = 24)

	N	%
1 I got better.	10	41.7
2 I didn't need help anymore.	13	54.2
3 I was not getting better.	7	29.2
4 I wanted to handle the problem on my own.	6	25.0
5 I had bad experiences with the treatment providers.	2	8.3
6 I was concerned about what people would think if they found out I was in treatment.	2	8.3
7 I was treated badly or unfairly.	-	0.0
8 The therapist or counselor left or moved away.	1	4.2
9 I felt out of place.	2	8.3
10 The policies were a hassle.	-	-
11 There were problems with lack of time, schedule change, or lack of transportation.	1	4.2
12 I moved.	-	-
13 Treatment was too expensive.	1	4.2
14 My health insurance would not pay for more treatment.	-	-
15 My family wanted me to stop.	1	4.2

No case.

Table 4-2

Reasons for dropping out of mental health treatment before the professional wanted them to stop (n = 24)

	Age (years)		Sex		Education (years)	
	20-49	50	Men	Women	0-12	13
	%	%	%	%	p	p
1 I got better.	42	-	0.02	8	33	0.24
2 I didn't need help anymore.	42	13	0.62	21	33	1.00
3 I was not getting better.	21	8	0.21	4	25	0.50
4 I wanted to handle the problem on my own.	17	8	0.79	4	21	0.55
5 I had bad experiences with the treatment providers.	8	-	1.00	4	4	0.49
6 I was concerned about what people would think if they found out I was in treatment.	8	-	1.00	4	4	0.49
7 I was treated badly or unfairly.	-	-	-	-	-	-
8 The therapist or counselor left or moved away.	4	-	1.00	4	-	0.27
9 I felt out of place.	8	-	1.00	-	8	1.00
10 The policies were a hassle.	-	-	-	-	-	-
11 There were problems with lack of time, schedule change, or lack of transportation.	4	-	1.00	-	4	1.00
12 I moved.	-	-	-	-	-	-
13 Treatment was too expensive.	4	-	1.00	-	4	1.00
14 My health insurance would not pay for more treatment.	-	-	-	-	-	-
15 My family wanted me to stop.	4	-	1.00	-	4	1.00

* p<0.01, Fisher's exact test.

No case.