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## **Patients' and relatives' views on unmet mental health care needs through a qualitative study: Symptoms are a major barrier**

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## **TITLE PAGE**

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### **Title:**

**Patients' and relatives' views on unmet mental health care needs through a qualitative study: symptoms are a major barrier**

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**Authorship:**

All authors listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors, and all authors are in agreement with the manuscript

**Contributions:**

NC obtained the funding grant.

NC, JB, EL, and VC designed the study.

TG and MF interviewed the participants and carried out the thematic analysis under the supervision of NC.

BC helped contacting participants and collecting sociodemographic data.

MF and NC wrote a first draft of the article, which was reviewed and finalized for publication by NC. The revisions and answers to reviewers were written by NC.

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The funding source played no role in study design; collection, management, analysis, and interpretation of data; writing of the report; or the decision to submit the article for publication.

**Ethics approval**

The study was approved by the ethical committee of the Hospices Civils de Lyon (Lyon University Hospitals). The procedures used in this study adhere to the tenets of the Declaration of Helsinki.

### **Consent to participate and for publication**

All participants signed an informed consent form before the interview and they were informed that the data would be published after being anonymized and aggregated.

### **Keywords**

Mental health; Health services accessibility; Qualitative research; Unmet needs; Relatives.

# 1 **MAIN TEXT**

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2

3 **Title:**

4 **Patients' and relatives' views on unmet mental health care needs through a qualitative**  
5 **study: symptoms are a major barrier**

6

7 **Abstract**

8 Unmet needs in mental health care are a prominent issue, and concern almost half of people with  
9 such disorders. *Psymobile* is a mobile outreach psychiatric team whose objective is to facilitate  
10 access to psychiatric services. Its intervention is at the request of relatives or social workers,  
11 making it possible to encounter situations of long-standing unmet needs.

12 Our objective was to understand the barriers to accessing mental health care as perceived by  
13 patients and their relatives.

14 We conducted a qualitative study with patients and their relatives using face-to-face semi-  
15 structured interviews and a hierarchical thematic analysis.

16 Four major themes were identified: psychological and behavioural barriers, socio-economic  
17 barriers, structural barriers and physical barriers. Anosognosia or lack of insight is cited as a  
18 primary barrier, as are fear of stigma, and former negative experiences. The complexity of the  
19 French care system and the lack of literacy about mental illnesses were also emphasised by the  
20 participants. Physical determinants, such as the distance to healthcare facilities, were rarely  
21 mentioned.

22 As a conclusion, outreach teams appear to be an appropriate way to address the issue of unmet  
23 mental health care needs when they provide psychiatric care.

24

## 25 **Keywords**

26 Mental health; Health services accessibility; Qualitative research; Unmet needs; Relatives.

27

## 28 **INTRODUCTION**

29 Unmet needs for health care describe a variety of situations in which adequate care is not  
30 provided to populations. People with psychiatric disorders are particularly affected by unmet  
31 needs for mental health care. For example, in Europe, a large survey estimated that almost 48%  
32 of people with mood, anxiety or alcohol use disorders which had a major impact on their lives  
33 or activities, had not consulted a mental health specialist in the past 12 months (Alonso et al.,  
34 2007). In contrast, for example only 8% of people with diabetes reported not using any services  
35 for their physical condition. According to the above-mentioned study, when the figures for unmet  
36 need for mental health care are related to the total European population, this treatment gap  
37 represents about 3% of the general adult population. Similar results about unmet needs in mental  
38 health care have been found in surveys in the United States (Kessler et al., 2005; Mojtabai et al.,  
39 2011) and this treatment gap affects most mental disorders (Kohn, Saxena, Levav, & Saraceno,  
40 2004).

41 Many determinants of unmet needs for mental health care have been identified: stigma of mental  
42 illness (Clement et al., 2015; Henderson, Evans-Lacko, & Thornicroft, 2013), lack of insight or  
43 low perceived need for treatment (Mojtabai et al., 2011), as well as various socio-demographic  
44 factors such as male gender, young age, low education, low income, unemployment and social  
45 isolation (O'Connor, Martin, Weeks, & Ong, 2014; Payne, Abel, Guthrie, & Mercer, 2013;  
46 Rickwood, Mazzer, & Telford, 2015). However, the influence of these determinants is complex.  
47 For instance, in a large survey on dropout from outpatient mental health care in the United States  
48 (Olfson, Mojtabai, Sampson, Hwang, & Kessler, 2009), similar determinants for dropout were

49 studied, but gender, age, and education level were not globally associated with higher dropout  
50 rates. Average-low income was associated with increased odds of dropout from psychiatric care,  
51 but only after  $\geq 3$  visits.

52 Surveys on unmet needs in mental health care give a good overview of the phenomenon.  
53 However, only a few studies have determined the precise experience of those with unmet mental  
54 health care needs (Kohn et al., 2004), probably because they are difficult to identify and reach.

55  
56 *Psymobile* is a mobile psychiatric outreach team created in 2012 in France. Its aim is to facilitate  
57 access to psychiatric services, in all situations where mental health problems can be considered  
58 a major obstacle. It is composed of two psychiatrists and four nurses. A psychologist also works  
59 part-time in the team. For each situation, the nurse acts as a case manager and is associated with  
60 a psychiatrist or psychologist. The nurse's task is first to gather information about the potential  
61 patient, and then to organise an initial home visit in the presence of the person who has made the  
62 request on behalf of the patient. The team's aim is then to enable the patient to continue their care  
63 in other settings. The *Psymobile* pair may make several visits to the patient's home, sometimes  
64 with other professionals, and usually initiate treatment to stabilize symptoms. The ability to  
65 intervene at the patient's home, at the request of relatives or social workers, without explicit  
66 request from the patients themselves, is a specificity of *Psymobile*, allowing access to situations  
67 of severe or long-lasting unmet needs. More than a thousand patients have been referred to this  
68 team since its creation, covering a variety of disorders and barriers to accessing mental health  
69 care. Patients may have received care in the past, or, in most cases, may never have been in  
70 contact with mental health care.

71

72 The objective of this qualitative study was to develop hypotheses on the factors determining  
73 unmet needs in mental health care, through exploring the direct experience of patients and their  
74 relatives .

75

## 76 **METHODS**

### 77 **Design**

78 This study can be qualified as a qualitative descriptive study, as described by Sandelowski  
79 ((Sandelowski, 2010; Sandelowski & Barroso, 2003), in so far as data are integrated and  
80 interpreted. To ensure the diversity of the population, we recruited participants who differed in  
81 age, sex, socioeconomic background, and who suffered from diverse pathologies, as per the  
82 purposive sampling method. This method ensures the inclusion of participants which will  
83 provide more meaningful data (Robinson, 2014). We conducted an inductive thematic content  
84 analysis that included several phases (Bardin, 2013). In the first phase, we examined the apparent  
85 messages through repeated reading of the transcripts in order to make sense of the whole. The  
86 units of meaning were then identified, categorized and juxtaposed to determine significant and  
87 crosscutting themes across the corpus, and create a simplified representation of the original data.  
88 The classification system, in the form of a table, corresponds to a hierarchical thematic analysis  
89 containing general themes, divided into sub-categories. The principal of “theoretical sufficiency”  
90 developed by Dey (Dey, 1999) was used as a methodical guarantee to ensure the saturation of  
91 the data. Consequently, we ended the study:

- 92 - Once the themes found could explain the data collected,
- 93 - Once the completion of two consecutive interviews brought forward no new themes.

94

## 95 **Data collection and analysis**

96 Data were collected through semi-structured interviews by Author 2 (MSc student) and Author  
97 1 (psychiatry resident), who were trained beforehand. The interviewers were supervised by the  
98 last and penultimate authors. All interviews were conducted in French, face-to-face, either at the  
99 participants' homes or at the Psymobile premises, except for one, which was conducted by  
100 phone. The interview questions were written by the last author and author 2. They differed only  
101 slightly for patients and relatives. The interview guides are provided as supplementary material.  
102 The questions were not modified from one patient or relative to another. The questions included  
103 some socio-economic information (age, sex, income level) and an open-ended question about  
104 difficulties in accessing mental health care. No hypotheses were made during the interview about  
105 possible barriers to access, and the interviewers let the participants describe their own  
106 experience. The last question asked participants to identify the factor they found most significant.  
107 Interviews lasted between 10 and 90 minutes. On average, interviews lasted 28 minutes with  
108 patients and 45 minutes with relatives. The interviews were recorded, anonymized, and  
109 transcribed verbatim. The analyses were carried out by Author 1 & 2 under the supervision of  
110 the Last Author using NVivo© v12 software for transcription and thematic analysis. The  
111 verbatim cited below were translated in English for publication by the first author and checked  
112 by the last author for accuracy.

113

## 114 **Population**

115 The subjects were either Psymobile patients or relatives. They resided in the Lyon metropolitan  
116 area. They were recruited for the study between February 2019 and September 2020. During this  
117 period, we tried to include all patients who had been seen by one of Psymobile psychiatrists. In  
118 addition, we also recruited people who had made a request for their relative. The psychiatrist

119 explained the principle of the study to them and one of the investigators contacted them in the  
120 following days to set up an appointment for the interview. Inclusion criteria were as follows:

- 121 - For patients: receiving or having received care from Psymobile between 2019 and 2020,  
122 consenting to a semi-structured interview ;
- 123 - For relatives: having applied for Psymobile care for a relative between 2019 and 2020, being  
124 able to trace, at least approximately, the course of their relative's disorder, consenting to a  
125 semi-structured interview.

126 The exclusion criteria were to be a minor or be under guardianship.

127 To ensure the diversity of the population, we recruited subjects who differed in age, sex,  
128 socioeconomic background, and who suffered from diverse pathologies, as per the purposive  
129 sampling method. This method ensures the inclusion of participants which will provide more  
130 meaningful data (Robinson, 2014). All participants were fluent in French.

131

## 132 **Ethics and quality**

133 All participants signed an informed consent form and gave their oral consent, which was  
134 recorded on tape before the interview. The collected information were anonymized after  
135 transcription. We proposed to send out the verbatim of their interviews to the participants, if they  
136 wished, for validation. No participant requested this. The study was approved by the ethical  
137 committee of the University Hospital (decision number 19-08 of January 23, 2019).

138

## 139 **RESULTS**

### 140 **Participants' characteristics**

141 The study included a total of 33 participants, 14 patients and 19 relatives. Relatives were included  
142 independently of the patients. Only about a quarter of the 50 patients who had given their initial

143 consent were eventually interviewed, and half of the 37 relatives, due to difficulties in contacting  
144 them again or meeting them when appointments could be arranged. These difficulties are similar  
145 to those usually encountered among Psymobile patients. The SARS-CoV-2 epidemic may also  
146 have played a role in the refusal to participate. Tables 1 and 2 present the socio-demographic  
147 characteristics of the study participants. As far as relatives were concerned, the participants were  
148 mainly women (82%), and mothers of patients (55%). As for the patients, they were mostly men  
149 (61%). In terms of economic resources, the median income of the relatives was over  
150 €2,500/month, while the median income of the patients was between €500 and €1,000, which  
151 corresponds to the social assistance level. The diagnoses were mainly schizophrenia: 47 %  
152 regarding patients, and 43 % regarding relatives.

153 Table 1: Socio-demographic characteristics of interviewed patients

154 Table 2: Characteristics of interviewed relatives and related patients

155

## 156 **Thematic analysis**

157 Four main themes were derived from the interviews analyses, regarding the individual and  
158 systemic barriers encountered by patients and their relatives: (i) psychological and behavioural,  
159 (ii) structural, (iii) socio-economic, and (iv) physical barriers. These barriers were related to  
160 individual factor (for example lack of insight, or lack of literacy about mental health care), health  
161 professionals (for example lack of information about diagnosis and treatment), but also the health  
162 care system (like high anticipated financial cost, complexity and lack of flexibility), and society  
163 as a whole (for example lack of local health care providers). There was no major difference  
164 between the difficulties encountered by patients and those described by relatives, except for  
165 physical barriers, which patients cited more than relatives. The distribution of thematic clusters  
166 in the interviews is shown in Figure 1.

167

168 Figure 1 : Distribution of thematic clusters in the interviews with patients and relatives

169

170 *Psychological and behavioural barriers:*

171 Persons suffering from mental health disorders and their relatives did not see mental health care  
172 as a way of relieving their symptoms, either because they did not think they needed health care,  
173 or because former attempts failed to help them get better. They often had a low level of  
174 knowledge about mental health and their social representations of psychiatric care could be a  
175 barrier.

176 The main barrier to accessing mental health care was anosognosia or lack of insight.  
177 Anosognosia can be defined as a difficulty by the person in being aware of symptoms and  
178 attributing them to a psychiatric disorder. Indeed, anosognosia or lack of insight was cited by all  
179 participants, patients as well as relatives, and 95% of patients and 50% of relatives considered it  
180 to be the main problem that prevented them or their relative from accessing to mental health care.

181 *Patient:* “First of all, I didn't see myself in such distress. Even though I knew that my behaviour  
182 was out of the ordinary, as I told you, simply I did not feel the need [for care].”

183 *Patient:* “No. I would never have taken the step of contacting a mental health care service  
184 myself. In my case, it wasn't I who took the initiative to access this care. It was my genitor who  
185 contacted Psymobile who then phoned me to ask me if I was willing to come for a preliminary  
186 interview and then determine whether I would continue with them or not. I came more out of  
187 curiosity than necessity.”

188

189 The second most cited barrier for patients was previous failures to access mental health care or  
190 unpleasant experiences with health care. Patients and their relatives were reluctant to seek mental

191 health care again when a previous attempt did not help them relieve their symptoms or had  
192 unbearable side effects:

193 *Patient:* “Yes, for example, for quite a long time I took cyamemazine, and it got me high, I felt  
194 like I was on drugs. When I was in this state I had difficulty speaking, I had no confidence in  
195 myself, I had difficulty thinking and so at work I would feel it.”

196 The last sub-theme of this cluster was the low level of knowledge on mental health care and  
197 social representations of psychiatry. We found an internalized stigma among patients: they  
198 refused to be considered as patients, especially because they thought that patients with  
199 psychiatric disorders are incurable or dangerous:

200 *Patient:* “When I was told to go to a psychiatrist, the first reaction we all have is: ‘yeah but I’m  
201 not crazy, I’m not like that’. We have this image of the person we met in public transport, who  
202 behaves in a very strange way... [...] In fact, you are afraid of being like that. ‘What if you fell  
203 into that too?’”

204 There also was a lack of knowledge and low levels of literacy about mental health disorders,  
205 particularly among family members, who sometimes found it difficult to distinguish psychiatric  
206 disorders from mere character traits:

207 *Relative talking about his/her son:* “I have the impression that the fact of suffering and that we  
208 see that he is suffering would give him a kind of power over us and that not being well would  
209 make us pay for something. In other words, it was his way of existing, suffering. It’s a bit like  
210 a child who wants to attract attention by being obnoxious or by throwing tantrums.”

211

212 *Structural barriers:*

213 As far as structural barriers were concerned, patients and relatives reported difficulties related to  
214 the organization of the mental health care system, in which they had difficulty finding their way  
215 around. They did not know whom to contact to get an appointment. They felt that there was a

216 multitude of professionals who they did not know if they were suitable, and that these providers  
217 were difficult to contact.

218 *Relative:* “I find that, especially in the city, there are quite a few possibilities. What possibilities  
219 to choose is a bit more complicated. Now, what is missing is almost a place to turn to at the  
220 beginning where you could find a kind of coordinator.”

221 *Relative:* “I don't know how to choose a shrink. We are guided one step to the right, one  
222 step to the left; we try to get information on the internet, which is unreliable though.”

223 The system was perceived as rigid, inappropriate and lacking in proactivity, forcing patients to  
224 adapt to the system and ignoring those who did not:

225 *Patient:* “If I wanted to see a psychiatrist or a psychologist I had to go to the practice [...] but  
226 because of my pathology my follow-up was not possible because I didn't go to the practice when  
227 I was in a scratching crisis [compulsive scratching] so I didn't have regular follow-up.”

228 The way the health care system was working gave also an impression of a lack of coordination.  
229 General practitioners were often no help to the patients or relatives in finding their way around.  
230 Participants emphasized the importance of a relationship between general practitioners and  
231 psychiatrists, and the role of the GPs in referring patients. Access to care in this already complex  
232 system was made more difficult by the long delays before getting an appointment, or even the  
233 refusal of some providers to give appointments due to the saturation of their treatment capacity:

234 *Patient:* “Also contacting unavailable health professionals. I contacted psychiatrists who didn't  
235 answer. So I left messages and they never replied, or they replied and clearly said 'we're out of  
236 space, call back in one year.’”

237 In this context, providers were tempted to neglect what they considered to be less critical or  
238 urgent situations, or even too difficult to address:

239 *Relative:* “That is to say, if our son had been aggressive or violent in the street, for example, or  
240 if he had attempted suicide or had put himself in danger, he would have been taken care of no  
241 matter what. But as long as there isn't anything serious, nothing is possible.”

242 *Patient:* “I was no longer followed up. And then, after my anxiety attacks continued, I turned  
243 to a sophrologist [therapist using sophrology as a relaxation method], who, after about ten  
244 sessions, referred me to the public outpatient psychiatric centre and I went. But they didn't  
245 accept my case, we'll say, they didn't consider it serious enough, in other words.”

246 Furthermore, some mental health care providers refused to tell patients their diagnosis. This  
247 made it more difficult for patients to accept the need for care and treatment. Relatives also  
248 mentioned this lack of information: they were refused information about the diagnosis because  
249 the patients were of age. This was particularly noticeable in the transition from adolescent to  
250 adult psychiatry:

251 *Patient:* “And then I was advised a number of drugs but I refused, not because I'm reluctant to  
252 take medication, but because they hadn't identified anything special. If they had said to me,  
253 'Well, you certainly have this pathology and we recommend this medication', I would have  
254 agreed to follow these treatments but, precisely because of the lack of an identifiable mental  
255 disorder, I refused. Then I stopped the sessions over there.”

256

### 257 *Socio-economic barriers*

258 In terms of socio-economic barriers, the main challenge to mental health care was overcoming  
259 isolation and desocialisation in order to access social assistance, as care is then mostly free.

260 *Relative:* “He was associated with a person and this partner died and he found it difficult to  
261 accept it, and from the day his colleague died the company closed. And then he didn't leave my  
262 parents' house anymore.”

263 *Patient:* “The first time was in 20XX, I had difficulties with my income, I had no income at all  
264 because of my pathology, I was no longer working, I had lost my job because I could no longer  
265 leave my home, I was no longer doing my administrative procedures, so I no longer had a health  
266 insurance, no administrative follow-up, no care, no psychological follow-up" [...] "As I told you,

267 it was not my decision. I was very isolated. So, I didn't give any sign of life to anyone. It also  
268 prevented me from taking any steps concerning health or anything else.”

269 However, in other cases, the anticipated or actual cost of care could also be a barrier. It should  
270 be noted that eleven of the fourteen patients were unemployed and therefore financially  
271 dependent on social assistance or on their relatives.

272 *Relative:* “This illness was treated free of charge. She was afraid that it would be expensive, she  
273 didn't know. Because in fact before, as soon as she went to the psychiatrist, it was 50 euros, so  
274 she thought it would be expensive. That's why it was a bit tricky too. As soon as she realized  
275 that it was free this time, she was happier. “

276

### 277 *Physical barriers*

278 Finally, physical barriers were the least cited by participants (by 43 % of patients and 32 % of  
279 relatives). The problems were related to physical conditions (walking difficulties, chronic pain,  
280 fatigue). The distance to the health care facilities by public transport could also be a barrier:

281 *Patient:* “No, I'm not physically well, but that's it. There's diabetes. I'm tired, I'm tired.”

282 *Relative:* “Because of the genetic disease he has, he has muscle pain. And he doesn't feel able  
283 to go out. He's not going to be well.”

284 *Patient:* “And once again, for me, the fact that there is a team of mobile psychiatrists is  
285 absolutely essential in terms of care. In my case, it's really just the distance, it's that there isn't a  
286 big enough network of psychiatrists here.”

287

## 288 **DISCUSSION**

### 289 **Originality of the study**

290 To our knowledge, this is the first qualitative study in France investigating unmet needs in mental  
291 health care. The way in which unmet needs were identified in our study is different from what

292 is described in the literature, where mainly surveys are used. However, it can be assumed that  
293 patients referred to Psymobile would not have sought care, but for the intervention of Psymobile,  
294 for two reasons: the request for care was not made by the patient but by a relative or a social  
295 worker; the average length of interruption of care for patients who had already used mental health  
296 services is more than one year before Psymobile referral (unpublished data).

297 Unmet needs assessment through surveys is often based on a self-estimation of functional  
298 impairment for some disorders only, excluding psychotic disorders (Alonso et al., 2007; Andrade  
299 et al., 2014; Chiu, Amartey, Wang, & Kurdyak, 2018; Demyttenaere et al., 2004; Evans-Lacko  
300 et al., 2018), or without being associated to a diagnosis of mental disorder (Alang, 2015;  
301 Bobevski, Rosen, & Meadows, 2017; Fennell, Hull, Jones, & Dollman, 2018; Fleury, Grenier,  
302 Bamvita, Perreault, & Caron, 2016; Walker, Cummings, Hockenberry, & Druss, 2015). In our  
303 study, the disorders of Psymobile patients can be considered to have important functional  
304 consequences, as their relatives or social workers felt that health care was needed. Furthermore,  
305 individuals suffering from severe mental disorders, such as psychotic disorders, are often more  
306 difficult to include in surveys, as they may be more difficult to reach. In our study, schizophrenia  
307 was the main diagnosis for 6/14 patients and 9/19 participants' relatives.

308

309 *Psychological and behavioural barriers:*

310 This study shows that psychiatric symptoms, and in particular anosognosia, have a major impact  
311 on access to care, according to both relatives and patients. Previous studies have shown that lack  
312 of insight and anosognosia reduce quality of life, impair adherence to care and treatment and  
313 worsen symptoms (Lysaker, Pattison, Leonhardt, Phelps, & Vohs, 2018; Mohamed et al., 2008;  
314 Siu et al., 2015). Patients also cite previous failures to access care and unpleasant experiences  
315 with health professionals as the second major barrier. This highlights the value of interpersonal

316 relationships on access to care, which is consistent with the literature (Sharf, Primavera, &  
317 Diener, 2010).

318 Our study also highlights the weight of stigma on access to mental health care, a weight shared  
319 by patients and their families. Stigma has a negative impact on diagnosis and access to care by  
320 causing self-exclusion. Families, on the other hand, can suffer from stigma by association, or be  
321 seen as 'second patients' (Rowaert et al., 2016). In addition, we found a lack of health literacy.  
322 Health literacy is a key factor in access to care, influencing prognosis and quality of life. The  
323 lower the quality of health literacy, the worse the access to care and the worse the prognosis  
324 (Bonabi et al., 2016; Wei, McGrath, Hayden, & Kutcher, 2015). Finally, families are often  
325 excluded from patient care (Dirik et al., 2017), whereas the scientific literature highlights the  
326 therapeutic benefits associated with including families in care (Javed & Herrman, 2017; NICE,  
327 2014). The lack of information shared with families fosters feelings of exclusion, prevents  
328 empowerment and devalues families' experiential knowledge and their role as caregivers (Dirik  
329 et al., 2017; Pharoah, Mari, Rathbone, & Wong, 2010). This demonstrates the advantages of  
330 patient empowerment, therapeutic education and informing patients and their families.

331

332 *Structural barriers:*

333 The French system of psychiatric care has two different operating modes: private practitioners,  
334 who can be freely chosen but who charge a fee, and public sector practitioners, who cannot be  
335 freely chosen but are free of charge. In addition, both psychiatrists and psychologists can  
336 perform structured psychotherapy, but most psychiatrists are not trained for this. In large  
337 metropolitan areas such as Lyon, there is also a highly specialized health care offer. This system  
338 can thus be confusing and disorienting, and also perceived as rigid and lacking proactivity.  
339 Community care centres offering more flexibility could have a place in the French mental health  
340 care system, as could the development of community psychiatric teams, which also reduce social

341 inequalities in health (Wahlbeck, Cresswell-Smith, Haaramo, & Parkkonen, 2017). There is a  
342 need to develop peer support, and case managers, who could act as 'navigators', helping patients  
343 to better orient themselves, thus improving their prognosis (Griswold, Homish, Pastore, &  
344 Leonard, 2010). The fact that patients and families were sometimes given the impression that  
345 access to care was reserved only for the most severe situations could generate an experience of  
346 powerlessness and the depreciation of their suffering. These feelings could be reinforced with  
347 long waiting lists, leading once again to patients and their families feeling their “experienced  
348 knowledge” denied (Dirik et al., 2017).

349

350 *Socio-economic barriers:*

351 We found in our study a smaller effect of financial barriers compared to the international  
352 literature. This can be explained by the fact that the French health system is combining the  
353 Beveridgian and Bismarckian models, which guarantees universal access to care. Moreover,  
354 thanks to disability compensation allowances, people with psychiatric disorders can have a  
355 minimum standard of living, even without working. In our study, half of the patients received  
356 such a benefit.

357

358 *Physical barriers:*

359 Geographical barriers were rarely mentioned. As our study was conducted in the Lyon  
360 conurbation, our study population was from urban areas, which often have a high density of  
361 mental health providers, both private and public. In addition, public transport is easily accessible.  
362 Our results may have been different in rural areas, with a lower density of mental health  
363 professionals and less public transport.

364

## 365 **Relevance for Clinical Practice**

366 This study highlights the impact of lack of insight and the need to seek a therapeutic alliance in  
367 order to provide mental health care. It also illustrates the burden of stigma experienced by people  
368 with mental illness, and the need to develop interventions to improve mental health literacy. In  
369 the context of the development of outpatient care in France (Assemblée Nationale, 2019),  
370 identifying the factors influencing unmet mental health needs should help to better target  
371 effective interventions. As a matter of fact, mobile outreach teams focusing on crisis intervention  
372 or social support leave aside a part of patients whose symptoms are a major barrier to accessing  
373 mental health care. As regards their relatives, literacy in mental health is also a major barrier, as  
374 symptoms may not be recognized as linked to mental disorders or be considered as not treatable.  
375 Finally, it is also interesting to note that most of the participants in the relatives group were  
376 women, and more particularly mothers of patients. This shows the importance of patients'  
377 mothers as their main social support.

378

## 379 **Limitations**

380 As already mentioned, the results of this study are partly related to the organization of the French  
381 health system, particularly with regard to socio-economic themes. Furthermore, we encountered  
382 difficulties in recruiting patients (inclusion rate of 24%), much more than relatives. This  
383 difficulty may be linked to the study population, which was often reluctant to seek care, and  
384 perhaps did not see the point of the study, when the disorders were not yet stable at the time of  
385 inclusion. Fear of possible SARS-CoV-2 infection during the interviews, or the general context  
386 of the lockdown may also have played a role. Other biases are also worth mentioning:  
387 representation bias, as the people furthest from accessing care are probably those we were unable

388 to interview, and social desirability bias, which consists of participants answering questions in a  
389 way that will be perceived favourably by the interviewer.

390

## 391 **CONCLUSION**

392 This study used a qualitative method based on semi-structured interviews with patients and  
393 relatives and a thematic analysis to identify factors determining unmet need for mental health  
394 care. The main barriers identified can be grouped into four themes: psychological and  
395 behavioural barriers, socio-economic barriers, structural barriers and physical barriers. They  
396 include factors that are simultaneously related to the individual, to health professionals, but also  
397 to the health system and to society as a whole. These results are consistent with what has been  
398 described in the international literature, with specificities related to the French health care system  
399 and to the participants' urban living environment. The results of this study could be used as a  
400 reference to build a future study, allowing a more detailed analysis of the determining factors of  
401 unmet needs and the treatment gap.

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## TABLES

**Table 1: Socio-demographic characteristics of interviewed patients (NA: Not available)**

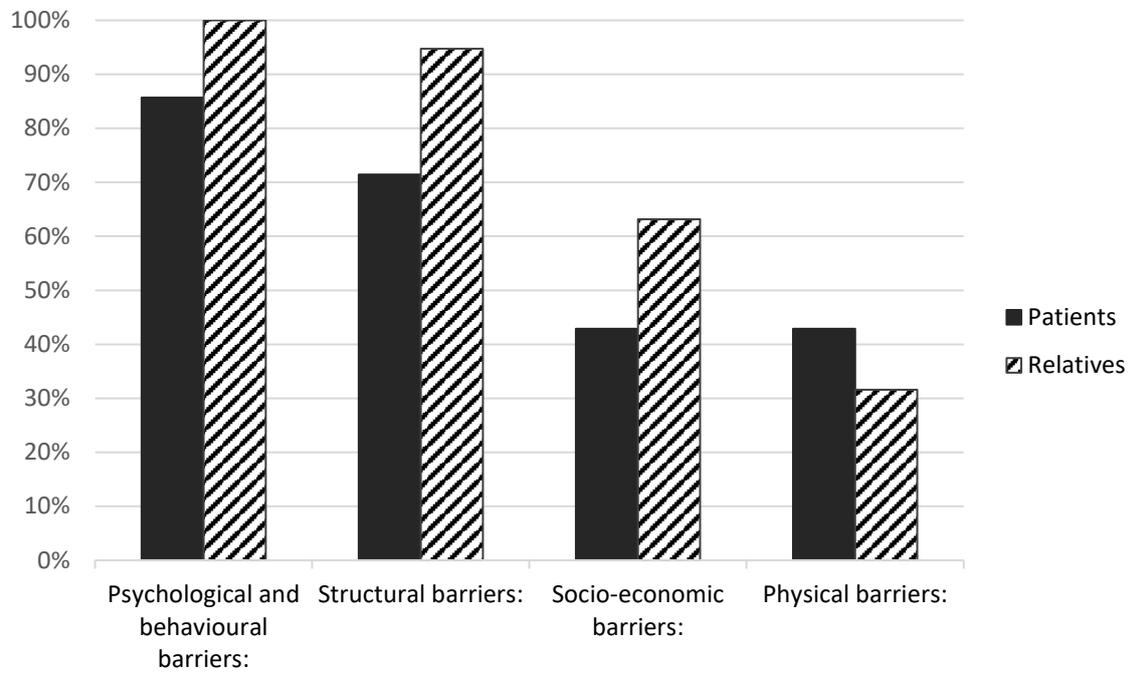
<b>PATIEN</b>	<b>GENDE</b>	<b>AGE</b>	<b>MONTHLY</b>	<b>MAIN DIAGNOSIS</b>
<b>T #</b>	<b>R</b>	<b>(YEARS)</b>	<b>INCOME</b>	<b>(CIM-10)</b>
<b>P1</b>	M	37	0 – 500 €	Personality disorder
<b>P2</b>	M	33	0 – 500 €	Schizophrenia
<b>P3</b>	M	26	NA	Anxiety disorder
<b>P4</b>	M	21	0 – 500 €	Schizophrenia
<b>P5</b>	F	41	500 – 1000 €	Obsessive compulsive disorder
<b>P6</b>	M	41	500 – 1000 €	Anxiety disorder
<b>P7</b>	F	NA	500 – 1000 €	Schizophrenia
<b>P8</b>	M	32	500 – 1000 €	Schizophrenia
<b>P9</b>	F	37	500 – 1000 €	Personality disorder
<b>P10</b>	F	39	500 – 1000 €	Major depressive disorder
<b>P11</b>	F	29	0 – 500 €	Anxiety disorder
<b>P12</b>	M	59	1700 – 2500 €	Major depressive disorder
<b>P13</b>	M	25	500 – 1000 €	Schizophrenia
<b>P14</b>	M	21	1000 – 1700 €	Schizophrenia

**Table 2: Characteristics of interviewed relatives and related patients (NA: Not available)**

RELATIVES			RELATED PATIENT		
#	RELATIONS HIP	MONTHLY INCOME	GENDE R	AGE (YEARS )	MAIN DIAGNOSIS (CIM-10)
<b>F1</b>	Parents	> 2500 €	M	23	Personality disorder
<b>F2</b>	Father	1700 - 2500 €	M	20	Bipolar Disorder
<b>F3</b>	Mother	> 2500 €	M	24	Schizophrenia
<b>F4</b>	Mother and daughter	500 - 1000 €	M	51	Alcohol abuse
<b>F5</b>	Daughter	1000 – 1700 €	F	69	Schizophrenia
<b>F6</b>	Parents	> 2500 €	M	35	Schizophrenia
<b>F7</b>	Mother	> 2500 €	M	21	Personality disorder
<b>F8</b>	Mother	> 2500 €	F	27	Eating disorder
<b>F9</b>	Mother	1000 – 1700 €	M	35	Personality disorder
<b>F10</b>	Mother	1000 – 1700 €	F	30	Schizophrenia
<b>F11</b>	Mother	1000 – 1700 €	M	41	Personality disorder
<b>F12</b>	Mother	> 2500 €	M	54	Schizophrenia
<b>F13</b>	Mother	1700 – 2500 €	F	25	Schizophrenia

RELATIVES			RELATED PATIENT		
#	RELATIONS HIP	MONTHLY INCOME	GENDE R	AGE (YEARS )	MAIN DIAGNOSIS (CIM-10)
<b>F14</b>	Mother	1700 – 2500 €	F	41	Schizophrenia
<b>F15</b>	Sister	500 – 1000 €	M	26	Anxiety disorder
<b>F16</b>	Mother	> 2500 €	M	21	Schizophrenia
<b>F17</b>	Sister	> 2500 €	M	42	Schizophrenia
<b>F18</b>	Wife	> 2500 €	M	63	Alcohol abuse
<b>F19</b>	Sister	NA	M	54	Alcohol abuse

## FIGURE



**Figure 1: Distribution of thematic clusters in the interviews with patients and relatives**