

BARRIERS TO ACCESSING MENTAL HEALTH CARE IN THE EASTERN CAPE PROVINCE OF SOUTH AFRICA

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ABSTRACT

The aim of this study was to explore and describe the perceptions of professional nurses concerning barriers to care for people with mental illness in the Eastern Cape Province, South Africa. The study was based on a qualitative, explorative and descriptive design.

A total of nine professional nurses working in primary, secondary and tertiary health care facilities were purposively selected. Unstructured interviews were conducted to collect data. Participants' responses were captured on an audio recorder and later transcribed verbatim. Participants' responses were then analysed thematically.

Two main themes and their related sub-themes were identified. The first theme concerns the perceptions of professional nurses regarding the societal barriers that may hinder people with mental illness from accessing and utilising mental health services. These barriers include socio-economic hardships, lack of knowledge and insight, lack of family support, embedded cultural beliefs and practices and stigma. The second theme highlights the barriers that professional nurses perceive within the health care system that influence access and utilisation of mental

health services. These barriers include inadequate support from stakeholders and leaders in the mental health sector and lack of financial, human and infrastructure resources.

Professional nurses made recommendations to improve mental health care. Those of high priority included enhanced mental health literacy among members of the public and a need for mental health stakeholders and leaders to increase their support of the mental health sector in an effort to improve access to mental health care.

KEYWORDS: barriers to accessing mental health care, help-seeking behaviour among people with mental illness, mental health care in low-income and middle-income countries (LMICs), public health care system in low-income and middle-income countries

INTRODUCTION AND BACKGROUND INFORMATION

In 2011, the World Health Organization (WHO) identified mental illness as one of the leading causes of disability worldwide, accounting for 13% of the total global burden of disease and as much as 25%–34% of the total burden of disease in low- and middle-income countries (LMICs) (WHO, 2011:1). However, two-thirds of people with chronic mental illness in LMICs will not receive treatment for their mental illness (WHO, 2011:1). A number of barriers to care have been identified (Seedat et al., 2009:346; Andersson et al., 2013:10–15) as hindering access to mental health services, thus leading to human rights violations (Drew et al., 2011:1664).

In South Africa, barriers to care may be due to poor socio-economic conditions, as some mentally ill persons might be homeless or live in unhygienic conditions, and lack education and income-generating opportunities (WHO, 2008:1). Furthermore, people with mental illness are also vulnerable to abuse, violence, neglect by their families and are often subject to high levels of stigma and discrimination (WHO, 2010:8; Drew et al., 2011:1666–1668). Additional barriers to care include lack of accessibility, acceptability and availability of essential health and social services as well as a lack of knowledge concerning mental health issues, cultural beliefs and language (Saxena et al., 2007:878–885). Further challenges include lack of appropriately trained mental health personnel, scarce mental health resources, budget constraints, lack of support from mental health leaders and slow integration of mental health care into primary health care services (Jack-Ide et al., 2012:51; Saxena et al., 2007:878–885).

Thus, the aim of the study was to explore and describe professional nurses' perceptions of barriers to accessing care for people with mental illness. Although nurses constitute the largest professional health care group working in mental health services, the WHO (2011:3) identified a shortfall of 128 000 nurses across fifty-eight LMICs. As psychiatric nurses tend to be the backbone of the service, their perceptions of barriers to care could provide a reliable indication of what is happening on ground level.

PROBLEM STATEMENT

Patel et al. (2008:4–7) state that limited research has been done on barriers impacting on access and utilisation of mental health services. Due to these barriers to care, people with mental illness in LMICs, like South Africa, may not receive the necessary treatment (Andersson et al., 2013:10–15; WHO, 2011:1–3). A better understanding of the barriers to care for people with mental illness may assist in improving access to such services.

AIM OF THE STUDY

The aim of this study was to explore and describe professional nurses' perceptions of barriers to accessing care by people with mental illness in the Eastern Cape Province of South Africa. A qualitative, explorative and descriptive research design was used to guide this study in order to capture and present professional nurses' perceptions about barriers impacting on accessing care by people with mental illness.

Population and sampling

Professional nurses working in primary, secondary or tertiary health care services in the Port Elizabeth area with a qualification in psychiatric nursing comprised the target population for the study. Professional nurses working with people with mental illness for a minimum of two years and who were willing to participate in the study were purposively selected to comprise the sample. A senior manager in charge of mental health services in the district assisted in the selection process by providing the researchers with a list of professional nurses who met the inclusion criteria and who would be able to contribute to the study. Nine professional nurses comprised the final sample.

Data collection

Data were collected by conducting in-depth unstructured interviews. The interviews took place from 22 March to 28 May 2012 in a private office at the participants' places of work. Participants were asked one main open-ended question, "What do you think are the barriers preventing individuals from accessing mental health care services?" This question was followed by probing questions in order to further explore participants' perceptions of barriers to care for people with mental illness. Interviews lasted 30–60 minutes, were audio-recorded and transcribed verbatim at a later stage.

Trustworthiness

Trustworthiness was enhanced by using Lincoln and Guba's strategies (Polit & Beck, 2012:584–585) of credibility, dependability, and transferability as outlined in Table 1.

Table 1: Strategies to ensure trustworthiness

STRATEGIES	CRITERION	APPLICATION
Credibility	Pilot study	A pilot study was conducted in order to ensure that the interview technique was effective in producing the desired results.
	Persistent observation	Careful observation and documentation of each participant and the context in which they worked was maintained throughout the interview process.
	Member checking	Each participant had the opportunity to review their transcribed interview and determine whether the conversation had been accurately documented. Only minor editing was required in some cases to enhance the authenticity of the verbatim conversation prior to data analysis.
	Peer review	The researchers consulted mental health experts in order to ensure authenticity of the findings and interpretation of the data.
	Reflexivity	Through a process of continual reflection, the researchers were able to understand the information from the participants' perspective and reduce subjectivity.
	Literature Control	A literature control was conducted by comparing the data with existing literature. This allowed the research findings to be contextualised within existing scientific knowledge.
Dependability	Coding the data	The researchers and an independent coder coded the data, and the findings were then compared in order to ensure that the identified themes and sub-themes portrayed an accurate representation of the data.
Transferability	Data saturation	Interviews ended when no new information was obtained and redundancy was achieved.
	Thick description	The researchers were able to elicit in-depth insights from participants, enabling a thorough description of the findings and the observed transactions and processes.

ETHICAL STANDARDS

Ethical approval was obtained from the Research Ethics Committee (Human) of the Faculty of Health Sciences, Nelson Mandela Metropolitan University, prior to conducting the study. Permission was also obtained from the Eastern Cape Department of Health and the management of the various health care facilities where the study was conducted. Ethical standards were maintained and particular items highlighted in the participants' consent form included beneficence, respect for human dignity, autonomy, confidentiality and justice (Gerrish & Lacey, 2010:28–33).

DATA ANALYSIS

The database, consisting of transcribed interviews and field notes, was systematically analysed according to the guidelines suggested by Tesch (in Creswell, 2003:192). The researchers and an independent coder immersed themselves in the data by reading the transcripts a number of times in order to get an overview of the database. Thereafter, a list of topics was generated and clustered according to similarity. Topics were then contextualised by using the most descriptive wording, after which themes were identified. Two recurring themes and related sub-themes emerged. The researchers and independent coder subsequently discussed their findings and reached consensus on the final themes and sub-themes.

Table 2: Research findings

THEMES	SUB-THEMES
Societal barriers that hinder people with mental illness from accessing and utilising mental health services	Socio-economic hardship may add to the challenges experienced by people with mental illness.
	Lack of knowledge and insight may reduce the likelihood of the person with a mental illness seeking help and correctly managing his/her mental illness.
	Lack of family support may hinder people living with a mental illness from accessing services and coping with their condition.
	Embedded cultural beliefs and practices may influence the willingness of people with a mental illness from accessing mental health services.
	Stigmatisation may hinder access and utilisation of mental health services.
Barriers within the health care system that influence access and utilisation of mental health services	Inadequate support from stakeholders and from leaders in the mental health sector results in a deteriorating health care system
	Lack of resources affects the availability and quality of mental health services

DISCUSSION OF RESULTS

Societal barriers that hinder people with mental illness from accessing and utilising mental health services

Participants indicated that a variety of societal barriers might hinder people with mental illness from accessing and utilising mental health services. These included socio-

economic hardships, lack of knowledge and insight into mental illness, lack of family support, embedded cultural beliefs and practices and stigmatisation.

Socio-economic hardships

Participants indicated that the majority of people with mental illness experienced social and economic hardships. They perceived public health care to be inaccessible as many patients might be unable to afford transport to and from the clinics, or to purchase medication from a private health care facility when the public health care facilities' drug supplies might be depleted. Consequently, some of these individuals rely on mobile health services, which are unreliable because transport is not always available. The professional nurses indicated that social and economic hardships were often attributable to a lack of education and training, employment opportunities, and discrimination in the work place due to the persons' mental illness:

“... due to poverty ... sometimes you have a family member that has been psychotic for months at home but they can't get them there”.

“Transport is a problem as the patient cannot always walk and may not have money for a taxi.”

The WHO (2007:3) asserts that the social and economic impact of mental illness is substantial worldwide, especially in LMICs where poverty and unemployment rates are high. Of the nine provinces in South Africa, the Eastern Cape Province has the second highest unemployment rate (37.4%) (Statistics South Africa, 2011) resulting in widespread poverty.

Lack of knowledge of and insight into mental illnesses

Participants pointed out that people with mental illness lack knowledge of and insight into their condition and might not understand that the condition can be treated. Participants asserted that this might reduce the likelihood of them seeking help and managing their illnesses effectively:

“The patient doesn't have any insight so they are incapable of understanding the illness and they are liable of just to get sicker and sicker unless you treat them.”

“... a lack of knowledge. I think often people don't know when it is time to access like mental health care services.”

A study conducted in South Africa (Seedat et al., 2009:346) revealed that people with mental illness often lacked awareness of their illnesses.

Participants stressed that many people with mental illness might not understand the importance of maintaining their treatment regimens and managing the related side effects. This, in turn, might negatively influence their compliance to treatment. In addition, non-compliance was more prevalent among people with mental illnesses who also abused substances and/or alcohol:

“When [people with a mental illness] experience side effects, they may see the mental health care as something that makes them worse. And they stay away and do not come back.”

“Once they feel better then they stop the treatment.”

“... those who are abusing substances are also less likely to reliably utilise services”.

Seedat et al. (2009:346) indicated that people’s perceptions that treatment would be ineffective for mental illness might present barriers to seeking care and adhering to prescribed treatment. This experience was also reported by the nurses who participated in the current study in the Eastern Cape Province.

Lack of family support

Participants indicated that families did not always provide the necessary care and support to a mentally ill family member. The participants reported that families may lack understanding as they perceived psychopharmacological treatment to be a permanent cure. When the patient was not cured, the family might become demoralised and less motivated to continue supporting the individual. Also, the family might not realise the importance of continuing treatment once the individual’s mental health has improved:

“... families [are] not always knowledgeable of what mental illness entails”.

“Sometimes [family members] try treating the patient in their own way with a little bit of knowledge they have got and they sometimes just make the patient sicker.”

Participants indicated that families coming from poor socio-economic backgrounds did not always have access to the necessary resources to support and manage their family members. However, people with a chronic mental illness who receive a disability grant from the state might be expected to use this money to support the needs of the family. In some cases, people with mental illnesses might be vulnerable to abuse as more powerful figures in the family could assume control of their grant money:

“Families sometimes offer very, very bad support. They don’t care ... no washing, not grooming, no feeding. Even when you refer the patient for admission, they don’t take him to the hospital.”

“... families are not always able to support in terms of finances and travel arrangements”.

“The patient may be on a grant but the family uses the money. He has to live on the street.”

Substance and alcohol abuse is a major problem in the Eastern Cape Province. People with mental illness who abuse substances can further complicate their condition and, among other things, this can lead to aggressive and destructive behaviour. As a result, families are less likely to accommodate the person with a mental illness:

“They are very problematic, those who are drinking [or abusing substances]. When they get home they do not want to take their medication. They are very manipulative. They cause problems The family gets tired after years of this.”

Caregiving for people with chronic mental illness may exceed the families' coping abilities, and may cause burnout and withdrawal from the ill family member (Hassan-Ohayon et al., 2011:79), especially where families have limited access to resources.

Embedded cultural beliefs and practices

According to the participants, many people belonging to the black African culture attribute symptoms of chronic mental illness to spirits and prefer to seek help from family and/or friends as well as the traditional healer (either the traditional doctor (izinyanga) or divine healer (isangoma)). Participants suggested that people with mental illness would often only seek help from a Western medical setting (such as a clinic) if the culturally preferred treatment failed to relieve their symptoms:

“Now the family doesn't really have knowledge about psychiatry. They will take the person first to the traditional healer If the family realise he is not getting better, they may seek out psychiatric care.”

“Our people may even think you are visited by the ancestors to show you things the family needs to know ... they may even put you on a pedestal, treating you a little bit special.”

According to Kneisl and Trigoboff (2013:167), cultural forces are powerful determinants of health-related behaviour. Tembani (2009:237–240) adds that the traditional health system continues to be a valuable resource for mental health services in South Africa. However, a recent study conducted in South Africa shows that medical health practitioners were more frequently consulted than traditional healers (Sorsdahl et al., 2009:434).

Stigmatisation

All participants indicated that a major barrier to accessing mental health services was stigmatisation experienced by people with mental illness, in that they might be discriminated against by members of their family, the community, and even health care professionals. The category, “mental health care user”, is often used by health care professionals when referring to a person with a mental illness. Such a categorisation was perceived to objectify the person with a mental illness and subsequently reduce the likelihood that this person would seek care. Consequently, a person with a mental illness might seek the counsel of a traditional healer as their illness might be understood in more socially acceptable ways as compared with those working in clinics and hospitals:

“... the husband will start telling the family ‘this one is mad’ and is an unfit mother ... she is threatened with losing her children, so she stops taking treatment”.

“[People with mental illness are] objectified as a mental health user. He would rather go for a traditional healer where he will be termed as ‘he is a student’ or as a ‘student to be a sangoma’, which is widely accepted.”

“... they’ve got a stereotype of mental [illness] being related uh as a witchcraft”.

Participants indicated that families themselves might be stigmatised by association and rather than risk rejection from the community they might refuse to assist the family member with a mental illness in accessing mental health care:

“... well you know they don’t bring the patient to the clinic because they don’t want to see accessing the mental health service It’s the stigma for his family.”

“[The family] would rather keep the family member ... in the house without treatment and telling other people ...”

Thus, stigma and discrimination might threaten people’s personal lives, reputation and status within their communities and consequently many people with mental illness worldwide could be reluctant to seek help (Saxena et al., 2007:884), as portrayed by the participants in the current study.

Barriers within the Eastern Cape Province health care system that influence access to and utilisation of mental health services

Participants indicated that the structure and operation of the Eastern Cape Province’s health care services might present barriers to people needing to access and utilise mental health services. These aspects included inadequate support from stakeholders and leaders in the mental health sector as well as the lack of resources needed to deliver mental health services.

Inadequate support from stakeholders and leaders

Participants stressed that they received very little support from stakeholders and mental health leaders in local and provincial government as mental health care has been poorly prioritised as compared with other health care services. This has resulted in a deteriorating health care system, making it progressively more difficult to implement policy and deliver quality services to people with mental illness. Participants reported a lack of collaboration between health care professionals and stakeholders and leaders in mental health and believed this contributed to inaccurate conclusions concerning the prevalence of mental illness and the pervasive impact of mental illness on society:

“... if you now take our Health Department, if you take it as a whole psychiatry are really, they always at the back”.

“... they [Eastern Cape Department of Health] didn't listen to us when we were complaining ...”

Due to insufficient political support and mental health leadership in South Africa, the country has inadequate mental health systems and consequently mental health care is grossly deficient (WHO, 2008:4). As a result, there has been an urgent call for mental health stakeholders and leaders at all levels of society to increase their investment in mental health care (Jacob et al., 2007:1073–1075).

Lack of resources affects the availability and quality of mental health services in the Eastern Cape Province

Participants commented that the lack of resources, mainly financial, human and infrastructure resources, impacted negatively on the availability and quality of mental health services being delivered.

Firstly, budget constraints made it difficult to deliver quality mental health services to people with mental illness, consequently leading to human rights violations. The participants stated that people with mental illness were exposed to inhumane and degrading treatment as facilities were overcrowded and unhygienic, and there was a lack of clothing and proper bedding. Although the participants were concerned about the availability of funds, they also indicated that the poor distribution of necessary funding could be due to the mismanagement of funds:

“We're in trouble because they didn't realise budget.”

“Our budgets have been cut and we have now just inherited another fourteen additional clinics.”

Mental health services are under-resourced in South Africa and consequently people with mental illness experience a range of barriers in accessing mental health care (Seedat et al., 2009:346). Of the 70% of countries worldwide that have specified budgets for mental health, 20% spend less than 1% of their total health budget on mental health (Patel et al., 2007).

Secondly, according to the participants, most clinics experienced a shortage of professional nurses and other health care professionals who form part of the mental health care team, namely psychiatrists, psychologists, medical doctors and social workers. Staff shortages often lead to a heavy workload for professional nurses and long waiting lines for people with mental illnesses. Under such conditions, professional nurses might become overwhelmed and consequently insensitive when dealing with people with mental illness. As a result, people with mental illness could become despondent and leave the health care facility without treatment:

“There is a shortage of nurses If one of us goes on leave, there is only one nurse left in the clinic.”

“We are trying to meet the patients’ needs ... but there is no-one to help us.”

“So the psychiatrist comes only once a month. Pharmacists are non-existent, so the nurses have to prescribe, dispense and order scheduled drugs”

According to the WHO (2011:3), nurses are the largest professional group working in the mental health sector and have an important role to play in caring for people with mental illness. Thus, the shortage of nurses in LMICs poses a barrier to mental health care (WHO, 2011:3), and this situation was also reported by the nurses in the Eastern Cape Province who participated in this study.

Participants reported that professional nurses, especially those working in primary health care clinics, lacked the necessary knowledge and skills related to mental illness. Consequently, people with mental illness are sometimes misdiagnosed and might receive inadequate treatment. In addition, a lack of knowledge among general medical staff at casualty units at state hospitals concerning the Mental Health Care Act (South Africa, 2002) might lead to improper admission procedures. Reportedly, families waited up to 48 hours before the person with a mental illness had been safely admitted to a 72-hour observation unit:

“... there is no in-service training at all [for health care professionals working in primary health care clinics and psychiatric clinics]. It’s even worse for the mental health, mental illnesses.”

“It makes things very difficult so we have to go on our own initiative just to decide what we going to do to help this patient.”

“When we refer them to [emergency room of a general hospital], they take a day, a day and a half before they are seen. They [the patient] just get up and walk away.”

Saraceno et al. (2007:1169–1170) suggest that LMICs should increase the training of mental health professionals as there are too few multi-disciplinary health care team members who are trained and supervised in mental health facilities. Likewise, the WHO (2010:37) urges governments to develop their mental health workforce, ensuring they receive sufficient training at all levels of mental health service provision.

Participants complained about the lack of management and supervision at the clinics. Consequently, professional nurses and other health care professionals working in the clinics are often accountable to no-one other than their immediate colleagues as there is no permanent on-site manager. This is because the few managers that do exist are only able to visit the different clinics once every few weeks, which, according to participants, was insufficient:

“There is a lack of management. We do not have a manager; us three nurses here at the clinic manage and supervise ourselves”

According to the WHO (2007:3), primary mental health care necessitates secondary care components such as support and supervision in order to be effective.

Thirdly, participants also discussed problems related to infrastructure and mentioned the lack of clinics and hospitals in the Eastern Cape, as well as their poor condition. Participants also complained of having to share office space with colleagues as office space is limited. Thus, the individual’s right to privacy is compromised, and participants reported that this might impact negatively on the individuals’ willingness to share their concerns:

“The clinic is very small. There is no privacy in the clinic. The patient does not want to talk about problems They are not eager to talk in front of someone.”

Burns (2008:48) also reported that mental health care facilities in South Africa are inadequate and ineffective in their ability to treat people with mental illness.

The lack of community-based health services was a major barrier to providing effective mental health care in the Eastern Cape Province, according to the participants. They stressed that once a person with a mental illness has been stabilised after having received treatment at a state tertiary level hospital, he/she is sent back to the community where there is a significant lack of publicly funded follow-up services:

“The patient comes from the hospital and is just dumped in the community ... no rehabilitation services.”

“We do not have a lot of half-way houses to send the patient to, especially when the family refuses to look after this person.”

The Eastern Cape Department of Health invested in outreach services by supplying vehicles and mobile clinics to make mental health services more accessible. However, participants indicated that these services were unreliable due to insufficient funding and lack of personnel:

“At the moment we can’t reach those people because we did mobile there ... we don’t have transport to go up to these patients that are staying in those faraway areas”

Similar situations have been reported by the WHO, indicating that due to the lack of a publicly funded network of mental health services, families of people with mental illness have to bear the economic and social burden of such care (WHO, 2007:3) as people with mental illness are denied access to professional mental health care.

CONCLUSION

Various barriers to care, both societal and organisational, hinder people with mental illness from accessing and receiving care. Socio-economic hardships make it difficult for such people to reach mental health services and families have minimal resources to care for the mentally ill family member. A lack of knowledge and insight into mental illness might reduce the likelihood of people with mental illness from seeking help, correctly managing their mental illness, and receiving the necessary support from their family. Cultural beliefs and practices could influence people’s help-seeking behaviours. Stigmatisation poses a barrier to accessing care for many people with mental illness. Organisational barriers could create challenges to caring for people with mental illness. Lack of support from stakeholders and leaders in the mental health sector has resulted in mental health services being poorly prioritised in the Eastern Cape Province. In addition, the lack of financial, human, and infrastructure resources creates unnecessary barriers to care for people with mental illness.

RECOMMENDATIONS

The process of integrating mental health care into primary health care should be fast-tracked. Community awareness programmes need to be implemented to increase the public’s knowledge about mental health issues. Such interventions could reduce stigma in the communities and increase people’s willingness to utilise mental health services.

Stakeholders must prioritise mental health within the health care system by increasing the financial, human, and infrastructure support to deliver mental health services. Collaboration needs to improve between health care professionals and leaders in the mental health sector.

LIMITATIONS OF THE STUDY

Professional nurses working in primary health clinics were not included in the sample of this study, but only those working in mental health care facilities. Thus, additional information could have been obtained from professional nurses working in primary health clinics. No patients and no relatives of patients were interviewed but their experiences could yield valuable insights into the barriers they encountered when accessing and utilising mental health services in the Eastern Cape Province.

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