WESTERN-TRAINED MENTAL HEALTH PRACTITIONERS' PERCEPTIONS OF PATIENTS' ACCESS TO MENTAL HEALTH SERVICES IN MASHISHING, THABA CHWEU LOCAL MUNICIPALITY, MPUMALANGA PROVINCE, SOUTH AFRICA

by

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DECLARATION

I, Rethabile Mokwena, declare that this Dissertation, **Western-Trained Mental Health Practitioners' Perceptions of Patients' Access to Mental Health Services in Mashishing, Thaba Chweu Local Municipality, Mpumalanga Province, South Africa** is my own original work. I can ensure that any instances in which someone else's work has been cited or referenced, it has been done so in compliance with University of Limpopo policies.

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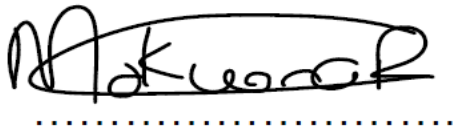

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SIGNATURE **DATE**

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ABSTRACT

This study explored Western-trained mental health practitioners' perceptions of patients' access to mental health services. The study objectives were to establish what Western-trained mental health practitioners perceive as factors that facilitate patients' access to mental health services, and to determine factors that practitioners perceive as barriers to patients' access to mental health services. Fifteen healthcare professionals (*n = 15*) were conveniently and purposefully sampled for participation. Semi-structured interviews were conducted to gather data. The data was then analysed thematically. The presentation and discussion of the findings are grounded in the Theoretical Domains Framework. The study found that there are multi-layered factors that enable and hinder patients' access to mental health care services in Thaba Chweu Local Municipality. Enabling factors included the following: a) improvement of nurses' knowledge of mental health; b) de-stigmatisation of mental illness; c) introduction of community rehabilitation centres and educational programmes; d) service access that is prompted by the need to manage various mental health problems; e) implementation of community mental health talks; f) mental awareness campaigns and mental health education; and the g) provision of quality mental health care services by professionals. Hindrances to mental health care delivery included the following: a) lack of follow-up systems of care for service user;community's lack of mental health knowledge and awareness; b) lack of adequately trained personnel; c) ill-treatment of service users by practitioners; d) lack of infrastructure and resources**;** e)physical and structural barriers to shortage of medication; f) stigma of mental illness**;** g) lack of social support; h)belief systems and cultural influences; i) patient denial and poor insight into mental illness, and; j) a lack of professional supervision for outpatient treatment**.** The findings suggest that improving access to mental health services by removing hindrances can be beneficial to mental health care users and society. Based on the Theoretical Domains Framework (TDF), the findings were examined, and conclusions were drawn. It is recommended that the government immediately address identified hindrances to mental health service delivery. The limitations associated with this study are also highlighted.

Key words: *mental health barriers, mental health facilitators, mental illness, access to health care, mental health perceptions*

LIST OF ABBREVIATIONS

NHS : National Health Service

SASH : South African Stress and Health

WHO : World Health Organisation

MHL : Mental Health Literacy

NCBH : National Council of Behavioural Health

TDF : Theoretical Domains Framework

CEO : Chief Executive Officer

TDR : Theoretical Domains Framework

WTMHP : Western-trained mental health practitioners

NIMH : National Institute of Mental Health

TCA : Tricyclic Antidepressant

OCD : Obsessive Compulsive Disorder

GP : General Practitioner

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CHAPTER 1: INTRODCUTION

1.1 Background to the study

Mental illness is a global health concern with a negative impact on people's quality of life (World Health Organization, [WHO], 2018). Globally, one out of eight people is battling some form of mental health condition (WHO, 2022). In South Africa, approximately one in six people is living with mental illness, and 75% of those affected might not receive any help (Pillay, 2019). Nguse and Wassenaar (2022) reported that prevalent mental disorders in the country range from depression, substance abuse and anxiety, all of which affect approximately 10% of the population. Although prevalence statistics that are documented gives a national picture regional statistics are lacking.

Mental illness is an issue that affects people of all races, genders, and socioeconomic backgrounds (Habig, 2022). Compared to men, women are more vulnerable to mental illnesses, such as mood disorders (Jacobs & Coetzee, 2018). A recent survey study suggested that black Africans showed higher psychological distress when compared to their White and Coloured counterparts in the post-apartheid South Africa (Harriman et al., 2021). A probable explanation offered to account for the racial disparities is that black South Africans suffered lasting traumatic events, social stressors, and psychological suffering. It is for this reason that comparatively, the country has a greater number of mental health issues when compared to similar low-to-middle-income countries. (Harriman et al., 2021).

Mental illness is the primary cause of disability (Acharya et al., 2017). There are existing factors that increase people's risk of suffering from mental illness (Vigo et al., 2016). Primarily, individuals who are from disadvantaged backgrounds, who suffer/ed abuse and traumas, social inequality, chronic medical conditions, or in general, lead a stressful life are prone to experiencing a mental health condition (WHO, 2022). Scheinder (2016) emphasises the point by arguing that people living in impoverished communities are more likely to develop mental health problems due to increased stress, exclusions, and insufficient access to social and economic opportunities. It is

for this reason that mental illness particularly due to economic challenges has been measured as a silent epidemic throughout Africa (Monteiro, 2015).

COVID-19 has recently emerged as another mental health risk factor. The pandemic has not only destabilised the economy, but has left South Africans unemployed, vulnerable, traumatised, depressed, and anxious (Nguse & Wassenaar, 2021) Like elsewhere, it has widened the mental health treatment gap, including disrupting access to mental health care services (WHO, 2022). Clearly, prioritising mental health care delivery has been a challenge for the South African government due to lack of human resources, insufficient funding, ineffective mental health policies, and many other sociodemographic factors (Netsereab, 2018).

Most people coming from disadvantaged backgrounds like in the Mpumalanga province, do not receive care or if they do, it is always of poor quality compared to that of people in urban communities (Habig, 2022). Many societal and organisational barriers have been identified to help explain why adults in the general population cannot and/or are not willing to receive professional mental health service (Gulliver et al., 2010). Barriers to mental help-seeking includes stigmatising beliefs, difficulty in accessing support, cultural barriers, negative past experiences, poor quality services, unemployment, and financial problems (Habig, 2022; Mack et al., 2022; WHO, 2022). In response to the inherent service access barriers, the WHO through the comprehensive mental health action plan 2013–2030, has called for efforts to help escalate access to mental healthcare services (WHO, 2022). Calls have also been made by some researchers on the need for strategies aimed at enhancing Mental Health Literacy (MHL), and reducing the stigma and discrimination of mental illness among the general public (Campos et al., 2018; Gronholm et al., 2017; Gulliver et al., 2012).

Several strategies to help improve access to mental health care have also been proposed. These include integrating mental health into primary health service, expanding community health interventions, training mental health paraprofessionals, health education in schools and in communities for improved health knowledge, and increasing social support from health professionals, family, and community (Brenman et al., 2014; Gronholm et al., 2017; Gulliver et al., 2012; Henderson et al., 2013; Monteiro, 2015). While these pronouncements have been made, South Africa has

been lagging while whether practitioners on the ground have heed the call is not being reported. It is in the light of the noted mental health access challenges that this study was undertaken in the Mpumalanga province, South Africa. The study examined existing mental healthcare service-related barriers and facilitators from the perspective of professional mental health practitioners.

1.2 Problem statement

Several studies have indicated that mental illness has become a global pandemic following the recent COVID-19 pandemic (Kumar & Nayar, 2021; De Kock, 2021; Shahriarirad, 2021). Nguse and Wassenaar (2021) add that COVID-19 not only took its toll on South Africa's socioeconomic state, leaving most South Africans unemployed and poor, but has also left the country in a mental health crisis. Accordingly, it is now more urgent for the world, including South Africa, to implement effective measures to control the growing scourge of mental illness (WHO, 2022). Despite ongoing efforts, the number of people suffering from mental illness is ever increasing while citizens have no access to care at all, or if available, it is of lower quality than what is the global minimum (Hennessy et al., 2022; WHO, 2022). Ideally, mental health should be easily accessible while potential factors that block access to care should be addressed as they appear. Regrettably, research suggests otherwise, whereby mental health stigma, lack of mental health knowledge and awareness, and a myriad of patient- and service-related factors all stand in the way of this ideal (Ali, 2015; Tristiana et al., 2018; Aguirre et al., 2020).

In South Africa, 92% of the general population of people suffering from common and severe forms of mental illness do not receive treatment (Sorsdahl et al., 2023). Sorsdahl et al. highlight that the mental health treatment gap in the country is ever widening, while an intersectionality of socioeconomic and political factors all influences patient health access, especially the previously marginalised communities. To highlight a few, inadequate healthcare infrastructure following apartheid special planning, lack of democratic governmental funding, and support, including failure to attract a specialised mental health force, contribute to access issues (Campos et al., 2018; Corrigan & Bink, 2016; Schierenbeck et al., 2013). As a result, a growing number of citizens continue to struggle with access to mental health care despite being in

desperate need of mental health attention. Although such studies have been conducted in some parts of the country, no similar studies have been carried out in the current study setting. To the knowledge of the researcher, this may be the first study to explore questions related to access to mental health services in the Thaba Chweu local municipality. However, mental illness not only places a burden on the individual living with the disease, but also on the economy, society, government, businesses, and family (Doran & Kinchin, 2019). As a result, ease of access to mental health services is an imperative that requires urgent attention (Monteiro, 2015). Most people living with mental illness represent the vulnerable and socially excluded populations that receive the poorest of support, fewer opportunities, and services (Mezzina et al., 2022). Schofield et al. (2011) claimed that people who struggle with mental illness' quality of life, including career prospects, are often compromised.

Users of mental healthcare services as well as society at large may therefore benefit from addressing barriers to service access. Some of the benefits include increased knowledge and education about mental illness; reduced stigma and stereotypes about patients with mental illness; patients' improved access to services by patients; and a decrease in the burden of mental illness. Despite the known benefits related to access to mental health services, it appears that there's no empirical research with either the service users or professionals for comparative purposes in the Thaba Chweu local municipality. The current study sought to explore mental health professionals' perceptions regarding patient service access experiences in the Mashishing area.

1.3 Operational definition of concepts

Mental health: it is an umbrella term that refers to "a state of wellbeing whereby the individual is aware of their own abilities, has the ability to cope with normal stresses, produce effective work whilst able to make contributions to their community". As such mental health refers to more than just a diagnosis of mental illnesses (WHO, 2004).

Mental illness: In this study, mental illness refers to "a psychological health condition that affects an individual's mood, behaviour, and their daily functions" (WHO, 2018).

Mental health care: In this study, mental health care is also understood to mean "a facility that renders health care treatment and rehabilitation to mental health care users" (Meyer & Matlala, 2019).

Mental health care access barriers: With respect to this study, a barrier is an obstacle that impedes patients from accessing mental health services (finances, resources, family, friends, and Western-trained mental health practitioners) (Schierenbeck et al., 2013).

Mental health care access facilitators: In this study, facilitators are people that aid patients to access mental health services (Schierenbeck et al., 2013).

Western-trained mental health care practitioners: This refers to, "someone who specialises in diagnosing and treating psychological mental health, behavioural and emotional illnesses; and they are trained as psychiatrists, psychologists, psychiatric nurses and social workers from a western perspective" (Fredheim et al., 2011).

1.4 Purpose of the study

1.4.1 Aim of the study

- This study explored Western-trained mental health practitioners' perceptions of patients' access to mental health services.

1.4.2 Study objectives

The objectives were as follows:

- To establish what Western-trained mental health practitioners perceived as factors that facilitate patients' access to mental health.
- To determine factors that practitioners perceived as barriers to patients' access to mental health services.

1.5 Significance of the study

This study will contribute towards an improved understanding of the enabling and limiting factors towards patient access to mental health care services in the Thaba

Chweu Local Municipality. It is envisaged that local authorities could rely on the study findings with a view to addressing existing mental health care needs of patients yet strengthening on the existing services. This empirical study will also inform the development of sound and targeted interventions that will benefit and enable patients' ease of access to mental health care services. More importantly, through this study patients service-related needs will be streamlined with a view to making the services more user friendly or efficient. On a national level, the study will help inform policy on improved mental healthcare access and a revision of existing strategies intended to improve mental health knowledge and awareness by addressing mental illness stereotypes, misconceptions, and stigmas (Campos, 2018; Rastogi et al., 2012; Evans-Lacko et al., 2012; Thornicroft et al., 2008).

1.6 Organisation of the study

Table 1: Description of study chapters

Chapter	Description
1	**Introduction:** This chapter contains the introduction and background of the research investigation, which includes definition of key concepts. Subsequently, it provides an overview of the study's problem statement, goal, research questions, ethical issues, importance, organizational structure, and summary.
2	**Literature Review:** Chapter two discusses literature review and theoretical framework. The review also focuses on the two objectives of the study. Therefore, the review is divided into the following sections: introduction, literature review and theoretical framework. Chapter two also constitutes the following topics: understanding mental health and illness, barriers to accessing mental health services and facilitators to accessing mental health services. Theoretical framework and its domains. Lastly, the summary.
3	**Research Methodology:** This chapter examines the data collection and analysis procedures used in the present research project. The chapter is broken down into the following sections: an introduction; a research

	paradigm; a research design and strategy; a study setting; a sample of data; data collecting and analysis; quality criteria; an ethical consideration; concluding remarks; and a summary.
4	**Study Findings**: This chapter offers study results embedded within the Theoretical Domains Framework.
5	**Discussion, Study Implications and Conclusion:** The focus in this chapter is on the discussion of the study's results, implications, and conclusion. The chapter is grounded in the Theoretical Domains Framework.

1.8 Summary

This chapter provided an overview of the study by identifying the prerequisites or driving forces behind it. A presentation of the study's aim and importance came after problematizing it. The second chapter will reveal the body of literature that already exists on the topic of investigation, as well as uncover the theoretical underpinnings of the research.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter comprises literature applicable to understanding barriers and facilitation of patients' access to mental health care. The review will focus on views of Western-trained mental health care practitioners towards patients' access to mental health services. The section will cover the following: prevalence of mental illness, societal stigma, limited mental health literacy, lack of funds to access services and facilitators' access to mental health care services.

2.2 Prevalence of mental illness and service access in Africa

Mental illness is "a global health burden and a major contributor to the years of living with disability (YLDs) and disability adjusted life years" (DALYs; WHO, 2022) in Africa. Failure to take care of one's mental health can affect one's daily functioning and well-being (Ali & Agypong, 2016; WHO, 2022). Unfortunately, mental illness in Africa appears to be an increasing epidemic that is expected to increase due to the high unemployment rate, cost of living and competitive labour market. Monteiro (2015) highlighted that mental illness is considered a silent epidemic in most countries on the African continent. In South Africa, mental and substance use disorders are also some of the leading causes of disability (Kemp et al., 2021). It has been reported that more than 10% of the South African population is battling with depression, substance abuse, anxiety, bipolar disorder, and schizophrenia (Ritchie & Roser, 2019; Uwakwe & Otakpor, 2014), and these conditions are the leading causes of disability (Kemp et al., 2021).

Noteworthy is that comprehensive mental health demographic studies are lacking on the entire African continent (Pillay, 2019). More concerning is that, despite mental illness emerging as a threat to nations, it is still not viewed as an emergency issue globally and on the African continent. Despite the rapid growth in people living with mental illness, access to mental health care services has also remained an issue (Craig et al., 2022; Barrow, 2016). This especially the case for vulnerable populations

in low-income countries, minority ethnic groups, and people in disadvantaged backgrounds and in rural communities (Pillay, 2019). For instance, a study done in Gambia suggests that over 120 000 of the population is battling with mental illness, with only 10% of the population having access to mental health services (Barrow & Faerden, 2021). Seemingly, about 12-13% of Namibians struggle with some mental health problems yet reports suggest that there are only a few practitioners that are available to provide mental health services in the country (Bartholomew & Gentz, 2019). This is not only an African issue, globally, most people affected with mental illness receive inadequate service and the effectiveness of treatment is limited, especially for patients with mood disorder, depression, schizophrenia, and other psychiatric disorders (Lake & Turner, 2017). Essentially, people who need the services the most are the least likely to receive the care (RAS, 2020).

In South Africa, despite growing number of cases of mental illness access to health care has remained a challenge. People are often reluctant, avoid or delay seeking help (Clement et al., 2015). Unfortunately, there are limited studies detailing barriers and facilitators of access to mental health care in the country. Some studies have suggested that, generally, adults are less likely to seek while not unpacking underlying reasons (Montiro, 2015). Additionally, some studies tend to focus on mental health seeking pathways rather than on access related issues (Cage et al., 2020). It is along the latter that this study was conducted to address the shortage. The next subsections will identify some of the documented or existing barriers and facilitators to mental health care services.

2.3 Barriers to accessing mental health services

Access to mental health services is hindered by numerous factors. Majority of people in South Africa are neglected, mainly due to structural and physical barriers such as unemployment, lack of services in rural areas, lack of funds, lack of awareness in mental health, few trained mental health professionals, lack of adequate mental health infrastructure, stigma and discrimination in the community and being ill-treated by people who are supposed to provide support and care (Sorsdahl et al., 2023; Pillay, 2019). Some of the hindrances are discussed below.

2.3.1 Stigma of mental illness

Mental health stigma has a bearing on patient mental health service uptake. Parcesepe and Cabassa (2013) state that “stigma is the negative belief that an individual or group intends to devalue, shame, fear, reject and discriminate people living with mental illness”. Stigmatisation maybe in the form of prejudice towards people affected with mental illness, ignorance regarding access to treatment and the negative attitude towards people living with mental illness (Henderson et al., 2013; Montes, 2021; Shalahuddin et al., 2022). Stigma and discrimination impact on patients’ willingness to access treatment, leading to a compromised quality of life (Ivanova et al., 2020; Kammimura et al., 2018; Monteiro, 2015; Montes, 2021).

Unfortunately, patients are even stigmatised by health care workers, that is, nurses, social workers and doctors providing treatment (Sartorius, 2007). The very same people who are supposed to be advocates of mental health and endorse it are part and parcel of the problem. Health professionals’ perceptions of mental illness and their attitude towards the mentally ill may be a factor that prevents patients from accessing mental health care services. According to Anguiano et al. (2019), health professionals are expected to inhibit a positive attitude towards patients with mental illness due to their professional knowledge. However, they are part of the problem, which leads patients to avoid using services, feeling marginalised or being labelled “crazy” (Al-Awadhi et al., 2017; Anguiano et al., 2019; Bartel, 2021). People living with mental illness are regarded and labelled as weak or pathetic; and such social beliefs that lack mental literacy, knowledge, negative attitude, and perceived stigma thwarts them from accessing the services (Clement et al., 2015; Fatuma, 2016; Monteiro, 2015; Salaheddin & Mason, 2016).

Some studies have reported on families also suffering from stigmatisation. Consequently, it prompts families to hide a family member suffering from an illness due to the fear of being rejected thus being robbed of social support (Kamimura et al. (2018)). Cementing the abovementioned social stigma does not only hinder or keep patients away from accessing mental health care, but it also prevents the society from being knowledgeable about mental health issues. Moreover, it becomes a challenge for people to know about it and to transverse the mental health care industry (Kaggwa et al., 2023; Monteiro, 2015). It is pivotal for the society to understand how social

stigma affects people living with mental illness and that there is a great need for mental education and change in the public's attitude.

2.3.2 Mental health literacy and access to care

Mental health literacy refers to knowledge, beliefs, and attitude one has towards individuals living with mental health illness (Choudhry et al., 2016). Unfortunately, most people have little or no knowledge of mental health. People fail to see the symptoms and do not know how to deal with them (NCBH; 2017). On the one hand, Miller-Matero (2018), citizens want to access mental healthcare services for themselves or a loved one, but they do not know where to go.

Irrespective, mental health literacy (MHL) still remains an alarming challenge in many developing countries because of stigma, poor MHL, negative attitudes towards the mental illness, the low rate of access to mental health disorders and perceived structural barriers (Mubbashar & Farooq, 2001; Peterson et al., 2011). Jorm (2011) highlighted that comparatively, MHL for physical diseases like obesity has taken the lead while less attention has been directed towards educating the public about mental illness, risk factors and interventions. Consequently, because of the lack of mental health literacy, a lot of patients fail to recognise the symptoms nor seek help at all or early during the onset of illness. If a person does not know that they have a problem or something is wrong, it is very unlikely that they would access treatment or help (Jorm, 2000). For instance, people would either suffer because of lack of knowledge that they are afflicted by mental illness or in part, due to the fear of being stigmatised (Bartels et al., 2021). In a study by Zifkin et al. (2021), it was found that lack of knowledge and information hindered patients' ability to access mental health services as they are unaware of the information, and do not know where to and how to access them, what kind of services are available for them and who to contact. It is for this reason that, interventions such having community outreach campaigns, school-based education programmes, advertisements on social websites, mental health first aid training, and using positive role models to "normalise" mental health problems are necessary to help improve mental health literacy knowledge (Ganasen et al., 2008).

2.3.3 Lack of funds and resources as hindrances to service access

Mental illness is linked to poverty in most middle- and-low-income countries (Lake & Turner, 2017). Nonetheless, health facilities do not have sufficient resources to cater for patients in such settings. Lack of resources in this sense may range from inadequate expert professionals, shortage of medications to inadequate infrastructure thus affecting accessibility and practice in these institutions (Sorsdahl et al., 2023). One study showed that 56% of patients do want to access mental health services, however, there are a lot of existing systemic barriers (Heath, 2019). According to Anguian (2019), GPs encounter significant barriers to provide good care to patients with mental illness due to scantiness of time, being short-staffed and lack of resources to specifically cater for mental health patients. A study done in Bangladesh by Nuri et al. (2018) revealed that mental facilities lacked trained personnel to detect and treat patients with mental illness. Bangladesh has one mental health institution with 200 beds in which one bed caters for every 100 000 persons. Patients' limited access to mental health care is caused by insufficient funds and scarcity of mental health resources that affect patients to seek and attain adequate care.

Patients hold a view that their only means to access help is through private health care services, which unfortunately, they could not afford due to lack of funds to buy medication and travel related costs (Nolan-Isles et al., 2021). In a Colombian study, Bartels et al. (2021) established that patients in rural settings encounter major financial barriers to accessing services as they needed to pay for transportation. The financial barrier forces them to choose between feeding themselves, their families, and catering for transportation. Such a challenge is prevalent across many countries, and in South Africa (Sorsdahl et al., 2023), irrespective of social welfare services given to some of mental health users. Patients' limited access to mental health care is not always due to lack of motivation but also due to a lack of resources to access these services (Sorkin, 2018; Magnus & Advincula, 2021).

2.3.4 Cultural barriers

Cultural understandings and beliefs serve as another impediment to mental health care access. Gopalkrishnan (2018) argues that culture has an influence in what is seen as right or wrong and what is acceptable and what is not. For most cultures, mental illness is appraised as a sign of weakness whereby negative emotions are suppressed. In worst cases, is cultural conceptions of illness which can in some cases prevent people from accessing health care. A study by Muhorakeye and Biracyaza (2021) in Rwanda established that patients with mental illness were harassed, said to be affected by the devil and called with bad names in the community. In cases, failure to distinguish between mental health problems and cultural expressions of illness also could stand in the way (Schierenbeck et al., 2013*).* In a study done in Gambia, Barrow and Faerden (2021) found that families believed that mental illness is caused by evil spirits, and the only way one can be assisted is to be taken to a traditional healer because psychiatric hospitals will worsen the conditions. For many communities, such cultural nuances and taboos hinders families from seeking professional support because of the fear of being cast out, rejected and ostracised.

Communities discourage people from talking about mental illness and believe that traditional healers and pastors can treat it compared to hospitals. They believe that mental illness is supernatural and only prayers and traditional interventions are ideal. For example, an earlier study by Andersson et al. (2013) established that among the Zulu people of South Africa, western medicine was perceived to be only effective in treating physical illness. Therefore, traditional healers were the preferred choice in cases of mental illness since healers shared similar cultural understandings with patients. Studies with Asians, Hispanics, and African Americans yielded similar views whereby people often believed that mental illnesses are better cured with cultural interventions as opposed to professional services (Leong & Kalibatseva, 2011). Similar views have also been reported in some parts of South Asia to signify the influence of cultural beliefs and practices on service access (Pelzang, 2012).

2.3.5 Negative attitude towards mental health patients by professionals

Practitioners' negative attitudes towards mental health patients is one of the greatest barriers in mental health care. An environment that is not kind and full of negative demeaning people leads patients not to seek for care. The effects of being stigmatised as mental health care patients include delayed care, isolation, neglect, and impaired self-esteem (Hansson et al., 2016; Al-Awadhi et al., 2017; Cremonini et al., 2018). How patients are treated by practitioners has a bearing on their access to mental health services.

Patients with mental illness need special treatment as compared to normal patients (Al-Awadhi et al., 2017; Natalia et al., 2019; Maier et al., 2015). Practitioners are supposed to be advocates of mental health, yet practitioners hold the same stigmatising attitudes towards mental health patients (Luigi et al., 2020). They dehumanise, devalue, and discriminate against patients living with mental illness. Stigmatising attitudes are some of the major contributing factors that push mental health patients to stop seeking for help and accessing services (Koutra et al., 2021; Minty et al., 2021). The fear and self-doubt that is instilled in patients by practitioners thereof influence how patients make informed choices about mental healthcare.

Despite all the efforts of trying to fill-in the existing gap in knowledge about mental illness, studies still show that the public's perceptions have not changed over the years. Mental illness patients are still portrayed as "crazy", attention seekers" and "sinners" (Cremonini et al., 2018; Hansson et al., 2016). Practitioners are trained mental health professionals who should endorse positive views and reduce stigma. However, they are problem and psychiatric patients are ill-treated, stigmatised, and discriminated by doctors, nurses, and social workers. Somli et al. (2020) concur that practitioners are overworked, and this leads to a lack of empathy, burnout, emotional exhaustion, and negative treatment towards patients. Singh et al. (2020) state that compassion fatigue is another factor that contributes to patients' ill-treatment.

Practitioners felt uneasy to attend to mentally ill patients. They believed that working with mentally ill patients was difficult and traditional health is more equipped to deal with them than modern medicine. They believe that patients with mental illness should be hidden from the community (Wakida et al., 2018). Patients in Bhutan are neglected

by health care professionals, and little attention and devotion is invested in mental health resources (Pelzang, 2012). Mental health practitioners should prioritise the safety and successful use of services by users, yet they are the very same people who thwart and make the process impossible.

2.3.6 Lack of adequately trained mental health personnel

There are several challenges in the delivery of mental health services in primary health care settings. Studies suggest that there is a limited number of trained mental health professionals; and specialists are scarce in public health. General practitioners shoulder the burden of carrying the first line of providing medication due to the shortage of psychiatrists (Caccavale et al., 2020, Goldberg., 2003). This weighs heavily on the institution, practitioners and on patients' utilisation of mental health services (Coombs et al., 2021). In Rwanda, mental health facilities do not have sufficient trained mental health practitioners. This results in patients having poor access to services (Muhorakeye & Biracyaza et al., 2021).

In a study done in Bhutan, there is community based psychiatric unit that caters for mental health care users. Despite the availability of a community mental health unit, they do not have social workers, psychologists, and occupational therapists. The facility is managed by physicians and there are less than 10 trained professionals to cater for the millions of people (Pelzang, 2012). The shortages of psychiatrists in California have affected hospitals and the country's mental health facilities. This has been a challenge to over 500, 000 patients receiving care for the past two decades (Caccavale et al., 2012). A study done in Limpopo found that a lack of human resources is a critical issue. Hospitals in Limpopo do not have enough practitioners because posts are not being filled; instead, they have been frozen (Netshisaulu et al., 2019). As such, roles assigned for certain speciality end up being allocated to available practitioners who are of less knowledge based on their training or overburdening those available, which in turn affects the quality of services that they provide to their patients or further being vulnerable to conditions of mental health themselves.

Patients' needs are not met due to lack of adequately trained health practitioners. There are no practitioners who can identify, recognise, and treat mental health

problems. The government needs to focus on recruiting and training more health professions who will be skilled enough to cater for mental health patients' needs (Schierenbeck et al., 2013; Coombs et al., 2021).

2.3.7 Shortage of medication

Koutra et al. (2021) revealed that over 70% of people with mental illness globally do not receive treatment. The shortage of medication is considered an influential factor contributing to patients' low access to mental health services. Additionally, it is a major crisis that compromises patients' mental health and full recovery. Many people with mental health illness in developed countries neither receive adequate mental health care treatment nor any treatment for their mental illness, especially the less disadvantaged, minorities, and the elderly (Lake & Turner, 2017). Lack of adequate treatment therefore may lead to patients finding no reason to continue with their healthcare visits or developing a sense of hopelessness towards the system as the patients hardly receive the required help they sought.

Despite the 85% of countries having a drug essential list that they use to get drugs, almost 20% of the countries do not even have one common antidepressant in primary care (Saraceno, 2004). According to Pelzang (2012), Bhutan does not have adequate medication for patients with mental illness. Community health centres face a challenge of getting access to psychotropic drugs due to poor purchasing and utilisation. Issues relating to availability of medications may in this sense disrupt the day-to-day functionality of mental health facilities causing overburdening on the facilities themselves and those that depend on them.

Evidence in Tanzania revealed that shortage of medication is a common challenge affecting most mental health care users (Henderson et al., 2013). The inadequate supply of medication is one of the major contributing barricades that make patients to default on their medication. This inconsistent, unavailability and unreliability supply of psychotropic medication affects patients from getting quality mental health care that they need. Psychotropic medication is the most important medication for patients diagnosed with major depression, bipolar and schizophrenia, more especially for patients to function fully in the society. With the perceived shortage, patients not only

suffer from overburdening of the illnesses but further face issues of social involvement and functionality within their societies leading to further issues of stigma and labelling.

According to Sunkel and Viljoen (2017) and Mental Health Matters (2019) South Africa faces severe shortages of mental health drugs, most particularly for illnesses such as depression, bipolar and schizophrenia. Mental Health Matters (2019) further indicated in their study that Department of Health reported this concerning issue to be associated with issues in supply. Based on the latter, it is evident that suppliers for mental drugs in South Africa have a hand in derailing progress to developing access to mental health in the country. An exploratory study by Mokwena and Ndlovu (2021) found that South Africa has a high rate of treatment default by psychiatric patients which according to Sunkel and Viljoen (2017) pose adverse economic effects.

2.3.8 Patients defaulting on medication

Mental health care users default on their treatment due to various factors. The main impediment to non-adherence to mental health care services is a lack of family support and mental health literacy, financial problems, distance problems, side effects in medication and being tired of taking medication. Muhorakeye and Biracyaza (2021) state that patients default on medication because of a lack of patient care at the hospital and after discharge. Patients lose interest in taking their medication and start getting involved in acts that trigger them and then start defaulting. A study done in Ethiopia revealed that patients stop taking their medication because they do not want to use western medication and think they would get better later (Wakida et al., 2018; Negash et al., 2020). Furthermore, a study in Tanzania concurs that patients default on taking their medication because of the unreliability and availability of medication in facilities (Henderson et al., 2013).

The Department of Health and Human Services (2017) argue that families have a bearing on the utilisation of mental health services and mental health itself. Many family members treat the hospital like a dumping ground where they dump mentally ill patients and then forget them. The lack of warmth and care is another barricade that pushes patients to stop taking medication because they feel neglected and worthless. The cases of default and relapse would be fewer if families supported patients with

mental illness. Moreover, patients stop taking their medication and utilising the services because of the negative side effects of the medication. In some instances, however, patients defaulting is merely associated to shortages of medications leading to patients receiving less of or not receiving medications on time (Sunkel & Viljoen, 2017). Additionally, some patients are reluctant to visit healthcare institutions due to negative attitudes and treatment that they receive in the hands of health professionals and communities (Mpheng et al., 2022). There is an existing lack of accountability for delivery of quality services that is associated to human resources in protecting and providing patients with adequate services. Patient default can thus be identified more as a consequence of other barriers and can be addressed by placing focus on removing such inhibitors to avoid second hand effects such as this.

2.4 Facilitators to accessing mental health services

In this section of the literature review, factors that promote access to mental health care services are presented.

2.4.1 Social support to accessing mental health care services

A strong support system is one of the most pivotal factors that aids in patients getting help, that is, having someone or people who provide you with emotional, social, and physical comfort whenever you need it (Canadian Mental Health Association, 2011). Moreover, Harahsheh (2016) has indicated in their study that, patients who have a strong support system stand a lower risk of defaulting on their treatment. Social support involves various social agents such as your family, friends, community, co-workers, church members or professional workers (CMHA, 2011; Harhsheh, 2016). Availability of emotional support in this sense helps promote a sense of belonging that patient's value. Additionally, Having non-threatening spaces and healthy environments aid in patients coping and overcoming societal misconceptions (UKEssays, 2018). Social agents play a vital role towards the development and coping of patients of mental healthcare. They promote a sense of belongingness and acceptance thus allowing patients to feel more integrated in their communities and normalise mental health. Building awareness on mental health therefore should be

inclusive of those that patients live with and around. This however, contrast what is happening in many societies and health care facilities where patients continue to be subjected to negative criticism by society members and practitioners.

In South-Eastern Europe, Tirintica et al. (2018) found that the most pivotal factor for accessing mental health care is to promote mental health in the society and awareness about the services being provided. Furthermore, Anderson et al. (2013) concur that the community needs to be assisted in mental health literacy for them to understand, be able to recognise the symptoms, the treatment that is available to them and when and where to access it. Promoting healthcare and providing awareness around it is one form of social support that patients and those around them require to build on the knowledge and reduce stigmas and myths around mental healthcare that affect help seeking pathways and stereotypes for healthcare users and their families. Families that support and build social relationships with patients will encourage them to seek mental health care (Gulliver et al., 2010). This is mainly because family have the ability to offer the emotional support that patients require and positive support as argued has a positive affect on patients coping mechanism.

Western-trained mental health practitioners should build a relationship with patients, that is, understanding and trusting as it will encourage patients to access their services (Lynch et al., 2018). Furthermore, the practitioners need to establish an environment that is positive, supportive, good, and healthy for patients' access. Having access to a positive support structure (family, friends & mental health practitioners) enables patients to access mental health services (Gilburt, 2008). This could be mainly because such support structures help in coping with and encouraging patients to acquire necessary help from healthcare institutions. Moreover, positive experiences by patients help encourage continued use of mental health services and help seeking behaviour as concluded in a study by Hemmings (2020). Thus, health workers need to understand, obtain, and maintain positive rapport and ensure a holistic support towards mental health for the benefit of patients. Adequate care and positive attributes from health care practitioners may thereof help in removing feelings of fear from patients when thinking of seeking healthcare services and provide patients with an inclusive and positive environment. As indicated in the barriers that stigmatisation form one of the hindrances that patients suffer from, adopting an optimistic perspective and

providing patients with adequate support may thus intervene in removing such barriers.

Furthermore, as argued by Baker (2021) that access to mental services is intensely associated with the lack in human capacity which create inconsistencies in communication and re-assessment of patients, developing healthy support systems and strengthening practitioner-patient relations may thus help provide patients with assurance and build trust around the health care system. With patients in the latter study reporting on issues of trust because of being re-assessed by different practitioners, the findings depict the importance of developing positive support systems with patients.

2.4.2 Intervention strategies towards mental health services

Health promotion interventions encourage appropriate help-seeking behaviour in mental health patients, particularly from disadvantaged and marginalised minority. This may lead to improvements in the mental health of this population. Intervention tools that establish positive influences in the promotion of mental health literacy should be implemented (Campos, 2018). Providing affordable mental health care services would improve patients' access as a lot of patients cannot access these services due to lack of funds/ resources. In line with the previous argument support systems in this case may further play a significant role as a remedial measure that immediate supporters can offer patient to address not only social barriers but also financial burdening on the patients.

Furthermore, to foster access to mental health services, "outreach programs" should be implemented in schools and communities where these mental health care services are located within patients' communities (Rastogi, 2012; Salaheddin &Mason, 2016; Thornicroft et al., 2008). This step further helps improve on the lack of mental health literacy and promotes knowledge base for societies. It further improves on the communication challenges that drifts patients from their practitioners. Moreover, there should be mental health awareness campaigns that educate and improve the public's awareness of services and resources that are available to them. Screening for psychological illnesses in primary care services such as clinics should be normalised

to enhance the mental well-being of patients (Colucci et al., 2015; Lynch et al., 2018). Building awareness around mental health and increasing its visibility and accessibility through outreach programmes helps to create positive environments and attitudes towards mental health. This further serve as sign of support and integration to those living with patients but most importantly those suffering from mental health illnesses.

According to Lake and Turner (2017), implementing these intervention programmes will enhance the populations' overall health and reduce the mental stigma associated with seeking mental health care. Anguiano et al. (2019) state that patients receive better and holistic care when mental health specialities and primary care work together. There should be an increase in psychiatric institutions and improvement in the availability of mental health care in communities (Nuri et al., 2018). Through joint accountability, accessibility to healthcare services can improve to better encourage service users to frequently use the services created for them and reduce barriers around accessing mental healthcare facilities. Additionally, it has the capacity to improve oversight amongst practitioners leading to improved monitoring and evaluation of patients' needs and communication between health systems and their users.

Engen et al. (2020) are of the view that there should be intervention workshops to educate and enhance nurses' communication and identification of patients with mental health. According to Al-Awadhi (2017), mental health workers need mental health training programmes (inter-disciplinary and reflective seminars) aimed at promoting a positive attitude and sympathy towards the needs of patients with mental illness. Training of this kind may then help address organisational issues and inconsistencies that are prevalent within mental health institutions. These programmes have, in several studies, shown to have had a significant impact on patients with mental health problems (Zifkin, 2021). Health education is proven to be an ongoing need, as such with the constant global developments on mental health, continuous learning is essential not only to those that make use of the services but be inclusive of those that offer the services. Building on to their knowledge can aid in developing further ways to reach their patients and continue to offer quality healthcare.

2.4.3 Raising mental awareness

According to Lynch et al. (2018), there should be a blitz about mental illness health on social media, the internet, radio stations, television, flyers, and billboards. According to Tirintica et al. (2018), mental health should be a daily topic that is spoken about everywhere, including information regarding the triggers, prevention measures and the services that are available to the public. This information should be made easily accessible in schools, churches and everywhere else. There should be shows and open debates that discuss and talk about mental health and the combating of the stigma around it (Zifkins, 2021). Moreover, there should be paid programmes to educate and let people know that there is help to mental health. Gulliver (2010) and Naslund et al. (2017) states that social media advertisements could serve as a facilitator for patients' access as they are easy to access, private and more comfortable than talking to strangers about one's problems. Television personalities could promote a positive attitude towards seeking help and speak against mental health misconceptions and stereotypes to raise mental health awareness. Increasing reflectiveness of mental health through media coverage could help health departments to reach a vast range of people and promotes mental health. This could further help address societal issues that serve as barriers towards accessing mental health services and further helps in educating patients and social agents about mental health. Increased visibility therefore normalises communications on mental illnesses and improve communication amongst users and their practitioners. As indicated in an explorative study by Baker and Naidu (2021) that patients of mental health reported defaults in clinic use in line with lack of communication by practitioners resulting in feelings of confusion and unimportance.

According to Al-Awadhli (2017) mental health providers should have training courses and "anti-stigma campaigns" to enhance the public's knowledge regarding mental health. Communities can also have colour fun run events about mental health like the one for cancer health awareness and to show support to those living with mental health. People should be able to freely open up about their experiences of mental illness. Mental health literacy not only educates but de-cultures existing beliefs and cultures around mental health therefore building advocacy and reinforcing the use of mental health services. Such awareness further details a sense of support towards patients of mental healthcare, linking awareness to developed support structures.

Mental health information should be published in public spaces to raise awareness (Posters and mental health signs “Your mental health is your responsibility”) (Colucci et al., 2015). Communities need to be made aware that mental illness is like any other physical illness, and that there is no shame in speaking up and seeking assistance. We must normalise mental health and talk about it to break the silence and the stigma and to demonstrate perceived support and acceptance towards patients. However, there are few studies on factors influencing access to MH care. Hence why this study is being done to understand Western-trained mental practitioners’ perceptions of patients’ access to mental health care.

2.5 Theoretical framework

The Theoretical Domains Framework (TDF) was adopted as a lens through which barriers and facilitators to mental health services are understood. The TDF has been utilised across numerous health care systems by researchers to assess barriers and enablers to help inform the implementation of appropriate interventions (Mosavianpour et al., 2016). While other theories focus more on individual factors such as beliefs and motivation, the TDF holistically addresses cognitive, social, and environmental factors. In a study that sought to identify factors that influence hand hygiene compliance, Smith et al. (2018) found that TDF was helpful in identifying barriers and facilitating factors associated with hands hygiene behaviour.

The original TDF was introduced in 2005 and consisted of an umbrella of 33 theories of behaviour change which consisted of 128 constructs that were sorted into 12 domains that have been developed systematically to identify and assess barriers and facilitators in human behaviour change (Mosavianpour et al., 2016; Sarmast & Kissoon, 2016). The framework has been widely used across different disciplines since 2005.During that period, its usefulness has been confirmed in different countries in the health care system (Mosavianpour et al., 2016; Philips et al., 2015). In 2012, the validity of the framework was re-evaluated and revised, and now the new TDF version covers 84 constructs sorted into 14 domains. The 14-TDF domains consists of 1) knowledge; 2) skills; 3) social/professional role and identity; 4) beliefs about capabilities; 5) optimism; 6) beliefs about consequences; 7) reinforcement; 8) intentions; 9) goals; 10) memory, attention and decision processes; 11) environment

context and resources; 12) social influences; 13) emotion; and 14) behavioral regulation (Cane et al., 2012; Atkins et al., 2017).

Domain one: Knowledge

This TDF domain talks about being aware and knowledgeable about the existence of certain things around you. It includes knowledge about conditions, procedures and scientific rationales of illnesses. This speaks to people being aware of mental illnesses, thus being able to identify and recognise the symptoms in oneself and of the next person.

Domain two: Skills

The skills domains speak to an individual's ability or competency to perform a certain duty or task. That is interpersonal, developmental skills and coping strategies. In essence, it is being trained in a certain skill or an inborn ability. It refers to patients' ability to cope with their condition, and professionals holding all necessary skills required to effectively provide services.

Domain three: Social/professional role and identity

It is an individual or a group that belongs or ascribes to a certain identity or role in a society or organisation. It includes the professional roles and identity that health care providers uphold in health care facilities and respective social contexts.

Domain four: Beliefs about capabilities

This domain represents an individual's abilities and capabilities to do certain things. It is their esteem, confidence, and talent to do something extraordinary. That is the perceived professional confidence and competence amongst health care workers and empowering health care users. Further, the developed self-esteem and confidence of mental health care users.

Domain five: Optimism

The domain speaks to an individual's ability to see things from a positive point of view, that is, to have a positive look at different outcomes in life. It relates to having health care workers developing a positive attitude towards mental health and believing that the goals set to improve and increase access to mental health services can be achieved.

Domain six: Beliefs about consequences

The belief about consequences domain speaks to an individual's ability and belief to accept outcomes of a given situation. It further assesses anticipated regrets; thus relates to patients' expectations of the treatment they may receive from health care providers and the anticipated regrets that may promote or demotivate users from revisiting mental health facilities.

Domain seven: Reinforcement

This domain speaks to decreasing or increasing the chances of a certain behaviour between two stimuluses. That is the probability of a response by arranging dependency relationships. This may include the development of follow-up systems to encourage users to revisit the facilities and further increase facilities within communities of reach.

Domain eight: Intentions

It is an individual's intent or decision to do a certain act or behaviour. This is the conscious move towards resolving a certain act. It may include interventions that the health care puts in place to ensure the effectiveness of their facilities and to empower patients and communities.

Domain nine: Goals

It is an outcome or an end goal that an individual wants to achieve. That is, goals put in place towards mental health and increasing access through awareness. Through perceived factors, health care professionals may be able to reach its goals.

Domain ten: Memory, attention, and decision processes

This domain speaks to an individual's ability to process, remember, and make conscious decisions regarding a situation. It focuses on having professionals that will be able to maintain consciousness and attention, and therefore, able to provide users with services that are efficient. It overlooks over-burdening of health professionals affecting their cognition and behaviour thereof.

Domain eleven: Environment context and resources

This domain speaks to an individual's surrounding environment that it builds or breaks a person's skills, behaviour, or ability. This domain addresses structural and physical contexts. It refers to hospital environments and communities having an impact on how users react to mental health.

Domain twelve: Social influences domain on emotion

It is an individual's external surrounding that can impact their thoughts and emotions positively or negatively. That is an individual's ability to conform or reject societal or external pressures. These are social and cultural beliefs that health care users and professionals hold towards mental health. This has to do with how mental health is perceived in social norms and alienation of mental health users.

Domain thirteen: Emotions

These are complex reactions that individuals have in response to dealing with a personal matter. It reflects on fears, anxiety, burn-out and affect. This relates to behaviours modelled by health care providers because of burn-out, and how such affect may pose as a threat to users and further lead to mental illnesses in both users and professionals.

Domain fourteen: Behavioural regulation

This speaks to an individual's ability to monitor, adapt, change, and break a certain behaviour. That is the steps taken to ensure that mental health users receive the best treatment possible and therefore manage the outburst. It further involves action plans put in place to improve accessibility.

The TDF has been used extensively and has stood out as a reliable and valid model to guide behavioural change efforts (Atkins et al., 2017). It is along these lines that the researcher found the TDF to be an appropriate linchpin for the present study. The framework facilitated or anchored the study by helping the researcher to systematically map out and study enabling and impeding factors to mental health service access in the study site. Furthermore, through the lens, the researcher was enabled to identify intervention strategies that could help enhance patients' access and utilisation of mental health care services.

2.5. Summary

This chapter examined in detail the literature on Western-trained mental health practitioners' perceptions of patients' access to mental health, as well as giving a theoretical framework. Lastly, the next chapter will outline and discuss the research methodology adopted in this study.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

The following chapter discusses the overall research design. It encompasses the following headings: research design, research paradigm, study setting, sampling, data collection, data analysis and its themes. Moreover, it outlines the quality criteria, ethical consideration. Lastly, this chapter will discuss the concluding remarks of the chapter**.**

3.2 Study design

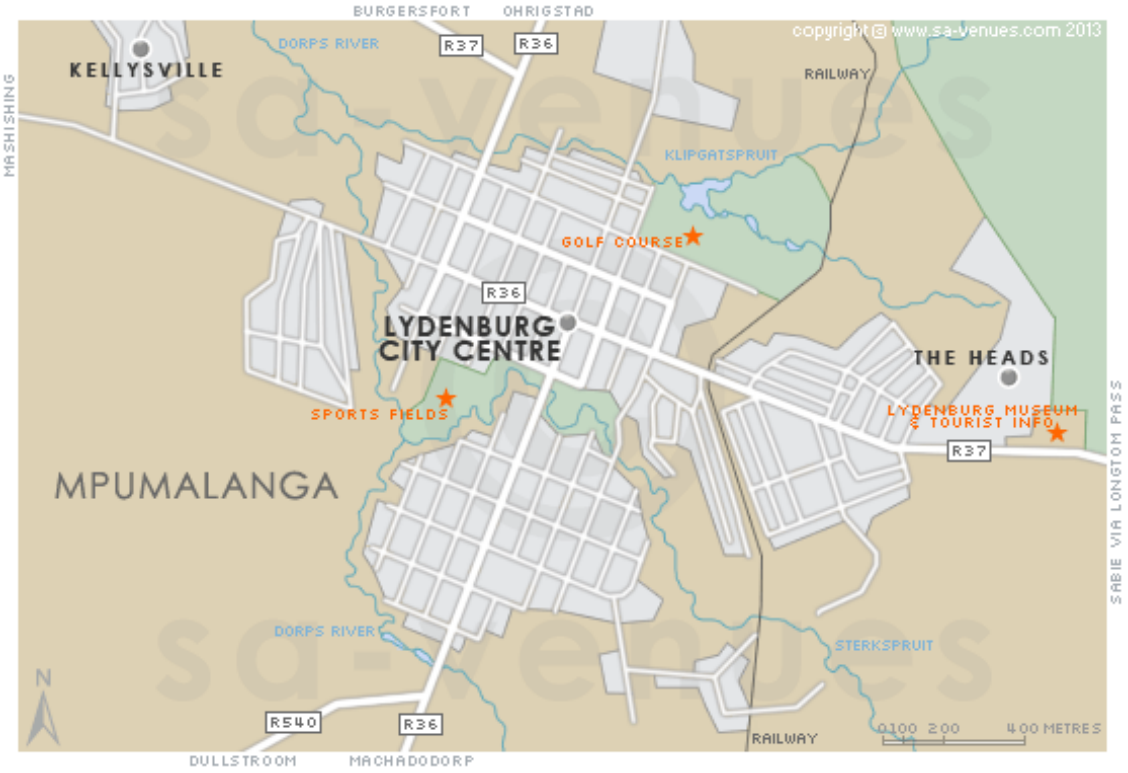
Paradigmatically, the present study is under girded by the interpretivist paradigm which is concerned with subjective meanings attached by humans to real life events. With this philosophy in mind, the researcher was able to scientifically formulate research questions and proceed to design the study by selecting appropriate research methods to help address or answer the study objectives (Kabir, 2016). To achieve the objectives, a qualitative research methodology was adopted. According to Brick and Green (2018), the qualitative research approach is a non-numeric data approach that allows the researcher to gather and interpret the views, existing beliefs, truths, or opinions of participants about ontological issues of the world of human experience. The researcher adopted an exploratory interpretive research design to get a broad and in-depth understanding of Western-trained mental health practitioners' experiences and perceptions of patients' access to mental healthcare services. An approach this nature is used when there is limited knowledge or information regarding a phenomenon of interest, and where the researcher seeks to gain a broad understanding of a situation, phenomenon, or community (Bless et al., 2006; Brink 1993).

3.3 Study setting

This research study was conducted in Mpumalanga Province's Ehlanzeni District Municipality (EDM), South Africa. Participating mental health settings are situated in

the town of Mashishing, previously called Lydenburg (See Figure 1). Mashishing is a town found in the Thaba Chweu Local Municipality (Thaba Chweu Local Municipality, 2023). The municipality has a population of over 100 000 people. The region is partly urban and partly rural. There is a 27.1% youth unemployment and most of them are classified as discouraged jobseekers. Practitioners in this study were accessed from Lydenburg Hospital and Wenakker After Care Centre. Wenakker is a residential facility caring for a limited number of intellectually disabled adults in Lydenburg Mpumalanga. Mental health problems in this area are becoming more prevalent due to increase in the population and urbanisation (Statistics South African, 2011).

Figure 1: Geographical map of Mashishing



3.4 Sampling

Bhardwaj (2019) defines sampling as a method in which a researcher identifies participants from the target population for research purposes. The sample of this study consisted of psychologists, social workers, general practitioners and nurses working in two mental health facilities in Thaba Chweu Local Municipality. Fifteen participants were purposefully sampled for participation from Lydenburg Hospital (*n = 14*) and Wenakker Mental Facility (*n = 1)* once gate-keeper permission was attained. The skewed distribution was due to lack of mental health professionals in Wenakker After Care Centre because it is an aftercare for persons with intellectual disabilities. These are the only public mental health care facilities in the region. Purposive sampling was adopted for the deliberate choice of professionals due to the pertinent qualities that they possess, including their proficiency and being well-informed about the phenomena of interest (Babbie, 2001; Bless et al., 2006; Glaser, 2008).

3.5 Data collection and procedure

Data was collected using semi-structured interviews (See Appendix 1 for interview guide), which allowed the researcher to ask follow-up questions. According to Blandford (2013), semi-structured interviews do not strictly follow a formalised list of questions but allows for open-ended questions and a more flexible discussion of answers. All interviews were conducted in English, which was the language of choice for the practitioners. Since the study was conducted in health care facilities, ethical issues had to be observed, including attaining permission from the university ethics committee (See appendix 4) and relevant government health authorities (See Appendix 5). Once all ethical clearances were secured, the researcher contacted each targeted institution and communicated with each Chief Executive Officer (CEO) and clinical managers to gain access to the practitioners.

All interviews were conducted during working hours in the respective health care facilities as was agreed to by the participants. Arrangements to meet with 14 practitioners were made by clinical managers and matrons working in the health facilities. For one case, the practitioner was contacted personally but interviewed in hospital. Upon securing appointments with each participant, the study aim, and

purpose were explained, including ethical issues. Subsequently, participants were made to sign informed consent forms, including granting permission to be recorded during the interviews. All interviews and some field notes were audio-recorded and recorded in a notebook, respectively.

3.6 Data analysis

Data in this research study research was analysed utilising the thematic content analysis (TCA), which is defined by Braun and Clarke (2006) as a qualitative analysing method that is utilised in research to identify, analyse and identify themes or patterns that are presented repeatedly within the data. In this study, the researcher employed the following steps as recommended by Braun and Clarke (2006) to analyse the data.

3.6.1 Familiarisation

In this phase, the researcher familiarised herself with the data collected by listening thoroughly to all the collected recordings. The researcher further transcribed the recorded data into a word document, which allowed the researcher to analyse and re-read through the notes that she transcribed. The researcher unearthed ideas of the patterns in the transcribed interview findings, which later propelled her to read through the data to her satisfaction. Using this technique, the researcher familiarised herself with the study and analysed the findings.

3.6.2 Coding

Familiarisation of the data collected abetted the researcher to thoroughly analyse her coded data according to which features of the data appeared more meaningful and interesting in the chosen study. The researcher identified codes that are more detailed than the themes, indicating the context of the conversation that is more common in the data.

3.6.3 Generating themes

The researcher identified patterns and developed themes from the coded data. The themes were developed by comparing them with the data (splitting or combining). The researcher categorised the codes into subthemes, and themes according to their

relationships with each other. These themes and subthemes are presented in chapter four.

3.6.4 Reviewing themes

A deeper review of the identified themes followed where the researcher questioned whether to combine, refine, separate, or discard initial themes. The researcher combined common themes, separated those that were not common in their different cyphers and discarded those that were not coherent. The researcher made sure that the data within the themes cohered together and gave meaningful and clear identification and distinction between the themes.

3.6.5 Defining and naming themes

The researcher analysed the data more than once to absorb them. The researcher further enhanced the identified themes and provided names and definitions that captured the core of each theme concisely.

3.6.6 Write-up

Finally, the researcher interpreted and discussed the findings in line with the theoretical framework, themes, research questions and literature review. The results and findings are discussed in Chapter 5

3.8. Quality Criteria

Credibility, dependability, transferability, and confirmability are key criteria used to assess the trustworthiness of qualitative research. The researcher demonstrates here below how, guided by the criteria, the study trustworthiness was ensured.

3.8.1 Credibility

Credibility refers to the extent to which study findings represent the real experiences of the research participants or the 'truth value' (Lincoln & Guba, 1985). The sampled participants were knowledgeable about the studied phenomenon, while their data were

analysed using a scientifically credible analytical stance. The analysis and presentation were anchored by the TDF model to help strengthen the study. The researcher used well-established research methods to collect and analyse the data. The credibility of the study is also strengthened by direct quotations that are used for illustrative purposes in the next chapter. All these efforts were meant to ensure that the study was credible and, where possible, that the study dependability can be established. One noted methodological weakness is the selection criteria of professionals, which is noted as a potential aspect that could compromise the integrity of the study.

3.8.2 Transferability

Transferability refers to the extent to which research findings can be applied or used in real-life practice, theory, and future research (Lincoln & Guba, 1985), which means the transferability of research findings to other contexts (judging relevance of the study) (Treharne & Riggs, 2014). A detailed description of the study context is provided in the preceding section, that is, the study setting. This was meant to help researchers first judge whether the targeted settings for transferability purposes are similar to the current study setting. Overall, qualitative research is not interested in the replicability and generalisability of research findings, as is the case in quantitative research. The findings of the present study are intended to aid in improving mental health care services in the Thaba Chue district. However, future studies in the Mpumalanga region could benchmark the present study to further explore this area of study. The transferability of the present study could be limited to public hospital settings while also considering the methodological weakness highlighted elsewhere in the study.

3.8.3 Dependability

Dependability refers to whether the research findings are reliable and consistent. It is the degree to which the research methods are documented. Dependability allows someone else to conduct and follow the methods and critique them (Polit et al., 2006; Sandelowski, 1986; Streubert & Rinaldi, 2007). The researcher ensured the

dependability of the present findings by strictly adhering to the study research methodology. The methodology is detailed step by step in this chapter to allow replication in similar contexts.

3.8.4 Conformability

Conformability is 'the degree to which the researcher's findings could be duplicated by other researchers' (Sandelowski, 1986). To achieve conformability, the researcher must keep all documentation, transcripts, and data collected during the study. The research findings are those of the participants' experiences and are not bias, motivations, interests, and views of the researcher (Treharne & Riggs, 2014). In this study, the researcher ensured that conformability is possible by keeping an audit trail throughout the research document, which is the case in the present study. The raw data are securely stored and will be made available on request for further analysis, interpretation, and evaluation of the findings of the current study.

3.9 Ethical considerations

3.9.1 Permission to conduct the study

The study obtained ethical clearance from the University of Limpopo Research Ethics Committee (See Appendix 4). Subsequently, permission to enter participating health settings was granted by the Department of Health in Mpumalanga (See Appendix 5). Accordingly, consent was further obtained from Mashishing Mental Health Facilities to interview participants.

3.9.2 Informed consent

Informed consent "ensures that participants are well informed and aware of all the risks involved in being part of the research study" (Sandelowski & Barroso, 2002). The researcher outlined to the participants the purpose of the study, the inherent risks, and limitations regarding participation. Participants were given an informed consent letter

(see Appendix 2) to read and an informed consent form to sign (see Appendix 3) as consent to understanding all the facets of partaking in the research study.

3.9.3 Voluntary participation

The researcher asked for participants' consent and informed them that partaking in the research study was voluntary, and that they had a right to refuse or withdraw from the study at phase of the study.

3.9.4 Benefits, risks, and avoidance of harm

Every researcher should abide by the moral principles and ethical rules when conducting a research study (Babbie, 2001). The researcher ensured that the participants do not experience any form of physical or mental harm. Interviews were conducted in a setting that was comfortable and harmless to participants, who were informed of all the risks of the study. Their rights and morals were protected.

3.9.5 Confidentiality, anonymity, and privacy

Confidentiality is an agreement that prevents/limits/restricts the sharing of information without the participant's knowledge or consent such as their names (Sandelowski & Barroso, 2002). The researcher protected the participants' information and identity. The data collected will only be shared between the researcher and the supervisor. To maintain confidentiality and anonymity, the researcher did not use the participants' real names in the study. Their rights and wishes to remain anonymous were respected, hence pseudonyms were used instead of their real names to identify them.

3.9.6 Respect and dignity

In this study, the researcher treated all participants with dignity and respect. Their rights were not compromised. The researcher ensured this by informing them of the right to withdraw/terminate from the study when they wish to do so and asked for the participant's consent to record the research process.

3.9.7 Data protection and Management

The researcher safeguards and keeps all the collected data (transcribed, field notes, audio files and consent forms) in a password protected computer and is stored in a computer folder that is also password protected because the information is confidential and private. The password to the folder is only known by the researcher. Any requests for the data will be evaluated first and authorised by the student in consultation with the supervisor. The destruction of the data will be considered after 2-calender years.

3.10 Concluding remarks

This chapter has described the adopted research methodology used in the study as well as the sampling method. Furthermore, the chapter has highlighted how the data of the study was conducted. Lastly, it outlined the method of analysis used to analyse the collected data. The following chapter presents the results of the study.

CHAPTER 4: RESULTS

4.1 Introduction

This chapter presents and interprets the research findings of the data collected. The names of the participants were replaced and not publicised to protect their identities. The chapter comprises various sections, including the demographic information of participants. Secondly, it presents themes that emerged from data as collected and analysed. Thirdly, challenges that are encountered by patients with mental illnesses when they want to access health care services are discussed. Lastly, the summary of the findings accumulated during the research study are presented towards the end of the chapter.

4.2 Demographic Data of Study Participants

Fifteen participants took part in this research study (See table 1). Eight were females and seven were males. Fourteen of the fifteen participants were medical personnel at Lydenburg Hospital, and one was from the Wenakker After Care Centre.

Table 1: Socio-demographic profile of the participants

#.	Sex	Age	Occupation	Facility
1.	F	60	Nurse	Lydenburg Hospital
2.	M	31	Medical Practitioner	Lydenburg Hospital
3.	M	29	Nurse	Lydenburg Hospital
4.	M	30	Nurse	Lydenburg Hospital
5.	M	56	Matron	Lydenburg Hospital
6.	F	58	Nurse	Lydenburg Hospital
7.	F	42	Nurse	Lydenburg Hospital
8.	M	32	Psychologist	Lydenburg Hospital
9.	F	35	Psychologist	Lydenburg Hospital
10.	M	38	Nurse	Lydenburg Hospital

11.	F	26	Social worker	Lydenburg Hospital
12.	F	28	Medical Practitioner	Lydenburg Hospital
13.	F	53	Nurse	Lydenburg Hospital
14.	M	28	Medical Practitioner	Lydenburg Hospital
15.	F	58	Senior Nurse	Wenakker Facility

Participants' distribution by occupation reveals that most participants were nurses (9), followed by medical practitioners (4) and psychologists (2). Distribution by gender reveals that nine (9) females took part in the study as compared to six (6) males. The majority of the participants in the research study were aged between 28 to 40 years. The status position can serve as an obstruct to the researcher who undertakes the study from gathering and obtaining certain information unless she is aware of this. The probability of using participants between ages of 26years to 60years is to confirm the research validity.

4.3 Themes and subthemes that emerged from the study

Themes related to the TDF domains were generated from the data as collected and analysed (see table 2 on page 2-4). In this section, study themes/findings are presented and linked to their related TDF-domains. Notably, of the 14 TDF domains, the study findings did not reveal any link to domain 3, that is, the social/professional role and identity.

TDF Domains	Themes	Representative Quotes
1. Knowledge	• Community's lack of mental health knowledge and awareness	*"Lack of knowledge and misguided public awareness is a concern. Our communities lack knowledge of mental health care, because they do show this when we discuss issues related to mental health problems. The reluctance by community members to educate themselves about patients suffering from mental illnesses is very alarming. Communities are clueless when we engage them about factors pertaining to health care services" (Participant R10, M, 38 yrs).*
2. Skills	• Improving nurses' knowledge of mental health	*"On our side as a hospital, we had a meeting where we discussed matters related to mental health care services. It was suggested that professional education should be offered to nurses who wish to further their careers in the field of psychological education. Measures to train nurses with regards to admission of psych patients should be implemented. Procedures and methods involved in admitting patients with psych complications were discussed thoroughly. Care and interventions were also included in our workshop to construct conscious educative strategies towards MHC patients" (Participant R4, M, 30 yrs).*
4.Beliefs about capabilities	• Lack of adequately trained mental health personnel	*"Medical practitioners are inadequately trained in psych courses and that hinders the progress to redress and confront concerns on patients suffering from mental health illness. Mental health patients are regarded as people*

		with special needs as such; they require monitoring and special attention" (Participant R3, M, 30 yrs).
5. Optimism	• De-stigmatisation of mental illness	*"From my point of view, I would encourage them to continue taking their medication. I always highlight to my patients that; mental illness is the same as any other physical illness. I will emphasise the fact that with treatment, their illness can be managed and be suppressed." (Participant R12, F, 28 yrs.).*
6. Belief about consequences	• Ill-treatment of service users by practitioners	*"Patients would say: I was there and I was ill-treated and I lost my child and I was treated badly and those are the things that make them develop an attitude" (Participant R8, M, 32yrs).*
7. Reinforcement	• Introduction of community rehabilitation centres and educational programmes	***"****There must be rehabilitation centres in the community, built to integrate these patients back into their societies through hand-work activities. Activities such as, gardening and carpentry. Hand-work activities promote self-independence and brain exercise. Psychologists should be deployed and positioned in rehabilitation centres to eradicate illiteracy and to educate community members about people living with mental illnesses." (Participant R1, F, 60 yrs).*

	• Lack of follow-up systems of care for service users:	*"There are no follow-up programs in place to monitor the patients' treatment schedule. In health care facilities and hospitals, patients are monitored by medical Doctors and nurses. The challenge arises when such patients are released back to the hands of the care-givers. Added on, they are confronted with stigma attached to their illnesses, transport issues and negligence from family members." (Participant R3, M, 29 yrs).*
8. Intentions	• Service access is prompted by the need to manage various mental health problems	*"Most of the patients show display inappropriate behaviours and hostility.at home. Patients become hostile and begin to act in inhuman nature, by breaking household appliances and insulting people." (Participant R10, M, 38 yrs.).* *"Abused patients feel anxious and are often distressed, because they are ill-treated by family members. Either mentally, physically or psychologically it is evident that these patients are abused and that raises concerns for both medical practitioners and community members." (Participant R1, F, 60 yrs.).*
9. Goals	• Implementation of community mental health talks, mental awareness campaigns and mental health education	*"Through public awareness campaigns as a medical practitioner, I frequently visit gateway clinic in Mashishing and hold health talks with the community. I inform them about the services that we render in our health care services. Additionally, I host mental health care issues at Mashishing radio station (Mash Fm" (Participant R9, F, 35 yrs).*

10. Memory, attention, and decision processes	• Provision of quality mental health care services by professionals	*"It has to do with the positive treatment we offer in our hospital. We render quality care to the patients of any age and colour, hence most of them prefer to come to our hospital". (Participant 13, F, 53 yrs).* *"Quality service and attention given to patients during first sessions we have with them, encourages them to continue with their treatment as per their prescription. Such reforms contribute enormously towards healing process of the patients." (Participant R9, F, 35 yrs).*
11. Environmental context & resources	• Lack of infrastructure and Resources • Physical and structural barriers	*"Our hospital facilities are not really constructed and structured to cater for people living with mental health illness. The only wards in our facilities are medical wards which accommodate all patients suffering from different mental illnesses in one unit. As such, medical patients are accommodated with mental health patients. With such difficulty, medical practitioners are unable to monitor and guard patients living with mental illnesses." (Participant R3, M, 29 yrs).* ***"**Financial constraints is a hindering factor to communities. Patients from rural farms have problems with transport availability because their only means of transport takes long hours to reach their villages. In some instances, there are no transport services throughout the day. Patients are*

	• Shortage of medication	*confronted with streets that are not roadworthy, others with potholes. As a result, such negative situations make it impossible for transportation services to render services to such communities." (Participant R6, F, 58 yrs).* ***"**We have shortages of medications in our facilities hence we cannot provide to patients. We individually check patients' medication and provide them with any medication that is readily available on our shelves. Tegretol is one we use mostly for its multipurpose for both behaviour and epilepsy. Our main challenge at this moment is shortages of drugs" (Participant R15, F, 58 yrs).*
12. Social influences	• Stigma of mental illness • Lack of Social Support	*"There is stigma around mental health and that makes people to be embarrassed and hesitant to seek medical assistance. Judgemental remarks from families and friends are also contributing factors. Mockery and general insults from family members deter patients' from continued adherence to treatment." (Participant R12, F, 28 yrs).* *"Due to stigma, many patients with mental illness are isolated from the community. Individuals within the society disassociates and distance themselves from them, because they are uninformed and ignorant with regards to patients living with mental illness." (Participant R3, M, 29 yrs).*

	• Belief systems and cultural influences	*"Family support is crucial because ignorant family members offer little to no support to patients with mental health challenges. Such patients develop suicidal thoughts as they feel abandoned and unloved by the society and their family members." (Participant R4, M, 30 yrs).* *"Squabbles and quarrels arise within the community because people in the community spread rumours that Y and Z bewitched that particular patient without any tangible evidence. With reference to traditional people, they believe in African ways as compared to Western methods of treating mentally challenged patients. Those families decide to take patients to traditional doctors, due to their deep rooted cultural beliefs" (Participant R3, M, 29 yrs).* *"Deeply -rooted cultural people put blame on superstitions and make claims that patients with mental illness are either possessed or suffering from demonic spirits. Community members will advise the family of the patient to consult a prophet or go to a seer" (Participant R2, M, 31 yrs).*
13. Emotion	• Patient denial and poor insight into mental illness	*"The problem lies with the patients commonly, they will skip their treatment and refuse to drink their medication. Mental health patients hold a belief that*

		they are not ill and as such there is nothing wrong with their sanity and how they behave." (Participant R3, M, 29 yrs). *"A patient refused to take his medication, because he strongly felt that consuming pills doesn't contribute to his well-being. Such patients are still in denial of their mental illness status". (Participant R13, F, 53 yrs)*
14. Behavioural regulation	• Lack of professional supervision for outpatient treatment	*"The behaviour of the patient doesn't frustrates them only, but even us medical practitioners are left frustrated. Patients who do not visit our facilities timelessly, often default and regress on their progress. After few months of treatment, patients believe that they are healed and can discontinue with their treatment.." (Participant R3, M, 31 yrs).*

Domain 1: Community's lack of mental health knowledge and awareness

In this study, practitioners shared their views that the barriers preventing patients from receiving the care they require include lack of information and education about mental illness, where to access available services, and platforms to use in order to access services.

> *"It is either they do not comply, or their families are just ignorant when it comes to these types of patients" (Participant R4, M, 30 yrs)."*
>
> *"If they do not have thorough understanding of the services they are furnished with; they will not seek more medical attention. Again, without adequate knowledge at their disposal they will disregard their right to medical services and exit the medical facilities" (Participant R1, F, 60 yrs)."*
>
> *"They would rather stay with a child who's not mentally stable at home and deprive the child freedom of association. They will hide the child from the society as to avoid gossip and stigma attached to mental health related illnesses. They don't know this is actually a mental illness" (participant R10, M, 38 yrs)."*

It is evident that within the current setting, patients and communities' lack of mental health knowledge is being met as a challenge. Equally, lack of awareness of mental health care services available for the uptake is a challenge. The last excerpt reveals a link between lack of knowledge and mental illness stigma and how both hinder patients' access to health care services.

Domain 2: Improving nurses' knowledge of mental health

The findings further exposed the need for nurses that lack knowledge of mental illness to be trained in the 2nd TDF-domain, that is, skills improvement. This was identified as a prevailing challenge that was necessary for improved patient care. Although efforts to address this challenge were in place in participating settings, they emerged as not

sufficient to foster patient reliance on available mental health services. The finding is supported by the following quotations:

> *"So, but we appreciate what the government is doing now, those that are single qualified and the sisters that did general nursing only are being sent for orientation on mental health and short courses on mental health for 3 weeks or 4 weeks. Now in medical ward, the sister that I said you should go see she's not mentally trained but she went for orientation. She understands only the basics of what should be done on mental health care user" (Participant R5, Pedi, F, 56 yrs).*

> *"But here we are planning to have nurses coming from bridging courses and who can engage them via in service training, that we can also arrange" (Participant R4, M, 30 yrs).*

> *"This health education should also be done at the clinics to educate practitioners. They should also have a specific group of people trained, who are equipped sufficiently to educate the society about challenges confronted by people living mental health condition" (Participant R7, F, 42 yrs).*

The above excerpts highlight the perception that available professionals do not possess sufficient mental health knowledge; hence there is a need for them to be educated, including reaching out to communities for knowledge transfer purposes.

Domain 4: Lack of adequately trained mental health staff personnel

Participants observed that the lack of professionally trained mental health workers was a cause for concern in their facilities. The noted shortage of psychiatrists, psychiatric nurses and clinical psychologists presented a challenge to patient care in these centres. The noticeable scarcity meant that patients did not receive quality mental health care. Herewith is what some participants had to say:

"When I say lack of resources, I mean human resources. In this hospital, you should have noticed that we have nurses and most of the nurses do not have psychiatric training, this include the Doctors. We just have medical doctors. I know they can perform those duties, but it was going to be much better if we had psychiatrists" (Participants R3, M, 29 yrs)."

"The other concern is lack of trained mental health care-givers; we don't have them in the wards through-out our shifts. For instance, as we are currently speaking now, there are no mental health trained personnel in the wards" (Participant R5, F, 56 yrs).

"In our facility, we do not have easy access to psychiatrists. We are confronted with patients who can benefit from a psychiatrist presence, such psychiatrists with qualifications to administer and monitor patients suffering from mental illness. I believe at times we are mismanaged and as such we fall short on stuff to oversee that patients suffering from mental illness are well taken care of. (Participant R2, M, 31 yrs).

Apart from specifically trained professionals, the findings revealed that there is a general shortage of health professionals in the centres as captured by Participants R8 and R9 below, respectively.

"The challenge is that we are not readily available unless your case is dire pressing issue or an emergency. So basically, we work on appointment basis and if we do not do that it is going to interfere and disturb our work load, do you understand?" (Participant R8, M, 32 yrs).

"The problem is being short staffed; we are short staff." (Participant R9, M, 35 yrs).

Patients do not receive adequate services as there is a shortage of trained personnel in mental health care facilities. Professionals do not have the right knowledge or capacity to fuller cater for patients with mental health needs. The lack of adequately trained personnel therefore serves as another hindrance to patient care in these settings.

Domain 5: De-stigmatisation mental illness and support of mental health care users

De-stigmatisation of mental illness by professionals and family members was identified as an enabler of patients' access to mental health care services:

> *"…We have to encourage most of them. You know with mental health patients they are sick, so they do not take their medication*" *(Participant R11, F, 26 yrs).*

> *"They are voluntarily brought in by family members whether it be an aunt, uncle, grandmother, mother, sibling or whatever the case maybe" (Participant R14, M, 28 yrs.).*

> *"It is the support and love we show them including showing them that we are not afraid of them". (Participant 13, F, 53 yrs.)"*

Patients access services because of a good support system that they have in their families and practitioners. Support and family play a pivotal role in influencing patients to access mental health care services. Family support and practitioner encouragement emerges as an enabling factor.

Domain 6: Ill-treatment of service users by practitioners

Participants pointed out that practitioners' negative attitudes and hostility towards patients served as another barrier to patient health care. The testimony is offered herein by some practitioners:

> *"Because you get ignorant and lazy staff. I am sorry to say this, but it is the truth. They do not make an effort to understand that this patient is mentally disabled, and the patient must be fed because he cannot feed himself" (Participant R15, F, 58 yrs)."*

> *"Also with regards to that, it is how patients are treated here; if they do come here for psychiatric related issues. A lot of time you encounter patients that are unruly, not particularly violent. You will find them being strapped to hospital beds and that plough anxiety in other patients when they see that happening.*

They become afraid that the same mechanism will be used on them" (Participant R14, M, 28 yrs).

"Doctors are deployed in these health care facilities, because they do discover that we did not treat the patient well. You just observe the patient for 72 hours and after the 72 hours the patient stabilises then we just discharge the patient instead of referring the patient" (Participant R4, M, 30 yrs).

It is apparent that the behaviour and attitude of patients who had a poor experience from the hospital is negatively impacted when they wish to seek medical assistance. Patients who have lost their loved ones at the hospital catastrophise hospitals and associate them with cemetery site. Such prior experiences hinder and interfere with patients who seek mental health care services in the future. Furthermore, the negative attitude and poor treatment they get from the practitioners is another impediment that will discourage them from accessing mental health care services in the future.

Domain 7: Reinforcements

Under this TDF-domain, two sub-themes emerged and are presented below:

*Introduction of community rehabilitation centres and educational programmes***:** Practitioners highlighted that patients need community rehabilitation centres after being integrated back into the community. This is a conducive environment that they go to on a daily basis for follow-ups, and to be assessed as to whether they have easily settled in their environment and cope well in the community. This is supported by the following statements:

"*If there can also be a home where the mentally challenged go to during the day and they are furnished with lessons and are taught by a qualified doctor and a professional mental health worker. They can get counselling there, simultaneously, they are kept busy at that particular facility and they also receive food parcels to eat". (Participant R1, F, 60 yrs)".*

"In the community at the Mashishing clinic, I know they have gardens and they have given the patients a portion where they are able to plough and plant. They are given seedlings to plant and when time to harvest emanates they sell their stock products to centres like Ejabulweni. At such centres, they cook for them and sell to those with big events such as weddings" (Participant R5, F, 56 yrs).

"They have a mini centre where they get food from time to time. That program we can also use it to give out medication because we know who is on medication. Where and how, remains an idea that still needs to be implemented. If somehow we come up with that program, I believe it can be a good program. It can be a feeding scheme that contributes to giving back to the community, where people living with such condition can come and collect food there" (Participant R3, M, 29 yrs).

Rehabilitation centres that empower patients after being integrated into the community are an enabler and enhances access to immediate and quality health care services. The results also show that already there are informal systems in place, which in hindsight, the government can formalise and scale up.

Lack of follow-up systems of care for service users: Practitioners conceded that patients that are uncensored after being discharged relapse. This prevalent issue was reported as an impediment to patients' access to adequate care:

"We do not help them in anyway until they start having an episode and they bring them in. We do not do follow-ups" (Participant R7, Tsonga, F, 42 yrs).

"We do not know what happened to him, because we don't have good follow-up systems and techniques" (Participant R3, M, 29 yrs).

"Here we do not have the home based care for people to visit the patients and to encourage them to attend their follow-up sessions, which is one of the effects that make them not to come" (Participant R4, M, 30 yrs).

"When we admit them in the hospital, they started with the treatment but when they go home they stop the treatment because there is no one to follow-up on

them even when the parents force them some come but others don't come back for the follow up" (Participant R1, F,60 yrs).

This finding reveals that patients are not followed-up or being monitored by professionals after being discharged. The lack of follow-up systems in the settings are met as a barrier to quality care.

Domain 8: Service access is prompted by the need to manage various mental health problems

From their experiences, practitioners perceived patients to seek professional services when in need of help with a wide-range of mental health problems. Here is what some of the service providers had to say:

"I think most of the time it's because they need our services" (Participant R8, F, 35).

"They come here because they need assistance" (Participant R11, F, 26).

"I can say the reason is that they need help that's why they come to our hospital." (Participant R1, F, 60 yrs.).

Mental health conditions such as acute stress reaction, schizophrenia, mood disorders and substance-related problems were some of the identified conditions pushing service users to seek health-care:

"But mostly here in Lydenburg, we have an issue with drug abuse. The nyaope pandemic that has spiralled out of control. Most of these drug abusers are drug induced mental health care cases. More especially, the drug induced psychosis due to the use of nyaope and dagga" (Participant R10, M, 38 yrs.).

"Most of the patients show signs of unwillingness and inappropriate mannerism at home. They display aggression and hostility take when under the care of their family members. Patients become hostile and begin to act in inhuman nature by breaking household appliances and insulting people." (Participant R10, M, 38 yrs.).

This particular finding reveals that patients continued to utilise mental health care services for various reasons but all related to mental ill health.

Domain 9: Implementation of community mental health talks, mental awareness campaigns, and mental health education

The results showed that there was a lack of mental health awareness drives and initiatives. There was therefore a need to introduce these drives and initiatives whilst others are scaled up. Aspects such as the media, consultative meetings with various stakeholders and participation by local mental health coordinators' offices could help improve communities' knowledge. Incorporating mental illness education into school curricula was also recommended as one strategy to help increase community awareness of mental health issues:

> *"So it's our responsibility to go back again to the issue of education. Where people are accessing this education. It can be in many ways as I have already mentioned through radio, meetings, and different stake-holders meeting, where we discuss such issues. The mental health co-ordinator office must be strengthened to eradicate illiteracy of mental health issues in the classroom setting. Social-workers should visit these families. More especially, in families where there is patient who is a mental health care user" (Participant R10, M, 38 yrs).*

> *"We do monthly awareness during the January, February, April and June months. We know what we are doing. Here you see its ADHD (in full). Every month there is something we are commemorating. So we make sure" (Participant R11, F, 26 yrs).*

Community education programmes needed to also make efforts to de-stigmatise mental illness as reflected by Participant R2 and R12 below, respectively:

> *"Obviously, I think education programs and de-stigmatisation. Making mental health care easily accessible is vital and important to assist with such challenges. We can do programs such as outreach programs as they do for other chronic conditions. We can also implement a lot of which we teach kids*

in Life orientation. In general, on how to look after yourself and general diet. We could introduce that and have a high focus on it in the school curriculum" (Participant R2, M, 31 yrs).

"Well, I think that begins with educating everyone and not just patients with mental illness. More of community education and also to explain to them that mental illness is a sickness of the brain, same as any other sickness. Over, I ought to diagnose patients that come to my office with other unidentified problems. They need to be screened for mental health problems, so that one can pick them up before it becomes a big crisis or a big illness. Again, I think at a young age at high school age, learners should be taught about mental health and about picking the signs. Lot of illnesses start to show themselves around high school age. This will assist the learners to recognise the signs and to see the symptoms either in themselves or in their friends, to assist them to get help. Social media also has a lot of influence on what we perceive as normal and abnormal, I think you can have a positive influence on social media as to mental health. In terms of schools, it should be a part of life orientation subject and their everyday life. You can always have campaigns going to schools and visiting communities and encompassing the mental MBT (in full) team to go out and make it practical, make posters, give talks and that kind of thing" (Participant R12, F, 28 yrs)."

It is evident that being visible, raising awareness, educating and engaging community continually can be fruitful. The aforementioned attest that patients and schools should be adequately informed. This is an enabler that aids patients dealing with mental illnesses to access the care that they need. Individuals within the society are encouraged to receive education and to ensure that they are aware of how to recognise the signs and symptoms of mental health issues, whether in oneself or in the next person. Patients need easy access as to who, where and how to access the services when the need arises.

Domain 10: Provision of quality mental health care services and creation of a positive hospital experience

Under this domain, subthemes emerged, that is, positive hospital experience and efficiency of staff and effectiveness of services. These were also identified as enabling factors that contributed to patients' continued access to mental health services.

Positive hospital experience: quality services were associated with positive experiences by users, which leads to continued reliance or access to the services. One participant said:

> *"It is because people love the services here. People from Burgersfort travel such long distance to access our facilities, so I think it is about the services" (Participant R3, M, 29 yrs).*

> *"It has to do with the positive treatment we offer in our hospital. We render quality care to the patients of any age and colour, hence most of them prefer to come to our hospital". (Participant 13, F, 53 yrs).*

Positive hospital experience encourages patients to continue relying on health care services. What this finding suggests is that a hospital that renders quality yet with friendly staff members enable patients to trust and appraise mental health services positively.

Efficiency of staff and effectiveness of services: Feeling better after accessing mental health care services was identified as another enabling factor.

> *"I guess, if a patient see the treatment is making some difference for them and such, make them lead a normal life, they are more inclined to come back here. They are also accountable to their families and society and also supports them to come back for the follow-up on the services" (Participant R12, F, 28 yrs)."*

It is a belief that getting better after receiving medical attention is one of the impacts that will encourage patients to go back and seek assistance again. A positive outcome serves as a facilitator for a patient to go back and do follow-up on their treatment and to continue utilising and accessing mental health care services.

Domain 11: Environmental context & resources

Under this TDF-domain, three sub-themes also emerged and are presented below:

Lack of infrastructure and resources: through their responses, practitioners indicated that the lack of psychiatric hospitals, poor health-care facilities and shortages of material and human resources all serve barriers to patients' access to mental health care services. This is confirmed in the following responses:

> *"We do not have a dedicated psychiatric facility and other tools. Patients end up being put on waiting lists due to the limited number of space in the medium term facility" (Participant R10, M, 38 yrs).*
>
> *"I cannot really attest that experts are there. I don't think we are really resourced sufficiently to give them an adequate care" (Participant R3, M, 29 yrs)."*
>
> *"We lack resources. We cannot commit ourselves fully to the community as we are experiencing shortages" (Participant R11, F, 26 yrs).*
>
> *"It is a big challenge on hospital staff, patients, mental health care users and other patients suffering from unrelated causes of illness. Wards are not modified or conducive enough to accommodate mental health care user. Windows, basins as I have already alluded they are being kept in both male and female medical general ward. A general ward where patients with other conditions are located" (Participant R5, F, 56 yrs).*

Patients cannot always access adequate care that they need because of infrastructural and resource-related challenges in the facilities. It was observed that the identified challenges not only affect patients negatively, but also practitioners' morale in terms of the discharge of their duties.

Physical and structural barriers: The results further showed that long distance to facilities, transport shortages, poor roads, and financial difficulties stand in the way of

some patients' access to services. Participant R9 and Participant R12support this observation as follows:

> ***"****I think the distance. You find that I am seeing someone from Rossenekaal and they have to come back for follow-up. Some do not come back because they don't want but because it is far due to the issues of transport" (, F, 35 yrs).*
>
> ***"****There are barriers in terms of finances and transportation and other contributing factors" (Participant R12, F, 28 yrs).*
>
> *"I think the transport issue is one of them. The police officers are not adequately resourced. We are supposed to trail them and still, they reiterate that there is no police vehicle on site, while their landline is inaccessible for you to call them. Their speed dial in most cases delays us and subsequently delays patients when we do not have any means of transport. Provided, you have a neighbour that can transport you without requesting money for petrol" (Participant R6, F, 58 yrs).*

Patients cannot access services because of inadequate economic muscles, and not because they do not wish to access these facilities. Lack of funds is a constraint as a lot of people cannot afford to pay for transport to come and receive health treatment. Further, free transport from state owned vehicles is not always available or easily accessible.

Shortage of medication: Participants asserted that not having sufficient medication, constantly putting patients on waiting lists and change of their medication is a challenge that complicates issues in terms of adequate care that they need. This can be avowed by the responses below:

> ***"****The other challenge that we are facing is the unavailability of medication, the sedatives specifically for the mental health care users and we have a challenge that emanates from last year even though such challenges can be prevented because alternative medications are there" (Participant R5 F, 56 yrs).*

"There is essential medication they couldn't provide. We have to individually analyse their, medication and substitute it with what we have. Like we do not have Tegretol, it is both for behaviour and epilepsy. The main challenge we have right now is the drugs" (Participant R15, White, F, 58).

Patients' medication has to constantly change, and they are prescribed different medications. Some of the medications have side effects on them.

Domain 12: Social Influences

Under this TDF-domain, three sub-themes have emerged and are presented below:

Stigma of mental illness: Western-trained mental health practitioners revealed that the feeling of shame, and of being judged and discriminated against are some of the challenges faced by patients when accessing mental health services. Hence this is the reason patients are reluctant to seek help. This is established in the following responses:

"One, I think that we have a long way to go. It is just the stigma attached, whenever someone is having a mental health problem the society turn to think that they are bewitched or something like that. That is the stigma that families of mentally challenged individuals have to deal with daily." (Participant R3, M, 29-yrs).

"Some of the patients stay indoors because the family does not want us to know that the patient needs help. They do not allow them to come out and socialise with people so that people can see that there is a problem and they can be examined and assisted" (Participant R6, F, 58 yrs).

"It might be stigma from the family members coupled with that stigma from the community" (Participant R14, M, 28 yrs).

"I think certain cultures in the South African setting, some are more willing to go on medication. While on the other side, some of them are linked to medical services because of the stigma" (Participant R2, M, 31 yrs).

Stigma is one of the factors that impede patients from seeking and accessing mental health services. Patients are stigmatised because they live with mental illness. They are scared of seeking help because of the existing stigma attached to mental illness and are afraid to be isolated. Some families hide their family members that are living with mental illness because of the fear of being stigmatised and being judged.

Lack of Social Support: Social support in the form of encouragement from the family and practitioners was perceived as an important aspect for patients' access and adherence to treatment. When practitioners were asked about their perceptions of how lack of support impedes patients from seeking help, they reiterated that this had a significant impact on the utilisation of mental health services as patients feel neglected and alone. This is pointed out in the following statements:

> *"They still need to be educated about mental health condition. Since they do not have ample education and support they need, they will abscond their treatments. Patients know us, so immediately when we see that these people do not come to us, it will imply that we are neglecting them. They need special treatment and hostile treatment turns them away" (Participant R4, M, 30 yrs).*
>
> *"I think maybe it is because of the support from home. They do not support them courteously hence they default." Participant R13, F, 53 yrs)*
>
> *"Sometimes their families mistreat them because of their behaviour. The patients feel neglected by their parents and the community at large" (Participant R1, F, 60 yrs).*

Patients with mental illness have little or no social support from mental health providers, community and from their families in accessing and utilising mental health care services. Patients end up defaulting and relapsing on their treatment and being reluctant to seek help because they feel neglected and that nobody associates and interacts with them.

Belief systems and cultural influences: Practitioners perceive culture as a barrier that influences patients not to pursue adequate health care that they need because of the different belief systems that they possess. This is affirmed by the responses below:

"This cultural ideology that someone has been bewitched and rather take him to church or take him to a traditional doctor. All those factors come into play, because some of them will bring them here and some of them will actually tell you that this person has been bewitched" (Participant R10, M, 38 yrs).

"Maybe they do not believe in counselling. Remember I said others come here because they have been forced not because they want to come. There are some people who believe that treatment is something you are supposed to see" (Participant R9, F, 35 yrs).

"For example, I know someone in my family who has postpartum depression and really struggled with it. It took a long time for her to get help because it is just not accepted in our society. You feel like there is some sort of a deficiency in some cases. There is a deficiency in faith. I can say in Abrahamic religions tend to have the ideology that if there is depression or mental health issues that are not so psychotic issues stem from a deficiency" (Participant R2, M, 31 yrs).

"With old people, I do not know what is wrong with them because if something happens to them they think they have been bewitched" (Participant R3, M, 29 yrs).

Patients, families and the community hold different views regarding mental illness. This is a problem that prevents patients from accessing mental health services: fear of being judged and the feeling of shame and embarrassment. Some communities believe that they are being punished for their sins. Families believe that it is witchcraft and others think that only churches and traditional healers can cure their "craziness".

Domain 13: Patient denial and poor insight into mental illness

Lack of insight into mental illness was identified as a barrier to mental health care. Patients defaulted and relapsed due to their denial of mental illness, while with others, it was due to lack of insight. This is indicated by the following responses:

"So they refuse to use them because they think they are okay and there is nothing wrong with them. Like if a person is psychotic, they say they are okay and when you try to give them medication it is war" (Participant R11, F, 26 yrs).

"I think a lot of the time with mental illness as soon as you are stable on your drug, technically you feel like you don't have a mental illness anymore." (Participant R12, F, 28 yrs).

"This is because they took medication without the consent of the family member, when they get better they stop taking their medication because they feel better they carry a notion that they don't need medication anymore" (Participant R11, F, 26 yrs).

"It is pressure and unemployment; you find that others are relapsing were unemployed or employed coming back then there is no employment". (Participant R5, F, 56 yrs).

Patients are not well informed about their mental illnesses, and as a result, they make uninformed decisions about their illnesses and treatment methods, while others are still in denial to accept their medical conditions.

Domain 14: Lack of professional supervision for outpatient treatment

There is perceived lack of professional supervision on treatment for outpatients, resulting in their relapsing. Furthermore, patients stop taking their medication because they believe that they do not need it, as they feel there is nothing wrong with them. Additionally, they do not see a reason to take them because they are not working.

"A lot of patients default on treatment and that is due to several factors. I do not like to think patients are lazy but there are barriers and issues pertaining to medication when coming to intervention when necessary" (Participant R3, M, 32yrs).

"They will come to a decision that this child does not need medication anymore. The patient is then released in the hands of the parents. When the parents see no patterns of the illness and no behaviour, they will assume he is healed and should discontinue taking medication. They will say all these tablets are giving him all these side effects" (Participant R15, F, 58 yrs).

Patients default on their medication because they believe that they have been cured or they do not need the medication anymore when they feel better. This means that they do not receive the best treatment possible, leading to an outburst of mental illnesses.

4.6 Summary of findings

The research study expresses different views from health care workers in terms of their perceptions of patients' access to mental health services in Mashishing, Mpumalanga Province. Western-trained mental health practitioners enunciated their views and thoughts on the barriers and facilitators of patients' access to mental health. Participants also highlighted that patients often experience hindrances that prevent them from getting care that they need. Furthermore, patients often experience stigmatisation from practitioners, the community and friends. These barriers were mainly described in terms of inadequate support, lack of follow-up systems, belief systems and cultural practices, shortage of medication and funding, transportation issues and limited health care facilities.

Participants identified lack of knowledge, patient denial, and poor insight into mental illness as factors that alienate patients and health care facilities. Lack of infrastructure, resources and adequately trained personnel, Western-trained mental health practitioners and poor treatment towards patients are some of the impediments that prevent patients from accessing mental health care services. Additionally, participants identified various enablers that aid in facilitating patients' access to mental health heath care services.

These factors will not only be beneficial to service users, but also to practitioners and the community at large. These enablers, which are sought to assist patients with diverse mental health problems, were designated as service providers. The de-stigmatisation of mental illness and social support are identified as enabling factors of quality of mental health services. Furthermore, patients highlighted that improving nurses' knowledge on mental health and implementing mental health talks and mental awareness campaigns can nullify issues related to mental health challenges. Education for the patients and introducing community rehabilitation centres for mental health care patients can assist the enablers and encourage patients to continue utilising mental health services.

CHAPTER 5: DISCUSSION

5.1 Introduction

The main objectives of the study were: (a) to establish what Western-trained mental health practitioners perceive as factors that facilitate patients' access to mental health care services; and (b) to determine factors that they also perceive as barriers to patients' access to mental health services. The discussion is nested within the TDF-framework while reflecting on previous scientific reports.

5.2. TDF Domain 1: Community's lack of mental health knowledge and awareness

Mental health awareness is essential for improved management of mental illness. When patients, their relatives, and general community members are well-informed about mental illness, service uptake and adherence improve (Zifkin et al., 2021; Kemp et al., 2021). Unfortunately, in the present setting, there is a perception that patients and their relatives lack such a knowledge. To this end, the lack of knowledge was identified as a leading hindrance to the management of mental illness. Patients themselves are in denial of their conditions due to poor insight. The community also hold negative views about mental illness. Consequently, patients are deprived of the necessary social support and are stigmatised by community members. Indeed, as was reported before, negative attitudes towards the mentally ill including being discriminated against compromises patients' quality of life (Ivanova et al., 2020; Kammimura et al., 2018; Monteiro). Based on the knowledge domain, it is important for all stakeholders to be aware and knowledgeable about mental health issues for uptake to be favourable. In this case, thus, user accessibility is hindered by lack of knowledge by all stakeholders. The data provides a clear understanding of how lack of knowledge may result in other behaviours (e.g.., stigma, non-adherence) which vast research has demonstrated to be an essential social barrier to mental health care access (Kammimura et al., 2018; Monteiro, 2015; Montes, 2021; Montes, 2021; Ivanova et al., 2020). Resultantly, the lack of knowledge domain goes on to impact on other significant aspect of mental health management. This will be demonstrated with the discussion of other TDF-domains' related findings.

5.3. TDF Domain 2: Improving nurses' knowledge of mental health

Mental health is a specialty area in which not all nurses working in primary health care settings are trained. The lack of professional training becomes a management issue, as was identified in this study. This is course for concern because nurses in the majority of clinics handle patients. In a study by Kemp et al. (2021), it was also revealed that there are gaps in training and supervision that serve as challenges for nurses willing to assist patients. Generally, there is lack of adequately trained mental health practitioners in most health care institutions (Coombs et al., 2021). It is in this regard that Schierenbeck et al. (2013) and Coombs et al. (2021) have proposed to government to upscale its efforts to recruit and train mental health professionals. This finding is in line with the skills domain (Mosavianpour et al., 2016), which speaks to mental health practitioners having the necessary skills and competence to provide patients with efficient services. This may further be linked to domain 10 (memory, attention, and decision processes), as a lack of skills by practitioners questions their ability to process and make concise decisions regarding a patient's condition. How the lack of training goes on to impact on patients' management and appraisal of the services they receive may need to be investigated.

5.4. TDF Domain 4: Lack of trained mental health personnel

The current study further revealed that there were shortages of mental health professionals (e.g., psychiatrist & psychologists) in the study setting. Consequentially, the few that are available are over-burdened and fail to provide patients with the necessary attention and empathy to promote their continued use of mental health services. The gap in trained mental health personnel weighs heavily on the available staff (medical doctors & nurses) who end up assuming the roles of psychiatrists or mental health specialists (Coombs et al.,2021; Pelzang, 2012). It further raises concerns regarding proper patient care, as general practitioners are the only ones that have some limited mental health knowledge regarding patients' medication. Evidently, staff is ill equipped or under-skilled to handle mental health cases. Patients can benefit from availability of psychiatrist and psychologists as this will lead to the rendering of quality and proficient services to them. Considering the general shortage of mental health providers in the country, the initiative to have workshops that educate and empower nurses about mental illness would mean that patients will be better

understood and managed (Schierenbeck et al., 2013; Coombs et al., 2021). These workshops will furnish medical personnel with ample skills and comprehensive knowledge to handle patients with empathy and compassion. Additionally, these medical workers will be able to educate and appraise patients about mental health care services accessible to them. Ideally, a need for skilled personnel remains a challenge that departments need to address by taking steps suggested in line with the TDF model to ensure that they meet their desired goals. There is a need to educate available personnel and train them about mental health whilst also ensuring that more people are taken to training to specialise in mental health.

5.5. TDF Domain 5: De-stigmatisation of mental illness

Social support from significant others (family, friends etc.) and practitioners emerges as another enabling factor. Families are an imperative support structure that aid patients to get help and serves as a gateway to better patient care. This suggests that creating mental illness stigma-free and supportive health care settings can potentially increase people's access to mental health services while serving to motivate patient adherence to treatment. This is echoed by Anguiano et al. (2019), who argue that there is a need for positive attitudes towards patients with mental illness, especially from health care professionals. Despite this need, studies revealed that many patients and their families continue to be stigmatised and receive little-to-no support, prompting them to hide or avoid seeking help (Kamimura et al., 2018). Findings on de-stigmatisation further prove domain five (optimism) as they indicate that providing patients with a surrounding that offers warmth and positivity reinforces the continued use of mental health services. This domain refers to the need for improved mental health knowledge by patients, relatives, community members and health professionals.

5.6. TDF Domain 6: Ill treatment of service users by practitioners

This study revealed that patients are often reluctant to use mental health services as a result of the ill treatment they experience in the hands of professionals. Sartorius (2007) has previously reported on the same undesirable treatment of patients by professionals. Mental health care users therefore end up developing a negative view of the system and become fearful of seeking mental health services. Perceived

behavioural changes caused by a lack of skills among professionals, such as ill-treatment of patients, fall under the belief about consequences domain, which reflects on the impact that professional behaviours may have on patients' expectations from facilities, leading to nonuptake of health services. The researcher reiterates that for improved access to mental health care, health professionals should lead by example and reduce the stigma of mental illness, including being advocates for the good care of mental health care providers (Anguiano et al., 2019).

5.7. TDF Domain 7: Introduction of community rehabilitation centres and lack of follow-up systems of care for service users

Lack of community rehabilitation centres and patient follow-up systems were identified as hindrances thus providing patients with facilities within/near them is critical towards maintenance behaviour and relapse prevention. This is important since patients can visit such centres regularly or be referred to after having been admitted in psychiatric facilities. This finding suggests the need for support and compassion that extend beyond the hospital bounds. Moreover, it shows that they are still cared for and accommodated for within the community. They can be arranged support groups that tap into their day-to-day environmental stressors while having access to recreational facilities. Both of which will help enhance and develop their skills for independent livelihoods.

Nuri et al. (2018) indicated that psychiatric institutions needed to be increased to improve the availability of mental health care in communities. Ideally, this move can help promote and educate people about mental health and remove misconceptions and unsupported beliefs around it. Additionally, this is in line with the reinforcement domain, which advocates for the development of a dependency relationship. This finding suggests that practitioners in the current study context are aware of their limited mental health knowledge, communities' lack of mental health knowledge and limited settings for health care. These therefore indirectly serve as community barriers to mental health care access, and therefore, require immediate attention.

Furthermore, a lack of follow-up systems for patients has been identified as one of the barriers to accessing adequate health care. The WHPs have indicated that many of

their patients relapse because there is no follow-up system that can be used to monitor their progress. Moreover, no follow-ups are being prepared to monitor whether patients have any issues with the medication, home environment and whether they are taking their treatment or not. In this regard, a need for a follow-up system is identified and in line with domain 7. This could help develop a dependency relation for patients, thus reinforcing the use of mental health services.

5.8. TDF Domain 8: Services are sought for the management of diverse health problems

Mental distress or suffering including serious mental health problems like psychosis or being suicidal prompted people to go out and seek mental healthcare. Gulliver and colleagues (2012) have also observed that about 27% of the population battling with mental health in South Africa seek help from mental health facilities. From this finding, people opt for mental health services when in distress or experiencing serious mental health problems like psychosis, suicide, or mood disorders. This result fits in with the intention domain of the TDF as they indicate that individuals are aware of the existence of mental illnesses and know when to seek help in mental health facilities. Being knowledgeable and aware of mental health has influenced individuals to seek help or take the necessary steps to acquire mental health care.

5.9. TDF Domain 9: Implementation of mental health talks, mental awareness campaigns, and mental health education for the patients

Another strategy for improved mental health care access is implementation of community-oriented mental health talks, awareness campaigns, and mental health literacy. Currently, all these are lacking thus hindering efforts to deal with mental health. Various studies have advocated for the need for outreach programmes in schools and communities (Salaheddin & Mason, 2016), mental health awareness campaigns to educate, and screen mental illness (Colucci et al., 2015), intervention workshops (Tirintica et al., 2018) and inter-disciplinary and reflective seminars (Zifkin, 2021). These measures are in line with which advocates forthe taking steps to resolve inaccessibility of mental health services and promoting increased access to services. This further shows the link between the goal domain and the reinforcement domain as

these measures may increase the chances of individuals seeking mental health services.

5.10. TDF Domain 10: Provision of quality mental health care services by professionals

An equally enabling factor is the provision of cost-effective or quality mental health care services. This could be in the form of creating a positive hospital environment, efficiency of staff, and effective services. A positive hospital experience assures mental health users that they can rely on the institution. Similarly, Gulliver et al. (2012) indicated that establishing an environment that is positive, supportive, good and healthy encourages patients to seek mental health assistance. Moreover, the findings rest in the memory, attention, and decision processes domain of the TDF model in that the domain entails taking appropriate and conscious measures to ensure that patients receive the best treatment when they visit hospitals. Additionally, by adopting this factor, the mental health sector may thus be in line with the goal domain as these measures will improve the accessibility of mental health services.

5.11. TDF Domain 11: Lack of infrastructure and resources, physical and structural barriers, and shortage of medication

Despite the growing statistics of mental health problems globally and in South Africa, patients' lack of access to quality mental health care services continues to be a service barrier (Barrow, 2016; Monteiro, 2015; Ritchie &Roser, 2019;). Research reveals that multi-layered factors often serve as barriers. In this study, an inter-sectionality of institutional, community, familial, professional, and patient-related factors were all identified as barriers to mental health service access i.e., there are shortages of psychiatric hospitals and medications, qualified personnel, conducive facilities, and resources. Lack of infrastructure and resources such as psychiatric medications result inpatients not receiving adequate care or full medical attention before being released back to the community, hence running the risk of relapse. These infrastructural and resource shortages not only lead to service access challenges. Patients also go on to

struggle with various structural and physical barriers such as lack of money for transportation, long periods travelling between their homes and facilities due to poor road infrastructure and long distances travelled. This aspect is in line with TDF domain 11, the environmental context and resource, lack of access to quality mental health services and mental health professionals affects the accessibility of mental health services by patients.

As a result, when a need arises, patients are destitute and cannot afford to seek for help. Most of the patients do not have access to personal cars. To get assistance, they need money to pay for the neighbour's personal transportation. The South African Police Services offers free services to assist in transporting mental health patients to hospitals, but sometimes it is a challenge because state-owned vehicles are continually utilised. Additionally, another challenge is getting an ambulance; but it is a long process to reach them to come and assist you. To place a call, it charges you extra rates, and the call needs to be transferred and directed. This whole process takes time, and you need immediate assistance. It takes 15 to 20 minutes, and it is overwhelming on the patients as they need assistance immediately.

In a study by Anguian (2019), it was argued that providing good care for patients was hindered by lack of resources to specifically cater for mental health. Lack of infrastructure and resources is perceived to be a challenge globally as studies such as that of Nuri et al. (2018) revealed that areas such as Bangladesh have only one mental health institution with only 200 beds, and the ratio of beds being 1:100 000 people.

The current study further found that institutions rendering mental health services must operate with limited medications and have no follow-up systems for patients. Similarly, Koutra et al. (2021) indicated that about 70% of the population globally suffering from mental illness do not receive treatment. The lack in treatment and follow-up systems may thus result in patients relapsing and therefore continuing to increase over-burdening the mental illnesses as opposed to the desired goal of combating and managing the outburst. This result contradicts the environment context and resources domain of the TDF model, which entails that the environment and resources available should be able to build the abilities and behaviours of both professionals and users, and further contradicts the reinforcement domain as the hospital environments do not

influence patients to revisit hospitals or continue to seek mental illnesses. The results further link to the emotion domain as they indicate how burn-out of mental health providers because of patient relapses leads to increased cases of mental illnesses, and that this may pose a threat to mental health users based on the treatment that the professionals will show them.

5.12. TDF Domain 12: Stigma of mental illnesses and lack of social support

Mental health stigma is one of the most reported barriers to mental health service access. Correspondingly, this study also found that mental health users continue to face a lot of stigmatisations. Stereotyping robs patients with mental illness, especially those with severe conditions and opportunity to access social support. In one study in Rwanda, Muhorakeye and Biracyaza (2021) found that mentally ill patients faced harassment as it is believed that they are affected by the devil. Mental health de-stigmatisation has been an ongoing debate and continues to be a thorny issue to patient care. Therefore, greater efforts need to continue to be directed at educating communities, families, and patients themselves about mental illness. There is a need to address negative social and cultural beliefs or attitudes towards mental illness. This requires programmes that may challenge existing social influences and behavioural regulations as indicated within the TDF model. Resultantly, such social influences further lead to lack of support towards mental health patients. Perceived stigma further aligns to the environmental context domain as it indicates how patients' surrounding have affected them. Moreover, the lack of social support experienced by patients rests in the social influence around them. In line with the social influence domain, findings have shown that patients' external surroundings have an impact on their thoughts and emotions. This finding further opposes the TDF model as they are not in line with the optimistic domain, which advocates for positive attitudes.

5.12. TDF Domain 12: Belief systems and cultural influences

South Africa is a diversified country with various belief systems and cultural practices. Unfortunately, in this study African traditional beliefs and practices were perceived to

be hindrances to patients' early presentation to mental health care services. This is despite service users holding positive views towards the traditional healing sector. For instance, in a study by Anderson et al. (2013), it was established that some Zulu people of South Africa believed that traditional health practitioners were ideal in treating mental illness, more so due to their understanding of patients' worldview; and that western medications were only necessary for physical illness. This finding is in line with the social influence domain as it indicates the impact that cultural beliefs have in promoting access and continued use of mental illnesses. Therefore, patients' beliefs towards mental illness and care will always be shaped or influenced by cultural and social norms around them.

5.13. TDF Domain 13: Patient denial and poor insight into mental illness

The study findings further revealed that individuals suffering from mental illnesses tend to be in denial of their mental conditions. Therefore, this leads patients not to take treatment and to avoid seeking for mental health care. This may be based on various factors such as an individual's cultural and belief systems and poor insight into their mental illness. Following a survey by the National Council of Behavioural Health (NCBH, 2017), it has been revealed that only a certain number of people can navigate the mental health space while the majority of people have little or no knowledge about mental health. They fail to identify and see the symptoms and have no knowledge of how to deal with them. The findings are in line with the emotions domain as patients then show multifaceted reactions towards their mental conditions. Moreover, their reactions in this regard contradict other domains such as domain 3 based on the social identity they may adopt or model.

5.14. TDF Domain 14: Lack of professional supervision for outpatient treatment

The lack of infrastructure and resources in mental health institutions has led to health professionals releasing patients back into their communities and having them as outpatients. The study has revealed that due to such limitations, health professionals may sometimes release patients as soon as they see that they are stable. However, having outpatients has resulted in many patients relapsing due to lack of professional supervision to ensure that they take their treatment adequately. Similarly, Biracyaza

(2021) indicated that patients default on medication due to lack of care at hospitals and after discharge, therefore, losing interest in taking their medication. This finding is in line with the behavioural regulation domain as it indicates a need for patients to be monitored to change and break certain behaviours. Ideally, there should be measures in place to ensure that mental health users continue to take treatment in the best possible ways. These could include having daily outpatient visits by health professionals; daily or weekly support group meetings in communities for outpatients; and daily messages to patients as a reminder to drink their medication and as a form of support to show that they are not on their own.

6. Concluding remarks

This study examined mental health care practitioners' perceptions of patients' access to mental health services. The researcher, in line with the TDF domains, found that there are various existing barriers and facilitators towards access to mental health services. Barriers such as lack of funds and knowledge, limited number of trained personnel, shortage of medication, mental health stigma and cultural beliefs are found to prevent patients from accessing mental health services. Mental health patients face many challenges in their communities and in hospitals. Patients shy away from seeking help because of fear of rejection, shame and ostracisation because of illness they did not choose.

Patients need support, compassion, understanding and education in this new society that views mental illness with shame, disgust, and ignorance. They face oppression, discrimination and prejudice as the media vilifies patients with an illness, they have no control over. They find courage and strength in families and from practitioners that endorse positive views and are advocates for mental health. The journey of the study had led to an honest exploration of views, perceptions, and stereotypes of patients with mental illness. Providing mental health practitioners with the necessary information about patients may help to deal with existing stereotypes.

CHAPTER 6: STUDY IMPLICATIONS AND CONCLUSION

This chapter offers implications arising from the study findings. Implications pertaining to the applicability of the Theoretical Domains Framework in research are offered first. Subsequently practice and policy related imperatives are offered. Towards, the end of the chapter the study a conclusion of the overall study is offered.

6.1 Theoretical implications

The current study supports the view that The Theoretical Domains Framework (TDF) is an important guide to mapping service access related barriers and facilitating factors. In the preceding chapter, how the model guided the study findings and discussion is evident. To illustrate how the theory informed the study, a summary if herein provide. The TDF is based on three umbrella facets which are cognitive, social, and environmental facets. It functions on 14 domains of identifying and assessing barriers and facilitators in human behaviour. It stipulates that human behaviour can be influenced by knowledge, skills, social/professional roles and identifying beliefs about capabilities, optimism, consequences, reinforcement intention, goals, memory affection and decision processes, environmental context and resources, social influences, behavioural and emotional regulations (Cane et al., 2012, Atkins et al., 2017).

The study findings have revealed that raising mental health knowledge in communities can serve a facilitatory role towards improved access to mental health care services. Unfortunately, in the study setting It was discovered that there is a lack of knowledge across users of services and professionals to cater for the users. There is a need to educate communities and health professionals about mental health to improve access to mental health services. The findings are in accordance with the first domain of knowledge, which addresses the need for people to be aware and knowledgeable about things that exist around them. This further stretches to other domains such as skills domain, which ascertains the need for individual abilities or competences to carry out tasks, and the professional role and identity domain, which identifies groups as belonging or carrying certain roles in an organisation. As a result, the study identified

a need for currently employed health professionals to acquire necessary or advanced mental health knowledge and skills for improved mental health care services.

Additionally, the study magnified on the need to address social issues such as mental health stigma and discrimination. This is inline with the fifth domain of the TDF-model, that is optimisms, which identifies existing negative attitudes of stigma towards patients, thus advocates for a need to de-stigmatise it by developing or showing patients of mental health positive attitudes. Developing optimism further reinforces domain six that addresses beliefs about consequences. By showing positive attitudes, mental health users and communities may then change their beliefs and perspectives towards mental illness. It further locates the reinforcement domain and intention as patients may choose to do follow-ups and continue to seek mental health assistance. Communities may also choose acts of activism towards mental health.

The Western-trained practitioners have outlined strategies to promote awareness such as health talks and awareness campaigns. This finding rests on the goal domain and memory, attention, and decision process in that by addressing and promoting awareness through strategies identified by the study, it is possible to educate people and increase accessibility, efficiency, and effectiveness of mental health services.

Moreover, the study revealed that there is inadequate infrastructure, resources, treatment/medications, and skilled personnel. The findings are in accordance with the eleventh domain, environment context and resources, which evaluate the impact that one's environment may build or break their skills, behaviour, or ability. Likewise, the domain relates to the variety of illnesses that were identified in the study resulting from the living contexts of patients. The illnesses and attitudes of patients, society and health professionals further rest in the behavioural regulation domain.

On domain number twelve, social influences, the study revealed that availability of social support forms part of factors foster access to mental services. Based on the findings, lack of support affected patients' use of mental services. It then becomes important for communities to be educated about mental illness, the nature of available services and the importance of providing social support to affect members. Additionally, on the twelve domains, the study further revealed that mental health users hold certain beliefs about mental illness that prohibit them from seeking

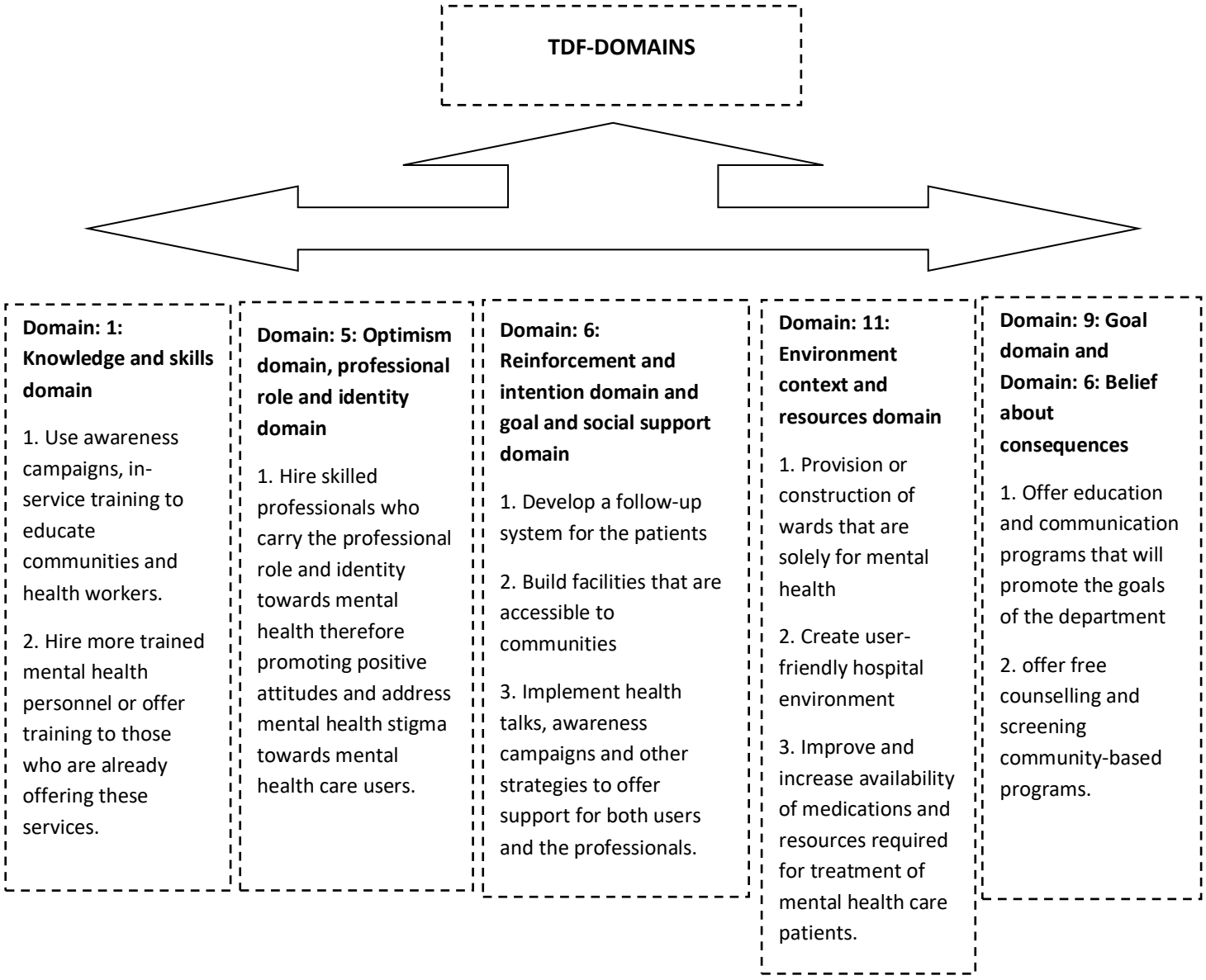
assistance from western services. The study findings further show various links that the TDF domains have with each other.

6.2 Practice and policy implications

The study findings indicate that a gap in both practice and policy implementation exist. Service users are subjected to inadequate care resulting from the lack of resources and shortage in medications that limit practitioners to provide users with fully packed services. It then becomes necessary for health professional to introduce mental health illness awareness and de-stigmatisation campaigns in the work setting. Equally, similar efforts should be implemented at a broader community level for the same purpose. It is argued that this is necessary towards change in attitudes and treatment of users. Optimistically, the favourable treatment could lead feelings of trust in the mental health care by those living with mental health conditions including the affected.

Policy implementation on the other hand, is challenged by the existing gaps in mental health knowledge. It is possible that policy implementers themselves lack necessary mental health knowledge to effect the necessary changes or could be that their priorities are elsewhere to effectively address existing limitations in mental health policy. The study findings therefore implies that there's need for a revised mental health policy in the country which amongst others advocates for aggressive efforts to address risk factors disabling people from utilising available mental health care services. For instance, existing healthcare policies advocate for access and adequate care, however, this ideal is in question since there are shortages of medications in health care centres. Existing physical and structural barriers identified by the study therefore needs to be addressed if access is to be improved. The present study proposes that for improved health care access in the study setting, the strategies highlighted and nested within the TDF- domains can be helpful.

Diagram 1: TDF-Domains supported by study results



The present study has paved the way for future researchers to carry out the same research on Western-trained mental health practitioners' perceptions of patients' access to mental health services. The research study was only limited to two health facilities in the Thaba Chweu Local Municipality. The Department of Health can commission a study focused on the whole province of Mpumalanga, including all mental health facilities. This gives future researchers a starting point. There was lack of representation by specialists in mental health, specifically psychiatrists and clinical psychologists. There was also limited credibility based on the number of social workers and psychiatric nurses available, particularly in one of the identified institutions

(Wenakkar) that only had 1 practitioner (senior nurse) available. Future research should attempt to address this deficit to help extrapolate the findings. Policy makers should commit to implementing policies involving education programmes for both service users and service providers that may focus on mitigating existing barriers and increase the use of health services. In line with the TDF model, the Department of Health should ensure that they place well- trained professionals who are knowledgeable about mental health and have abilities, capabilities and right skills to provide users with effective professional help that will further promote continued use of the system.

The government, following the TDF model's proposition for reinforcement, should introduce mental health education as a subject from primary school level. I suggest that there should be online, hotlines and free counselling services to people who do not want to use services privately, thus increasing the chances of people to use mental health services. The Department of Health should make the screening for mental health illness a prerequisite to all patients coming to hospitals. I suggest that the Department should establish and normalise monthly mental health awareness and campaigns. The media plays a pivotal role in influencing the level of awareness of mental health illness. Further, research designing health communication campaigns with the purpose of decreasing barriers in the utilisation of mental healthcare services are suggested. These measures may improve accessibility to mental health services. Moreover, hospital managers need to ensure that their employees offer their patients services in a context that promotes the continued use of the facility, and that there are enough resources for professionals to provide users with adequate health services. This relates to domain 11 of the TDF, which advocates for an environmental context and resources that promote accessibility.

6.3 Limitations of the study

The study has some limitations. Most participants came from the Lydenburg Hospital with only one participant interviewed from the Wenakker after care centre. Therefore, the views of professionals in the public sector could be limited especially with the reality prevailing in the private sector. Secondly, the study was limited one district thus the findings cannot be taken to mean the same for other districts. This suggests a need for more studies to be conducted to aid with comparative analysis with other regions. Also, the study primarily concentrated on the perspectives of practitioners, without incorporating the viewpoints of patients in this context. It is therefore necessary for the voices of patients and their families to be recorded for a broader understanding of the situation. One important methodological limitation could be the identification of the 14 practitioners by clinical managers and matrons working in the health facilities. It could be possible that the managers identified practitioners who potentially could be aligned to them in perspective thus give one sided perspective. Thus, the study credibility may have been weakened thus prompting for future studies to adopt a different sampling procedure for uninfluenced and varied experiences.

6.4 Conclusion

This study explored Western-trained mental health practitioners' perceptions of patients' access to mental health services. Numerous barriers to mental health access have been identified. Moreover, the study revealed that patients experience mainly financial barriers that hinder them from accessing services. Many communities still stigmatise and label mental health patients because of lack of knowledge. This is because culture influences and shapes how people view the world around them. This includes how people perceive and react towards patients living with mental illness. Despite the challenges associated with patients receiving care, facilities were also found to lack adequate care, trained practitioners, infrastructure, and medications. A situation which compromises patient access to mental health services. Consequently, an interplay of these barriers leads to non-adherence or defaulting on medications by patients.

Service access barriers (or enablers) determine the willingness of patients to make use of mental health care services. With research studies showing the negative impact of patients' access to health care from WTMHP perceptions, the TDF theory has assisted in assessing and identifying factors that will enable patients' access to mental health services. It has assisted in developing practical ways that which if adopted, could help improve patient access to mental health services. This is particularly true for mental health facilities which participated in the present study. Additionally, the study indicated that the South African government should implement strategies to make mental health services more easily accessible while improving efforts to protect patient confidentiality and privacy. This includes online hotlines and free counselling services to people who do not want to be known. Mental health should become a normal conversation in communities to alter unhealthy cultural perceptions and stigmas around it. Communities should have campaigns and educational programmes to eradicate and bridge the paucity of knowledge regarding mental health. Moreover, the government should bridge the lack of skilled practitioners by funding practitioners' trainings, workshops and seminars that will be invested in educating and providing awareness to practitioners.

The study then provided ways of eliminating existing barriers and educating patients, the community and practitioners about mental health and how to transverse it. Mental health patients face many challenges in their communities and in hospitals. Patients shy away from seeking help because of fear of rejection, shame and ostracisation because of an illness they did not choose. Patients need support, compassion, understanding and education in this new society that views mental illness with shame, disgust, and ignorance. They face oppression, discrimination and prejudice as the media vilifies patients with an illness, they have no control over. Patients find courage and strength in families and from practitioners that endorse positive views and are advocates for mental health. The journey of this study had led to an honest exploration of views, perceptions, and stereotypes of patients with mental illness. Providing mental health practitioners with the necessary information about patients may help to deal with existing stereotypes.

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APPENDICES

Appendix 1: Interview guide

1. To establish what Western-trained mental health practitioners perceive as facilitators enabling clients' access to their services	a) What are reasons or factors that you think make clients to use your services or consult you? b) How do you think the identified factors motivate clients to continue using your services?
2. To determine what Western-trained mental health practitioners perceive as barriers that hinder clients' access to their services	(a) What do you perceive as barriers that hinder clients' access to your services?
	(b) How do you think the barriers particularly hinder clients' access to the services?

Appendix 2: Informed consent letter

Department of Psychology
University of Limpopo
Private Bag X1106
Sovenga
0727
Date _____

Dear participant

Thank you for showing interest in this study that focuses on Western-trained mental health practitioners' perceptions of clients' access to their services within Mashishing area. The purpose of this study is to explore Western-trained mental health practitioners' perceptions of patients' access to mental health services.

Your responses to this specific interview will remain strictly confidential. The researcher will not attempt to identify you (name) with your responses to the interview questions, or disclose your name as a participant in the study; instead the researcher will use pseudonyms or numbers. Please be warned that your participation in this study is voluntary and that you have the right to terminate your participation at any time you wish to do so. Kindly answer all the questions as frankly and honestly as possible. Your participation in this research is very important.

Thank you for your time

Yours Sincerely

_____ _____

Masters student Date

_____ _____

Supervisor Date

Appendix 3: Participants Informed Consent form

I _____ hereby agree to participate in a mini dissertation research project that is about Western-trained mental health practitioners' perceptions of clients' access to their services within Mashishing area.

The purpose of the study has been fully explained to me. Participation in this study is voluntary and I can withdraw from the study at any stage. I understand that this is an academic research project whose purpose is not necessarily to benefit me personally. I understand that access to records that pertain to my information in the study will be restricted to persons directly involved in the study, and that the information I give is important. The study is strictly confidential.

Signature: …….

Date: ……..

Appendix 4: Ethical clearance certificate from the University of Limpopo.

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE

ETHICS CLEARANCE CERTIFICATE

MEETING: 14 September 2021

PROJECT NUMBER: TREC/202/2021: PG

PROJECT:

Title:	Western-trained mental health practitioner's perception on patients' access to mental health care services in Lydenburg, Thaba Chweu district.
Researcher:	R Mokwena
Supervisor:	Dr MW Makgahlela
Co-Supervisor/s:	Prof T Sodi
	Dr MB Modipane
School:	Social Sciences
Degree:	Master of Arts in Clinical Psychology

PROF P MASOKO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: REC-0310111-031

Note:

i) This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.

ii) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.

iii) PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

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Appendix 5: Research permission letter from the department of health

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

Indwe Building, Government Boulevard, Riverside Park, Ext. 2, Mbombela, 1200, Mpumalanga Province
Private Bag X11285, Mbombela, 1200, Mpumalanga Province
Tel I: +27 (13) 766 3429, Fax: +27 (13) 766 3458

Litiko Letemphilo | Departement van Gesondheid | UmNyango WezeMaphilo

Enq: 013 766 3766
Ref: MP_202201_008

Research Permission Letter

Ms Rethabile Mokwena
P. O. BOX 4448
LYDENBURG, 1120

STUDY TITLE: ***WESTERN TRAINED MENTAL HEALTH PRACTITIONERS' PERCEPTIONS ON PATIENTS' ACCESS TO MENTAL HEALTH CARE SERVICES IN LYDENBURG, THABA CHWEU DISTRICT***

Dear Ms Mokwena

The Provincial Department of Health Research Committee has approved your research proposal in the latest format you sent, and hereby grant you permission to conduct your research as detailed below.

- Approval Reference Number: MP_202201_008
- Data Collection Period: 15 February 2022 to 30 December 2022

Approved Data Collection Facilities:

WENAKKER AND LYDENBURG HOSPITAL MENTAL HEALTH CARE FACILITIES

Kindly ensure that conditions mentioned below are adhered to, and that the study is conducted with minimal disruption and impact on our staff, and also ensure that you provide us with a soft or hard copy of the report once your research project has been completed.

Conditions:

- *Researchers not allowed to make copies or take pictures of medical records.*
- *Kindly notify the facility manager a week BEFORE you start with data collection to ensure that conditions are conducive in the facility.*
- *The FINAL RESEARCH FINDINGS must be uploaded on the NHRD website.*

Kind regards

DR C NELSON
MPUMALANGA PHRC CHAIRPERSON
DATE: 31/01/2022

MPUMALANGA
THE PLACE OF THE RISING SUN

Appendix 6: Turn-it-in Report

WESTERN-TRAINED MENTAL HEALTH PRACTITIONERS' PERCEPTIONS OF

ORIGINALITY REPORT

8%	7%	4%	3%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	ulspace.ul.ac.za Internet Source	2%
2	Submitted to Stadio Holdings Student Paper	1%
3	repository.up.ac.za Internet Source	1%
4	www.researchgate.net Internet Source	<1%
5	uir.unisa.ac.za Internet Source	<1%
6	1library.net Internet Source	<1%
7	ujcontent.uj.ac.za Internet Source	<1%
8	Submitted to King's College Student Paper	<1%
9	researchspace.ukzn.ac.za Internet Source	<1%

Appendice 7: Editorial letter

507 Caledon Village, Cell +27794848449, Email: kubayijoe @gmail.com

03 April 2023

Dear Ms Mokwena

SUBJECT: EDITING OF DISSERTATION

This is to certify that the dissertation entitled 'Western-trained mental health practitioners' perceptions of patients' access to mental health services in Thaba Chweu District' by Rethabile Mokwena has been copy-edited, and that unless further tampered with, I am content with the quality of the dissertation in terms of its adherence to editorial principles of consistency, cohesion, clarity of thought and precision.

Kind regards

Prof SJ Kubayi (DLitt et Phil)