SOCIAL WORK IN MENTAL HEALTH
https://doi.org/10.1080/15332985.2021.1927283

Routledge
Taylor & Francis Group

Mental health care services in rural South Africa: a human capabilities approach

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ABSTRACT

It is estimated that a significant proportion of people living in South Africa have a mental illness and do not have access to mental health services. This relates to barriers that contribute to help-seeking behavior. Semi-structured interviewers were conducted with a sample of 11 stakeholders and 35 parents. Data were thematically analyzed and results revealed that participants had limited knowledge of what mental health is. Also highlighted was the lack of structural and human mental health care resources, and stigmatization. Addressing the issues related to mental health care services could contribute to ensuring that people have access to good health.

KEYWORDS

Bodily health; barriers to mental health care; help-seeking behavior; human capabilities; service availability; stigmatization

Introduction

Health is defined as a state of complete physical, mental, and social well-being and not just the absence of illness or disease (World Health Organization (WHO), 2013). This definition shows that there are various aspects that contribute to an individual's overall health. Mental health, which is an integral part of overall health, is defined as a state of psychological well-being (Pilgrim, 2020) or the absence of mental illness (Manwell et al., 2015). It is a state whereby individuals can realize their abilities, cope with the normal stresses of life, work productively, and contribute to their communities (WHO, 2013). It includes their ability to form and maintain relationships and identify and express emotions adequately. This highlights the importance of mental health and well-being as it contributes to a person's ability to navigate through life and successfully deal with subjective challenges/difficulties. For many individuals, however, this is not always the case.

Approximately 85% of the world's population live in low- and middle-income countries (LMICs) (Rathod et al., 2017). Moreover, an estimated 80% of individuals who have mental health disorders live in LMICs (Rathod et al., 2017). Rathod et al. (2017) promulgate that mental illness is a significant

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contributor to the total burden of disease in LMICs at a rate of 8.8%. The latter demonstrates the degree to which mental illness affects the population in these countries. In addition, Naidoo, Nyembezi, Thomas, Lachman, and Kagee (2019) indicate that several studies have shown that poor and marginalized individuals are at greater risk of suffering from mental health-related problems. Thus, mental illnesses and disorders affect a substantial amount of people living in LMICs, adding to the disease burden in poorer and marginalized communities.

According to a national comorbidity study conducted in the United States, most mental disorders emerge by 24 years of age (Rickwood, Mazzer, & Telford, 2015). It is believed that LMIC groups are becoming more aware of mental illness. There is thus greater acceptance of it within these communities, including by policymakers. As a result, LMIC are starting to provide the necessary resources for the development of mental health care services (Rathod et al., 2017). However, current predictions indicate that by 2030 depression will be the third leading cause of disease in low-income countries and the second leading cause in middle-income countries (Rathod et al., 2017). Thus, although there has been an increase in mental health/illness awareness in LMICs, mental health care service availability and accessibility continues to be significant in these countries as they are vulnerable to poor mental health.

Literature review

In South Africa, it is estimated that for a 12-month period there is a 16.5% prevalence rate of common mental disorders (CMDs). These include, for example, anxiety, mood and substance use disorders, and post-traumatic stress disorder (PTSD) (Brooke-Sumner, Lund, Selohilwe, & Petersen, 2017; WHO, 2017). Although CMDs vary in intensity and duration, they impact an individual's everyday functioning. Furthermore, it is estimated that about 30.3% of the South African population will have experienced at least one CMD in their lifetime (Brooke-Sumner et al., 2017). This is supported by Pillay (2019) who noted that one in six South Africans suffer from a CMD, 41% of pregnant women are depressed, and approximately 60% of South Africans potentially suffer from PTSD as a result of motor vehicle crashes and crime. However, it is reported that one in four people with a CMD and only 27% of South Africans who have a severe mental illness (SMI), such as schizophrenia, severe bipolar disorder, and depression, receive treatment (Petersen et al., 2016; Pillay, 2019). Evidently, a significant proportion of South Africans who experience a CMD/SMI do not receive treatment. This may be related to challenges and barriers to accessing mental health services.

A number of studies report on the barriers related to the treatment of mental illness (Bruwer et al., 2011; Mojtabai et al., 2011; Schierenbeck, Johansson, Andersson, & Van Rooyen, 2013). The barriers identified are

social, organizational, and structural, and include participants' low perceived need for treatment, stigmatization by society, affordability, and accessibility of health care, as well as a shortage of mental health service providers. It is recommended that resource-poor countries, like South Africa, develop approaches that target the community-level engagement around mental health (Burgess & Burgess, 2016). This will assist in improving the accessibility to mental health services in poorer communities. Additionally, approaches targeted at a community level can improve community members' knowledge of mental health, the importance thereof, as well as their capability to reach their full potential and function efficiently and adequately within their society. Therefore, establishing what the barriers are in poorer communities within the South African context may assist in developing effective treatment programs and interventions.

Theoretical framework

This research made use of Nussbaum's (2000) human capabilities approach (HCA) to develop the methodology and interpret the study's results. Nussbaum identifies 10 fundamental capabilities that individuals need to function, arguing that these should be the goal of all public policies (Nussbaum, 2011). According to Nussbaum (2003, p. 33), "capabilities refer to the importance of what people are actually able to do and to be". She contends that if any of the 10 capabilities are lacking, the individual may fall short of leading a basic human life (Nussbaum, 2000). These central key capabilities include life; bodily health; bodily integrity; sense, imagination and thought; emotions; practical reason; affiliation; other species; play; and control over one's environment (Nussbaum, 2011).

The current study focused on the second capability identified by Nussbaum (2000), namely, *bodily health* (being able to have good health), which includes mental health. Additionally, this study endeavored to understand the participants' knowledge and understanding of mental health, the availability of mental health services, and community members' help-seeking behavior in poor-resourced communities. Building on previous research, this study seeks to contribute to the existing body of knowledge by focusing on the South African rural context. This study also employed the human capabilities framework, specifically looking at the freedoms and opportunities related to an individual reaching their full capabilities as identified by Nussbaum (2003). The following research questions were formulated to guide this study:

(1) How do people in rural areas within South Africa understand mental health?
(2) What mental health care services are available in these communities?

(3) How often are mental health care services accessed by community members?
(4) What are the barriers to accessing mental health care services in rural communities in South Africa?

Methods

Design

This study utilized a qualitative method, whereby semi-structured individual interviews were conducted (Creswell & Creswell, 2018). Interview schedules were centered on the 10 central human capabilities proposed by Nussbaum. These functioned as the "yardstick" of living a "humane" life.

Setting

The study was conducted in two purposively selected rural areas of South Africa – Calvinia and Lambert's Bay. Calvinia is located in the Northern Cape province and has an unemployment rate of 41.5% (Statistics South Africa (StatsSA), 2019). Lambert's Bay is located in the Western Cape and has an unemployment rate of 22.7% (StatsSA, 2019). South Africa is a post-apartheid country that used the racial categories of "White", "Indian", "Black", and "Colored" to differentiate between individuals with different skin tones and features. With a total population of 9,680 (StatsSA, 2011a), Calvinia is a predominantly Afrikaans-speaking (96.9%) Colored community (83.0%). Lambert's Bay, on the other hand, is a fishing community on the West Coast of the Western Cape province. This town is particularly known for its white beaches, wildlife, lobsters, and tourist attractions. With a total population of 6,120 (StatsSA, 2011b), Lambert's Bay is also a predominantly Afrikaans-speaking (90.9%) Colored community (74.5%) (StatsSA, 2011b). Unemployment and poor public service delivery are major concerns across both communities, giving rise to additional challenges such as crime and substance abuse (Nel, Taylor, Hill, & Atkinson, 2011).

Study population

In total, the sample of this study comprised 46 participants – 16 from Lambert's Bay and 30 from Calvinia from which 52.1% were female. The participants included (1) parents and/or caregivers, and (2) stakeholders who agreed to share their understanding and knowledge of health services in the community, service availability, and mental health, as well as their perceptions of community members' understanding of mental health. Parents and/or caregivers predominantly consisted of mothers or grandmothers who had one

or more child under 18 years of age. Stakeholders were made up of social workers, dieticians, nurses, community health workers, and police officials. Overall, the study consisted of 11 stakeholders and 35 parents who were interviewed during the data collection phase. The bulk of the participants were parents (mostly mothers) who were purposively sampled (Creswell & Creswell, 2018) via non-governmental organizations (NGOs) and door-to-door canvasing.

Research instruments and data collection

The study utilized two semi-structured interview schedules, one for the parents and one for the stakeholders. Interview schedules were guided by existing literature on parents' and stakeholders' perceptions of mental health, barriers, and the HCA.

The parents' interview schedule consisted of 24 questions aimed at parents' understanding of mental health and the identification in their children. However, this article only used data based on the first two categories on the interview schedule: "knowledge about mental health" and "mental health in children."

Furthermore, the stakeholders' semi-structured interview schedule consisted of 11 questions focused on available social and health services as well as community life in terms of their interactions with one another, with researchers placing particular focus on community members' interactions with people who present with a possible mental illness.

Interviews ranged from 15 to 40 minutes with the parents and 40 minutes to 1 hour and 10 minutes with the stakeholders. Leading questions asked were followed by probing questions based on the participants' responses. Interviews were conducted in English and Afrikaans as these are two of the predominant languages in the Western Cape. Interview schedules were translated into Afrikaans and then back-translated to ensure quality, accuracy, and compatibility with the original interview schedules.

Data collection procedures

Ethical approval was obtained from the Humanities and Social Sciences Research Ethics Committee (HSSREC) at the University of the Western Cape (UWC). Parents were recruited by door-to-door canvasing. The researchers inquired whether anyone older than 18 years resided in the home as a parent and requested their participation. Additionally, the researchers also gained access to participants via community-based organizations. Stakeholders were recruited by means of accessing the local social workers and individuals in the health profession, such as dieticians and police officers. The purpose of the study was clearly explained to all the participants. In

addition to informing them in a language that they understood and/or preferred that participation was completely voluntary, verbal consent was obtained from all the participants and confidentiality was ensured by removing any identifying information, such as their names.

Data analysis

All Afrikaans interviews were translated into English during the transcribing phase. Thematic analysis, which is often used in qualitative research, was used to analyze the interviews (Braun & Clarke, 2006). The thematizing of meanings is commonly found across various forms of qualitative analysis. This method of analysis consists of the following six steps: (i) familiarizing yourself with your data; (ii) generating initial codes; (iii) searching for themes; (iv) reviewing themes; (v) defining and naming themes; and (vi) producing the report. In accordance with the above-mentioned steps, the researchers first familiarized themselves with the data by reading and re-reading the transcriptions. Thereafter, they generated initial codes. Once coding was completed, the researchers searched for themes by sorting the different codes into ideas that were related. The next step included the identification and naming of themes to ensure that meanings were captured and definitions for each theme were generated. Once each theme was described and defined, quotations from the transcripts were used to illustrate and capture the essence of the themes. Results were then written up in an article.

Results

The main findings that emerged from the analysis pertained to the stakeholders' perceptions of community members' knowledge of mental health, community interactions, barriers to help-seeking behavior, available mental health services and resources, parents' understanding of mental health, and stigmatization related to the presence of mental illness.

Perceived attitude of community members toward individuals who display mental illness

This theme attends to stakeholders' perceptions of the acceptance from community members by those who, according to them, display symptoms of psychological dysfunctions. Participants spoke of community members becoming more tolerant and accepting of those who may be mentally ill, and families providing the needed care and support. Participants expressed their face-value perceptions of community and family members' tolerance, acceptance, and care and support, as follows:

> "I would say it's more – it's as if people accepted it more. It's not like in the past where you are there, and we are here, and you are not normal, and you don't act like us, so we treat you different or we avoid him because we don't understand it. Like I said, now it seems as if the community is more tolerant and acceptant – seems like it". (Social Worker, Female, 37 years old).

> "If they are on medication, we have a lot of people with mental illnesses that stay with their family; if they control their medication, then they [are] fine" (Dietician, Female, 36 years old).

Across communities, stakeholders believe that in recent years community members are more tolerant and accepting of those who show symptoms of mental illness. This is evident by community members not treating them differently or attempting to avoid them. As people with mental health challenges would potentially require medication and adequate care, the stakeholders remarked that families make sure that individuals who receive professional care take their medication, especially when they have been given prescription medication.

Mental health as a concept

This theme emerged from the common reports of stakeholders that community members have a limited understanding of what mental health is. These statements made by the stakeholders were supported by the parents' account of what they believe mental health to be. This theme consists of two sub-themes, namely, *lack of knowledge and understanding of mental health* and *parents' understanding of mental health*. Both are described in more detail below.

Lack of knowledge and understanding of mental health

The stakeholders perceived the community members as having limited knowledge or understanding of what mental health is, as reported in the extracts below:

> "Yes, they don't understand and they're still in that 1980 that you aren't, you don't have a mental problem, they don't take depressive seriously" (Social Worker, Female, 27 years old).

> "Oh, that is very poor, we struggle with mental health issues" (Dietician, Female, 36 years old).

Community members were viewed as tending to avoid mental health issues that they did not understand. There was no clear indication of whether they are exposed to information relevant to mental health. Participants indicated that they experience challenges related to mental health as it is something they, as a community, struggle with.

Parents' understanding of mental health

The parents who participated in the study were asked to reflect on their understanding of mental health. Very few knew what mental health was, regardless of their age or education level.

> "*Mental health – it means you have the Lord on your side, or am I correct? It goes around being on the side of the Lord, so that you can't do the wrong things like drugs and alcohol, that is what I understand about it*" (Mother, Grade 12, Female 23 years old).

> "*No, I don't really know what that means, that sicknesses, I only worked at a school with children for all these years*" (Grandmother, Grade 9, Female 58 years old).

From the findings, it was apparent that most of the parent participants had no understanding or knowledge of what mental health is. Mental health was viewed as being linked to substance use and as an illness.

Barriers to help-seeking behaviors

Given that the stakeholders spoke about community members' attitude toward individuals with a mental illness in terms of acceptance and assistance, discussions also revolved around possible barriers to seeking help for mental health issues. Participants reflected on potential challenges and the reasons why individuals who may require psychological assistance often do not receive or seek help. The following three sub-themes were identified within this theme: *context-related barriers, lack of resources*, and *stigma*. These are discussed in more detail below.

Context-related barriers

This sub-theme was identified as it is linked to mental health services being viewed as expensive or non-existent within the community, with the nearest treatment facility located in a neighboring town and the procedure for receiving help being time-consuming. This is confirmed in the following excerpts:

> "It's too an expensive service. I know this psychiatrist that comes here – comes from, I think, Paarl. That's the closest psychiatric ward that we have. So, they kept in Clanwilliam for a while, and then, if there's an opening in the ward in Paarl, then they would go there and then wait for another opening for Stikland . . . With the psychiatrist, you have to go through the psychiatric sister, nursing professional, she makes your appointment in Clanwilliam and then you will see him, and when you get there, [there] are about 50 patients sitting there and waiting for him, so it's like a sausage machine" (Social Worker, Female, 60 years old).

> "We only have one mental hospital in the whole of the Northern Cape, so yes, people have to take care of their family members themselves . . . Most of them, they need to be referred to Kimberley, which is forever – far away – it's a 7-hour drive" (Dietician, Female, 36 years old).

Lack of human resources

According to the stakeholders, there are limited services available that particularly focus on mental health and mental illness. In the different areas where the data were collected, the participants echoed that there are limited staff who specialize in mental health-related services. It was stated that for one of the areas there is only one psychologist for the entire district who visits the local clinic once a week, and a psychiatric sister who visits the clinic once a month.

> "*As I said, it's about one psychologist for 4 towns. He does one day a week. And if he goes on holiday, then there's no one. Its only one psychologist that works Citrusdal, Clanwilliam, Grawater, [and] Lambert's Bay. So, he works the whole area . . . Psychiatric sister visits here once a month and then she would refer clients to the psychiatrists . . . I wish I could have a psychiatric sister in the staff for everyday because, you know, people that really get sick here, psychotic – the police have to take them to Clanwilliam, so they [patients] already in that state then they have to go in a police van to the hospital, and often when they get there, at Clanwilliam hospital . . . before the police van is back home in Lambert's Bay, they [patients] already back home because there isn't really security there*" (Social Worker, Female, 60 years old).

While the Lambert's Bay area does receive some sort of assistance for patients who require mental health assistance, the latter was found to be lacking in Calvinia. The extensive lack of resources in Calvinia is confirmed in the excerpts below.

> *"We don't have a psychiatrist; we don't have a psychologist . . . People who try to commit suicide, there's no proper, nothing, nada, support; there's no support, there's no psychiatrist, there's no psychologist"* (Hotel Manager, Female, 49 years old).

> *"We need more therapy treatments in our community so it can help the people"*. (Child and Youth Care Worker, 36 years old).

Stigma

Although it was found that community members have become more accepting of people who present with symptoms of mental illness, stigmatization was still found to be prevalent. Participants spoke of how people with mental illnesses are treated:

> "We get a lotta people with schizophrenia; we have a lady that's in hospital for the last three months, but now her family doesn't want her, she is psychotic". (Dietician, Female, 36 years old).

> "Like I said, if your behaviour is not seen as normal then I would set you on that side and it's like I don't understand it and sometimes I can even say that I am scared of you, that is why I would rather not go there and avoid you". (Social Worker, Female, 37 years old).

> "A person must help them but some of them throws them with stones . . . " (Child and Youth Care Worker, 37 years old).

Creating awareness

There were disparate views of whether community members would be interested in receiving information regarding mental health. This was related to mental health being viewed as intellectual and potentially being hard to understand. However, it was reverberated that the way in which information is delivered may be more appropriate if presented in layman's terms:

> "Well, I worked in a psychiatric hospital, so for my clients I would explain what is going on when someone is depressed or whatever illness. In my layman's terms, I will try to explain to them whether anyone else is doing that, I don't know". (Social Worker, Female, 60 years old).

> "The pamphlets won't do it because they won't read it. If I don't understand that concept, that word, even then, why bother, and it's a thing of intellectual capacity. So if I get a pamphlet, then I'll put it there and won't even bother … If you could get to the caregivers especially, they would welcome stuff like that to be able to understand it better … And also, the others, younger siblings maybe, because if I don't understand the behaviour, I would avoid you. I won't be so – I won't be socializing with you but socializing with a other person who I see has normal behaviour … but also making them aware". (Social Worker, Female, 37 years old).

The participants suggested that to create awareness, information on mental health needs to be disseminated among community members in an understandable manner. This includes interpreting information using local terminology. The participants further expressed the need for information regarding mental health at all developmental stages, which includes young children, adolescents, young adults, parents, and grandparents. Doing so will foster awareness of mental health and mental illness across all age groups, allowing for better affiliation and inclusion of people who may present with symptoms of mental illness. It will also aid in early identification.

Discussion

This study aimed to understand participants' knowledge and understanding of mental health, mental health services availability, and community members' help-seeking behavior in poor-resourced communities, using the HCA as a framework. The results of this study show that within Calvinia and Lambert's Bay, there is a lack of mental health awareness and understanding. This relates to community members' behavior and attitude toward those who present with mental illness symptoms, help-seeking behaviors, and the barriers related to it, as well as parents' misconceptions of mental health and their understanding thereof. It is postulated that the attitude and beliefs possessed by the broader public related to mental illness significantly contributes to individuals with mental health issues accessing or receiving treatment (Gibbons, Thorsteinsson, & Loi, 2015). The beliefs and attitudes of community

members regarding mental illness can aid in the recognition, management, and prevention of CMDs (Gibbons et al., 2015). Therefore, providing the broader community with the necessary information regarding mental health and illness could assist in early identification, societal acceptance, reduce stigmatization among community members and the family, and promote help-seeking behaviors for mental illness treatment where needed, thus breaking down the barriers related to help-seeking behaviors.

Within this study sample, various barriers were identified by stakeholders with regards to seeking treatment for mental health issues. In particular, context-related barriers were identified, which included the lack of structural resources and affordability; lack of human resources (e.g., qualified staff who specialize in mental health issues, such as psychologists and psychiatric nurses); and stigma toward people who present with mental health-related problems. Specifically, addressing the stigma related to people with mental illness contributes to the burden of mental illness experienced within a country (Semrau, Evans-Lacko, Koschorke, Ashenafi, & Thornicroft, 2019). This relates to prejudice and discrimination being internalized by individuals who have mental health issues or a more severe mental illness, thus contributing to disadvantages in their personal relationships, work, and education (Semrau et al., 2019). This goes against Nussbaum's second human capability, which is for each person to have bodily health. Nussbaum (2003) maintains that an individual should be able to have good health. From the study's findings, it is argued that the bodily health of community members who experience mental health-related issues is violated. This is evident by their lack of structural and human resources as well as the lack of knowledge they possess. The latter contributes to stigma and discrimination.

Therefore, providing mental health services at a community-based level in poor-resourced communities within South Africa, such as public hospitals, local clinics, religious institutions, and community-based organizations, can promote mental health among community members and at the same time address existing challenges (Anyebe, Olisah, Garba, & Amedu, 2019; Burgess & Burgess, 2016). These services should include information related to mental health, psychoeducational services, the detection and treatment of CMDs, referral services, and the rehabilitation of those with a mental illness in the community (Anyebe et al., 2019). This, in turn, will contribute to the freedoms and opportunities everyone should have equal access to for them to reach their full capabilities as identified by Nussbaum (2003).

The stakeholders alluded to the absence of mental health services at the community level as there is only one psychologist for the entire district, and a psychiatric nurse who frequents these communities once a month, with the nearest facility providing psychological assistance being situated in the neighboring town. This then contributes to the challenges community members face when attempting to access mental health services and social workers

providing services within these communities. Therefore, providing these services and allowing for easier access, especially in low-income areas at a community-based level, will assist in reducing stigmatization, increase knowledge of mental health, and improve help-seeking behavior and acceptance from community and family members.

Another way to improve mental health help-seeking behavior could be to create community awareness and integrate mental health into various institutions. This relates to participants reporting that a different approach needs to be taken when relaying information regarding what mental health is to ignite interest among community members. Thus, psychoeducation needs to take place at a community level in a way that community members will understand. This includes ensuring that it becomes context- and time-specific. For instance, McClellan, Ali, Mutter, Kroutil, and Landwehr (2016) and Sampogna et al. (2017) reiterated that the mass media, such as television broadcasts, newspapers, magazines, and social media platforms, including Facebook and Twitter, are often used to spread public health messages. These platforms could be used to inform and change people's behaviors, beliefs, and opinions toward those who may be struggling with a CMD, which could then contribute to the reduction of stigmatization, and the acceptance and improvement of help-seeking behavior.

Acceptance and awareness of mental illness may also assist and empower social workers working with clients who present with CMD to provide the necessary treatment and support for both client and social worker. It is suggested that further research be conducted on psychological support delivered to rural community members via faith-based organizations and traditional healers, as this steers away from the elitist and Western perspective of mental health and takes into consideration South Africa's context. Furthermore, providing community-based campaigns can also improve awareness, understanding, and interest. A study conducted by Henderson, Robinson, Evans-Lacko, and Thornicroft (2017) found that participants who were aware of a mental health campaign were more likely to seek help for mental health issues and feel more comfortable when disclosing mental health problems to their family, friends, and current or prospective employers. Thus, providing awareness that is likely to reach a wider range of people improves how people view, feel about, and deal with mental health-related issues. Addressing the identified challenges related to mental health help-seeking behavior can act as contributing factors to ensuring that the 10 capabilities identified by Nussbaum (2003) are not lacking, thus allowing all individuals to lead a basic human life without discrimination, marginalization, and exclusion, be it economically, politically, or socially.

Limitations

This research study made use of a qualitative research method. Therefore, the findings cannot be generalized beyond the sample. Furthermore, although the study provides a new perspective by use of the HCA, future research could include parents' or caregivers' perspectives and willingness to receive psychoeducation and their interest in how to best receive information concerning mental health. In addition, the available qualitative data from the parents and stakeholders are in line with the current study's findings as it focuses on mental health awareness and service availability and how it relates to help-seeking behavior by use of the HCA.

Implications

Regardless of the identified limitations, this study offers important insights on how a cohort of rural South Africans understand mental illness and mental health care availability in rural areas. The findings suggest that there are limited mental health care services available in the rural areas where the data were collected. These include accessibility and how often practitioners visit these areas. This study aims to develop a body of knowledge that will inform policymakers when developing policies related to mental health care services. It also seeks to provide guidance for mental health practitioners, such as community social workers, to assist families and communities to better understand what is available, how often it is made available, and the procedures related to receiving help. This could be used to improve procedures and patient care.

Conclusion

Addressing the identified barriers related to seeking mental health support could assist in ensuring that all individuals reach their full human capabilities. This study particularly focused on Nussbaum's (2003) second capability, namely, *bodily health*. By addressing the issues related to mental health services, access to services, community perceptions, and stigmatization, and providing psychoeducation could contribute to ensuring that every person has access to good health and makes use of these services with the necessary knowledge and without fear of judgment. This could consist of community members being provided with psychoeducation to improve their understanding and perception of mental health, as well as reducing stigmatization, improving the structural and human resources, and creating mental health awareness that is context- and time-specific.

Disclaimer

The author(s) views expressed in the submitted article are his/her own and not an offered position of the institution or funder.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by the National Research Foundation [115460,118551,118581].

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