

Original Research

Public healthcare personnel's experiences and opinions on access and readiness to provide mental health care in a remote rural area in South Africa

AUTHORS



Divan Rall¹ MSc, MA, PhD Candidate *  [<https://orcid.org/0009-0004-4281-005X>]



Leslie Swartz¹ PhD, Professor  [<https://orcid.org/0000-0003-1741-5897>]

CORRESPONDENCE

* Divan Rall divanrallphd@gmail.com

AFFILIATIONS

¹ Department of Psychology, Stellenbosch University, Private Bag X4, Matieland, Stellenbosch 7745, South Africa

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Abstract

Introduction: WHO encourages decentralising mental health care away from the tertiary locus of care into lower levels of care so as to reform mental healthcare worldwide. Recently, attempts have been made to facilitate the integration of public mental health care into general healthcare systems in South Africa. It is well established that the country's public healthcare system faces numerous multifaceted challenges – including very limited human, structural and material resources needed to accommodate and treat patients. We studied the experiences and opinions of public healthcare workers at primary healthcare clinics and the associated referral hospitals, focusing mainly on exploring their views on the ability and readiness for access to and provision of mental health to state health patients.

Methods: The Mental Health Knowledge Schedule (MAKS), the Mental Illness: Clinicians' Attitudes Scale (MICA-4) and a purpose-made questionnaire were used for data collection. The data from the MAKS and MICA-4 were imported into IBM SPSS Statistics Software to yield descriptive information, and Spearman's rank

correlations were performed between the measures. The purpose-made questionnaire produced descriptive quantitative data and qualitative data that were analysed through conventional content analysis.

Results: Results from the MAKS suggest that participants experienced gaps in mental health knowledge and had fair levels of familiarity and ability to recognise different mental health conditions. Results from the MICA-4 suggest that participants in our study generally displayed a positive attitude towards people with mental illness and aspects involving psychiatry. Quantitative results from the purpose-made questionnaire describe aspects around mental health services, training, resources and care. Qualitative findings suggest healthcare workers wished for more mental-health-specific resources and contact with the healthcare system to facilitate interventions and care.

Conclusion: This research presents possible solutions to the challenges faced in public mental health care. Some of these solutions are within workers' control, while many of the solutions

to the successful integration of more comprehensive basic care are out of their ambit of control, remaining locked up in policy and implementation rather than in field-level practice.

Keywords

integrated mental health care, public mental health care, rural mental health care, South Africa, task-shifting.

Introduction

Historically, mental health care has been provided primarily at institutions. This practice has changed, and the WHO guidance of devolving mental health care away from the tertiary locus of care into lower generalist levels (eg secondary and primary care facilities)¹ is fundamental to mental health reform worldwide. We know that, globally, the decentralisation of mental health care has introduced many hurdles – not only in lower income regions, but also in wealthier countries¹⁻³.

South Africa has a history of mental health care provided primarily at tertiary level in institutions⁴. However, over the 30 years since the end of apartheid, attempts have been made to decentralise and streamline the integration of public mental health care into general healthcare systems at primary and secondary levels. The currently implemented *Mental Health Care Act 17 of 2002*⁵ serves as the national guideline to implement policy into practice, thereby increasing access and the quality of care to mental healthcare users (MHCUs). This, of course, has implications for the roles workers and facilities are now called upon to play.

As early as the year 2000, Petersen noted that while the integration of mental health into broader, less specialised, healthcare sectors in South Africa may enhance accessibility, this access to a decentralised service may not equate to improved care provision⁶. She added that major adjustments in healthcare delivery need to occur nationally in order to integrate mental health care into lower, less specialised levels of care, thus offering the best service possible⁶. Almost a decade later, Burns reflected that about 15 years after health care restructuring for the country was envisaged, tremendous challenges were still being experienced in implementation of the guidelines of the Act – especially at community healthcare and district hospital levels⁷.

It is well established that the South African public healthcare system faces numerous and multi-faceted challenges⁸⁻¹⁰. The public mental healthcare sector in particular is one of the hardest hit domains and is severely stretched for resources. This includes very limited human resources to provide clinical services, in addition to structural and material resources needed to accommodate and treat patients. The National Department of Health, it appears, is very aware of the complexities involved in the successful integration of mental health care, a decade ago acknowledging that there are systematic weaknesses¹¹ that hinder service execution in the country. The Department of Health constructed a National Mental Health Policy Framework and Strategic Plan (NMHPFSP) 2013–2020¹¹ to guide the country in areas of mental health promotion, prevention of mental illness, treatment and rehabilitation interventions, towards improved mental health services to all South Africans. In its attempt to address deficits in service delivery, the strategic plan directed that mental health training courses should be launched, targeting all general healthcare workers at primary health care (PHC) level, as well as those in district and regional hospitals, so as to equip staff

with skills for basic assessment, identification, treatment and referral of complex cases – and that by 2015 all healthcare workers working in general health settings would have received basic mental health training, ongoing routine supervision and mentoring.

At PHC level, nurses are usually responsible for the assessment, treatment and management of MHCUs. Patients that cannot be promptly treated and discharged at clinic level are then referred to a higher level of care at hospital level. At hospital level the medical doctor is usually responsible for the assessment, treatment and management of mental health patients¹². Basic mental health training can be vital in assisting these non-specialist healthcare personnel in providing adequate basic mental health care to their patients. Additionally, the NMHPFSP 2013–2020 aimed to establish teams of mental health specialists to support general healthcare workers who may not have specialist skills at, for example, PHC level. It envisaged the establishment of inpatient departments in general hospitals to facilitate access to voluntary admission, assisted care, emergency mental health services, 72-hour assessment of involuntary MHCUs, ongoing care, treatment and rehabilitation. Lastly, the Department of Health planned to stock healthcare facilities, at all levels of care, with psychotropic medication in line with standard treatment guidelines and the essential drug list.

Clearly, a key component of successful mental healthcare provision at general healthcare level is seen to rest in South African policy that recognises the skill set, training and attitudes of general healthcare workers in the mental healthcare field. A number of South African studies have shown that, despite various multidimensional challenges^{4,13-15}, it is possible to empower non-specialist frontline healthcare workers, such as community healthcare workers and nurses, with skills in detecting mental disorders and supporting patients with care¹⁶⁻¹⁸. These studies offer an important contribution to the upgrade of mental healthcare delivery. The studies are, however, not designed to examine mental healthcare delivery as it exists in the country, within the context that, at policy level, the broadscale interventions and changes, as discussed above, were due to have been made by 2015. The question arises 'How do healthcare workers in general healthcare settings experience the integration of mental health services and see their role and skills at present?'

This question takes on particular significance in the more rural, underserved areas of the country. Many of the experimental interventions discussed above were conducted in or close to urban areas in wealthier parts of the country. However, as in other parts of the world, particular challenges exist in remote and less resourced areas. The current study is based in the Eastern Cape province of South Africa, one of the poorest in the country¹⁹, and in a rural district. Petersen et al noted that, locally, there remain significant service gaps intra- and interprovincially²⁰. De Kock and Pillay further highlight that fewer than 40% (302 out of 762) of the registered psychiatrists in South Africa work in the public sector,

which is responsible for the biggest majority of health services in the country, and that most of these clinicians are still centralised in or around urban areas²¹. They note that only 2% (7 of the 302 registered public health psychiatrists) work in rural primary healthcare settings. One of the questions that arises is 'How does the disproportional provision of mental healthcare between urban and rural parts of the country impact access to and provision of mental health services in rural South Africa?'

The data we present here were part of a larger project that investigated issues regarding access and provision of mental health care in the Dr Beyers Naude Local Municipality (DBNLM) area in the Eastern Cape province of South Africa. We studied the experiences of public healthcare workers at PHC clinics and the associated referral hospitals, focusing mainly on exploring their views on the ability and readiness for access to and provision of mental health care to state health service users in the area. We hope to provide insight into the status quo of mental healthcare services, and to explore possible progress made and challenges faced in terms of workable integration of mental health care in this part of the country.

Methods

Research setting

The population of DBNLM was 82 197 in 2016²². Research was conducted at primary and secondary healthcare facilities in surrounding small towns: Aberdeen, Graaff-Reinet, Jansenville and Willowmore. Data were collected from five PHC facilities, one community daycare centre and three local general hospitals in the district²³.

Research design

The larger project consisted of various substudies and utilised methodology from both quantitative and qualitative research designs to collect data from facility managers, healthcare workers that provide mental health services, and MHCU participants. Facility managers and healthcare workers could volunteer to participate in completing set questionnaires and/or partaking in a once-off semi-structured interview with the first author, who is also the primary investigator. In the presented work, we report on data generated from the questionnaires provided to participants.

Participants

Participants for this study were facility heads/managers at their respective facilities and/or healthcare personnel who provided treatment to MHCUs. The sample included 45 participants (Table 1). Participants were anonymised into three groups during data analysis for the larger project (#1–26, 2#27–40 and 3#41–45).

Table 1: Descriptive information for study participants (n=15 primary and 30 secondary healthcare personnel)

Study participants	n
Healthcare worker role	
Chief executive official	1
Clinical associate	1
Facility manager	1
Healthcare worker	1
Home-based care worker	1
Medical officer (doctor)	5
Nurse	24

Nursing manager	1
Operational manager	4
Pharmacist	4
Radiographer	1
Social worker	1
Mean period of work (years)	
At current healthcare facility	7.17
At Eastern Cape Department of Health	14.8

Study procedures

We advertised the project at the various healthcare facilities in the area, and telephoned participants who volunteered, scheduling appointments to obtain informed consent and to enrol them in the project. Once-off appointments of approximately 1 hour's duration were scheduled for data collection. Participants were provided with three questionnaires for completion. Participants were compensated for their travelling fees and to buy a meal after their participation, if desired.

Measures

We utilised three measures to collect data. First, we used the Mental Health Knowledge Schedule (MAKS) (Supplementary file 1), developed by the Evans-Lacko research group²⁴ at INDIGO Network, which comprises an international group of researchers that are committed to developing knowledge about mental illness-related stigma and discrimination. Second, we used the Mental Illness: Clinicians' Attitudes Scale (MICA-4) (Supplementary file 2), also developed by the INDIGO Network. Third, we used a purpose-made questionnaire (Supplementary file 3) which focused on obtaining data pertaining to aspects of healthcare workers' demographics and items that investigated different topics regarding access to and provision of mental health care.

The MAKS is a 12-item, self-report measure that investigates stigma-related and disorder-specific mental health knowledge. The MAKS is divided into two domains. The first section, comprising items 1–6, investigates mental health knowledge, and the second section, comprising items 7–12, evaluates a person's degree of recognition of and familiarity with mental health conditions to aid in contextualising their responses to other items^{25,26}. The MAKS is scored on an ordinal scale, with the potential for respondents to obtain a score of 6–30 for each domain, with higher scores representing increased knowledge related to mental health stigma and familiarity with mental health conditions. The MAKS has been found to be a brief and feasible measure to evaluate and track stigma-related mental health knowledge²⁵. The Evans-Lacko research group has suggested that the MAKS be used in conjunction with other attitude- and behaviour-related instruments²⁴.

The MICA-4 is a 16-item, Likert-type self-report measure that assesses clinicians' attitudes towards people with mental illness and aspects involving psychiatry. The MICA-4 has demonstrated a validity measure that can be used to inform intervention planning and has the potential for respondents to obtain a score ranging between 16 and 96²⁷. Clinicians obtaining overall high scores on the MICA-4 display increased negative stigmatising attitudes towards people with mental illness and psychiatry²⁸.

Our purpose-made measure is a 31-item questionnaire that focused on obtaining data regarding aspects of healthcare workers' demographics and items that investigated different topics pertaining to access to and provision of mental health care. Items on the questionnaire consisted of Likert scale-type measures, as well as items that allowed participants to report and elaborate on their responses qualitatively.

Data analysis

The MAKS and MICA-4 measures that were incomplete were eliminated and excluded from analysis. A total of 38 MAKS and 41 MICA-4 measures were analysed to provide descriptive statistics (Tables 2,3). Additionally, we ran a Spearman's rank correlation between 34 viable MAKS and MICA-4 measures using the Statistical Package for Social Sciences v29 (IBM Corp; <https://www.ibm.com/products/spss-statistics>). We investigated the relationship between the MAKS and MICA-4 (total scores) and evaluated the relationship between mental health knowledge items on the MAKS (items 1–6) and the MICA-4 (total score).

The demographic and Likert-scale responses from the purpose-made instrument were scored to provide descriptive data. For qualitative data, we specifically analysed qualitative responses on two items from our purpose-made questionnaire:

- 'What factors may help facilitate access to mental health care at your facility in the future? Please tell us about all the changes you may wish to see if you think changes would be helpful.'
- 'What would be the best system to deliver mental health care in your area? Please describe in detail.'

We discarded the questionnaires from respondents who failed to answer the items investigated from the qualitative analysis. Following elimination, a total of 36 questionnaires were analysed. The qualitative responses were analysed through means of conventional content analysis²⁹.

Ethics approval

The project was approved by the Health Research Ethics Committee of Stellenbosch University (reference S21/07/117 (PhD)). The Eastern Cape Department of Health granted permission to access and study public sector employees and MHCUs at the different facilities in the DBNLM area. Each participant provided written informed consent to participation. The questionnaires were available in the three prominent languages spoken in the area: Afrikaans, English and isiXhosa. Participation was voluntary and participants were remunerated to cover their travelling costs to the research site and to buy a meal if needed.

Results

The findings obtained from investigations after analysis are as follows.

MAKS

A total of 38 MAKS measures were analysed to yield descriptive data.

The minimum score obtained on the MAKS (total) was 34.00 out of 60. The maximum score obtained on the MAKS (total) was 56.00 out of 60. The MAKS (total) mean score was 46.79 (standard deviation (SD) 3.74).

The minimum score obtained on the MAKS (items 1–6) was 16.00 out of 30. The maximum score on the MAKS (items 1–6) was 28.00 out of 30. The MAKS (items 1–6) mean score was 22.84 (SD 2.78).

The minimum score obtained on the MAKS (items 7–12) was 16.00 out of 30. The maximum score on the MAKS (items 7–12) was 30.00 out of 30. The MAKS (items 7–12) mean score was 23.95 (SD 2.49).

Table 2: Summarised descriptive statistics for the MAKS

Items	n	Minimum	Maximum	Mean	Standard deviation
1–6	38	16.00	28.00	22.84	2.78
7–12	38	16.00	30.00	23.95	2.49
Total	38	34.00	56.00	46.79	3.74

MICA-4

A total of 41 MICA-4 measures were analysed to yield descriptive data. The minimum score on the MICA-4 was 21.00 out of 96. The maximum score on the MICA-4 was 66.00 out of 96. The mean score on the MICA-4 was 40.90 (SD 8.93).

Table 3: Summarised descriptive statistics for the MICA-4

n	Minimum	Maximum	Mean	Standard deviation
41	21.00	66.00	40.90	8.93

MAKS versus MICA-4: Relationship between mental-health-related knowledge and stigmatising behaviour

We computed a Spearman's rank correlation between 34 viable MAKS and MICA-4 measures to inform the relationship between stigma-related and disorder-specific mental health knowledge and clinicians' attitudes towards people with mental illness, including other aspects involving psychiatry. Analysis found a weak negative correlation between the measures ($r=-0.297$; $p=0.088$), but this was not significant.

We also correlated the relationship between stigma-related mental health knowledge (items 1–6 on the MAKS) and stigma attitudes as measured by the MICA-4. The Spearman's rank correlation between the MAKS (items 1–6) and the MICA-4 found a weak negative correlation between the measures ($r=-0.322$; $p=0.063$), but the relationship was not significant.

Purpose-made questionnaire

This section reports on descriptive data generated by items of the purpose-made questionnaire (Table 4). Thereafter, we report on the responses on the Likert-type items on the same instrument (Table 5).

Approximately half (55.6%) of our respondents reported receiving mental health training before working at their current place of work. Only 22.2% believed their exposure to mental healthcare training was sufficient. As few as 8.9% of workers reported receiving a mental health refresher course in the previous 2 years. Lastly, 84.4% of workers thought there were areas of their ability to provide care to MHCUs that needed further training or development.

The majority (57.8%) of workers agreed, compared to 31.1% who disagreed, that they could identify MHCUs from other physical care patients with ease. Only 22.2% of workers agreed, whereas 60.0% disagreed, regarding feeling comfortable that they could

provide adequate care to a mental healthcare patient. Furthermore, 60.0% of staff agreed and 35.6% disagreed that there was constant availability of first-line psychotropic medications at

their place of work. The vast majority (84.4%) of workers agreed, whereas 13.4% disagreed, that interventions were needed at their facility in order to provide better mental health care to MHCUs.

Table 4: Responses to descriptive items on the purpose-made questionnaire

Item description	Agreed (%)	Did not respond (%)
Had mental health training before working at current facility	55.6	0
Believed their exposure to mental healthcare training was sufficient	22.2	11.1
Had received a mental health refresher course in the previous 2 years	8.9	2.2
Thought there were areas of their ability to provide care to psychiatric service users that needed further training or development	84.4	0

Table 5: Responses to Likert-type items on the purpose-made questionnaire

Statement item	Agree (%) [†]	Disagree (%) [‡]	Not sure	Did not respond
I can easily identify a mental health service user from other physical care patients.	57.8	31.1	8.9	2.2
I feel comfortable that I can provide adequate care to a mental healthcare service user.	22.2	60.0	17.8	0
There is constant availability of first-line psychotropic medications (eg antidepressants, mood stabilisers, anxiolytic and antipsychotics) at the facility where I work.	60.0	35.6	4.4	0
Interventions are needed at my place of work so that it can provide better mental health care to service users.	84.4	13.4	2.2	0

[†] 'Strongly agree' and 'agree' were combined and considered to be agreement with the statement item.

[‡] 'Strongly disagree' and 'disagree' were combined and considered to be disagreement with the statement item.

Qualitative responses

The qualitative items focused on participants' opinions of factors needed to facilitate mental health access and service delivery at their place of work. The analysis of the qualitative data yielded two

themes, each with respective subthemes from participants' responses on the purpose-made questionnaire. The two themes and subthemes are outlined below and summarised in Table 6.

Table 6: Summary of themes and subthemes that emerged during qualitative analysis

Theme and subthemes	Description
1	Health workers express a need for more mental healthcare specific resources
a	Assistance from mental health specialist workers to provide routine services
b	Receiving extra mental health-related training to improve their service delivery abilities
c	Healthcare facilities to be accommodated with infrastructural changes for more suited mental health service delivery
2	Contact with healthcare system for interventions and care
a	Community-based interventions
b	Appointment-based treatment at healthcare facilities
c	Psychiatric outreach services

Theme 1: Health workers expressed a need for more mental-healthcare-specific resources

This theme, with its subthemes, represents participants' needs for additional resources to facilitate mental healthcare access and service delivery at their facilities. The forms of resources included aspects such as a wish for assistance from mental health specialist workers, extra mental health training for general care facility staff and infrastructural changes to improve the lack of resources at their place of work. Given the prominence of this theme, we analysed whether it was differentially expressed by different cadres of healthcare workers (eg nurses compared to doctors), but we detected no patterns of this nature.

Subtheme 1a: Assistance from mental health specialist workers to provide routine services

Many participants expressed their need for assistance from mental health specialist workers to provide regular services and support general staff at their facilities to improve the level of care (participant responses were in written form).

Dedicated professional/clinician to render specific service. Support staff. Do sessions, eg recreational, have specialist services eg psychiatrist come to facility to see clients.

(Participant 3#45)

First, appoint a psychologist, psychiatrist or counsellor. (Participant 2#38, translated from Afrikaans to English)

Other colleagues additionally expressed that mental health specialists should be appointed on a full-time basis, in a permanently placed position on site, to offer their services.

Permanent/routine psychiatrist or psychiatric clinician to assess MHCUs and treat on routine basis. (Participant 3#44)

Facilities must have dedicated staff assigned for mental health care ... a full-time psychiatrist and psychologist is a necessity ... we need to have a full-time psychiatrist that can assess all mental health patients, before scripts are renewed. (Participant #3)

Participants also indicated that multidisciplinary teams may be a helpful resource at their facility.

Having a stationed multidisciplinary team including a psychiatrist, psychologist, social worker, advanced psychiatric nurse, etc. (Participant 2#31)

The appointment of psychiatric doctors, psychologists and specialist nursing staff in the field will be an advantage. (Participant 2#29, translated from Afrikaans to English)

Subtheme 1b: Receiving extra, mental-health-related training to improve their service delivery abilities

Many of the participants noted their need to receive extra mental-health-related training to improve their care abilities.

The training of staff ... (Participant #8, translated from Afrikaans to English)

More training in the handling/management of patients with mental health problems must be given to professional people ... (Participant 2#27, translated from Afrikaans to English)

More training to clinicians and other health care givers ... training of present clinicians. (Participant 2#35)

Staff needs to be trained more often. (Participant #3)

Subtheme 1c: Healthcare facilities to be accommodated with infrastructural changes for more suitable mental health service delivery

Many of our participants were of the opinion that infrastructural changes at facility level were needed in order for better accommodation of mental health services at their place of work.

Move the psychiatric patients out of the chronic cases room ... Supply a separate area where they feel comfortable when they are treated. (Participant 3#42, translated from Afrikaans to English)

Participants elaborated that the buildings should be further developed or extended to better accommodate mental health services and patients.

Changes to the infrastructure are required. (Participant #18, translated from Afrikaans to English)

The infrastructure must be enlarged to allow time and attention as well as a place for them [MHCUs]. (Participant 2#38, translated from Afrikaans to English)

Setting up two or three rooms where we can consult with the patients. (Participant #8, translated from Afrikaans to English)

Some participants indicated that their facility lacked an isolation room where severely ill patients could be safely accommodated during 72-hour observations. They suggested that such a room should be made available at their facility.

Isolation rooms for the patients. A unit staffed by psychiatrically trained staff that focus specifically on these patients. (Participant 2#27, translated from Afrikaans to English)

If we can have a 72-hour observation unit in the facility. (Participant #16)

Participants reported the need for a separate ward where patients can be admitted for observation.

Infrastructure ... 72-hour observation ward with proper trained personnel. (Participant #5)

A unit for mental health consumers ... Trained staff to man the unit. (Participant #22, translated from Afrikaans to English)

Participant 2#30 summarised theme 1 and its subthemes by reporting the following necessary changes for improved access to mental health care at their facility.

1. *Infrastructural changes.*
2. *Increased security.*
3. *Isolation room and restraints.*
4. *More psychologists. (Participant 2#30)*

Theme 2: Contact with the healthcare system for interventions and care

This theme, with its subthemes, illustrates participants' opinion that contact with the healthcare system is essential for access and delivery of mental health to MHCUs at their facilities. Contact with the healthcare system included community-based interventions, regular follow-up for treatment at facility level and psychiatric outreach services.

Subtheme 2a: Community-based interventions

Many participants indicated that mental health services should be extended further than facility-based services and that treatment should be accessible and delivered at community level. Participants identified community-based psycho-education to reduce stigma about mental health, and awareness campaigns and prevention at community level.

Training regarding mental health illnesses supplied to the community will help because there is a stigma attached to these illnesses. (Participant #24, translated from Afrikaans to English)

Education to the community – awareness campaigns are needed for better service delivery. (Participant #10)

Prevention on community level. (Participant #25)

Participant 3#43 was of the opinion that healthcare workers, such as social workers, should be more involved with the community where their facility is based.

The social worker to be more involved in [the] community and youngsters. More indabas and events to make the community aware. (Participant 3#43)

Participant 8 provided a suggestion of what such awareness campaigns and *indabas* (a local way to describe meetings that discuss serious topics of concern) could possibly focus on in the community.

Awareness programs regarding alcohol and drug abuse and pointing out/explaining the symptoms of mental health patients. (Participant #8, translated from Afrikaans to English)

Subtheme 2b: Appointment-based treatment at healthcare facilities

Health workers reported that MHCUs should attend the facility on an appointment-based system for improved access and treatment, and regulated follow-up.

A functional appointment system. (Participant 2#36, translated from Afrikaans to English)

Do booking for their dates ... follow-up dates ... [and] checking the same date in the facility for their treatment. (Participant 2#40)

Other colleagues had a slightly different view on appointment-based treatments, with specific mental health treatment days or appointment slots at facilities for MHCUs for facilitated access and service delivery, and specific nurse allocation.

Psych day in the month to book patients ('clinic') for reviews and check-ups at the facility. (Participant #17)

Specific days should be set aside for them [MHCUs] for the supply of medication and talks [group sessions]. (Participant 2#37, translated from Afrikaans to English)

Allocate a specific nurse to them [MHCUs]. Arrange specific times or days on which the focus will be on them. (Participant 3#42, translated from Afrikaans to English)

Subtheme 2c: Psychiatric outreach services

Many participants highlighted the need for psychiatric outreach services to rural communities for better access and delivery of mental health care, with particular reference to medication requiring psychiatric prescription. Outreach teams would usually travel from tertiary health facilities to rural areas to provide specialised services on certain days.

Psychiatric outreach programs must be instituted again to enable the regular monitoring of these patients. (Participant 2#39, translated from Afrikaans to English)

The reinstatement of the psychiatric outreach to GRT [town of Graaff-Reinet] in order to support the management of our psychiatric patients on a regular basis. (Participant 2#27, translated from Afrikaans to English)

Psychiatric outreaches – by psychiatrists + psychologists to evaluate patients ... State psychiatrist – to do psychiatric outreaches as was done in the past to evaluate patients. Presently no patients are reviewed by a psychiatrist. (Participant 2#34, translated from Afrikaans to English)

Psychiatric outreaches to the community will help a lot because many of our medications may only be prescribed by a psychiatrist. (Participant #24, translated from Afrikaans to English)

Discussion

To our knowledge, this investigation was the first of its kind and adds to our existing knowledge on issues regarding access and provision of mental health in the DBNLM area²³. The primary goal of this study was the exploration of public healthcare personnel's experiences and opinions on access and readiness to provide mental health care in the area. We utilised various quantitative and qualitative instruments to explore healthcare workers' experiences and opinions. Our sample consisted of 45 participants from 12 vocational areas, where the majority of the participants worked in a secondary healthcare setting. We acknowledge that our relatively small, thin sample may be a limiting factor that may influence our argument in the presented article.

The results from the analysis of the MAKS provide some informative insights into healthcare workers' degree of stigma-related and disorder-specific mental health knowledge in this region of South Africa. The healthcare workers in our sample obtained a mean score of 46.79 (SD 3.74) on the MAKS (total). This level of mental health-related knowledge can be compared to performances measured (mean 45.57, SD 4.25) by other local studies that evaluated a specifically trained group of non-matriculated (ie has not completed secondary schooling), unqualified community healthcare workers in the Western Cape, a wealthier, urban province³⁰. In terms of knowledge related to mental health stigma, as measured by the MAKS (items 1–6), our sample displayed slightly more knowledge compared to other international literature^{31,32} and was in line with local general healthcare workers from metropolitan areas in South Africa³³. As similarly noted by Kigozi-Male et al³³, the results from our sample on the MAKS (items 1–6) suggest that there are gaps in mental health knowledge among general healthcare workers. The mental-health-related knowledge gaps are not surprising as our purpose-made questionnaire found that only approximately half of healthcare workers received mental health training before being employed. Our questionnaire further showed that only about 1 out of 10 healthcare workers had received refresher courses on mental health in the previous 2 years and only 22.2% of workers were of the opinion that their exposure to mental healthcare training was sufficient.

From the results obtained from the MAKS (items 7–12) it can be argued that participants in our study displayed a fair level of familiarity and ability to recognise different mental health conditions (mean 23.95, SD 2.49). The findings from our purpose-made measure resonate participants' ability to note mental health conditions, as 57.8% reported that they could easily identify an MHCU from other physical care patients. The question, however, arises about whether they possess the skills or knowledge to effectively manage mental health cases following diagnosis of MHCUs' mental health condition. The answer suggested from our findings is, mostly, no – only one out of five (22.2%) general healthcare workers felt that they could provide adequate care to mental health patients. Such statistics are concerning and brings into questions how MHCUs may be treated and managed at remote facilities where healthcare workers have to exercise services with limited knowledge and resources.

The results from the MICA-4 suggest that participants in our study generally displayed a positive attitude (mean 40.90, SD 8.93) towards people with mental illness and aspects involving psychiatry. Local research by Eksteen et al³⁴ highlighted the value that mental health-specific training/knowledge offers in reducing clinicians' stigmatising attitudes towards MHCUs. Eksteen et al compared the attitudes of a group of medical students to those of working psychiatrists³⁴. They suggested a noticeable difference between, for example, fifth-year prepsychiatry-trained students (mean 43.9) and working psychiatrists (mean 32.7)³⁴. These results offer valuable confirmation that stigmatising attitudes can be reduced and overall level of care can be enhanced if healthcare workers receive sufficient training in mental health. While our analyses on the relationship between the MAKS and MICA-4 suggested a weak relationship, indications were that higher mental health knowledge in healthcare workers decreased their stigmatising behaviour towards mental illness and psychiatry.

Considering the issues discussed above, it is not a surprise that 84.4% of workers thought that there were areas of their ability and aspects of their place of work that needed intervention to provide enhanced care to MHCUs. While routine training may help healthcare workers be better equipped to engage with (eg reduce stigmatising behaviour), treat and manage their mental health patients, it must be recognised that healthcare workers will inevitably be required to treat patients with more complex problems that need more specialised care, and more mental health-specific resources are desperately needed in the Eastern Cape province. We argue that lack of mental health-specific knowledge or negative attitudes towards MHCUs are not the primary issues that challenge adequate access and delivery of mental health care in this part of the country. The information obtained from our participants suggests that many facilities still lack critical strategic interventions, as outlined by the NMHPFSP 2013–2020, and systematic weaknesses remain.

While first-line psychotropic medication seems to be readily available at most facilities, and can be regarded as a pivotal resource to facilitate access and delivery of care, many facilities receive very limited services from specialist clinicians like psychiatrists and psychologists to review, renew and manage patients with mental illness. The context of mental health care in the DBNLM area looks significantly different than in urban areas of South Africa, like in the Cape Town region, where public sector psychologists routinely service the dedicated PHC facilities assigned to them. Furthermore, most facilities seem to lack the infrastructural accommodations to perform adequate mental health care.

Conclusion

The healthcare workers who participated in our study provided insights to their experiences of working and providing mental health care in resource-constrained rural areas of South Africa. While our findings may not necessarily be generalisable to broader contexts, they may serve to inform other, similar healthcare settings locally and internationally. The decentralisation of mental health care services as an ideal has implications that may require critical consideration while keeping in mind the multitude of nuances that form part of the mental health spectrum before implementation. The healthcare workers in our study provided us with possible solutions to the challenges they face. Their proposed solutions are, ironically, in line with the goals of the NMHPFSP 2013–2020 and appropriate mental healthcare legislation. Some of these solutions, such as seeing MHCUs on an appointment-based system, are within their control and have been shown to be helpful and effective by their colleagues in the area²³. Yet many of the solutions to the successful integration of more comprehensive, basic mental health care seemed to be out of their reach and remained locked up in policy and implementation, rather than in field-level practice. General healthcare workers at PHC and hospital level in our study informed us that they and their health facilities in this part of the Eastern Cape are not adequately equipped. They wanted to help, but they did not have the expertise, the infrastructural support or the specialist clinicians to realise their intent. There are gaps: they were underresourced and struggling. The comments made by our participants are in line with our

observations during site visits of overcrowded, underresourced health settings that impacts healthcare workers' ability and readiness to provide mental health services in the area.

This may pose questions not of healthcare workers' ability or interest, but rather about broader healthcare planning and provisioning. This may have implications beyond this study and, indeed, internationally. The strategy of integrating mental health into lower levels has many potential benefits, including streamlining of services – but where resources are stretched and personnel poorly prepared and supported, the policy of integration may mask a greater problem: the undue burden on personnel. In contemporary South Africa, these issues may be further exacerbated by recent budget cuts in the public healthcare sector. Hoare and Matisonn, writing more generally about healthcare workers in South Africa, described the 'moral distress' experienced by such workers when they cannot provide the care they would wish to³⁵. This was also an issue for participants in our study, but is likely to be a problem more broadly for healthcare workers in rural settings asked to do more than they reasonably can be expected to do. This is not just an issue for mental health care in the narrow sense, but also for health service planning and management globally.

Limitations

Our primary goal was to provide area-specific exploratory information – yet we acknowledge that we report on results of a relatively small sample, and the generalisability of findings may be questioned in the larger South African context. Additionally, our sample consisted primarily of nurses who have been working in the Department of Health for more than a decade, on average. As a result, our findings may fail to report on accounts of more recently trained healthcare workers.

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Conflicts of interest

Divan Rall was the primary investigator in this research. He is also a clinical psychologist serving in the DBNLM public health sector. His dual role capacity may have influenced the information collection and interpretation. The Eastern Cape Department of Health granted permission to study public health workforce and MHCUs on the condition that the department was presented with the findings before publication.

Research data availability

Data are available from the corresponding author on reasonable request.

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