CHALLENGES IN DEVELOPING AND INTEGRATING COMMUNITY CLINICAL PSYCHOLOGY SERVICES IN NON-URBAN AREAS OF KWAZULU-NATAL

Evy-Terressah Busisiwe Siyothula

Student number: 202511457

Supervisor: Professor Anthony L. Pillay

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DECLARATION

I, Evy-Terressah Busisiwe Siyothula declare that:

(i) The research reported in this dissertation, except where otherwise indicated, is my original work.

(ii) This dissertation has not been submitted for any degree or examination at any other university.

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Supervisor: [redacted] Date: 25 May 2023

Professor Anthony L. Pillay

DEDICATION

‘Courage is not the absence of fear but rather the judgment that something else is more important than fear’. James Neil Hollingworth

‘If God brings you to it, He will bring you through it’. Author unknown

To all my support network for being a safety net and voice of reason, especially when to me, giving up seemed like a sensible thing to do.

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LIST OF ABBREVIATIONS AND ACRONYMS

AMS: Air Mercy Services

BREC: Biomedical Research Ethics Committee

DOH: Department of Health

GBD: Global Burden of Diseases

GIS: Geographic Information System

HICs: High-Income Countries

HPCSA: Health Professions Council of South Africa

KZN: KwaZulu-Natal

LMICs: Low- and Middle-Income Countries

MDT: Multi-disciplinary team

MHCU: Mental health care user

PHC: Primary health care

PSYSSA: Psychological Society of South Africa

PWMI: People with mental illness

WHO: World Health Organization

UHC: Universal Health Coverage

UNICEF: United Nations Children's Fund

SPSS: Statistical Package for Social Sciences

DEFINITION OF TERMS

Primary Health Care

WHO and UNICEF (2021) define Primary Health Care as an inclusive approach to health care that aims to ensure high quality of health and well-being that is evenly distributed and focuses on people's needs very early in the quest for health promotion, and disease prevention, to treatment, rehabilitation and palliative care, as close as feasible to people's everyday environment.

Low- and Middle-Income Countries (LMIC)

The World Health Organization categorized member states into four income groups (low, lower-middle, upper-middle, and high). This classification is based on the income of the countries released annually by the World Bank and founded by the Atlas gross national income per capita estimates (WHO, 2020). South Africa falls under the LMIC category.

Mental Health

To capture the essence of mental health, the WHO states that there is no health without mental health, that mental health is a basic human right, and it forms an integral part of well-being. Galderisi et al. (2017), proposed a new definition of mental health that reflects the complexity of persons and highlights a dynamic state of internal balance that enables individuals to use their abilities in congruence with the universal values of society, display basic cognitive and social skills; ability to recognize, express and adjust one's emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles without compromising the harmonious relationship between the body and mind.

Mental health literacy

According to Jorm et al., (2012), mental health literacy goes beyond knowledge and beliefs about mental disorders that help in their recognition, management, or prevention, to include

knowledge that benefits the mental health of the individual or others, and developing efficient self-help strategies to manage or prevent less severe mental disorders.

Non-urban areas

Researchers highlight the difficulty of defining rurality. According to Vergunst (2018), this difficulty is influenced by the fact that different stakeholders use various aspects to define rurality, while others omit the term completely (Gaede & Versteeg, 2011). Likewise, South Africa has no standardised definition of rurality. Merriam-Webster (n.d.) dictionary defines non-urban as 'not of, relating to, characteristic of, or constituting a city, not urban. Urban and rural in the South African context consider the extremes of the spectrum and leave out areas that fall under semi-urban, semi-rural, peri-urban, and deep rural (among other terms used). Further, what 'rural' refers to in the context of South Africa and other LMICs is very different from what it refers to in other (especially Western) countries, given the minimal infrastructure and development. The term 'non-urban' is used in most published academic works to refer to this geographical context in South Africa (Duncan et al., 2007). Therefore, in this thesis, 'non-urban' refers to areas away from the city or the metropolitan areas, where the municipal infrastructure and services are sparse.

Community psychology

According to Edwards (1999), community psychology is a psychology by the people, for the people and with the people. Duncan et al. (2007) define community psychology as a branch of applied psychology concerned with understanding people in their community setting, using different interventions that include prevention, health promotion, and social action, to facilitate change and improved mental health and social conditions that go beyond the focus on the individuals and include groups, organisations and communities. Similarly, (Maseko et al., 2017), describe community psychology as understanding people [collectively] within their world and using that understanding to advance their well-being.

ABSTRACT

The World Health Organization continues to encourage the integration of mental health services into primary health care. Primary health care was identified as a means to facilitate community access to health services closer to where people live. In this thesis, the researcher explores the progress (or lack of progress) in developing and integrating community clinical psychology services in the non-urban areas of KwaZulu-Natal (KZN), South Africa, in response to the World Health Organization's call to invest in the integration of mental health services into primary health care. The integration of mental health services into primary health care in KZN was implemented from the year 2007. This study aimed to track the integration process of the clinical psychology services in the KZN non-urban areas, particularly, assessing the availability, accessibility and acceptability of services as indicators of the integration process in these contexts. The researcher explored the clinical psychology integration process from different perspectives. These include the distribution of clinical psychology services in non-urban areas of KZN and the clinical psychologist-population ratio; the experiences and views of clinical psychologists and health care providers working in non-urban areas; as well as the mental health knowledge and preferences of non-urban service users when they receive clinical psychology services. The format of the thesis is presented in the published articles and manuscripts ready for submission for publication. A mixed-method study design using quantitative and qualitative research approaches was utilised to provide a broader perspective of the process of integrating clinical psychology services in non-urban areas of KZN. The SPSS and content and thematic analysis were used to analyse the quantitative and qualitative data. Findings from the first three studies highlighted inequitable distribution and inadequate mental health resources, particularly focusing on clinical psychology services, between the urban and non-urban areas of KZN. Both the clinical psychologists and other health care providers expressed the need for training and access to information that empowers them to work confidently in resource-constrained settings. The fourth study highlighted service users' priority focus on receiving clinical psychology services with less concern over demographic preferences (in terms of the clinical psychologists' age, gender or language) when consulting clinical psychologists. The findings reflect that concerted efforts from health stakeholders are necessary to enhance the integration of clinical psychology services into mainstream health services in non-urban areas of KZN.

CHAPTER 1

INTRODUCTION

My journey to the present study

As I reached this stage of bringing together the pieces of this project, including positioning and repositioning my thoughts/ experiences of the very long journey of this thesis; my long-term mentor and supervisor Professor Anthony L. Pillay suggested that I should write an introductory section on my journey as a health care and community mental health care service provider. The purpose of this exercise was to contextualise how long it took me to be aware of clinical psychology as a profession and a mental health service also available to underserved communities in the past South African political context. I became perplexed and unsure of how to proceed. In my search for direction, I came across the article of Professor Chabani Manganyi; a legend and trendsetter who has lived to tell his story in one of his articles titled "On becoming a psychologist in apartheid South Africa" (Manganyi, 2013). In this article, Manganyi shares his reflections/experiences as the first Black clinical psychologist during the apartheid era and his subsequent professional trajectory as a clinician, a writer and an academic across different socio-political contexts locally and abroad. He describes an intellectual memoir as a form of writing within the family of studies and terms it 'life writing' (Manganyi, 2013, 278). He further describes the intellectual memoir as "more limited in its reach than a regular autobiography and a lens through which the history and development of one's academic and professional career can be examined while shedding light on the particular history of the discipline concerned" (Manganyi, 2013, p. 278-279). For me, this naming and description of an intellectual memoir articulated what I understood to be the task that Professor Pillay referred to and enabled me to formulate my professional journey as a clinical psychologist who straddled professions and South African political history, while also challenged and frustrated by the disparate health service distribution in the country.

I was among the first group of professional nurses who trained under the then-new dispensation of the integrated nursing qualification in nursing (general, community and psychiatry) and midwifery. This form of training was a watershed in nursing education from the previous traditional nurse training model that offered the general nurse qualification, and an additional

year for each post-basic course of community health nursing, psychiatric health nursing and midwifery. That meant that the previous 6-year training to attain these credentials was condensed to four years. Needless to say, this change sparked alienation / non-acceptance between the seniors and aspirant nurses. The new training model required adaptation and a paradigm shift in theoretical and practical training. While I do not want to claim that I know what informed this new nurse training model, in retrospect, I believe that it was aimed at aligning professional nurse training with the World Health Organization's (WHO) definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948).

While this definition of health has been criticized for constructing health as the absolute state of well-being and 'medicalizing' society (Sartorius, 2006), it captures the essence of well-being as not only judged by the physical aspect but highlights the mental and social aspects as equally important. The integrated nurse training exposed trainees to the multiple aspects of health, and I became very interested in mental health and community health care. This interest culminated in my pursuing a profession in mental health as a clinical psychologist. It is noteworthy to highlight that I gained adequate information about psychology as a career and accessed psychology resources during my training towards becoming a professional nurse. Pillay and Thwala (2012) documented a similar picture in their study that explored the preparedness of rural students from historically disadvantaged communities for psychology studies at university. They found that 48.1% of the students first heard about psychology upon entering a university, 75.7% had no access to books on the subject and only 44.6% received information from their school teachers about psychology as a career. It is disheartening to know that many years after the WHO included mental health as an important component of health in its definition, a significant percentage of previously disadvantaged university students in South Africa were unaware of the discipline. If this was the picture among the university students 18 years after the demise of apartheid, the picture must have been worse among the previously disadvantaged rural communities during apartheid which created and maintained a race-based system of unequal development.

My interest in community mental health grew when I was employed as one of the clinical psychologists working with community psychiatric nurses, as a team tasked with the

development of community clinical psychology services, particularly, in the previously disadvantaged, rural and remote areas of KwaZulu-Natal (KZN) where no such services existed. The psychiatric nurses provided services to the then stand-alone mental health services to support the local mental health services. They introduced the psychology team to the relevant stakeholders at the health facilities. My colleagues and I drove to different areas for needs assessment and to start monthly clinical psychology services in the communities where none existed. Joining the Air Mercy Services (The Red Cross flying doctor services) in partnership with the Department of Health enabled state-employed clinical psychologist teams from Pietermaritzburg to reach more non-urban areas in a shorter travel time. Pillay, Kometsi & Siyothula, (2009) documented the profile of patients seen in this programme at one of the sites. A similar approach was documented in outlying areas in Australia (Sutherland & Chur-Hansen, 2014). While this manner of clinical psychology service delivery is different from the traditional model, it is important to emphasize that without such monthly clinical psychology service, many non-urban areas of KZN did not have clinical psychology services. It is unfortunate that this itinerant service to the KZN non-urban areas ended in August 2020 due to the effects of the COVID-19 pandemic, but was also affected by funding difficulties.

The Department of Health in KZN responded to the WHO call to integrate mental health into PHC a few years after my initial involvement in the community mental health team. This new approach to mental health care service delivery brought about the dismantling of the stand-alone mental health services and moved the care of mental health care users (MHCUs) into primary health care (PHC) facilities. The MHCUs had to access their medications and follow-up services from their local PHC clinics. While this approach is sensible to ensure that MHCUs health care needs are addressed at one point of service delivery, with possibly less stigma, its implementation is not without challenges.

The WHO emphasized that integration is successful when mental health is incorporated into the health policy and legislative frameworks, and supported by senior leadership, adequate resources, and ongoing effective governance (WHO, 2008). In KZN and elsewhere, the successful integration, as depicted by the WHO, is far from meeting this standard. There are non-urban health districts that have only one clinical psychologist to cater to the mental health needs of a population of more than half a million (Siyothula, 2019). In some districts, there are

no clinical psychologists. Considering that clinical psychology sessions take about an hour, the need for follow-up sessions, and the number of patients who could be helped in a day, it is clear that clinical psychology services are currently far from adequate in non-urban areas. These contextual challenges inspired my effort to explore the challenges of developing and integrating community clinical psychology services in the non-urban communities of KZN. Four areas of focus shaped my thinking, namely, the distribution of community clinical psychology services, the views and experiences of clinical psychologists and other health professionals working in KZN non-urban areas, and the mental health knowledge and preferences of mental health care service users referred to clinical psychologists in KZN non-urban health districts.

Background to the study

Over the past two decades, the World Health Organization (WHO), international governments, regional health bodies such as the Pan American Health Organization, the European Union (EU) Council of Ministers, the World Federation of Mental Health, the Royal College of Psychiatrists, and researchers (Burns, 2010; Prince, et al., 2007; Saxena & Skeen, 2012; Uddin et al., 2019; Vergunst, 2018; Wainberg et al., 2017a; WHO & World Organisation of Family Doctors [WONCA], 2008; WHO, 2013) have intensified efforts to raise awareness of the impact of mental health on the global burden of disease. The WHO stated that there is "no health without mental health"; a slogan that continues to gain significant support through research-based evidence (Prince et al., 2007; Saxena & Skeen, 2012). Research indicates that mental health plays a pivotal role in realizing optimal health goals (Burns, 2010; Prince et al., 2007; Saxena & Skeen, 2012; WHO, 2013). The documented research evidence unpacks the impact of mental illness on the global burden of disease which is not only limited to health but also affects economic and social development worldwide.

Access to mental health services for all citizens remains a major challenge in low and middle-income countries including South Africa. However, there is limited mental health service provision to communities living in non-urban areas, the majority of whom are black and poor (Ahmed & Pillay, 2004; Mkhize & Kometsi, 2008). Furthermore, those who do receive psychological services are likely to be served by someone who does not speak their language. This continues to pose a challenge for service users to utilize and optimally benefit from these

services (Ruanne, 2010). The provision of mental health care at the primary health care level has been slow, unevenly distributed between urban and non-urban communities, and continues to face multiple challenges. As a result, clinical psychology services are often misunderstood and not readily accepted by both service users and other service providers. Where available, under-utilization, unrealistic expectations and inappropriate referrals are commonplace.

Although there is much research on mental health, there is limited research on access, provision and utilisation of services in non-urban areas in countries like South Africa. The present research seeks to explore the challenges in developing and integrating mental health services in non-urban communities in KZN. Further, it seeks to address the gap in current research and the provision of mental health services across geographic and economic divides. This is important because past research shows that, there are persistent inequalities in the provision of mental health care services, particularly in non-urban areas (Ahmed & Pillay, 2004; Burns, 2010; Mkhize & Kometsi, 2008; Ruanne, 2010), impeding the effective treatment of mental illness. Jorm et al. (1997) identified mental health literacy as an important component of mental health care. They defined mental health literacy as knowledge, attitudes and beliefs about mental disorders that aid their recognition, management and/or prevention. It also involves accurate information seeking and influences help-seeking behaviour. Mental health literacy further incorporates awareness of risk factors and causes of self-treatment and non-treatment of mental disorders (Jorm et al, 1997). Mental health literacy is a significant concern in poorer communities, and Kometsi (2016) noted this in South Africa as well.

Statement of the problem

According to Morena & Sousa (2021), mental illness accounts for about one-third of the world's burden of diseases and many health systems struggle to adequately meet this health demand. They further note that 70% of mental health care users receive their follow-up care in primary health care (PHC) settings. However, PHC settings, especially in Sub-Saharan countries are not fully resourced to meet the mental health care demands, thus exacerbating the mental health treatment gap (WHO, 2010). The treatment gap between the available mental health care services and the number of people needing care is well documented (De Kock & Pillay, 2017, Stein, 2014, Vergunst, 2018). The World Health Organization has promoted the mhGAP (WHO, 2010) as a guide to address the problem, but various countries developed their

own context-specific and evidence-based interventions (Morena & Sousa, 2021). However, implementation challenges persist to varying degrees across the globe. With the advent of South African democracy in 1994, the previously marginalised and disadvantaged majority of black South Africans looked forward to an era that considered and upheld their human rights. They hoped for economic and political emancipation from a period that did not promote equal development among its citizens (Pillay, Kometsi & Siyothula, 2009). However, most continue to experience the repercussions of the past. Basic services remain unequally distributed between black and white communities, and between urban and non-urban communities, with the economic gap between the rich and the poor continuing to widen (Pillay, Ahmed & Bawa, 2013). The World Bank report also noted South Africa to be the world's most unequal country (Sulla et al., 2022).

The President of the country, in his 2012 state of the nation address, alluded to the persistence of what he called the 'triple challenges' (poverty, inequality and unemployment) faced by the government; which continue to deter the dream of political and economic liberation (Zuma, 2012). Burns (2010) documented risk factors for mental illness in KZN which include poverty, inequality, unemployment and the high incidence of HIV/AIDS. The province of KZN is the second largest province in South Africa, described as one of the predominantly non-urban provinces with the majority of the population in non-urban areas (Statistics South Africa, 2011), and "home to many black South Africans" (Mkhize & Kometsi, 2008, p, 104). However, the national census (2011) indicated the difficulty of clear-cut urban-rural percentages due to the readjustment of boundaries and free movement of people between urban and rural settings. Also, according to the cited literature, the definition of 'rural' is rather complex. Hence, the term 'non-urban' is more widely accepted and used in academic works as an umbrella term that accommodates the various levels of 'rurality' (Vergunst, 2018), which is why the term 'non-urban' is used in this thesis.

Against this background, the availability and access to mental health services in KZN non-urban communities is a serious concern. Further, research has also established that the successful management of diseases, like HIV/AIDS, tuberculosis and others, depends on the effective management of mental health problems. Therefore, this makes KZN a high-risk area, not only for mental health concerns, but also for other significant health problems which require

high motivation and adherence to treatment for optimal control (Burns, 2011, Flisher, 2010, Prince et al., 2007; WHO, 2008). Effective mental health service delivery is dependent on a collaborative approach between the members of the multidisciplinary team and relevant stakeholders e.g. the departments of social development and education. Although the KZN Department of Health has classified the cadre of clinical psychologists as one of the scarce skills, and there are many newly qualified clinical psychologists seeking employment, a large proportion of the population in non-urban areas does not receive adequate mental health care. It is envisaged that examining the distribution of the cadre of clinical psychologists as members of the multidisciplinary team will identify:

- the need for clinical psychology services in the province,
- the needs, experiences and expectations of clinical psychologists, health care providers, and,
- the needs, views and expectations of mental healthcare users.

The WHO (2008a) proposed the task-shifting approach (which refers to skills transfer to trained non-specialist staff with the support and supervision of specialists) as a means of alleviating human resource shortages aimed at optimizing the delivery of health services in under-resourced areas. Joska & Sorsdahl (2012), Petersen et al. (2009), Sorsdahl, Stein & Lund (2012) and Tomlinson et al. (2009) also supported task shifting to provide basic psychological services as a viable means to address the scarcity of mental health service providers in non-urban areas. While this suggestion carries a plausible potential to relieve human resource constraints; there is a paucity of research that examines: (1) the distribution of mental health services in non-urban areas of KZN, (2) the needs, experiences and expectations of clinical psychologists and health care providers who refer patients for psychology services, and (3) the needs, experiences and preferences of mental health care users. Further, the proposed skills transfer is threatened by the scarcity of trained professionals to support and supervise the non-professional staff. The proposed study intends to gather the information that will inform the delivery of clinical psychology services in non-urban communities of KZN, explore the challenges faced by mental health care service providers and service users, identify knowledge gaps, and aid in enhancing clinical psychology services that will be relevant to the needs of non-urban communities, thus contributing to optimal provision and utilization of services.

Rationale for the study

South Africa's response to the global discourse on poor investment in mental health care has seen the development of the comprehensive Mental Health Care Act (no 17 of 2002) and the 2013-2020 National Mental Health Framework. However, implementation of these milestones has not followed the expected momentum (Mulutsi, 2017; Ramlal, 2012; Szabo & Kaliski, 2017). Inequitable distribution of resources, insufficient human resource and infrastructure are among the factors that have fuelled unavailability, inaccessibility and minimal relevance of mental health services to meet the needs of all South Africans, especially the underserved non-urban communities (De Kock & Pillay, 2017; Docrat et al., 2019; Morgan, 2015; Siyothula, 2019; Vergunst, 2018). While the importance of the availability, accessibility and relevance of mental health services is well documented (Schierenbeck et al., 2013; Stein, 2014), the voices and experiences of service providers, service users and their service preferences of clinical psychology at the community level are missing. By exploring and documenting these aspects of mental health service delivery, it is hoped that important insights will be gained by the relevant stakeholders and contribute to enhancing the implementation of the South African mental health legislation and policy framework and advance their implementation to benefit all South Africans.

Research aim

This study aims to examine the availability, accessibility and acceptability of clinical psychology services in non-urban areas of KZN, as well as mental health awareness (mental health literacy), service utilization, and the needs and expectations of service users and general health care providers in those areas.

Objectives of the study

- To examine the distribution of public mental health services that offer clinical psychology services in non–urban communities of KwaZulu-Natal.
- To examine experiences and challenges faced by clinical psychologists working in the non-urban public hospital settings of KZN.
- To explore the referral agents'/sources' (i.e. general medical doctors, nurses, social workers and occupational therapists) awareness of mental health problems and available clinical psychology services.

- To examine referral sources' needs and expectations, their challenges and experiences when referring patients for clinical psychology services.
- To examine non-urban patients' awareness of mental health problems and attitudes toward clinical psychology services as well as their preferences during clinical psychology consultation.

Research Questions

1. What is the distribution (ratio of clinical psychology services to the population) of clinical psychology services in the non-urban health facilities of KwaZulu-Natal (KZN)?
2. What are the experiences and challenges faced by the clinical psychologists working in the non-urban areas of KZN?
3. What is the referral sources' awareness of the presentation of mental health problems and available clinical psychology services in the non-urban areas of KZN?
4. What are the referral sources' understanding of the role of clinical psychologists?
5. What is the level of mental health awareness/ literacy and understanding of mental health problems and attitudes regarding clinical psychology services in the non-urban communities of KwaZulu-Natal?

Outline of the methodology

A mixed-methods approach was used in this study. Creswell (2007) advocates for the mixed research methods to acquire a context-specific inquiry and explanation of the results of the research problem. This approach aimed at capturing the experiences and perspectives of participants in the three groups, namely; (i) clinical psychologists working in non-urban contexts of KZN, (ii) referral agents i.e. general health care providers who refer (or would like to refer) service users to clinical psychologists, and (iii) service users referred to clinical psychologists. Utilizing the mixed-method approach gave participants an opportunity to elaborate on their quantitative responses to enrich the understanding of their perceptions of and attitudes to the clinical psychology services in non-urban areas of KZN. The data collection research questionnaires were developed by the researcher under the guidance of the supervisor to target specific contextual information from participants for the purpose of this research. They

covered the participants' demographics, preparedness and competency to work in resource-constrained settings, participants' appraisal of the non-urban working environment and service users' mental health knowledge and their views/attitudes towards clinical psychology services. Their preferences were explored in the following areas: the age, gender, race and language of the consulting clinical psychologist. All participants were adults and participation was voluntary.

The published papers and submitted manuscripts that form the subsequent chapters of this thesis include detailed sections covering the methods, sampling, data collection instruments and data analysis. Relevant literature reviews, results, discussion of results, study limitations, and conclusions with recommendations are also presented for each published article and submitted manuscript.

Significance of the study

The results of this study have implications in the following areas:

- Distribution of non-urban clinical psychology services in KZN: The intention of this aspect of the study is to document the inequity in the distribution of clinical psychology services, which can assist the Department of Health (DOH) to bridge the service provision gap between urban and non-urban areas. This will also help government address the constitutional requirements of the country with respect to equity, redress and basic health services for all. By creating more clinical psychology positions, the clinical psychology/population ratio imbalance could be addressed and the mental health service coverage in these settings could be improved. This aspect of the study addresses the first objective of the study and is presented in the published paper in Chapter 4. The KZN Provincial Department of Health Geographic Information System (GIS) was consulted for the information on the health districts' population and the distribution of state-employed clinical psychologists throughout the province. This included community service clinical psychologists, who are recently qualified practitioners who are required to undertake one year's service in a government health facility before being allowed to practice independently.
- The experiences and views of clinical psychologists working in non-urban areas of KZN are presented in chapter 5. This chapter outlines the work, training and related experiences of clinical psychologists in KZN non-urban settings. This chapter also

explored the preparedness of clinical psychologists to work in resource-constrained settings such as rural communities. Clinical psychologists were interviewed about the extent to which their training prepared them to work in non-urban areas with minimal resources. The study also investigated whether clinical psychologists felt that other health professional and service users understood their role in the public health care sector. Gaining information in these focus areas will assist in adapting the clinical psychology training models to equip clinical psychologists with competencies to meet the needs of the country and the populations they serve.

- Chapter 6 presents the experiences and views of health care professionals who refer patients to clinical psychologists. Their understanding of clinical psychology services and mental health needs of their patients was assessed. This information was intended to identify possible knowledge gaps in the training of other health professionals such as medical doctors, nurses, social workers, etc. which obviously influences their understanding of the mental health needs of their patients and how these could be addressed to ensure optimal service delivery. Also, this information impacts whether patients are appropriately referred for mental health interventions.
- Results of the investigation into the awareness of mental health problems among service users', and their views and attitudes regarding clinical psychology services, are presented in chapter 7. This study also assessed participants' understanding of the role of the clinical psychologists and their practitioner preferences with respect to age, race, gender and language. Considering that the vast majority of people living in non-urban KZN are black and first-language IsiZulu-speakers, while most clinical psychologists in South Africa are white and do not have this language proficiency, this is a serious mental health service concern (Pillay & Nyandeni, 2021; Pillay & Siyothula, 2008). It is expected that this information will aid the DOH to identify areas that require support to address the challenges experienced by service providers, enhance the understanding of the service users' mental health needs, and assess challenges that impact the progress of the integration of mental health services to the PHC.

Literature search

The literature search included web-based search engines to locate peer-reviewed journal articles and grey literature. In addition to Google Scholar, the following academic databases

were also used: EBSCOhost, Medline, PubMed and PsychInfo. The following search words and phrases were used: clinical psychology; community; experiences of rural psychologists; mental health care; mental health services; non-urban; non-urban psychologists, mental health care; patients' preferences; rural; rural mental health services.

Overview of thesis

This thesis has 8 chapters. Chapter 1 is an introductory chapter that presents an outline of the study. Chapter 2 presents an overview of the relevant literature. Chapter 3 outlines the methodology of the study. Chapter 4 addresses the distribution of clinical psychology services in non-urban areas of KZN. The paper was published in the *South African Journal of Psychology*. Chapters 5 presents the views and experiences of clinical psychologists working in non-urban areas of KZN. The paper was also published in the *South African Journal of Psychology*. Chapter 6 presents findings of the experiences of health professionals who refer mental health service users for clinical psychology services and Chapter 7 presents the service users' views and preferences of clinical psychology services in non-urban areas of KZN. Both Chapters 6 and 7 are the manuscripts submitted to academic journals for publication. Chapter 8 synthesises all of the findings in a composite discussion and conclusion, and further presents the study limitations and proposals for future research and measures to address mental health and clinical psychology service challenges in the non-urban areas in KZN, South Africa.

On a technical note, since this thesis is a PhD by manuscripts in accordance with the University of KwaZulu-Natal; the referencing format is as follows:

a) References for published articles and unpublished manuscripts follow at the end of these articles.
b) The references for the rest of the contents of this written work is at the end of the document.

Conclusion

Chapter 1 outlined the author's personal journey, the background to the study and the statement of the problem relating to the under-provision of clinical psychology services in the non-urban areas of KwaZulu-Natal. The chapter further outlined the research aim, the objectives of the

study, an introduction to the methodology and an overview of the thesis. The literature review is presented in Chapter 2 and provides a theoretical and research context for the thesis.

CHAPTER 2

LITERATURE REVIEW

Introduction

Attainment of optimal health for all remains a global concern. The WHO, as the driving force behind the optimal attainment of health, continues to call for a holistic view of health and encourages concerted efforts toward its fruition (WHO, 2013). In its constitution, the WHO defines health as the state of complete physical, mental and social well-being which is not limited to the absence of disease or susceptibility to illness. This widely encompassing definition is an illustration that all three aspects of health are important if optimal health is to be attained. This view further clarifies that merely the absence of disease or illness cannot be assumed to be an attainment of optimal health (Saxena & Skeen, 2012). It is therefore not surprising that persistent consideration of only the physical over the mental and social aspects of well-being has failed to satisfy the WHO and the research community that the goal of optimal global health will be realized, hence the call to pay equal attention to all three aspects of health. Failure to pay equal attention to health's physical, mental and social dimensions opens the global community to stunted and imbalanced health care systems. The impact of mental disorders on the global burden of disease is well documented, with earlier research stating that 13-14% is attributed to neuropsychiatric disorders (Burns, 2010; Prince et al., 2007; Saxena & Skeen, 2012). Furthermore, the WHO report states that "neurological and substance use disorders account for nine (9) of twenty (20) leading causes of years lived with disability and 10% of the global burden of disease" (WHO, 2013, p. 7). Recent research states that 7% of the global burden of disease as measured in the Disability-Adjusted-Life-Years (DALYs) and 19% of years lived with disability is attributed to mental and addictive disorders (Rehm & Shield, 2019). These authors also propose that future research should provide a better analysis of the role of mental and addictive disorders in the shifts in life expectancy. The above statistics indicate a worrying increase in the impact of addictive, mental, neurological and substance use disorders on the global burden of disease.

The disabling effects of mental disorders are not confined to the disease itself but also aggravate the sufferers' inability to assess risk, impaired impulse control of risky behaviours, compromised self-care and help-seeking behaviours. Furthermore, discrimination by the

health care system and society whereby mental health care users do not receive the same quality of care as the general population with physical health care needs is equally concerning (Saxena, Thornicroft, Knapp & Whiteford, 2007). These factors are believed to worsen the plight of mental health care users compared to the general population as demonstrated by the documented impact of mental disorders on the global burden of disease and poor management and control of manageable health problems (Burns, 2010; Saxena et al., 2007).

Despite the documented impact of mental disorders on global health; researchers argue that mental health is not given due consideration as a global economic and human rights issue (Ahmed & Pillay, 2004; Burns, 2010; Matthers & Loncar, 2006; Prince et al., 2007; Saxena & Skeen, 2012; WHO, 2005; WHO, 2013). The WHO called for investing in mental health and highlighted the benefits of prioritizing mental health in its effort to illustrate the pervasiveness and severity of the impact of mental disorders on health, education and social spheres (WHO, 2013). Further, the global mental health forum, the WHO reports, and other researchers have explicitly linked mental health and the millennium development goals (MDGs). They argued that the exclusion (which they call a serious oversight) of mental health in the millennium development goals poses a direct threat to the global community's efforts to address some of the social ills stated in the millennium goals (Burns, 2010; Prince et al., 2007; Tsai & Tomlinson, 2015; Whiteford et al., 2013; WHO, 2005).

More than four decades ago the Alma Ata declaration indicated that health is a basic human right and identified comprehensive primary health care (PHC) as the main health care approach through which the WHO's efforts to attain holistic health for the global community could be realized (Kigozi, 2007; Mkhize & Kometsi, 2008). Saint-Pierre et al. (2018) define collaboration in the health care context as a process of problem-solving, shared responsibility for decision making and the ability to carry out care plans while working towards a common goal. Similarly, Janssen et al. (2020) define collaborative care as an interdisciplinary health care approach on a spectrum of parallel care to collaborative networking. According to Janssen et al. (2020), parallel care refers to a referral process with minimal overlap of services, whilst collaborative networking is a non-hierarchical, co-provision of patient care and the intentional inclusion of family, educators, and/or community in the healthcare process. Further, these authors emphasize the importance of incorporating collaborative

competency among doctors in their training. They identified six main themes within the collaborative competency domain, namely, patient-centred care, a common concern, a collaborative attitude, respect, clearly defined roles and responsibilities, mutual knowledge and understanding, communication and leadership. They consider these themes important for the smooth collaboration between different healthcare tiers. It could benefit the health sector to extend the collaborative competency as explained by Janssen et al. (2020) to all members of the MDT and the relevant stakeholders.

The involvement of all stakeholders with a common interest in the outcome of healthcare is necessary to achieve optimal health care and a means to eliminate stakeholders working against each other. While (Alderwick et al., 2021) did not find convincing positive results of collaboration between stakeholders in healthcare, they propose that local collaborations should be understood within their broader political context, together with other interventions and factors that interact to shape population health. Therefore, collaboration should be viewed as a means to orientate stakeholders about the objectives and the reasons for the existence of each resource in the population, and how each can contribute to the common population benefit.

The PHC approach invests in a collaborative relationship between healthcare users and healthcare providers that allows users and their support network to be involved in their healthcare (Alderwick et al., 2021; Bruner et al., 2011; Janssen et al., 2020; Saint-Pierre et al., 2018) Further, inter-sectoral collaboration across different divisions of government (formal and informal) healthcare sectors is strongly encouraged, and considered to be an efficient healthcare approach (Kriegner et al., 2021; Petersen et al., 2011) This is an evolutionary development from the previous hospital-based care which relied on health care workers in the hospital setting as the 'experts' and main role players in health care. Bruner et al. (2011) support the implementation of changes in models of health care to meet the needs of diverse, and underserved patient populations. They also argue that collaboration among providers is one way to promote accessible, comprehensive and continuous care in healthcare organizations. It is worth noting that PHC is a health care approach that also promotes the involvement of the community in health care and is regarded as the key factor in promoting access to health (Petersen & Lund, 2011; WHO, 2001; WHO, 2013). The WHO's call for the return to the Alma Ata declaration continues to firmly position PHC at the centre, as a means of realizing optimal

health care (WHO, 2008). However, PHC itself has not been without challenges. PHC continues to face numerous barriers which include, poor infrastructure, inequity in the distribution and quality of services between state-run health facilities and the private sector, inadequate human resources, inaccessibility of health care services on a geographical basis; as well as difficulties in meeting the unique needs of non-urban, under-resourced, communities (De Kock & Pillay, 2017; Docrat et al., 2019; Siyothula, 2019; Vergunst, 2018). Services which consider as dominant, the world view of advantaged communities, lack relevance, and this must be recognised in planning considerations. The barriers listed above; are reported to affect both high-income and middle to low-income countries to varying degrees; with the latter being the hardest hit (Burns, 2009; Kigozi, 2007; Mkhize & Kometsi, 2008; Peiris, Brown & Cass, 2008; Petersen & Lund, 2011; Saxena et al; 2007; Sebunnya et al., 2010; Smith et al., 2013; Szabo, 2013; WHO, 2008).

Integration of mental health services into PHC

Historically mental health as a specialised aspect of health care was considered a tertiary level service. As a result, mental health services were (and continue to be) centralized in metropolitan areas leaving the remote, non-urban areas devoid of these services (De Kock & Pillay, 2017; Docrat et al., 2019; Pillay et al., 2009; Siyothula, 2019; Vergunst, 2018). On the African continent; unequal distribution of services was largely economy-based, whilst in South Africa, the apartheid regime endorsed division and inequality on a racial basis as well (Burns, 2009; Mkhize & Kometsi, 2008; Lazarus, 2005). However, support for the integration of mental health care into primary health care services, as initially proposed by the Alma Ata declaration, persists in the mental health discourse (Kigozi, 2007; Rifkin, 2018)

The support for the integration of mental health services was motivated by the strong research-based evidence which confirmed a link between mental health and other physical health concerns; and that successful management of these health concerns is dependent on effective management of mental illness (Burns, 2011; Flisher, 2010; Prince et al., 2007; WHO, 2008). However, the development and integration of mental health care services into PHC remain a challenge on a global scale, but considerably more so in poorer countries (Burns, 2009; Kigozi, 2007; Mkhize & Kometsi, 2008; Peiris, Brown & Cass, 2008; Petersen & Lund, 2011, Saxena

et al., 2007; Smith et al, 2013; Ssebunya et al., 2010; Szabo, 2013; WHO, 2008). This challenge is aggravated by multiple factors. Inadequate funding for mental health, insufficient resources, limited public awareness regarding mental health, insufficient training and supervision of PHC staff to diagnose and treat mental disorders, and reluctance to work with people with mental illness impact the integration of services into PHC. In addition, Peiris et al., (2008) called for collaborative interaction between indigenous knowledge systems and science to promote and strengthen relevant, safe, and accepted interventions by service users and service providers. They propose that an inclusive rather than exclusive service can promote service utilization and move beyond culture and science boundaries.

The treatment gap in mental health care

Flisher (2010) pointed out that many African countries do not have mental health policies, and even the existing ones are outdated and not informed by research linking mental illness and poverty. Furthermore, he argued that the existing treatment gap between those in need of treatment and those who receive treatment can be breached by developing and implementing relevant mental health policies. Similarly, (Lund, 2010) documented findings from the MHaPP consortium on the state of mental health in Ghana, South Africa, Uganda and Zambia that highlight multiple barriers to optimal mental healthcare in these African countries. The study findings propose valuable recommendations for addressing the identified barriers which include resource constraints, human rights violations, disjointed healthcare systems, exclusion of accessible and affordable local traditional resources and gender disparities that perpetuate women's vulnerability to mental illness. These views support the assertion that inadequate political support and collaboration between the stakeholders within and beyond health care maintain the barriers to accessing health services and undermine efforts toward the desired universal, equitable and comprehensive health care status envisioned by the World Health Organization (Lund, 2010; WHO, 2013).

In September 2013 the South African Department of Health released the national health policy framework and strategic plan 2013-2020 after consultation and collaboration with the relevant stakeholders. This document reflects the commitment of the South African National Department of Health to further transforming mental health services and setting the momentum

in achieving accessible, equitable, comprehensive and integrated mental health services at all levels. It further acknowledges the role of mental health as a precursor to optimal health and the existence of challenges that require attention (Department of Health Republic of South Africa 2013). While this is a move in the right direction; implementation of the proposed strategies, remains to be seen.

Culture and mental health

The intersection of culture and mental health has dominated the global health discourse for many years. This has intensified in recent years due to globalization and the recognition of cultural influences in mental health presentations and treatment (Johnston, 2019). Healthcare providers are challenged more than before as they are increasingly faced with the reality of serving diverse populations and the need to develop culture-sensitive competencies to meet the increasing and complex healthcare needs of diverse populations (Tribe & Thompson, 2017). Tribe (2005) describes culture as a multi-faceted concept encompassing gender, class, religion, language and nationality, among other variables. She further notes that different cultures have specific worldviews that underpin how they approach life and explain their life events, and that these different vantage points impact their lives. For example, Western cultures tend to focus on the individual, while African cultures tend to focus on the familial, community and societal worldviews. As globalization takes the central position in human existence in this era, health care providers, particularly in the mental health sector should be culturally sensitive, understanding of diverse cultures and the impact of culture on the clients they serve. Fernando (2014), states that a monocultural understanding of mental health could pose challenges when applied blindly to non-western cultural contexts without a clear understanding of the complexity of trans-cultural work. Further, Tribe (2005) asserts that cultural diversity worldwide, significantly impacts many aspects of mental health, with the cultural impact ranging from how specific cultures perceive health and illness, to health-seeking behaviour, and attitudes of health practitioners and the mental health systems. According to Hernandez et al., (2009), culture defines what is considered to be a problem and the preferred solutions to the problem.

Given the significant influence of culture on health, including mental health, health care providers should be always cognisant of the pertinent role of culture on health especially in multicultural societies, like South Africa. In mental health care, language plays a significant role in articulating mental health concerns that impact functioning on different levels. Further, language is the pillar of the therapeutic interventions that take place in an interpersonal space, where both verbalised and observed communication orientate the service provider to the service users' context and clinical presentation. The understanding gained through communication enables service providers to assess, diagnose and formulate interventions aimed at ameliorating the symptoms of concern. Language discordance in health care poses a 'double barrier' to the effectiveness of health care. To the service user, it interferes with access to services (Rackers, 2018) and isolates the service user in need of care; to the health care provider, it threatens an accurate assessment of the presenting problem, optimal service delivery and the providers' confidence in the rendered health care. Similarly, according to Tribe (2007, 160), "*the experience of being unable to express oneself verbally can be a frightening and disempowering experience for anyone*". This should be understood in the context of Kleinman's Explanatory Model of illness which highlights the significant problems that can arise in the management of health problems when there is discordance between patients' experience of their illness and the meanings they hold and the clinician's understanding of the problem (Kleinman, et al., 1978).

In language-discordant contexts, Tribe (2007), advocates a bicultural interpreter who is capable of offering linguistic and cultural meanings to augment the provider's understanding of a client's clinical presentation and worldview. It is, however, important to be mindful of the reality that language concordance does not always mean culture concordance. Belief systems to which one ascribes, socio-economic status, and level of education are among the variables that could impact cultural concordance even among individuals of the same social group. To illustrate this, (Chipps et al., 2008, 93) noted that *"most health care professionals (including African health care professionals) have been trained in Western traditions of helping"*. Therefore, intentional cultural competence as proposed by (Matthews & Van Wyk, 2018) remains pivotal in working with clients from diverse cultures. The same is necessary for mental health care providers, particularly in the South African non-urban context where the health care sector relies on nurses and assistance from language-concordant volunteers or co-workers who are untrained interpreters, to facilitate communication between the majority of health care

providers and their clients (Chipps et al., 2008). This is also due to the large proportion of the health care workforce not being proficient in the languages of their patients (Al Shamsi et al., 2020).

Non-urban health care providers' views of mental health services and referrals

Most non-urban communities in low- and middle-income countries (LMICs) carry a significant burden of mental illness, especially considering the adversities they experience (Burns, 2010; De Kock & Pillay, 2017). However, there is simultaneously a substantial treatment gap between the burden of mental illness, and available mental health care resources in these communities (Burns, 2010; De Kock & Pillay, 2017; Stein, 2014; WHO, 2018). According to Sawadogo et al., (2020), between 76% to 85% of people with severe mental disorders in LMICs do not receive any form of mental health intervention. Stein (2014) also found that 75% of people with common mental disorders (e.g. depression, anxiety and substance abuse) in South Africa do not receive treatment. Furthermore, Statistics South Africa (2017) estimates the poverty rate to be about 81.3% in non-urban areas compared to 40.7% in urban areas. The high rate of poverty could add to the high treatment gap, as mental health needs are likely to be displaced in the prioritising of needs. According to De Kock and Pillay (2017), the treatment gap in KwaZulu-Natal is approximately 75% to 85% and more than one-third (40-45%) of the non-urban South African population reside in areas where resources are scarce and unevenly distributed (De Kock & Pillay, 2017; Morgan, 2015; Siyothula, 2019)

The perceptions of primary health care service providers and patients regarding mental health services affect the widening/narrowing of the gap between service provision and disease burden (Maimela et al., 2015). Furthermore, whether patients are referred for mental health interventions and whether the referred patients accept mental health referrals depend on the experience and attitudes of primary healthcare practitioners. As a result, reaching patients in need of mental health treatments is a complex process that depends on the accessibility and availability of services, as well as the experiences and views of the referring health service providers.

A multidisciplinary approach to mental health care is essential for the effective management of mental illness. The multifaceted manifestation of mental health problems necessitates a wide

range of expertise and competencies from a multidisciplinary team (MDT). As a result, a healthy and functional relationship within the MDT is advantageous for optimal service delivery. Primary health care providers, such as doctors and nurses, are the first point of contact for service users in need of health care. According to Ashcroft, Kourgiantakis, and Brown (2017), there is evidence to support the value of a collaborative care approach from medical and non-medical professionals in managing the mental health needs of diverse populations and contexts.

Health professionals' perceptions are not only pertinent to patient referrals to mental health specialists such as psychologists, but they also determine the motivation of the referral, whether the referral benefits the patient or the referral is a means to 'dispose of' patients who could not be helped by biomedical interventions. Further, researchers have warned that patients sense the negative perceptions of health professionals toward them or their mental illness (Cabassa et al., 2014; Smith, Mittal, Chekuri, Han, & Sullivan, 2017), and this attitude can influence the patient's level of commitment to mental health care and the prescribed intervention strategies. Therefore, encouraging a positive attitude to mental health services is necessary to set a positive tone for service users' perceptions and acceptance of mental health care. According to Dube and Uys (2016), most nurses in primary health care (PHC) are unable to identify mental illness. They noted that being a health care provider does not guarantee adequate knowledge or a positive attitude towards mental illness. Therefore, examining health professionals' understanding and perceptions of mental health services and mental health care users (MHCUs) is critical in determining and planning the way forward for mental health services.

Furthermore, mentally ill patients experience stigma from multiple sources (Li et al., 2014; Mosaku & Wallymahmed, 2017). Similarly, mental health care providers may also experience discrimination from colleagues in general health care because of their passion and preference to serve people with mental illness. Sawadogo et al. (2020) argue that health professionals are not exempt from traditional beliefs, prejudices, and negative attitudes towards MHCUs. These constitute additional barriers to mental health care access, and they may predispose young health professionals to negative attitudes and stigmatizing patients with mental illness (PWMI) (Kato et al., 2013). Considering the high incidence of mental disorders and that the WHO advocates integrating mental health into PHC (WHO, 2018), every health professional is likely to encounter patients with mental illness. As such, they should be able to identify and refer PWMI timeously and appropriately. Hence, health professionals' training should invest in

understanding mental health and mental illness to optimise holistic patient care and access to available mental health services. Triplet (2017) found that, in Australia, even in professions closely tied to mental health care, such as social work, only 45% of training schools offer a mental health class and specific mental health skills development. Therefore, Triplett (2017) recommended that focus on the local context and clear links to field education could improve social workers' mental health curriculum. This should be extended to the training of all health professionals, as it can serve to enhance practitioner confidence and competency in dealing with mental health issues.

The proposal to incorporate mental health care into PHC is a global drive (WHO, 2018). However, issues that maintain access to mental health services persist. For example, the number of clinical psychologists is limited in PHC and especially non-urban settings, despite the documented high incidence of mental health problems presenting at that level, and that the majority of those in need of care are unable to access mental health services (De Kock & Pillay, 2017). Issues like poor infrastructure, human resource constraints, and inequitable distribution of services, as well as access challenges and diversity of non-urban communities, are among the nodal points that mark rurality (DeAngelis, 2016). These severely impact the mental health care service use by patients and referring health care providers, as well as the service delivery by mental health care specialists like clinical psychologists (DeAngelis, 2016; Sutherland & Chur-Hansen, 2014). Due to the comorbidity of physical symptoms, mental health problems, and psychosocial stressors in patients presenting at PHC, primary health care professionals play a significant role in identifying and treating patients needing care, and in referring more complex cases to mental health specialists (Haftgoli et al., 2010; WHO, 2018).

Mental health care users' preferences regarding service use

The medical mental health model does not offer service users enough control or choice in different aspects of their mental health care (Rackers, 2018). The issue of limited control and choice is mostly prevalent in resource-constrained settings like South African non-urban areas. This has its roots in the apartheid system that promoted separate development and unequal distribution of resources along racial and geographical lines. Despite the demise of apartheid, these legacies and divisions persist and extend to gender, class, health, education and economic inequality (De Kock & Pillay, 2017; Mathews & Van Wyk, 2018; Siyothula, 2019; Vergunst, 2018). Further, according to Rackers (2018), race and gender play a significant role in the

choice of the mental health provider. She describes the relationship between the service provider and service user as a powerful and close interaction that is influenced by factors like personality traits and circumstances (voluntary or institutionally-mandated) under which mental health care interactions occur (Rackers, 2018). Rackers (2018) also notes that the demographics of the provider and the extent to which they match those of the service user may be more important than previously thought. However, limited control and options, as well as pressing clinical presentations, can significantly impact the quest for provider-service user match and compatibility.

Buchanan (2015) warns against the effects of social desirability on self-reported service provider preference, especially as portrayed in research. Political correctness may play an important role in how participants respond to research questionnaires about the demographic preferences regarding health care providers. Thus, in-group bias should also be considered in the research about preferences in the service provider-service user dyads (Buchanan, 2015; Krumpal, 2014). Further, Buchanan, (2015) noted that clinical psychology ought to consider the impact of multiple identities on mental health and move beyond their comfort zones, to meet their clients in their contexts which influence mental health symptom presentation and their world view. While it is necessary to consider the service users' preferences in terms of service providers' contexts and worldviews, the pressures of accessing service delivery and the need for symptom relief may take precedence. Waweru et al. (2020) in their study in one LMIC found that patients placed more emphasis on the health service providers' ability to maintain confidentiality and reluctant to engage on the interpersonal aspects of interaction (which include taking account of patients' preferences, considering psychological and social aspects of health and illness and involving them in decisions) with their health care provider. This finding was different from a HIC study where patients placed equal value on the interpersonal aspects of care and technical competence of the health service provider. This points to the influence of focus and patients' expectations from their health care visit, as well as the need for the health service provider to respect the patients' autonomy in choosing the extent of involvement in their health care (which may be different from that of a health service provider).

Considering that the world is increasingly becoming digital, this may be an additional avenue to develop. Mental health should aspire to use digital platforms to access the population it aims

to serve. (Lal et al., 2015), in their study assessing preferences of young adults diagnosed with first-episode psychosis, found that the majority of participants are receptive to receiving health-related services through social media and mobile technologies. Further, they propose that mental health should collaborate with the target population to remain relevant and efficient. Similarly, Aschbrenner et al., (2019) found that most adolescents receiving public mental health services had access to smart phones and frequently use social media platforms. Thus, digital mental health and wellness may be cascaded to community mental health settings. Firth and Ho (2019) advocate for digital health technology that is desirable, accessible and affordable to support youth with mental illnesses as they often engage in risky behaviours that predispose them to early mortality from physical diseases in adulthood. While all three proposed qualities of digital health technology are relevant, affordability should be prioritised to ensure that under-resourced areas in LMICs are not excluded. As the world recovers from the devastation and pressure on mental health resources caused by the COVID-19 pandemic, stakeholders should demonstrate focused and practical efforts to adapt traditional ways of mental health service delivery and invest in technology as an alternative means of service delivery to promote mental health care and treatment adherence (Alan et al., 2019).

Knowledge of mental health problems and services (Mental health literacy)

Jorm et al. (1997) define mental health literacy as the understanding and views about mental health problems that assist in their identification, treatment and/or prevention. Jorm (2012) views knowledge as central to mental health literacy because it facilitates access to accurate mental health information, available self-help strategies and professional resources that can be accessed. Further, mental health knowledge also helps to identify risk factors and influence the correct attitude to the awareness of how mental health problems present. Therefore, assessing service users' knowledge of mental health problems and available treatment services could shed light on their level of mental health literacy. This can provide an opportunity to identify knowledge gaps and address misconceptions.

Further, Sutherland and Chur-Hansen (2014) found that psychologists working in non-urban areas acknowledge clinicians' limited understanding of the influence of local culture on clinical presentation, which is significant to intervention and treatment planning. Hence, having a

relevant, local knowledge base that allows the clinician to meet diverse mental health needs is vital to achieving efficient and contextualized clinical practice in non-urban areas. Given the distinctiveness and complexity of mental health needs, disease burden and treatment gap in LMICs, particularly in non-urban areas, familiarity with culture-specific help-seeking behaviours and service preferences in such contexts is important for optimum mental health interventions and service delivery.

According to Idriss et al. (2020), African communities are known to rely on self-management of minor or less complex health problems through traditional knowledge systems, cultural practices and religious means. While similar means of managing health concerns are also found in other non-urban communities worldwide, (Idriss et al., 2020) also found that healthcare-seeking from formal health institutions is often accessed only after other options are exhausted. Similarly, Shai and Sodi (2015), in their study of a South African non-urban community, found that mental health help-seeking was varied. Traditional interventions were easily accessible and tended to precede or be jointly used with Western health interventions. The secure and trusting relationships offered by immediacy, accessibility and shared cultural understanding of community life earn traditional healers esteemed positions, often making them the first contact point for 'expert' explanations, understanding and management of illness, health or life issues (Idris et al., 2020; Zingela et al., 2019). Further, the shared beliefs (with indigenous healers) about the spiritual causes or explanations of illness could influence the preference for consultation with traditional healers before Western-based interventions (Zingela et al., 2019). The latter approach could be perceived as lacking the knowledge and understanding required to diagnose and respond to ancestral influences or witchcraft (*izinto zabantu/ man-made*). Therefore, interventions from traditional healers could be perceived as accurate due to the shared worldviews with clients and their families. Traditional healers could also be trusted because of their believed possession of 'special powers' to provide sought-after insights and interventions to manage the destabilizing health concern. According to (Hom et al., 2015), mental health literacy, positive appraisals of services, encouragement from significant others (e.g. family and friends), and seeking support, are essential factors that influence help-seeking. Hom et al. (2015) referred to these factors as facilitators to care, thus viewing the responsibility to access care as a shared endeavour between the patient and their support networks.

Labys, Susser and Burns (2016) highlight the value of considering locally relevant insights in understanding mental illness and help-seeking behaviours in rural and non-urban communities, mainly because some service users are more traditional in their worldviews and may not be willing to access Western healthcare as a first point of call. Kirmayer and Pedersen (2014), strongly encouraged the Department of health to strive for a broader approach to health care to acknowledge the vital roles played by formal and informal stakeholders in healthcare provision, especially for indigenous and non-urban communities. (Vergunst, 2018) also recommended the inclusion of established mental health help-seeking pathways in these contexts to enhance accessibility and equity in the distribution of mental health services in non-urban communities. In his view, the success of task sharing should extend beyond the health sector and prioritize investment in mutually trusting relations between the formal and informal health sectors. Equally, Mathews and Van Wyk (2018) encourage a collaborative process in health care that includes all stakeholders in the system or organisation. However, there is a paucity of research that captures the mental health understanding and views of non-urban health service users. Thus, there is a need to explore service users' views and preferences in non-urban contexts to gain information to assist service planning.

Clinical psychology services in non-urban areas

According to (Matthews et al., 2010), the plight of non-urban communities is worse than their urban counterparts because of limited access to services, including psychological services.

For many years, mental health care and clinical psychology services in South Africa operated at the tertiary level of health care. For mental health to fit into all the levels of care, it has to adapt to the various contextual structures and dynamics in the health system. In non-urban settings, mental health care has to fit into the established and multifaceted system of health care, some of which are discussed below. Vergunst (2018) states that South African non-urban communities are complex, and this relates to historical inequities, cultural considerations and a general lack of infrastructure and service delivery. Some of the factors that contribute to the complexity of these communities include significant barriers to accessing health care, for example, high transport costs due to traveling long distances to health care facilities, multi-layered pathways to mental health care, and lack of community mental health service platforms. While there is no readily available data on the percentage of clinical psychologists who go into government health services, private practice, or corporate work, the clinical psychologists /

population ratio in state health facilities indicates that clinical psychology and mental health services in KZN remain skewed and a scarce skill (De Kock & Pillay, 2017; Siyothula, 2019). Of course, it is known that there are many newly qualified clinical psychologists desperately seeking public service jobs, but few employment positions are available.

The scarcity of mental health services in non-urban areas means these communities have to seek alternative health care options. For example, Patel (2011) highlighted the significant role of traditional healers, particularly in the African context. He also alluded to the complementary nature of Western and traditional health care systems even in well-resourced countries. In the (South) African context, traditional healers play an important role, are accessible, and share a similar community understanding of the conceptualization of illness (Mkhize & Kometsi, 2008). Shai and Sodi (2015) found that traditional healers are most likely to be consulted first or together with Western medicine for health concerns, and this finding supports Patel's (2011) view on the value of both health systems. This argues well for a model of collaborative health care that could see the development of a formal relationship between the national health authorities and the traditional healers' professional body, thus formalising and regulating traditional health care practice. The work of Ngcobo and Gqaleni (2016) illustrate the benefits of cultivating a healthy, open, trusting and information-sharing relationship between traditional healing and Western healing practices. This kind of relationship could enhance traditional healing medicines and protect the public against the potentially harmful effects (if any) of untested and unregulated medicines.

Likewise, non-urban residents have a known culture of strong networks that provide an immediate support base and possible distrust of external help, including clinical psychologists who may be viewed as outsiders with limited to non-existent local sociocultural, political, and economic understanding (Chipps et al., 2011). According to Hastings & Cohn (2013) being suspicious of service providers who are not part of the local community is common in non-urban social life, and psychologists are not exempt from that suspicion. The distrust may subject psychologists to scrutiny with increased expectations to prove themselves to gain the trust of non-urban residents (Schank & Skovholt, 2006). Furthermore, Zingela et al. (2019) ascribe the distrust between the Western and traditional parallel health systems to the minimal comprehension of the effectiveness of intervention strategies used by each, in managing health

concerns. Lack of knowledge is also implicated, but the systemic effects of colonialism must be seen as a major culprit.

Considering that mutual trust is necessary for effective psychotherapy, cognizance of social and psychological dynamics that extend beyond service users and service providers, as well as parallel health systems are essential for psychologists working in non-urban communities. These are important intricacies of non-urban contexts that may impact service access and delivery (Allen, 2021; Sutherland & Chur-Hansen, 2014; Sutherland, 2014; Zingela et al., 2019).

On the one hand, the strongly interconnected networks, deep socio-historical, and political roots, strong family ties, enduring attitudes towards life, and high reliance on religious activities are among the defining qualities of non-urban communities (Riding-Malon & Werth 2014), which can safeguard against psychological distress. On the other hand, this reliance on families and communities usually means that they are the first resources for help and support to their mentally ill members. However, the same act of caring carries the risk of predisposing families of the mentally ill to psychological distress (Iseselo et al., 2016). Therefore, psychologists working in non-urban contexts should be familiar with these dynamics and help-seeking trajectories, to be aware of the possibility of delayed presentation for mental health care and the prospects of intense and costly mental health interventions. Non-urban mental health service providers should also consider establishing collaboration with both formal and informal health resources to enhance access to help (Idriss et al., 2020), by creating psycho-educational spaces in the formal health systems and showing interest in learning from informal health resources.

Training issues and challenges for psychologists in non-urban areas

Globally, psychology scholars have raised concerns about urban-based and exclusive training that mainly caters to urban communities and have called for training that equips psychologists with relevant, inclusive, flexible, and context-sensitive clinical competencies (Pillay, Ahmed & Bawa, 2013; Riding-Malon & Werth, 2014; Sutherland & Chur-Hansen, 2014). Also, Werth et al. (2010), found that most non-urban psychologists deal with specific ethical dilemmas not commonly found in urban areas, suggesting that current clinical psychology training is not

sensitive to all clinical contexts. To meet the unique health needs of non-urban communities, Sutherland & Chur-Hansen (2014) emphasize the need for training to incorporate clearly defined competencies for mental health care service providers. Therefore, training models that emphasize brief, evidence-based, community-oriented, and culturally sensitive mental health interventions equipped for effectiveness in resource-constrained settings are necessary (Kohrt et al., 2018). For a diverse and resource-constrained country like South Africa, Mkhize & Kometsi (2008) advocate a collaborative approach and warn that "the training of mental health professionals is incomplete if it does not include exposure to, and collaboration between, the Western and traditional health care systems that continue to exist side-by-side in South Africa" (Mkhize & Kometsi, 2008, p. 110). Hence, competencies that pay attention to the dynamics of non-urban communities and relevant context-specific issues like higher levels of unemployment, poverty, financial stressors, and challenges in accessing services (Vergunst, 2018), are long overdue. Similarly, Petersen et al. (2012) and Vergunst, (2018) advocate utilizing readily accessible informal community interventions, adequate training, supervision, support, and interest in the community-sensitive interventions that could enhance mutual benefits for non-urban service providers and service users.

A shift from traditional mental health care training approaches is necessary for psychology to remain abreast of the globally changing social and economic landscape. It is important to remember also that non-urban environments, in countries like South Africa, have huge challenges in multiple areas, and mental health problems have to be understood and managed within those community contexts. Ahmed and Pillay (2004) emphasized that the training of clinical psychologists in South Africa should be mindful of the country's context and equip them to address the diverse needs of the majority of the population dependent on state facilities. Therefore, clinical psychologists' training requires an approach that invests in this essential aspect of the behavioural health workforce (Domino et al., 2019; Jameson & Blank, 2007). Domino et al. (2019), further encourage the training of clinical psychologists that incorporates recruitment, retention and an increase in the supply of clinical psychologists practicing in non-urban contexts. Such a training strategy should prioritize the mental health needs of the population it serves and impart relevant skills, attitudes, and expertise (Sutherland et al., 2014). According to Urbanoski et al. (2012), sensitivity to the service users' context improves the therapeutic alliance, which is fundamental in the quality of the relationship between the service provider and the service user, and predicts treatment outcomes.

Furthermore, non-urban interventions require integrating communal perspectives to effectively impact diverse settings (Sutherland et al., 2014). Communal approaches occurring in non-urban areas include the active involvement of non-specialists, family, and the community in the treatment of mental health care users, which could increase accessibility and acceptability of services, thus reducing discrimination and stigma of mental illness (Kohrt et al., 2018). Unfortunately, the current training of clinical psychologists largely focuses on individualized interventions (Pillay et al., 2013) that are informed by a Western worldview, and clinicians struggle to adapt these approaches to mental health care in non-urban contexts in LMIC's.

Furthermore, in a culturally and linguistically diverse country like South Africa (Johnston, 2011), professional training should reflect the equitable representation of the country's diversity. Pillay and Siyothula (2008) found that only 14% of clinical psychologists registered with the Health Professionals Council of South Africa were black Africans, and most were trained post-1994 (i.e. post-apartheid). While this finding reflected growth from the pre-1994 training of black clinical psychologists, the racial representation of clinical psychologists does not match the racial constituency of the South African population, where black Africans account for over three quarters of the nation (Statistics South Africa, 2021). In a follow-up study, Pillay & Nyandeni (2021) recently found that only 14.8% of the clinical psychologists trained in the subsequent 12 years were Black African. According to these authors, their findings reflect minimal growth in the training of clinical psychologists who are culturally competent or speak the indigenous languages of the majority of South Africans dependent on state health facilities. This slow progress perpetuates the pre-democratic inequalities in accessing basic health services by all South Africans (Pillay & Nyandeni, 2021). The statistics are even worse for clinical psychologists who work in the non-urban areas of KZN, where there are extremely few (Siyothula, 2019). Therefore, without training models that equip clinical psychologists with relevant competencies for all the contexts they practice in, an incompatibility between the expectations of service providers and service users is likely to ensue and compromise positive mental health treatment outcomes (Kohrt et., 2018; Morales et al., 2020).

Theoretical framework

The vision and the mission of the KZN Department of Health are ensuring the delivery of "optimal health for persons of KwaZulu-Natal and to develop a sustainable, coordinated, integrated and comprehensive health system at all levels, based on the primary health care approach through the district health system" (DOH KZN, 2013, p, 6). Against this provincial health ideal, the present study was conceptualised within the context of providing clinical psychology services where people live, in other words, in or as close as possible to communities. With the author's long-standing concern about the deficient clinical psychology services in South Africa's non-urban communities, the Community Psychology framework emerges as the most appropriate theoretical framework within which to situate this research. In this regard, a brief description of the community psychology approach is presented below to provide a broad base to contextualize the variables explored in this thesis, and especially their significance in enhancing clinical psychology and mental health services to people in non-urban communities.

Community Psychology and the Mental Health Model

Community psychology emerged within a context of dissatisfaction with the traditional mental health approaches that involved large mental health facilities (psychiatric hospitals) to which people had to go for help, which usually entailed inpatient treatment over lengthy periods (Hersch, 1968). The need to provide mental health and clinical psychology services in areas where people reside, is a vital component of this approach, and considering the historical under-provision of services in non-urban communities, this must be viewed as a priority.

Arumugam (2001) unpacked the field of Community Psychology and, in particular, the Mental Health Model within the framework, as a model that attempts to improve the mental health of communities residing within a demarcated geographic area. He further stated that one of the primary hypotheses of the model is that early and large-scale intervention increases the prospects of reducing mental health problems within the designated area and could be cascaded to areas with similar constituencies or characteristics. Edwards (1998) also noted that the Mental Health Model focuses on individuals living in clearly defined localities served by health facilities at the community level. However, the model assumes the availability of

funding and service delivery infrastructure. In the apartheid system, the availability of funding and distribution of resources was dependent on race, economic class, geographical area, and non-urban areas bore the brunt of the inequitable distribution of services (De Kok & Pillay, 2017; Matthews & van Wyk, 2018; Vergunst, 2018).

The increased susceptibility to mental health problems of under-resourced non-urban communities, and the country as a whole, has become a growing public concern that is also seen in other low- and middle-income countries (GBD, 2020). According to Riemer et al. (2020), achieving constructive change in a community depends on being aware of links between the individual's needs and global, political, economic and cultural development. While the mainstream psychological approaches focus on the individual and family as the primary units of theory and intervention, the mental health model's focus shifts to a broader community/ population (Duncan et al., 2007). According to the model, understanding the context(s), the impact and risk / causative factors could help a larger group of people (Duncan et al., 2007).

Against the premise of the mental health model, this thesis explores the following critical issues: distribution of clinical psychology services as part of mental health resources in the KZN non-urban areas, the experiences of service providers in these contexts, and the preferences of service users. These explorations will provide insight into aspects of the availability, accessibility and acceptability of clinical psychology services in these settings. The information will aid the KZN Department of Health by offering a more accurate assessment of the situation to better inform the implementation of its vision and mission.

Overview of non-urban clinical psychology services in KZN, South Africa

South African clinical psychology evolved from an exclusive, racist past where access to the profession, training opportunities and services, were largely reserved for white citizens (Manganyi, 2013). While the intentions and efforts of the profession to change the previous exclusionary stance are commendable, the much-needed transformation has been very slow (Pillay & Nyandeni, 2020; Pillay & Siyothula, 2008). More than 80% of the population are African and dependent on the public health system for their health needs and almost a third (32,15%) of the South African population lives in non-urban settings (Ngobeni et al., 2020; World Bank, 2023). Almost 75% of the population has no access to mental health services

(Council for Medical Schemes, 2014). Most non-urban KZN health districts do not have specialists or functional multidisciplinary teams (De Kock & Pillay, 2017).

The South African Air Mercy Services (AMS) in partnership with the Department of Health provided the 'flying doctor' services in KZN until August 2020. The South African Air Mercy Services either transported patients from outlying communities with inadequate or no specialized health care to tertiary institutions or transported health specialists from urban to non-urban health facilities to provide services (Caldwell et al., 2018). Clinical psychologists also joined the AMS to reach non-urban patients needing mental health care services closer to where they live (Pillay et al., 2009). Sadly, this valuable service was disrupted by the COVID-19 pandemic, leaving many non-urban communities once again without basic mental health input. While the AMS and Department of Health (DOH) partnership stopped a few years ago in other parts of the country, in KZN it continued on an annual contract basis until August 2020. Although poor investment in mental health could partly explain the cessation of this valuable partnership that benefited non-urban communities, other health specialists utilized the same mode of transport to reach remote areas and their services also ended in the same period.

Currently, a few district hospitals in outlying areas have employed clinical psychologists, but these are few and far between. The next chapter explores this issue in more detail.

CHAPTER 3

METHOD

Study design

The study adopted a mixed-method design to address the objectives. This design was considered to be appropriate because it follows the process of inquiry in data collection that covers the quantitative information and describes the participants' responses (Jackson, 2012). This inquiry process enabled the researcher to access both qualitative and quantitative information from the participants' responses.

Aggarwal and Ranganathan (2019) state that questionnaires used in survey methods to elicit information from participants are useful when the researcher's interest is in the perceptions, beliefs, attitudes or opinions about the research topic. Further, Creswell (2014) states that the main supposition of the mixed-method research approach is that it provides a more in-depth understanding of the research problem than either a qualitative or quantitative approach alone. Based on the reported benefits of the mixed-method research approach, and the author's quest for both quantitative data and qualitative information, it was considered an appropriate research approach. This methodological consideration also facilitated a broader understanding of the research problem.

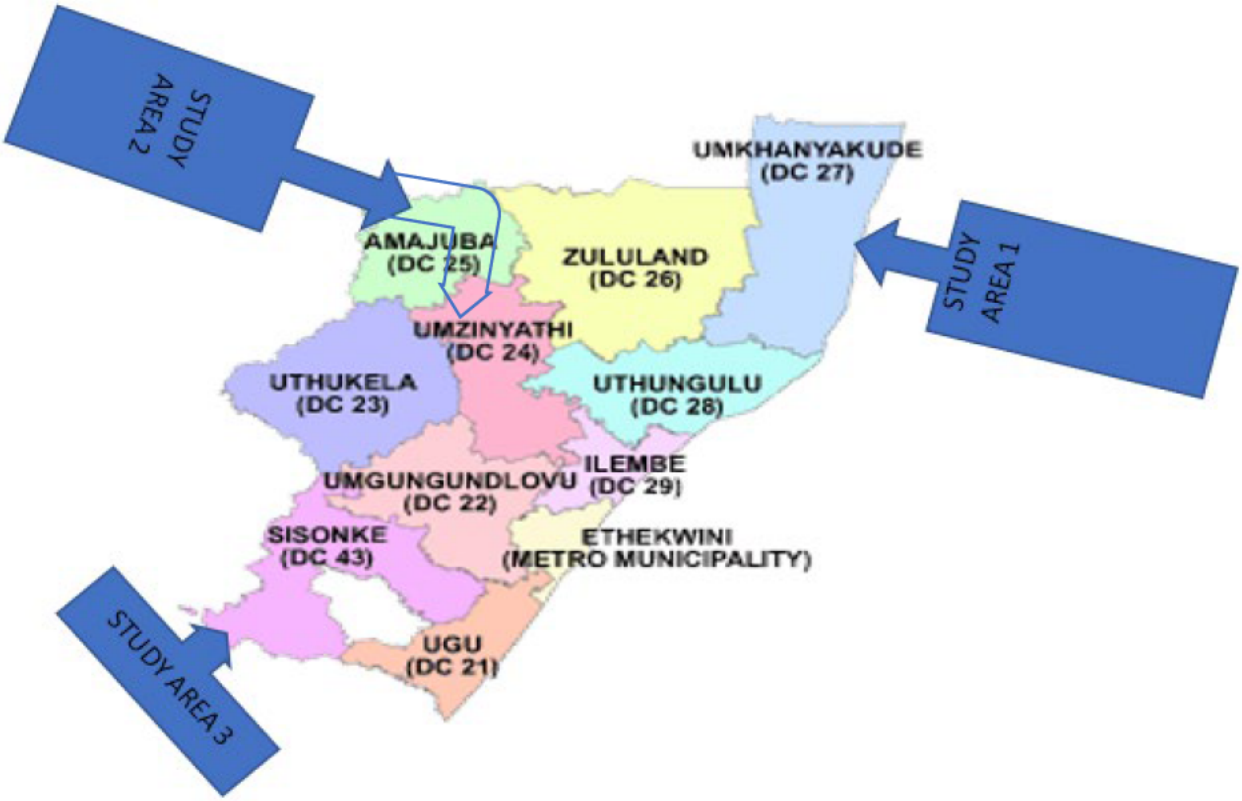
The different studies reported in this thesis follow in subsequent chapters, and each outlines the specific design used to meet the respective goals and aims of the study.

Study area

The present research focused on the KwaZulu-Natal province of South Africa, and specifically three health districts. These were uMkhanyakude (DC 27) which has 5 district hospitals, uMzinyathi (DC 24) which has 4 district hospitals, and Harry Gwala (previously known as Sisonke district, DC 43) which has 6 district hospitals. The three districts represent a cross-sectional gradient of the province and, in particular, the non-urban districts in the province. The population of each district is as follows: uMzinyathi district: 510 838, uMkhanyakude district: 625 846, and Harry Gwala district: 461 419 (The Local Government Hand Book, 2014). All 3 districts are designated as non-urban or deep rural areas by the KZN provincial Department of

Health. Monthly itinerant clinical psychology services are provided to the district hospitals where there are no resident clinical psychologists. Of course, such service frequency and the itinerant nature is wholly inadequate for the relevant communities. The Department of Health's Geographic Information System (GIS) was utilized to access specific information on the three purposively selected districts which are believed to be reasonably representative of the non-urban areas of the KZN province.

Figure 1: The study areas in the map of the health districts of the KwaZulu-Natal province



Sampling

A cross-sectional study design was utilized for the recruitment of samples of patients, health professionals referring patients for clinical psychology services, and clinical psychologists. Patients in the outpatient waiting area in hospitals of the three purposively selected districts were approached consecutively for participation. The aim was to reach a targeted sample size

of 183 patients. This was considered a self-weighting sample, based on the differential patient load seen at the various health facilities, as follows: 4 district hospitals for uMzinyathi district, 5 district hospitals for uMkhanyakude district and 6 district hospitals for Harry Gwala district. Although 183 patients were targeted for inclusion, based on a statistician's calculation, only 40 participants responded, constituting a 21.85% response rate. While the response rate is considerably below the targeted sample size, information gathered from these participants was considered valuable for inclusion as one of the components in the data analysis of this research project.

This sample size maintained the same precision of ± 5% and 95% confidence assuming a non-response or refusal rate of 10% proportion. Precision for estimating a single population proportion: The precision was calculated using the formula, $Z^2\left(1-\frac{\alpha}{2}\right)pq/d^2$ (where $Z(1-\alpha/_2)$ =1.96 at 95% confidence; p=proportion of mental health care users with a certain level of mental health awareness and/or literacy; q=1-p and d=absolute allowable error. For this study, as there is no prior knowledge with regard to the proportion of the population who have a specific level of mental health awareness and /or literacy, maximum possible variability i.e. p=0.5; q=0.5 and a precision (d) of ± 5%. Thirty (30) clinical psychologists (resident and visiting) in state employment who work in non-urban areas of the 3 health districts and 60 hospital-based referral sources were targeted for the service providers' sample.

Inclusion criteria

Patients

The following patients were considered for inclusion in the study:

(1) Patients who understood the questions were asked to participate
(2) Patients who were not currently manifesting psychotic symptoms at the time of the study
(3) Patients who were above the age of 18 years

Referral agents

Healthcare providers (i.e. medical doctors, nurses, social workers and occupational therapists and other health workers) who refer patients for psychological consultation were considered

for inclusion in the study. A total of approximately 60 participants were targeted. All willing participants from each health facility were considered for inclusion in the study.

Clinical Psychologists

Both resident and visiting clinical psychologists in state employment who rendered services in non-urban communities were considered for inclusion in the study. Approximately 30 participants were targeted for inclusion. All willing participants from the clinical psychologists' group were included.

Exclusion criteria:

Patients

The following patients were excluded from participation, following the researcher's screening of prospective participants:

(1) Patients experiencing a personal crisis and requiring urgent medical or mental health intervention,

(2) Patients who were unable to consent or understand their rights, due to their physical or mental health status,

(3) Patients who were under the age of 18 years at the time of the study.

Referral agents

(1) Health professionals who did not refer patients to clinical psychologists were excluded.
(2) Health professionals not employed in the identified non-urban hospitals were excluded.

Clinical psychologists

(1) Clinical psychologists who have not worked in non-urban public health facilities

Procedure

The researcher held briefing sessions to inform each prospective participant about the research and the fact that participation was voluntary. They were also informed that a decision not to participate or to withdraw from the study at any time will have no negative consequence for them. Following a briefing of prospective participants to introduce the study and read the information document, the researcher read the information leaflet for participants who indicated that they preferred the researcher to do so (participants were not asked to explain their preference to preserve their dignity if the request was due to the inability to read). The researcher asked participants to repeat in their own words their understanding of their right to choose to participate, not to participate, or to be able to withdraw from the study at any point. Participants were also given an opportunity to ask questions or raise concerns. The ability to repeat their rights to participate, withdraw at any time, or not to participate, as well as the implications of their decision, was taken as a reflection of their understanding of the conditions of the study. This, together with the absence of obvious or severe mental health symptoms, gave the researcher the confidence in terms of their fitness to provide informed consent.

Referral agents and clinical psychologists considered to be prospective participants were approached for participation, and briefed about the study. They were also given the information sheet (see Appendix) with details about the study. Additional details were given verbally and in response to any questions they raised. Those who indicated a willingness to participate were given a consent form to sign. The referral agents were identified at the hospitals concerned through the institutional management, and the clinical psychologists were identified in a similar way for those in full-time employ at the hospitals. Since there were other clinical psychologists who did part-time work at these non-urban hospitals, they were identified through the provincial Department of Health mental health structures.

Demarcation of the studies within the larger project

The first section of the study entailed a brief literature review focusing on (1) challenges of mental health integration in high-income countries (HICs) and low- and middle-income countries (LMICs), (2) differences between urban and non-urban communities, (3) literature on the non-urban communities internationally, and (4) the distribution of mental health services

and psychology services in the non-urban areas of KZN. Data was obtained from the electronic search engines and the KZN provincial Department of Health's geographic information system (GIS).

The subsequent sections of the study explored (1) the views, attitudes and experiences of state-employed clinical psychologists who work or worked in non-urban communities, (2) the views, attitudes and experiences of health care providers (i.e. doctors, nurses, occupational therapists, social workers and other health care workers) in non-urban communities who refer to clinical psychologists, and (3) the views, attitudes and expectations of mental health care users in an outpatient waiting area in each of the non-urban health facilities targeted in this project.

The questionnaire and information brochure for the mental health care users' (patients') sample were translated into isiZulu, the dominant indigenous language in the KwaZulu-Natal province, and back-translated into English to ensure accuracy and reduce ambiguity. Two IsiZulu-speaking clinical psychologists were engaged to translate the questionnaire and information brochure for mental health care users. Translation guidelines suggested by Babbie and Mouton (2001), Flisher (2007) and Rosnow and Rosenthal (1996) were followed. The WHO (2014) also outlines the process to be followed when instruments are translated to meet the linguistic needs of diverse cultural and ethnic groups. Discrepancies between the original and translated version of the questionnaires were resolved through discussion and consensus between the translators and adjustments were made where it was necessary to do so. However, the reliability of the items within the survey and the subject's willingness to answer items honestly can be potential threats to internal and external validity and are possible study design limitations (Aggarwal & Ranganathan, 2019). Since the questionnaires were purpose-designed to collect descriptive information from various stakeholders, and were not used to compare to other groups, there was limited concern about the instruments' psychometric properties. The information provided by the participants constituted their views and attitudes and were accepted at face value.

The following tools were developed:

a) The questionnaire for the clinical psychologists working in non-urban areas
b) The questionnaire for the non-urban health professional referring to clinical psychologists

c) The questionnaire for non-urban mental health service users referred to clinical psychologists.

Description of the instruments

The data collection research questionnaires were developed by the researcher to target specific contextual information from participants for the purpose of this thesis.

The following tools were developed:

a) The questionnaire for clinical psychologists working in non-urban areas
b) The questionnaire for non-urban health professionals referring patients to clinical psychologists
c) The questionnaire for non-urban mental health service users referred to clinical psychologists.

The questionnaire for clinical psychologists covered the participants' demographics, preparedness and competency to work in resource-constrained settings, and participants' appraisal of the non-urban working environment. The questionnaire for the referring practitioners targeted the needs, experiences, and expectations of clinical psychologists, as well as their understanding of clinical psychology services. The third questionnaire, for mental health care users, focused on the needs, mental health knowledge and the views/attitudes towards clinical psychology services, as well as their preferences for clinical psychology services & providers. Patient preferences were explored in terms of the following: age, gender, race and language of the consulting clinical psychologist. These instruments were informed by the researcher's clinical psychology experience in non-urban communities, as well as literature. The descriptive information that was included was not pre-tested and constitutes a study limitation.

Data analysis

Quantitative data was analysed using the descriptive statistics from the different versions of the Statistical Package for Social Sciences (SPSS). The version used for each study depended on the available licensed version at the time of the data analysis, for example, versions 25 to 27 were used for different studies.

Qualitative data from open-ended questions were analysed using both content analysis and thematic analysis to ensure that all data was utilized and appropriately interpreted. The researcher identified and coded the themes emerging from the qualitative questions (Denzin and Lincoln, 2013) and collaborated by a second reader. In cases where there was a discordance between the two readers, the issue was engaged and the relevant narratives carefully examined. This was done until consensus was reached and this procedure was conducted to address the issue of trustworthiness.

The distribution of mental health and psychology services was mapped and plotted by a GIS specialist from the KZN Department of Health. The distribution was outlined according to the WHO's human resource for health guidelines (WHO, 2009).

Ethical considerations

Ethics clearance for this research project was obtained from the Biomedical Research Ethics Committee (BREC) (BE199/15) of the University of KwaZulu-Natal and the KZN Department of Health. Further, gatekeeper permission was obtained from the health district offices of the three districts that were studied. Informed consent was obtained from all participants. After reading or having the information sheet read to them, participants were asked to indicate that they have read (or had it read to them) and understood the purpose of the study by signing an informed consent form which was kept separately from the completed questionnaire, to keep the questionnaire responses anonymous. They also ticked an appropriate box on the top of the questionnaire demarcating consent. Participants were requested not to write their names on the questionnaires, to ensure anonymity. The data has been stored in a locked cabinet in the researcher's office to ensure confidentiality.

Although the study was not anticipated to evoke negative effects, arrangements for mental health interventions to support participants who could have suffered adverse reactions as a result of participation in the study were made. The researcher negotiated with clinical psychologists in the research sites (or as close as possible) for such participants to be seen for assistance, if needed. To the researcher's knowledge, none of the participants suffered any adverse effects or requested mental health assistance as a result of participation.

Dissemination plan

Results of the various studies in this project were disseminated in different formats and scholarly outlets. Papers were presented at the annual psychology conferences of the Psychological Society of South Africa (PsySSA), two papers were published in the *South African Journal of Psychology*, and two manuscripts have been submitted to other health related journals. All of the published and submitted manuscripts are and included in this thesis, constituting the chapters that follow.

Chapter outline

Chapter 3 outlined the research method, study design, study area, sampling strategy and sample size for each study. It also presented data collection methods, data analysis, dissemination and ethical considerations. Chapter 4 presents the first of the published papers titled: *Clinical psychology service distribution and integration into primary health care in KwaZulu-Natal, South Africa*, which was published in the *South African Journal of Psychology*.

It must be noted that each of the subsequent chapters presents the specific research methods employed to meet the study objectives detailed in that chapter, which are either published papers or manuscripts submitted to journals. For that reason, the methodological information presented in this chapter is less detailed.

The next chapter presents an overview of the clinical psychology service distribution in primary health care in KwaZulu-Natal.

CHAPTER 4

PAPER 1

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PsySSA
Psychological Society of South Africa

Article

Clinical psychology service distribution and integration into primary health care in KwaZulu-Natal, South Africa

Evy-Terressah Busisiwe Siyothula[1,2]

Abstract

Inadequate investment in mental health care by the governments of both high- and low-income countries contributes to recurrent challenges of uneven distribution of and access to mental health services between urban and non-urban communities. While recent research has acknowledged the role of mental health in well-being and the cost of failure to invest in the sector, prioritising mental health to the same degree as physical health remains a challenge. This article highlights the unequal distribution of mental health services, and psychological services in particular, in KwaZulu-Natal. This is achieved by considering the background of psychology in South Africa and KwaZulu-Natal and then examining the ratio of clinical psychologists to the KwaZulu-Natal population. Furthermore, the article explores the geographical distribution of psychological services in KwaZulu-Natal and concludes with a discussion of the impact of uneven mental health service distribution on service provision and utilisation in non-urban areas of KwaZulu-Natal.

Keywords

Clinical service, mental health care, non-urban areas, primary health, psychology

Influential bodies such as the World Health Organization (WHO), Pan American Health Organization, European Union Council of Ministers, World Federation for Mental Health, and the United Kingdom Royal College of Psychiatrists have raised concerns about failure to pay adequate attention to mental health, which they assert is a fundamental part of health (Saxena, Thornicroft, Knapp, & Whiteford, 2007). Concerns highlighted by research findings indicate the serious impact of mental disorders on the global burden of disease (Burns, 2010; Prince et al., 2007; Saxena & Skeen, 2012; WHO, 2013). Steel et al. (2014) in their systematic review and meta-analytic study (1980–2013) estimated the global prevalence of common mental disorders to be one in five respondents who met the diagnostic criteria within a year of assessment. This high incidence of mental disorders demonstrates the magnitude of mental health needs and the significance of prioritising mental health.

[1]Department of Behavioural Medicine, University of KwaZulu-Natal, South Africa
[2]Fort Napier Hospital, KwaZulu-Natal Department of Health, South Africa

Corresponding author:
Evy-Terressah Busisiwe Siyothula, Fort Napier Hospital, P.O. Box 370, Pietermaritzburg 3200, South Africa.
Emails: busi.siyothula@kznhealth.gov.za/bsiyothula@gmail.com

The WHO and global research community advocate investing in mental health to redress its omission from the millennium development goals' agenda. According to researchers, such omission not only undermines optimal health benefits, but is also costly and constitutes a human rights violation (Burns, 2010; Prince et al., 2007). The WHO's (2015) call for attention to the promotion of the dignity of persons living with mental illness further contributes to ensuring that, globally, mental health issues receive due consideration. Continued global mental health discourse further emphasises the importance of attending to mental health and other health issues equally. Researchers also state that failure to attend to mental health is detrimental to the well-being of the world population (Prince et al., 2007). Furthermore, poor attention to mental health incited multiple calls to revive and accelerate principles of the Alma Ata Declaration which encourages an integrated and comprehensive health care system through the primary health care (PHC) approach (Kakuma et al., 2011; Lund et al., 2012; Petersen, Ssebunya, Bhana, Baillie & MhaPP Research Programme Consortium, 2011; WHO & World Organisation of Family Doctors [WONCA], 2008). Likewise, Lawn et al. (2008) emphasised upholding the declaration's core values of universal access to care, equity, community participation, inter-sectoral collaboration, and appropriate use of resources.

The World Health Assembly adopted the Comprehensive Mental Health Action Plan 2013–2020 and urged United Nations member states to act on agreed objectives of strengthening leadership, governance, and provision of integrated mental health services to meet proposed mental health targets (WHO, 2013). The objectives mentioned above are relevant to this article as it also supports integration of psychology services into the PHC package of health care. While commendable consideration of mental health has been observed globally, the persistent high prevalence of mental disorders indicates that focused efforts, particularly in low- and middle-income countries (LMICs), remain essential. LMICs have unique contexts that require special attention. Like other LMICs, South Africa's health budgets, infrastructure, and human resources should reflect robust investment in mental health, as recommended by the WHO (2013).

History of mental health services in South Africa

Although high-income countries have more mental health resources than LMICs, the imbalance between available resources and necessary services is noted globally (WHO, 2011). However, the impact of this imbalance is mostly prevalent in the African continent where the health care demand is much higher than available resources. While South Africa is economically and socio-politically better off than most African countries, it continues to reflect perceptible ramifications of economic disparities from the apartheid regime. The apartheid regime promoted segregation of South African citizens along geographic, racial, cultural, and class lines. In addition, during apartheid, better-resourced mental health services were accessible to the privileged minority. The rest of the population, particularly in non-urban communities, relied on poorly resourced and unevenly distributed mental health services that did not uphold human dignity (Burns, 2011; Cooper, 2014). Key societal resources in education, health, and the economy continue to reflect this inequality. Similar segregation along race and gender lines persists in the profession of clinical psychology (Cooper, 2014; Pillay & Siyothula, 2008).

The advent of democracy and efforts of professional associations like the Psychological Society of South Africa have played a major role in unifying and changing the face of South African psychology (Cooper, 2014). The Mental Health Care Act (MHCA), No. 17 of 2002, has also been instrumental in driving access to mental health care and upholding the rights of persons with mental illness (Burns, 2009). The MHCA is considered to be one of the accolades of South Africa's democracy as it promotes a shift from mainly hospital-based mental health services to decentralised mental health care. One of the key factors of the MHCA is the promotion of collaboration between stakeholders and

active participation of communities in their own care. However, concerns about the implementation of the Act and its effectiveness through designated levels of care for optimal benefit have been raised. Constraints in infrastructure, financing, and human resources are among the hurdles that hinder optimal implementation and benefits of the Act (Ramlall, 2012; Ramlall, Chipps, & Mars, 2010).

The 2012 Ekurhuleni Declaration on Mental Health signalled a hallmark in persuading the South African government to consider the plight of persons living with mental illness and implementing measures that safeguard their dignity. The declaration encouraged the government to respond to the call by the WHO to invest in mental health by making South Africa a signatory of the United Nations Convention on the Rights of Persons with Disabilities (Burns, 2009; WHO, 2013). The National Mental Health Summit held in April 2012 contributed to the development of a detailed and aspirant South African National Mental Health Policy Framework and Strategic Plan, 2013–2020 (Department of Health [DOH], 2012; Stein, 2014). In this document, the government upholds the need for dignity of mental health care users by committing to the provision of accessible, quality, and adequate mental health services. The government further affirms that access to mental health care is not a privilege but a constitutional human right (Burns, 2009). Nevertheless, while the policy provides a comprehensive framework for the delivery of mental health services in South Africa, there are concerns that implementation has not followed with the same enthusiasm (Morgan, 2015). Hence, researchers caution against the ripple effects of apathy and negligible investment in mental health remain pertinent (Lund et al., 2012).

The integration of mental health and clinical psychology services into PHC in KwaZulu-Natal

Integration of mental health services into PHC is an international vision of bringing services closer to the people (Petersen et al., 2009; WHO, 2001). The KZN DOH responded to the MHCA and the WHO's call to integrate mental health services into PHC by forming a task team in 2004 to facilitate this process. The task team was mandated with examining and integrating all available mental health documents into a new document called The Strategic and Implementation Plan for Delivery of Mental Health Services in KwaZulu-Natal (KZN) (Mkize, Green-Thompson, Ramdass, Mhlaluka, & Dlamini, 2004). The purpose of this document was to guide the implementation of mental health service delivery in KZN. This newly constructed document included operational plans, time frames, and specific recommendations for community mental health services and forensic psychiatry. It also emphasised the provision of adequate human resources for implementation of its recommendations (Mkize et al., 2004).

The envisaged benefit of integrating mental health into PHC was the promotion of inclusive health care service that caters for the intricate health needs of communities (Bhana, Petersen, Baillie, Flisher, & The MHaPP Research Programme, 2010). However, implementation of the much-anticipated integration of mental health services into PHC is imbued with challenges (Bhana et al., 2010). While the constructed document provided a comprehensive framework for the delivery of mental health services, scarcity of specialist mental health professionals, including clinical psychologists, hinders availability of the proposed members of the multi-disciplinary team at PHC level. The PHC level is considered to be the community's first point of contact with the health care system. The task team's framework proposed 'staggering' the availability of specialised mental health team members (clinical psychologist, social worker, and occupational therapist) on a part-time basis in community health centres and district hospitals, with the full team (including a psychiatrist) only available at regional and tertiary levels (Mkize et al., 2004). In reality, particularly in non-urban settings, most PHCs have none of these team members. While this document pioneered decentralisation of mental health services, delayed involvement of the full multi-disciplinary team indicates a missed opportunity of early

investment in mental health and ensuring that it forms an integral part of PHC. Furthermore, failure of clinical psychology as an independent profession to assert and advance its position in the provision of mental health perpetuated the traditional medical hospicentric model. Hence, clinical psychology services remain in hospitals where leadership of the mental health team is often under psychiatry and the independence of clinical psychology is unclear.

Petersen et al. (2009) assessed the progress of decentralisation and comprehensive integration of mental health services into PHC in KZN and found that progress is hindered by 'lack of resources within the primary care package' (p. 140). In addition, Stein (2014) states that decentralisation of mental health services seemed to have been misunderstood to mean disassembling experienced mental health teams and views this kind of thinking as a crucial factor contributing to the slow and negligible progress in integration of mental health services into PHC. The adverse effect of decentralisation was removing stand-alone mental health clinics from the community back to hospitals. Furthermore, placing mental health services in the same premises with other health care services, without the accompanying resources, expertise, and commitment, has stalled successful integration of mental health into PHC. The majority of PHCs in KZN do not have support services of multi-disciplinary teams, training, and supervision for non-specialist mental health care workers. More than a decade later, the task team's proposal of integrating clinical psychology services into PHC has not been implemented. Despite initiatives from clinical psychologists of the Midlands Hospital Complex in the mid-1980s (Pillay & Kramers-Olen, 2014), little progress has been made. While these efforts contributed to community psychology services, integrated and comprehensive health services at PHC level have not gathered the desired momentum in KZN.

It is disheartening to observe that involvement of the multi-disciplinary team at PHC level has not been effected and non-urban communities in KZN continue to struggle to access optimal mental health services. To date, there are still non-urban health districts in KZN with only one clinical psychologist expected to meet the psychological needs of approximately half a million people. As a result, these districts rely on monthly services of 'fly in' clinical psychologists transported by the Air Mercy Services from metropolitan areas (Pillay, Kometsi, & Siyothula, 2009; Pillay & Kramers-Olen, 2014). While this effort is better than the absence of clinical psychology services, it is limited by irregular visits as flights depend on suitable weather conditions. In KZN, only two community health centres have resident psychologists (KwaZulu-Natal Department of Health, 2015).

The introduction of community service for newly qualified clinical psychologists by the National Department of Health has brought limited relief to the lack of mental health care in rural areas. Distribution of placements between urban and rural areas is inequitable, and newly qualified clinical psychologists prefer urban areas to rural areas where services are needed most. While the intention of mandatory community clinical psychology service was admirable, there is often lack of service continuity due to delays in completion of a dissertation which qualifies new clinical psychologists to start community service (Pillay & Harvey, 2006). This defeats the purpose of this government initiative to address human resource disparities in disadvantaged rural areas and improve local access to all health services (DOH, 2006). These recurrent human resource disparities and limited progress in the integration of mental health services into PHC reflect inadequate investment in mental health and the prioritisation of mental health care in South Africa (Bhana et al., 2010; Mkhize & Kometsi, 2008).

The distribution and ratio of psychologist to population in KZN

Fragmented and skewed distribution of health resources and personnel between rural and urban areas, public and private sectors, high-income countries and LMICs, and primary and tertiary health care contexts is well documented (Ashmore, 2013; Burns, 2009; Cooper, 2014; De Jager, Hofman, Khan, Volmink, & Jina, 2012; Saxena et al., 2007). Prior to 1994, South Africa had 14 disjointed health

Table 1. Ratio of clinical psychologists to population in KZN health districts.

District	Population	No. of psychologists	Population:psychologist ratio	Ratio: percentage/100,000 of the population
Amajuba	507,468	5	101,494	0.985
eThekwini	3,464,205	34	101,888	0.981
Harry Gwala	464,419	1	461,419	0.217
Ilembe	638,660	2	319,330	0.313
Ugu	733,228	9	81,470	1.227
uMgungundlovu	1,052,730	32	32,898	3.040
Umkhanyakude	638,011	4	159,503	0.627
Umzinyathi	514,217	1	514,217	0.194
Uthukela	682,798	4	170,700	0.586
Uthungulu	937,793	4	234,448	0.427
Zululand	824,091	1	824,091	0.121
Total	10,457,406	97		

departments. Ten years into democracy, in 2004, the DOH acknowledged that efforts to redress past disparities had not fully materialised but had instead evolved into a two-tiered health care system (the public and private sectors) which perpetuated inequality. According to Ashmore (2013), the imbalance in these contexts continues to contribute to the ongoing struggle to effectively manage diseases and maintains their high impact on the global burden of disease. Ashmore's claim is supported by the documented research on the pervasive impact of South Africa's quadruple disease burden (HIV and tuberculosis; chronic illness and mental health; injury and violence; and maternal, neonatal, and child health) (Burns, 2011; Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009) and increased susceptibility of non-urban areas to these diseases (Burns, 2011).

According to Ashmore (2013), South Africa has adequate supply of health workers above the expected benchmark per 1000 people as stipulated by the WHO's Global Atlas, and the minimum benchmark of 2.5 health workers per 1000 people, as defined by the Joint Learning Initiative in 2004. Ashmore (2013) states that this health worker/population ratio sets South Africa above most African countries and affirms its status as a middle-income country. However, he also points out that inequitable distribution of health workers between and within South African provinces, and between public and private sectors, only caters for health needs of the advantaged minority while the majority continue to have limited access to health care even during the democratic era. This undermines South Africa's success in addressing public health problems and developmental challenges (Ashmore, 2013; De Jager et al., 2012).

Contrary to the health care situation in LMICs, high-income countries are reported to have a ratio of psychiatric health workers to population that is about 200 times higher than in LMICs (Ashmore, 2013). These figures reflect inequalities in distribution of mental health services across the world (WHO, 2014). Likewise, inequity in distribution of clinical psychology services between health districts in KZN remains prevalent as illustrated in Table 1. Figure 1 also displays the distribution of psychologists in KZN per health district. The map below depicts the concentration of clinical psychologists in two metropolitan districts of uMgungundlovu and eThekwini, followed by the semi-urban Ugu district.

While the study by Lund et al. (2012) found that in South Africa the ratio of clinical psychologists (0.32/100,000 population) is higher than that of psychiatrists (0.28/100,000 population), it is important to consider the duration and frequency of clinical psychologists' sessions. Ideally, clinical

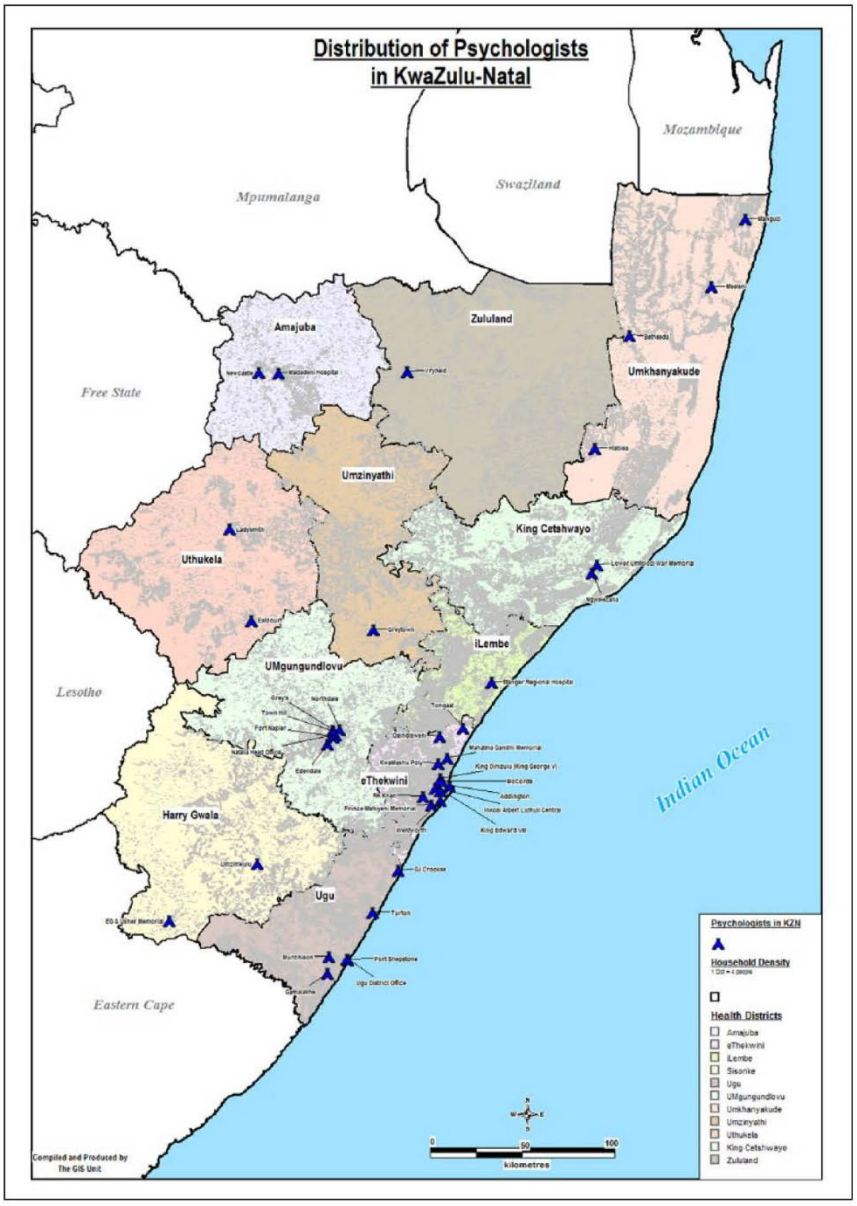

Figure 1. Distribution of clinical psychologists in KwaZulu-Natal.
Source: Printed with permission from KZN DOH Geographic Information System.

psychologists allocate at least an hour for each consultation and often have follow-up sessions. This means that the clinical psychologist can only see five to six patients per day if depth and quality of service is to be maintained. Furthermore, as part of quality mental health, efficiency of psychological interventions should translate into enduring and generalisable self-regulation skills that can promote autonomy and productivity (Barry, Clarke, Jenkins, & Patel, 2013). Viewing clinical psychologists' work against this backdrop, it is evident that there are inadequate numbers of clinical psychologists to meet the needs of the South African population particularly in non-urban areas.

Challenges that impact service provision and utilisation

While the role of mental health care in effective management of all health concerns is well documented (Mayosi et al., 2012; Petersen et al., 2015; WHO & WONCA, 2008), there is a dearth of research focusing on the role of clinical psychology. Like mental health care services in general, the effectiveness of clinical psychology services relies on availability, mutual collaboration, and support for both service providers and service users. Some of the factors that influence effectiveness of clinical psychology interventions are discussed below.

Human resource constraints

The enduring human resource shortage in the health sector is a global concern that impedes universal health coverage (Campbell et al., 2013). Considering that mental health care relies on human resources instead of advanced technology or equipment (Stein, 2014), continued concerns about scarcity of mental health personnel and its impact on effective service delivery, particularly in LMICs, is justified. This scarcity is well documented in the WHO Mental Health Atlas Series (WHO, 2011, 2014; WHO, Department of Mental Health, & Substance Abuse, 2005). In LMICs, concerns over the scarcity of human resources for mental health is accentuated by concentration of available mental health professionals in urban areas, while susceptible rural areas remain poorly attended (Burns, 2011). While unpacking reasons for health professionals' preference to work in urban areas is beyond the scope of this article, frustration from professional isolation, poor infrastructure, and lack of resources like formal interpreters (Elkington & Talbot, 2015) for providers who do not speak the local language could be among the contributing factors. South Africa, like most LMICs, still faces repercussions of underdeveloped and under-resourced non-urban areas (Burns, 2011) despite commendable efforts of the democratic government to redress these injustices of the apartheid system. The government also introduced monetary incentives for staff working in non-urban settings; however, this effort has not improved the situation as much as it was anticipated. While Campbell et al. (2013) propose striving for a match between distribution of human resources for health and population needs, the majority of non-urban communities continue to operate with inadequate health personnel, particularly in mental health. Pillay and Kramers-Olen (2014) point out that an insufficient number of trained clinical psychologists perpetuate the imbalance between mental health needs and service provision in underprivileged communities. Furthermore, sparsely distributed clinical psychology services contribute to the poor awareness of the role of clinical psychologists. This frustrates both psychologists and service users, as their expectations from consultations are often incongruent.

Access to mental health services

Provision of quality mental health care is threatened by inaccessibility of services. Mental health services stem from an era where services were located in the tertiary level of health care in specialised psychiatric hospitals. These health care facilities were not easily accessible to communities as they required a complex referral process and out-patient follow-up services were provided at standalone mental health clinics. Access to mental health services in non-urban areas should not only be narrowly viewed from the angle of availability of services and human resources. For example, Ruane (2010) states that language and class differences are barriers to accessing psychological services. Therefore, access to services should consider the geographic layout of the catchment area and affordability of transportation to health facilities which is often costly for non-urban service users (Mkhize & Kometsi, 2008; Pillay et al., 2009; Swarts, 2013). With the rising cost of living,

unemployment, and poverty in LMICs particularly affecting previously disadvantaged non-urban communities, funding mental health needs is frequently overtaken by basic needs like access to food and shelter. Mental health needs which are often inaccurately perceived as not life threatening tend to be pushed down the priority list until it is too late to manage them with simple interventions. The WHO (2013) in the mental health action plan 2013–2020 states that 'People with mental disorders experience disproportionately higher rates of disability and mortality' (p. 7). The assertion that approximately 75% of people with a mental illness have no access to services and that this constitutes the mental health treatment gap prevalent in LMICs, including South Africa, should be understood against this background (Williams et al., 2008; WHO, 2016).

The WHO's Mental Health Gap Action Programme (mhGAP) intends to enhance services for mental, neurological, and substance use disorders particularly in LMICs (WHO, 2016). However, access to services should not be limited to only taking services to the communities and assuming that physical presence of the mental health component within the PHC setting is sufficient. Contact with the service point without the necessary resources cannot meet complex mental health needs. Access to services should translate to service users' ability to utilise and benefit from the service demonstrated by the effective management of identified mental disorders and optimal quality of life. While deinstitutionalisation and dissolution of stand-alone psychiatric clinics initiated integration of mental health services into PHC, there has been a failure to provide access to expert mental health professionals, which compromises the quality and benefit from mental health care (Stein, 2014). Therefore, access to services should consider that mental health care, including psychological interventions, are rarely a once-off occasion but constitute commitment to regular follow-up sessions for lasting impact. Failure to appreciate the long-term nature and value of the mental health consultation process impedes effectiveness of care, despite its accessibility. Hence, viewing access to services in a continuum of physical contact with the service point, quality and relevance of the service rendered, how the service is perceived and received and service impact in improving the quality of life could contribute to the service user's satisfaction and adherence to treatment. Therefore, access to services should consider availability, utilisation, and benefit from the rendered mental health services.

Conceptualisation of mental illness and utilisation of services

Different communities explain mental health issues in ways relevant to their specific contexts and their worldviews. Cultural explanations of mental illness dominate mental health issues. Inherent to these explanations is the stigma attached to mental illness which influences help-seeking behaviours (Jorm et al., 1997; Mkhize & Kometsi, 2008; Patel et al., 2007; Shai & Sodi, 2015). To address stigma, Lund, Kleintjes, Kakuma, Flisher, and The MHaPP Research Programme Consortium (2009) recommend investing in community involvement through establishment of a multi-sectoral community collaborative management forum. According to Lund et al. (2009), this collaboration can reduce stigma and encourage community control over their mental health. While this approach can alter how mental health is viewed and received, awareness that non-urban communities continue to rely on traditional healing interventions for chronic and manageable mental health needs is important. Shai and Sodi (2015) identified multiple pathways to health care which include both Western and traditional health care, depending on whether symptoms are acute or chronic. An earlier national study on traditional healers' treatment of common mental disorders in South Africa by Sorsdahl et al. (2009) found that alternative practitioners including traditional healers and religious advisors appear to play a notable role in the delivery of mental health care services. Labys, Susser, and Burns (2016) confirmed the complexity of pathways to mental health care in rural South Africa and found that more than half of service users reported no contact with

formal health care services. Moreover, those authors proposed consideration of services beyond formal health services and community-based interventions. It must be borne in mind that perceptions and understandings of mental health issues influence the types of services that are utilised and these should be considered in service planning and development. The influence of the cultural context in conceptualising mental illness, mental health needs, and importance of cultural sensitivity in mental health service delivery is well documented.

Understanding of clinical psychology in non-urban settings

The previous tiered structure of the South African health system meant that mental health and clinical psychology services were only available at tertiary level which limited access to these services (Cooper, 2014). Clinical psychologists' roles and scope remain misunderstood not only by service users but also by providers and caregivers (Rhohleder, Miller, & Smith, 2006; Swarts, 2013). While each professional has a unique health care role, focus area, and scope of practice, this misunderstanding affects the expectations and outcomes of consultation. In the PHC settings, inappropriate referrals are commonplace and such referrals are rarely explained to the health care users. Valuable consultation time is taken up as the service provider required to explain his or her role. Lack of understanding of each mental health service providers' role affects the treatment outcomes and formation of a strong therapeutic alliance (Ssebunya, Kigozi, Ndyabanangi, & MhaPP Research Programme Consortium, 2010) and contributes to a high rate of once-off sessions (Swarts, 2013). Therefore, beneficial interventions are disrupted by dissonance of expectations and goals between service providers and service users (Jorm et al., 1997).

In addition, psychological services in non-urban settings compete with traditional and medical models of care, where service users often leave sessions with concrete evidence of consultation that can be used between sessions and requests for medication at the end of the consultation are common. Mental insights or reflections from a psychological consultation may not be viewed as equally effective. The unintended effects of unclear understanding of the clinical psychologists' role may lead to underutilisation of the few available services and dissatisfaction for both psychologists and service users.

Conclusion

Research has shown that people living in non-urban settings are equally susceptible to mental illness and have complex mental health/ psychological needs. Considering that integration of mental health services into PHC is an international drive, concerted efforts to include clinical psychology services in all levels of care in non-urban settings is necessary to achieve global mental health coverage.

Collaboration between the department of health and training institutions to find robust means to mitigate the current integration challenges are necessary. Therefore, introducing middle-level workers such as registered counsellors could provide relief. They are not only an already available resource with psychological training, but they also have a clearly defined scope of practice (Health Professions Council of SA, 2004) to perform basic psychological and primary mental health screening, basic assessment, and psychological interventions. Furthermore, community health workers are effectively used to meet non-specialised health needs. Adopting a similar approach in mental health care could facilitate early identification, support, and timely referral of people in need of mental health services. While this is not a suggestion to replace clinical psychologists by registered counsellors and community health workers, utilising existing resources could avail the limited number of clinical psychologists, particularly in non-urban areas to provide training, support, supervision, and specialised psychology services. Considering financial and human resource

constraints in the public health sector and the reality of the prevalence of mental illness, the department of health should find innovative, flexible, and cost-effective ways of prioritising mental health services. Adopting such task sharing strategies as recommended by the WHO and other researchers could contribute to integrating psychology services into PHC. Furthermore, given the growing advancements of technology in health care, public mental health care should also explore strategies to utilise this medium of communication to optimise access, support, and service delivery in under-resourced settings.

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In Chapter 4, the researcher overviewed the clinical psychology service distribution in primary health care in KwaZulu-Natal. In this paper, the researcher presented the ratio and distribution of clinical psychology services in KZN primary health care, as a means to assess progress (or lack thereof) of the integration progress in the non-urban areas of KZN. This paper is published in the *South African Journal of Psychology* and titled "Siyothula E-TB. (2019). Clinical psychology service distribution and integration into primary health care in KwaZulu-Natal, South Africa. *South African Journal of Psychology*, 49(3), 391-402. doi:10.1177/0081246318815337". This paper addressed objective 1 of this thesis: "To examine the distribution of public mental health services that offer clinical psychology services in non–urban communities of KwaZulu-Natal".

The following chapter (5) presents the paper published in the *South African Journal of Psychology* under the title: "Siyothula E-TB. (2022). Experiences and views of clinical psychologists working in non-urban areas of KwaZulu-Natal, South Africa. *South African Journal of Psychology*, 52(3), 404-415. doi:10.1177/00812463221106828. In this paper the researcher explored and documented the perceptions and insights of clinical psychologists working in non-urban areas of KZN.

CHAPTER 5

PAPER 2

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Article

Experiences and views of clinical psychologists working in non-urban areas of KwaZulu-Natal, South Africa

Evy-Terressah Busisiwe Siyothula

Abstract

The process of integrating mental health care into primary health care remains slow in many non-urban areas of low to middle-income countries. The present study explored clinical psychologists' experiences of working in non-urban areas of KwaZulu-Natal to assess the progress of integrating mental health into primary health care. Twenty-nine clinical psychologists participated in this study and provided input on the following areas: clinical psychologists' preparedness, through training, to work in resource-constrained non-urban areas; availability of mental health resources; and understanding of the clinical psychologists' role in their work context. Over half (51.7%) of the participants reported that their training did not prepare them to work in resource-constrained non-urban areas and more than two-thirds (72.4%) reported a lack of basic resources needed for optimal mental health care in non-urban areas of KwaZulu-Natal. The findings reflect the need for comprehensive training of clinical psychologists to enhance their competency and confidence to work in resource-constrained settings. Furthermore, investment in the promotion of clinical psychology services and more conducive mental health service environments is necessary.

Keywords

Clinical psychology, clinical psychology training, competency, non-urban areas, resource constraints

According to the World Health Organization (WHO; 2011), mental health is a neglected priority, and the disparity of health resources between low- and high-income countries remains a global concern (Caldwell et al., 2018; Vergunst, 2018). Morales et al. (2020) emphasize that service disparities carry the risk of poor mental health outcomes in non-urban communities, which compromises efforts towards optimal mental health coverage (WHO, 2013). Furthermore, the scarcity of

Department of Behavioural Medicine, University of KwaZulu-Natal and Fort Napier Hospital, South Africa

Corresponding author:
Evy-Terressah Busisiwe Siyothula, Department of Behavioural Medicine, University of KwaZulu-Natal and Fort Napier Hospital, PO Box 370, Pietermaritzburg 3200, South Africa.
Emails: bsiyothula@gmail.com; siyothulab@ukzn.ac.za; busi.siyothula@kznhealth.gov.za

community-based mental health services, particularly in non-urban areas, is not limited to low- and middle-income countries but is observed worldwide (SASOP, 2017). A similar trend is prevalent in South Africa, particularly in KwaZulu-Natal (KZN). The state of mental health in KZN non-urban areas is described as both dreadful and degrading due to resource constraints (De Kock & Pillay, 2017; Morgan, 2015). Although researchers state that the prevalence of mental disorders in non-urban areas is not different from that of urban areas (Riding-Malon & Werth, 2014; Sutherland & Chur-Hansen, 2014; Vergunst, 2018), access to the few existing mental health resources and their utilization remains a persistent concern that weighs on families and communities (Burns, 2010; De Kock & Pillay, 2017; Morgan, 2015; Vergunst, 2018). Therefore, attention to the dynamics of non-urban communities, mental health service users' needs, training and clinical competencies of mental health service providers in these settings is essential.

Psychology services in non-urban areas

For many years, mental health and psychology services operated at the tertiary level of health care; for mental health to fit in all the levels of care, it has to adapt to various contextual dynamics. In non-urban settings, mental health care has to fit in the established and multifaceted system of health care; some of these dynamics are discussed below. Vergunst (2018) states that South African non-urban communities are complex. Some of the factors that contribute to the complexity of these communities include significant barriers to accessing health care, for example, high transport costs due to travelling long distances to health care facilities, multi-layered pathways to mental health care, and lack of community-based psychosocial rehabilitation platforms (Vergunst, 2018). While there are no readily available data on the percentage of clinical psychologists who go into private practice, the clinical psychologists/population ratio in state health facilities indicates that clinical psychology and mental health services in KZN remain skewed and a scarce skill (De Kock & Pillay, 2017; Siyothula, 2019).

The scarcity of mental health services in non-urban areas predisposes these communities to alternative health care options. For example, Patel (2011) highlighted the significant role of traditional healers, particularly in the African context. He also alluded to the complementary nature of Western and traditional health helping systems even in well-resourced countries. In the (South) African context, traditional healers also play an important supportive role, are accessible, and share a similar community understanding of the conceptualization of illness (Mkhize & Kometsi, 2008), leaving less room for Western mental health care services as the primary point of contact. Shai and Sodi (2015) found that traditional healers are most likely to be consulted first or together with Western medicines for health concerns; this finding supports the assertion by Patel (2011) on the value of both health systems.

Similarly, non-urban residents have a known culture of strong networks that provide an immediate support base and possible distrust of external help, including clinical psychologists who may be viewed as outsiders with limited to non-existent local cultural, political, and economic understanding (Chipp et al., 2011). According to Hastings and Cohn (2013), 'it is hard for rural psychologists to be accepted . . . suspicion of outsiders is not uncommonly recounted as facets of rural social life' (p. 2). The distrust may subject psychologists to scrutiny with increased expectations to prove themselves to gain the trust of non-urban residents (Schank & Skovholt, 2006). Furthermore, Zingela et al. (2019) ascribe the distrust between Western and traditional parallel health systems to the minimal comprehension of the effectiveness of intervention strategies that each system uses in managing health concerns.

Considering that mutual trust is necessary for effective psychotherapy (Allen, 2021), psychologists working in non-urban communities should be aware of the dynamics that are beyond the

clinical contexts (Zingela et al., 2019). These are important intricacies of non-urban contexts that may impact service access and delivery (Sutherland & Chur-Hansen, 2014).

On the one hand, the strongly interconnected networks, deep socio-historical and political roots, strong family ties, enduring attitudes towards life, and high reliance on religious activities are among the defining qualities of non-urban communities (Riding-Malon & Werth, 2014), which can safeguard against psychological distress. On the other hand, this reliance on families and communities usually means that they are the first resources of help and support to their mentally ill members. However, the same act of caring carries the risk of predisposing families of the mentally ill to psychological distress (Iseselo et al., 2016). Iseselo et al. (2016) also highlight that the families' belief system may contradict that of mental health specialists and deter them from seeking help, thus depriving them of support and timely intervention from the health care system. Therefore, psychologists working in non-urban contexts should be familiar with these non-urban dynamics and help-seeking trajectories to be aware of the possibility of delayed presentation for mental health care and the prospects of intense and costly mental health interventions. Non-urban mental health service providers should also consider establishing collaboration with both formal and informal health resources to enhance access to help (Idriss et al., 2020). This collaboration could be attained by creating psycho-educational spaces in the formal health systems and showing an interest to learn from informal health resources.

Training issues and challenges for psychologists in non-urban areas

Globally, psychology scholars have raised concerns about urban-based and exclusive clinical training that mainly caters to urban communities and call for training that equips psychologists with relevant, inclusive, flexible, and context-sensitive clinical competencies (Pillay et al., 2013; Riding-Malon & Werth, 2014; Sutherland & Chur-Hansen, 2014). Also, Werth et al. (2010) found that most non-urban psychologists deal with specific ethical dilemmas not commonly found in urban areas; this suggests that current clinical psychology training may not be sensitive to all clinical contexts. To meet the unique health needs of non-urban communities, Sutherland and Chur-Hansen (2014) emphasize the need for training to incorporate clearly defined competencies for mental health care service providers. Therefore, training models that emphasize brief, evidence-based, community-oriented, and culturally sensitive mental health interventions are necessary for effectiveness in resource-constrained settings (Kohrt et al., 2018). For a diverse and resource-constrained country like South Africa, Mkhize and Kometsi (2008) advocate a collaborative approach and warn that 'the training of mental health professionals is incomplete if it does not include exposure to, and collaboration between, the Western and traditional health care systems that continue to exist side-by-side in South Africa' (Mkhize and Kometsi, 2008, p. 110). Hence, competencies that pay attention to the dynamics of non-urban communities and relevant context-specific issues such as higher levels of unemployment, poverty, financial stressors, and challenges in accessing services (Vergust, 2018) are long overdue. Similarly, Petersen et al. (2012) and Vergunst (2018) advocate utilizing readily accessible informal community interventions, adequate training, supervision, support, and interest in community-sensitive interventions that could enhance mutual benefits for non-urban service providers and service users.

A shift from traditional mental health care training approaches is necessary for psychology to remain abreast of the globally changing social and economic landscape that is particularly prevalent in non-urban areas. Ahmed and Pillay (2004) emphasized that the training of clinical psychologists in South Africa should be mindful of the country's context and equip them to address the diverse needs of the majority of the population dependent on state facilities. Therefore, clinical psychologists' training requires an approach that invests in this essential aspect of the behavioural

health workforce (Domino et al., 2019; Jameson & Blanck, 2007). Domino et al. (2019) further encourage the training of clinical psychologists that incorporates recruitment, retention, and an increase in the supply of clinical psychologists equipped to practise in non-urban contexts. Such a training strategy should prioritize the mental health needs of the population it serves and impart relevant skills, attitudes, and expertise (Sutherland & Chur-Hansen, 2014). According to Urbanoski et al. (2012), sensitivity to the service users' context improves therapeutic alliance, which is fundamental in the quality of the relationship between the service provider and the service user dyad and predicts treatment outcomes.

Furthermore, non-urban interventions require integrating communal perspectives to effectively impact diverse settings (Sutherland & Chur-Hansen, 2014). Communal approaches prevalent in non-urban areas include the active involvement of non-specialists, family, and the community in the treatment of mental health care users, which could increase accessibility and acceptability of services, and help reduce discrimination and stigma of mental illness (Kohrt et al., 2018). The current training of clinical psychologists largely focuses on individualized interventions (Pillay et al., 2013) that are informed by a Western worldview.

Furthermore, in a culturally and linguistically diverse country like South Africa (Johnston, 2011), training should reflect the equitable representation of the country's diversity. Pillay and Siyothula (2008) found that 14% of clinical psychologists in the Health Professionals Council of South Africa register were Black Africans and were trained post-1994. While this finding reflected growth from the pre-1994 training of Black clinical psychologists, the racial representation of clinical psychologists does not match the racial constituency of the South African population, where the ratio of Black Africans accounts for over three-quarters of the population (Statistics South Africa, 2021). Recently, Pillay and Nyandeni (2021) found that of the clinical psychologists trained between 2008 and 2020, only 14.8% were Black Africans. According to these authors, their findings reflect minimal growth in the training of clinical psychologists who speak indigenous languages of the majority of South Africans dependent on state health facilities. This slow progress maintains the pre-democratic inequalities in accessing basic health services by all South Africans (Pillay & Nyandeni, 2021). These statistics are even lower for clinical psychologists who work in the non-urban areas of KZN (Siyothula, 2019). Therefore, without training models that equip clinical psychologists with relevant competencies for all the contexts they practise in (Kohrt et al., 2018), the incompatibility between the expectations of service providers and service users is likely to ensue and compromise positive mental health treatment outcomes (Morales et al., 2020).

Background to the current study and KZN context

South African clinical psychology evolves from an exclusive past regarding access to training and psychology services (Manganyi, 2013). While the intentions and efforts of the profession to change the previous exclusions are commendable, Pillay and Nyandeni (2021) found minimal growth from the previous study (Pillay & Siyothula, 2008). More than 80% of the population are African and are dependent on the public health system for their health needs (Ngobeni et al., 2020, Pillay & Siyothula, 2008), and a third of the South African population lives in non-urban settings (World Bank, 2012). Almost 75% of the population has no access to mental health services (Council for Medical Schemes, 2014). Most non-urban KZN health districts do not have specialists or functional multidisciplinary teams (De Kock & Pillay, 2017). The South African Air Mercy Services (AMS) in partnership with the Department of Health (DOH) provided 'flying doctor' services in KZN until August 2020. AMS either transported patients from outlying communities with inadequate or no specialized health care to tertiary institutions or transported health specialists from urban to non-urban health facilities (Caldwell et al., 2018). Clinical psychologists also joined the AMS to reach

non-urban patients needing mental health care services closer to where they live (Pillay et al., 2009). Sadly, this valuable service was disrupted by the Covid-19 pandemic, leaving non-urban communities once again without basic mental health care. While the AMS and DOH partnership stopped a few years ago in other parts of the country, in KZN it continued on an annual contract basis until August 2020. Although poor investment in mental health could partly explain the cessation of this valuable partnership that benefited non-urban communities, other health specialists utilized the same mode of transport to reach remote areas and their services also ended in the same period.

This article aims to explore the experiences of clinical psychologists rendering services in non-urban areas of KZN on a full- or part-time basis to understand the receptiveness of the non-urban health environment to clinical psychology services and (indirectly) assess the progress of mental health integration into primary health care.

Method

A purposive, descriptive cross-sectional research design (Polinkas et al., 2015) was considered relevant for this study to document the expectations and experiences of clinical psychologists working in non-urban settings.

Participants

State-employed clinical psychologists with past and current experience of working in primary health clinics and district hospitals in Harry Gwala, UMzinyathi, and Umkhanyakude health districts in KZN were approached by the researcher for participation in this study. Thirty participants were targeted and 29 responded, constituting a 96.6% response rate.

Instrument

A brief self-administered semi-structured questionnaire was used to collect quantitative and qualitative data. The questions covered demographics, designation, and years of professional experience. The following questions were also asked: Do you feel that your training prepared you to work in non-urban settings? What has been your experience when you consult clients referred for psychological intervention? Do you feel that your clinical setting provides you with the resources to help you meet the mental health needs of the patients? The questionnaire was designed based on the literature in this area of research.

Procedure

Participants were given an information brochure describing the purpose of the study, conditions of participation, the consent form, and a self-administered questionnaire. The questionnaire took approximately 30 min to fill in. Participants were requested to omit identifying details to facilitate anonymity. The researcher collected and stored the questionnaires in a locked filing cabinet.

Ethical considerations

Ethical clearance for this study was obtained from the Biomedical Research Ethics Committee (BREC) of the University of KwaZulu Natal and the KZN DOH. The voluntary nature of participation was clarified, and a decision not to participate would have no adverse consequences for participants. Only participants who consented were included in the study.

Data analysis

SPSS version 25 was used to analyse quantitative data, while thematic data analysis was used for open-ended questions. Coding was performed by the researcher and verified by an independent non-participant who is familiar with qualitative research. Where participants' verbatim responses are quoted, participants have been allocated numbers.

Results and discussion

The age range of participants was 24–60 years with a mean age of 38.93 years. The majority identified as female, 21 (72%); 7 (24%) were males; and 1 (3.4%) identified as other. Finding that the majority of participants were female is in keeping with the international gender distribution in professional psychology. Cynkar (2007) found a similar percentage (72%) of females enrolled in professional psychology programmes in the United States. Locally, a similar trend of gender imbalance in psychology is reported by the Health Professions Council of South Africa (HPCSA, 2017) and Skinner and Louw (2009), who describe it as the global feminization of psychology, influenced by more women than men entering and staying in the profession. Most participants, 24 (82%), were independent practicing clinical psychologists, and only 4 (13.8%) were doing their community service. The wide gap between independent and community service clinical psychologists could reflect the slow growth rate in the discipline of clinical psychology (Pillay & Nyandeni, 2021) and maintains the skewed population/clinical psychologists' ratio in non-urban areas of KZN (De Kock & Pillay, 2017; Siyothula, 2019).

The psychologists' experience in the profession ranged from 1 to 34 years. Just under half of the participants (44.8%) had between 1 and 5 years of experience and 31% had professional experience of 11 years and above. Finding that almost a third of interviewed participants worked in non-urban areas is encouraging as human resource constraints in non-urban areas remain prevalent (Sutherland & Chur-Hansen, 2014). Yet a significant shift is required to reverse an imbalance in the psychologist/population ratio that interferes with psychologists' ability to meet the community needs in this context (De Kock & Pillay, 2017; Siyothula, 2019). Almost two-thirds, 62% (18), of the participants render services in non-urban areas on a full-time basis. However, this percentage is not reflective of the current provincial trend as most non-urban areas in KZN do not have clinical psychology services (Siyothula, 2019). Participants may have referred to their full-time employment status rather than the frequency of rendering services in non-urban areas as required by the question. Almost a third (31%) of the participants render services on a part-time basis by either flying in and out or driving in and out; this reflects the state of clinical psychology services in non-urban areas of KZN. A similar approach to the provision of clinical psychology services in non-urban areas of Australia has been reported (Sutherland et al., 2017).

Competency for non-urban context

Only 17% of the participants reported preparedness to work in a non-urban context from their theoretical training. Schweinsberg et al. (2021) support the integration of work readiness in the training of graduates. The low percentage of participants' readiness indicates the need for the theoretical aspect of psychology training to invest in offering graduates essential competencies that enable them to cope with the demands of diverse contexts in which they practice. Over a quarter of participants (27.6%) referred to their internship as the component of training that prepared them for non-urban work as expressed by Participant 14:

> As an intern, I was exposed to working in the community (+) with translators while getting intense supervision.

The above participant's response indicates that the internship equipped her with the skills for clinical practice. However, for effective mental health service delivery to be rendered during the internship, basic competency should be developed by the end of the theoretical training (Ahmed & Pillay, 2004). The internship should consolidate and enhance theoretical knowledge under clinical supervision and equip interns with skills that could not be obtained from the classroom environment (Stiles-Smith et al., 2019).

Although almost half (48.28%) of the participants reported that their training prepared them for working in non-urban settings, their explanations emphasized the practical training during internship, without specific reference to theoretical training:

More than half (51.72%) of the participants indicated that their training did not adequately prepare them for working in a non-urban context. For example, Participant 4 stated,

> We were trained in assessment methods that were not often valid for the rural context. We did not receive training in short-term interventions.

In addition, Participant 16 stated,

> We were not trained in working through interpreters, in particular, informal interpreters.

For these participants, their training was deficient and failed to equip them with relevant competencies for non-urban settings. Researchers also emphasize the value of clinical training that equips non-urban service providers with context-sensitive and discipline-specific competencies (Ahmed & Pillay, 2004; Schweinsberg et al., 2021; Sutherland & Chur-Hansen, 2014). Therefore, the finding that most participants expressed failure of their training to adequately equip them to work in the non-urban context where the majority of state-dependent South Africans reside (World Bank, 2012) is a major concern.

The lack of focus on the gap in preparing clinical psychologists to efficiently work in resource-constrained settings is captured in the statement by Participant 13: 'Insufficient focus in my training (35 years ago!) on non-urban/ rural/ community psychology work'. This participant's expectation of focused attention to all the areas of clinical practice from the theoretical aspect of the training is not unreasonable. There is growing research that highlights the need to support students with skills for the working environment as a vital function of tertiary institutions (Schweinsberg et al., 2021). Failure of training to equip psychologists with competencies for all aspects of clinical practice could hinder the expected efficient mental health service delivery at the beginning of the internship as indicated by Pillay and Kramers-Olen (2014).

Job satisfaction

Zopiatis et al. (2014) stated that workplace issues could influence employee attitudes. Therefore, it is important to understand the impact of job-related issues and develop strategies to improve both individual and organizational performance. The majority of participants, 24 (82%), expressed satisfaction with working in non-urban areas; for example, Participant 2 stated,

> Non-urban community is deprived of psychological intervention; therefore, for me being the service provider is rewarding.

Only 5 participants (17.2%) expressed dissatisfaction.

Explanations from the satisfied participants included appreciation from service users and psychologists' conviction that they provide the much-needed service. Furthermore, awareness that obstacles faced by service users referred to urban areas for mental health needs are not only limited to costly transport (Pillay et al., 2009; Vergunst, 2018) but also prolonged waiting periods convinced psychologists of the value of their services. Also, delays in timely interventions may result in complex mental health issues requiring specialized and costly treatments (Wang et al., 2007). Interestingly, none of the participants mentioned the financial incentive (rural allowance) paid to service providers to encourage them to continue working in non-urban areas in contrast to the Australian non-urban respondents who cited this benefit as one of the motivating factors to continue non-urban practice (Sutherland & Chur-Hansen, 2014). Only a few participants (13. 8%) expressed reluctance to continue working in non-urban contexts and cited personal professional development, lack of support, and experiencing non-urban work to be emotionally demanding. This finding reflects that non-urban work does not provide psychologists with access to peer support and supervision as in urban areas. Although the study was conducted prior to the Covid-19 pandemic, which opened opportunities for online resources, accessing them is not without its challenges. Zalat et al. (2021) report that unstable Internet connections interfere with uninterrupted online attendance of courses. Online support should not be a substitute for dependable face-to-face support, which is an option available to urban practicing colleagues.

Professional misconceptions

Hughes et al. (2013) define professional misconceptions as discipline-inconsistent beliefs that originate from internal and external sources and reflect a genuine, replicable, and general phenomenon related to core beliefs about the discipline. Only 31% of the participants expressed that other health care professionals understand the role of clinical psychologists. This is a serious concern considering that community clinical psychology services are rendered within the district hospitals and primary health centres where these health professionals are the first contact for health care needs. If they do not understand the role of the clinical psychologists, there will be delays in appropriate and timely referrals (Wang et al., 2007). Almost two-thirds (62%) of the participants stated that other health care professionals who refer patients for psychological interventions do not understand the role or scope of practice of clinical psychologists. Participants based this assertion on the number of inappropriate referrals and unrealistic expectations from the referral sources which were often outside the scope of practice of clinical psychologists as reflected by the following responses. Participant 22 stated,

> Frequent inappropriate referrals suggest that other professionals do not understand the role or scope of practice of clinical psychology.

Participant 26 stated,

> They don't entirely (understand) – you realize this in the referrals they send to you and how and when they expect your intervention.

Furthermore, 89% of the participants believed that service users misunderstood the role of clinical psychologists in this study. Participants mentioned being confused with other health professionals and cited requests by service users for medication (prescribed by medical doctors and psychiatrists) as the basis of their conclusion.

Resource constraints, challenges of working in non-urban areas and impact on service delivery

Resource constraints were reported by more than two-thirds (72.4%) of participants; lack of basic resources such as a conducive working environment, assessment tools, computer equipment, access to telephone, and Internet services were some of the reported deficits. Also, access to play therapy facilities, translators for non-IsiZulu-speaking psychologists and relief for vacation leave were reported as barriers to optimal service delivery as expressed by Participant 4:

> 'No Assessment tools provided and ordered. Often the consulting rooms lacked privacy or were noisy and interruptions often occurred. Services of an interpreter were often difficult to secure'.

In addition, heavy workload, lack of support from management, time constraints for long-term therapy, missed follow-up sessions, many incidents of one-off sessions, professional isolation, and stunted professional growth were mentioned as prevalent challenges in non-urban contexts. For five participants (17.2%), these challenges contributed to their reluctance to continue working in non-urban areas. Also, staff shortages amplified by the 'freezing' of existing vacant posts caused by the moratorium in KZN and the lack of explicit strategies to retain resident clinical psychologists in state employment maintain the challenges expressed by participants. Despite recent new health posts to mitigate the effects of the Covid-19 pandemic, this initiative has not reversed the skewed psychologists/service users' ratio in KZN non-urban areas.

Insights from clinical psychologists

Forty-eight percent (48%) of the participants shared additional perceptions of the state of mental health in non-urban areas and the understanding of clinical psychologists' role. For example, participant 19 stated that

> Non-urban areas are usually underserviced. People living in these areas are likely to have been previously disadvantaged. Continuing working in these areas can be viewed as a movement towards social justice.

Participant 21 stated that

> Systemic problems are very frustrating- inadequate recognition of mental health needs by the Dept of Health therefore insufficient resources but huge pressure for services.

Furthermore, participants' responses reveal frustration from the perceived lack of investment in mental health and the resultant compromise of mental health services. Other responses highlighted hopes and desire for a change in the current situation of mental health in non-urban areas as expressed by the response of Participant 26:

> Being employed in non-urban areas is not that bad- provided there is sufficient support and provision of resources. Many people need our services though they don't realize it. It would be easier if resources were available.

Despite most participants' willingness to continue to work in non-urban areas, the current working conditions remain a challenge.

A limitation of this study is the small sample size, and therefore, the findings cannot be generalized. Another potential limitation is that some participants' responses may have referred to their

full-time employment status rather than the frequency of working in non-urban settings as intended by the researcher. A face-to-face interviewing approach may ameliorate this limitation.

Conclusion

Participants' responses in this study indicate that the traditional training has not adequately prepared clinical psychologists to work in non-urban areas confidently. This finding amplifies the need for training models that equip aspirant clinical psychologists with the necessary competencies to practise in diverse and non-urban settings (Jameson & Blanck, 2007; Pillay et al., 2013; Sutherland et al., 2017). Similarly, most participants raised concerns about the resource constraints that persist in non-urban areas of KZN. While the value of integrating mental health into primary health care is well documented, the state of mental health in non-urban areas continues to reflect poor investment and neglect of mental health care. Therefore, moving forward, there is a need to focus on enhancing clinical psychology training to include non-urban work as well as addressing finance and other resource deficits in non-urban health care in South Africa.

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ORCID iD

Evy-Terressah Busisiwe Siyothula https://orcid.org/0000-0001-7219-771X

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CHAPTER 6
PAPER 3

Health professionals' experiences of clinical psychology services in non-urban areas of KwaZulu-Natal, South Africa

Abstract

Mental health relies on the multidisciplinary team (MDT) approach to effectively manage mental disorders. Collaboration among MDT members optimizes mental health interventions' holistic efficiency. For the smooth functioning of the MDT, it is important for team members to understand the role each of them plays to facilitate appropriate and timely referral when necessary. This study explored the health professionals' experiences of clinical psychology services in non-urban areas of KZN. Fifty six health professionals shared their experiences, expectations and needs when they refer patients for psychological interventions in this mixed-method study. The majority of participants reported a satisfactory understanding of the role of the clinical psychologist and that they would refer patients for clinical psychology interventions when necessary. However, over a quarter of participants reported that they do not feel that their training adequately prepared them to work in non-urban areas where resources are limited. There is a need to adjust the curricula to equip health professionals to practice in different contexts where their clients live.

Keywords: Health professionals, experiences, clinical psychology services, non-urban areas

The prevalence of mental health problems in low- and middle-income countries (LMICs) is concerning, and most non-urban communities in these countries carry a significant burden of disease (Burns, 2010; De Kock & Pillay, 2017). Research highlights a considerable treatment gap between the burden of mental disorders and mental health care resources in non-urban communities (Burns, 2010; De Kock & Pillay; 2017; Stein 2014; World Health Organization (WHO), 2018). Sawadogo et al. (2020) state that 76% to 85% of people with severe mental disorders in LMICs do not receive treatment. Stein (2014) reported that 75% of people with common mental disorders in South Africa do not receive any treatment. This problem is exacerbated by the fact that 40-45% of the South African population resides in non-urban areas where resources are scarce and unevenly distributed (De Kock & Pillay, 2017; Morgan, 2015; Siyothula, 2019).

The gap between service provision and disease burden may be aggravated by the perceptions of primary health care workers and patients since they can influence the health care trajectory that is followed (or avoided) in pursuit of mental health care (Maimela et al., 2015). Further, the experiences and actions of primary health care professionals influence whether patients get referred for mental health interventions and whether the referred patients accept and commit to the referral. Therefore, reaching mental health patients is a multifaceted challenge; it depends on the availability and accessibility of services and the referring health professionals' perceptions of mental health services.

A multidisciplinary approach to mental health care is key to ensuring the effective management of mental illness. The multifaceted mental illness manifestation requires diverse expertise and competencies from the multidisciplinary team (MDT). Therefore, a healthy and functional relationship in the MDT is beneficial for optimal service delivery. Primary health care providers like doctors and nurses are the first port of call for service users in need of health care. Ashcroft, Kourgiantakis, and Brown (2017) reported evidence supporting the value of the collaborative care approach from medical and non-medical professionals to manage the mental health needs of diverse populations and contexts. Therefore, the MDT's expertise, experiences, collegiality, and perceptions of mental illness determine whether they consult with each other and refer patients to relevant mental health specialists when necessary (Corrigan et al., 2014).

Health professionals' perceptions do not only determine whether patients get referred to mental health specialists such as psychologists but also determine the motivation of the referral, whether the referral benefits the patient or the referral is a means to 'dispose of' patients who could not be helped by purely biomedical interventions. Further, researchers caution that patients sense a negative attitude from a health care professional towards them or their ailment (Cabassa et al., 2014; Smith, Mittal, Chekuri, Han, & Sullivan, 2017), and this attitude influences their level of commitment to the health system and the prescribed treatment regimen. Hence, the health care providers' mental health knowledge and perceptions influence their enthusiasm and attitude towards referring patients to mental health care specialists when the need arises.

Dube and Uys (2016) found that most nurses in primary health care (PHC) are unable to identify mental illness. This indicates that being a health care provider does not automatically translate into sufficient knowledge or a positive attitude towards mental illness. Therefore, examining health professionals' understanding and perceptions of mental health and mental health care users (MHCUs) is essential in evaluating the holistic effectiveness of health interventions.

Furthermore, mentally ill patients experience stigma from multiple sources (Li et al., 2014; Mosaku & Wallymahmed, 2017). Mental health care providers might also experience discrimination from non-mental health colleagues, based on their passion and preference to serve the mentally ill. Sawadogo et al. (2020) argue that health professionals are not exempt from traditional beliefs, prejudices, and negative attitudes toward MHCUs. These constitute additional barriers to access mental health care, predisposing young health professionals to negative attitudes and stigmatizing patients with mental illness (PWMI) (Kato et al., 2013).

Considering the high incidence of mental disorders and that the WHO advocates integrating mental health into PHC (WHO, 2018), every health professional's likelihood of encountering patients with mental illness is high. As such, they should be able to identify and refer PWMI timeously and appropriately. Hence, health professionals' training should invest in understanding mental health and mental illness to optimise holistic patient care and access to available mental health services. Sheehan et al. (2010, in Triplett, 2017) found that, in Australia, even in professions closely tied to mental health care such as social work, only 45% of the training schools offer a separate mental health class or module and specific mental health skills development. Focused local contextualisation and explicit links to field education could improve social workers' mental health curriculum (Triplett, 2017). This asserts the value of adequate clinical exposure of health professionals to the mental health context, to enhance their confidence and competency in dealing with mental health issues.

The proposal to incorporate mental health care into PHC is a global drive (WHO, 2018). However, various PHC facilities still do not have adequate mental health care resources and personnel. The number of clinical psychologists is limited in non-urban primary health care settings, despite the documented need (De Kock & Pillay, 2017). Issues like

poor infrastructure, human resource constraints, and inequitable distribution of services, as well as access challenges and diversity of non-urban communities, are among the nodal points that mark rurality (DeAngelis, 2016). These factors severely impact mental health service use and delivery (DeAngelis, 2016; Sutherland & Chur-Hansen, 2014).

Against this background, the present research explored the experiences and views of public sector health professionals referring patients to clinical psychologists in the non-urban areas of KwaZulu-Natal, South Africa. Due to the comorbidity of physical symptoms, mental disorders, and psychosocial stressors (Haftgoli et al., 2010), primary health care professionals play a significant role in identifying, treating, and referring patients needing care (WHO, 2018) to mental health specialists.

Purpose of the study

The present study explored the experiences and views of health professionals in KZN's non-urban contexts to inform clinical psychology service development in these settings. The objective was to explore other healthcare workers' understanding of mental health care and the role of clinical psychologists within the healthcare system. Another purpose was to establish whether these health care professionals understand the need to refer patients for psychological interventions and identify concerns and knowledge gaps (if any) when referring patients to psychologists. Documenting the health professionals' views and experiences could also inform hospital managements about challenges faced by health professionals, while treating MHCUs in the general health care setting.

Method

A descriptive, cross-sectional, mixed-methods research study was conducted in three rural district hospitals in KwaZulu-Natal.

Participants

A purposive sampling method was utilised to sample health care professionals such as doctors, nurses, social workers, occupational therapists, speech therapists, and dieticians within the hospitals. These professionals form part of the MDT that potentially refers patients to clinical psychologists. The participants' age range was 21-62 years. Sixty health professionals were targeted, as per statistical calculation, but 56 responded, constituting a 93.3% response rate.

Instruments

A self-administered open-ended questionnaire was used to collect data. The first part of the questionnaire covered participant demographics. The second part explored the participants' experiences and preparedness to work in non-urban settings, job satisfaction, involvement with mental health services, mental health knowledge, understanding of the role of clinical psychologists, their experiences of referring patients to the clinical psychologist, as well as their expectations and views on the conduciveness of their working environment to the mental health needs of their patients.

Procedure

Data were collected from participants working in the three non-urban KZN district hospitals that were selected for the study. All participants were given information sheets before consenting and completing survey questionnaires. The completed questionnaires were collected on the same date that they were given. Each questionnaire took approximately thirty minutes to complete. Participants were advised that their involvement was voluntary and they could withdraw from the study at any time without consequence.

Ethical considerations

Ethics clearance for the research was obtained from the University of KwaZulu-Natal Biomedical Research Ethics Committee (BE 199/15). Participants gave consent to participate in the study and participation was voluntary.

Data analysis

The SPSS version 26 programme was used to analyse the quantitative data. Thematic analysis was done for qualitative data (Braun & Clarke, 2019). Coding was performed by the researcher and corroborated by a colleague who was familiar with qualitative research procedures.

Results

Sample characteristics

Table 1 presents the sample characteristics, after which the qualitative results are presented.

Table 1: Sample demographics

Demographic variables		
	N (56)	%
Gender		
Male	10	17.8
Female	45	80.3
Not stated	1	1.8
Age		
20-35	37	66.1
36-55	15	26.8
56+	4	7
Profession		
Nurse	7	12.5
Medical officer	16	28.7
Social worker	16	28.7
Occupational therapist	5	8.9
Employee Assistance Practitioner	1	1.8
Speech and language therapist	2	3.6
Physiotherapist	2	3.6
Dietician	1	1.8
Missing data	6	10.7
Work experience		
1-5 years	27	48
6-10 years	11	20
11 and above	15	27
Missing data	3	5.3
Non-urban work experience		
1-5 years	30	54
6-10 years	10	18
11 and above	14	25
Missing data	2	3.5

Knowledge of mental health care and the role of clinical psychologists

Just over two-thirds (37/ 66. 07%) of the health care workers reported insufficient knowledge of mental health care, and 34% reported sufficient mental health knowledge.

Insufficient mental health knowledge (subjectively noted) was attributed to deficient training, lack of exposure or outdated mental health knowledge. For example, Participant 12 stated:

> *I have experience and previous training* [MRCPsych], *but the training was a long time ago and would love more.*

The majority (54/ 96.42%) of participants indicated that they understand the role of the clinical psychologist. Of the 56 participants, 24/ 42.85% were aware that clinical psychologists assess, diagnose, and intervene in mental health or emotional difficulties. However, others had a superficial idea of the clinical psychologist's role. For example, Participant 20 stated:

> *Psychologists round up the holistic care of an individual; they touch the facets of life that other professionals can't reach.*

Expectations and challenges of referring to psychologists

All participants reported that they would refer to clinical psychologists and 42 (75%) were pleased with the outcomes of their referrals. Only one participant was not pleased with the outcome of referring to a clinical psychologist. Six (10.71%) omitted the question and 7 (12.5%) had not referred patients for clinical psychology interventions. Some of the reasons stated by the 7 (12.5%) who had not referred include a lack of clear referral pathways, a limited range of health services and staff shortages in their hospitals, as reported by Participant 27:

> *The services available to MHCUs in our institution are currently very limited. I feel as though referral procedures and services available are lacking, due to staff shortage and lack of infrastructure.*

Those who referred reported that they expected the clinical psychologist to provide results and solutions to patients' difficulties, as stated by Participant 16:

> *Results! I expect a diagnosis! Problem identification and plan to* [treat] *and intervention to healing and wellness.*

Experiences and perceptions of working in non-urban areas

More than two-thirds (38 / 67.87%) of the participants stated that they were not trained to work in non-urban settings, 15 (26.78%) reported that they were trained, and 3 (5.35%) did not respond to the question. The excerpts below capture some of the responses of those who reported that their training did not prepare them to work in non-urban areas,

> Participant 11: "*Lots of things I was taught were assuming I had all the needed resources. I haven't got enough of an idea of all the other health professionals."*

> Participant 30: *"The training was not adequate. Circumstances in non-urban areas are very difficult. People have a lot of challenges and are far away from resources."*

Those who reported that their training prepared them for non-urban work, despite inadequate resources, distinct cultures and worldviews between service providers and service users articulated some of their views as follows:

> Participant 24: "*It* [training] *taught me how to manage patients, with and without the availability of resources. It helped me recognise patients that need a referral."*

> Participant 38: *"We had six months of community block in the 3rd year and 4th year, which I feel prepared me for a rural setting, even though there are differences related to culture, beliefs and way of life."*

Conducive environment to meet patients' mental health needs

More than two-thirds (38 / 67.87%) of participants viewed the non-urban working environment as not conducive to meeting MHCUs' needs. Twelve (21.42%) reported that the environment was conducive, whereas one (1.78%) gave mixed views. Another one (1.78%) was unsure and four (7.14%) did not respond.

The three primary factors that participants felt made the environment unconducive were poor infrastructure (reported by 26 (46.42%); poor patient management systems such as patient referral systems, mental health education, and stigma (reported by 16 (28.57%); and shortage of mental health care specialists (reported by 13 (23.21%)

Although most of the participants found the non-urban environment to be unconducive to service delivery, 37 (66.07%) reported that they were satisfied with their jobs, whereas 16 (28.57%) were not satisfied, and 2 (3.57%) had ambivalent responses, with one (1.78% not responding to the question. The main factors that participants felt could enhance job satisfaction are reported in Table 2.

Table 2: Factors that participants felt could enhance job satisfaction

Variable	N	%
Availability of resources	36	64.2
Education and training	10	17.8
Support staff and patients	9	16.0
Addressing stigma	2	3.5
Safety and security for staff and patients	4	7.1
Knowledge of cultural differences	1	1.7

* Participants could give more than 1 response

Participants' views on how to enhance mental health service delivery in non-urban areas

Participants reported that to improve mental health service delivery in non-urban areas, firstly, a political willingness to support mental health is needed from the national government and other government departments, as expressed by these participants:

> Participant 20*: "Our government/Department of Health should look seriously into the need for more psychologists for all institutions to complete the well-being of individuals. Mental health should not be undermined, especially by higher authorities."*

> Participant 47: "*There has to be cooperation especially SAPS* (South African Police Services) *and to have a mental health institution in the district at least."*

Secondly, participants noted a need for task-shifting and sharing between health care professionals such social workers and psychologists. Participant 28 expressed this as:

> *Social workers need to know how to do psychological assessments even though there is no psychologist. There are more mentally ill patients who need their grants to be received, and we cannot help because there is no psychologist.*

Lastly, mental health needs to be prioritised and destigmatised, as expressed in the following extract from Participant 22:

> *Mental health should be taken as the priority, as the other conditions, and mentally ill patients should not be stigmatised and* [should] *be placed in a conducive environment as other patients.*

Discussion

Two-thirds (66.1%) of participants were in the category of young health care professionals, reflecting that they are still interested in working in non-urban areas. However, the disparity between young and experienced health care professionals is a concern because it means that young health professionals are left without experienced health professionals to mentor and supervise them. This is especially worrying in this sample, where most of the participants reported that their training did not adequately prepare them to work in non-urban settings and their training lacked mental health care focus (Adams, 2023). In other words, doubly disadvantaging people with mental illness living in non-urban communities.

Participants' years of professional experience ranged from one to 39 years; 48% of the sample had one to five years of experience, while a higher proportion (54%) of young professionals had one to five years of experience in a non-urban context. This could be explained by the wish of young professionals to gain experience in their respective fields before specialising or moving to a different work context, as well as perhaps a commitment to rendering health services where they are needed, despite the challenges of non-urban contexts. The compulsory community service introduced by the Department of Health to alleviate inequitable staff distribution between urban and non-

urban areas could also explain the relatively higher percentage of young professionals in non-urban hospitals (Gumede et al., 2021; Reid et al., 2018).

The most represented professional groups of participants were medical officers and social workers (28.6% each). Nurses and medical officers are the first responders in a district hospital for most patients presenting at the health facility with complex health concerns. While other members of the MDT, like social workers and occupational therapists, form part of the hospital organogram, mental health specialists (clinical psychologists and psychiatrists) remain scarce in district hospitals, especially in non-urban areas of KZN. Where specialists are available, service delivery and use are likely to be minimal if cultural beliefs dominate the aetiology of a disease or they are inundated with inappropriate referrals (Siyothula, 2019; Wegner & Rhoda, 2015). Failure to differentiate specific professional roles of specialists (by referral sources) could contribute to fewer or inappropriate referrals. Therefore, it was important to explore the mental health knowledge of health care professionals and their understanding of the role of clinical psychologists.

It is worrying that nearly two-thirds of non-urban health professionals rated their mental health knowledge as insufficient. This could mean that their ability to identify mental health needs is suboptimal and has the potential for missing critical diagnoses and opportunities for early mental health interventions. Although in a systematic review by Wakida et al. (2018), a similar concern emerged, the knowledge gap was not context-specific. However, it was seen as a barrier to the integration of mental health services into PHC, which has been proposed by the WHO over four decades ago. Given South Africa's attempt to include mental health care into PHC, this knowledge gap is a concern and can pose a serious barrier.

Spagnolo et al. (2018) found that deficiencies in mental health knowledge, attitudes toward mental health, and level of confidence/self-efficacy among non-specialists constitute a treatment gap that impacts the quality of care rendered to MHCUs. Therefore, investing in comprehensive, up-to-date and evidence-based mental health knowledge for all health care professionals, to empower them to execute their caring role efficiently remains important and could also enhance holistic and optimal service delivery. Some of the reasons given by participants who expressed insufficient mental

health knowledge included being recently qualified, lack of resources for up-to-date knowledge, and lack of practical experience in mental health. Considering the global drive to involve non-specialists in mental health care, in response to inequitable distribution and low availability of mental health specialists, robust strategies to equip them with mental health knowledge and support should be prioritised.

It was encouraging to learn that most participants' responses reflected a sufficient understanding of clinical psychology services, consistent with their scope of practice. An even higher percentage (93%) of participants stated that they refer their patients for psychological interventions. Participants' appraisal of referring to clinical psychologist was generally positive; 75% reported being pleased with the clinical psychologists' interventions and acknowledged the unique value of psychological interventions. Only one participant expressed being displeased with the outcome of the psychologist referral. While this participant's response may seem statistically insignificant, it highlights the importance of being always mindful of proficient service delivery that meets patients' needs, and this should remain central to patient care. Therefore, diligence and the ethical practice of delivering the same quality of care that health professionals expect for themselves or loved ones' health consultations should be upheld. The remainder of the sample had either not referred patients to clinical psychologists or did not share their views of the outcomes of the psychologist referrals. When referring to clinical psychologists, participants' expectations included assessments, assistance with the diagnosis, psychological interventions, provision of reports and recommendations, and contributing to the patient's management plan. These expectations are consistent with the clinical psychologists' scope of practice.

More than a quarter (27%) of participants stated that they do not feel adequately equipped or trained to work in a non-urban context. This gap was articulated by participants who viewed training in well-resourced settings as a factor that deprived them of an opportunity to develop competencies for working in under-resourced settings. These participants' responses implied that their training failed to consider context-specific needs and assumed that adequate resources *will always* be available across different contexts. Such training appears to have disregarded the well-documented inequity and resource constraints in South African non-urban settings (De Kock & Pillay, 2017; Siyothula, 2019; Stein, 2014; Sutherland & Chur-Hansen, 2014; Swarts,

2013). Clearly, the training of health professionals in LMICs needs to consider resource constraints and train students accordingly.

Furthermore, some participants were deprived of the necessary context-specific competencies, and this also adversely impacted the quality of care that they can provide to non-urban communities. It is unfortunate that this results in a situation where rural patients do not receive the same standard of health care as their urban counterparts. Training that ignores the country's social matrix compromises the quality of service to the very population it claims to serve. It is not unreasonable to expect a competent health professional to treat MHCUs to address their health needs effectively. Finding that only just over one-third (34%) of participants stated that they had sufficient mental health knowledge is a cause for concern, and health professions training schools need to take note.

The majority of participants viewed the working environment in district hospitals in the study area as unconducive to the patients' mental health needs. Factors reported as contributing to an unconducive environment include poor infrastructure, patient management systems, and staff shortage. Participants' views of the unconducive working environment in non-urban district hospitals correspond with the literature on the non-urban mental health contexts of LMICs and reflect the low priority given to mental health care (Bird et al., 2011). Finding that less than a quarter of the present participants viewed the environment as conducive to mental health care is a concern and reflects poor/ slow investment in mental health care (Rathod et al., 2017; Wainberg et al., 2017b). Other participants reported a recent change from the previously unconducive environment and stated that the change was welcomed, however, there is room for improvement to reach satisfactory level of mental health resources. Over a third (39%) of the sample emphasized that a conducive environment, that protects the welfare and dignity MHCUs, is important. The WHO (2015) also alluded to the importance of upholding MHCUs' dignity. The unconducive environment needs urgent attention, as it threatens optimal and quality mental health care, as well as staff retention in non-urban contexts (Mulaudzi et al., 2020). The frustration of being limited by the working environment to render quality services could be another reason why the proportion of older and experienced professionals was low in this study, compared to younger professionals.

Although lack of training and resources made working in the non-urban areas unconducive, most participants reported being satisfied with working in non-urban hospitals. Research shows that job satisfaction is influenced by several factors, including the working environment and the resources to meet the job demands (Mehta, 2020). The present finding is, therefore, somewhat surprising, but may relate to the personal reward that comes from doing good. Over one-third (36%) of the sample raised a need to have adequate resources e.g. infrastructure, resident clinical psychologist and other multidisciplinary team members who are trained and experienced mental health personnel. Participants listed these resources as important factors that could contribute to their job satisfaction and efficient service delivery. The shortage of mental health specialists in non-urban areas is a global concern and reflects a low investment in building functional mental health management teams in these settings (Mongelli et al., 2020; Siyothula, 2022). It could also indicate low confidence in participants to meet patients' mental health needs without specialist support. This is concerning given the research evidence on the debilitating effects of mental illness and the comorbidity of mental and physical disorders (Rathod et al., 2017; Wainberg et al., 2017b).

Further, routine staff rotation of nurses in some general hospitals removes dedicated and experienced mental health staff and compromises the quality of service delivery. Such rotations disrupt stability in this cadre of the health team, which forms an important part of the MDT. Participants also pointed out that the involvement of the health facilities management team was important for their job satisfaction and efficient service delivery. These statements articulate the significant role that the management team should play in facilitating quality mental health services and supporting the mental health personnel. Educating stakeholders in the mental health/PHC integration process is also emphasized by Petersen et al. (2011), especially because this is not a concept that is widely understood. Many health workers were trained on the dichotomous model of mental health care that saw mental health care restricted to specialist mental health facilities far removed from general hospitals and district/community clinics (Maconick et al., 2018). However, the shift in policy and practice models need to be integrated into professional training.

Lack of confidence in mental health knowledge exposes a gap in the training of health professionals. It is also a broader concern than commonly realised, because mental health impacts health in general. Williams (2018) eloquently articulated the significance of mental health in his reflection on the annual public health conference titled "There is no health without mental health". Apart from the morbidity of mental disorders, people with mental health problems have greater vulnerability to physical illness which also compromises treatment adherence due to impaired psychological (Launders et al., 2022; Sartorious, 2013). Only two (3.5%) participants in this study mentioned the impact of stigma on mental health care, which is surprising, considering that research cites stigma as one of the major barriers to accessing mental health care (Knaak, Mantler, & Szeto, 2017).

Conclusion

The integration of mental health care into primary health care provides the strategic space to identify, treat and appropriately refer patients to mental health specialists when necessary. Finding that most participants expressed insufficient mental health knowledge is concerning, and indicates the need for ongoing mental health education, as proposed by the WHO (2018). This investment in mental health care would enhance non-mental health professionals' confidence to identify and manage mental illness competently, and to address the access and service utilization challenges prevalent in poorer countries (Carbonell, Navarro-Perez, & Mestre, 2020). Training programs for health sciences should pay adequate attention to mental health to equip health professionals and bridge the mental health knowledge gap that has been expressed by participants in the present study.

This study also highlighted the concern about the working environment in non-urban settings as being unconducive to the effective treatment of MHCUs. This exposes the slow uptake and insufficient priority offered to mental health in non-urban settings and highlights the importance of treating MHCUs in an environment that upholds their dignity. Rathod et al. (2017) cited similar challenges that impede the integration of mental health services in the LMICs' PHC settings. However, despite the inequitable distribution of clinical psychology services between urban and non-urban settings (De Kock & Pillay, 2017, Siyothula, 2019) findings in the present study asserted the value of

clinical psychology in district level health facilities and reported a high rate of referrals (93%) as well as favourable perceptions of outcomes among referring practitioners.

It is clear that concerted efforts are needed from government and health authorities to invest in mental health care resources in non-urban communities. This is essential if we are to bridge the gap between the burden of mental disorders and the effective treatment programmes, as well as mental health promotion initiatives. The gap between mental health service needs and the available and accessible mental health services remains a global concern. Furthermore, robust strategies to capacitate and support health professionals for mental health care in non-urban areas remain essential to address the recurrent human resource constraints. Focused attention to non-urban communities' mental health needs is necessary, not only to ensure that they receive the care they need, but also in recognition of the high levels of stress and vulnerability faced by these underserved communities.

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CHAPTER 7
PAPER 4

Mental health service users' knowledge and attitudes regarding referral to clinical psychologists in non-urban health districts of KwaZulu-Natal, South Africa

Abstract

Approximately one-third of South Africans reside in non-urban areas and access to mental health services is a challenge. This research explored mental health service users' knowledge and attitudes regarding clinical psychology services in some non-urban areas of the KwaZulu-Natal province. Forty service users participated in the study. Most of the participants (62.5%), were referred by medical doctors and 85% reported that they would recommend mental health consultation to others. Most of the participants did not show preference regarding the clinical psychologists' age, gender, or race. The findings reflect non-urban communities' adaptation to the reality of the scarce resources within the healthcare sector and a greater concern about obtaining some level of service appears to predominate.

Keywords: Mental health service users, knowledge, attitudes, clinical psychologists' referral, non-urban health districts

Jorm et al. (1997) introduced the term mental health literacy and conceptualized it as an understanding and views about mental disorders that assist in the identification, treatment or prevention. Similarly, Jorm (2012) positioned knowledge at the centre of mental health literacy to facilitate access to accurate mental health information, available self-help strategies and professional resources. Further, mental health knowledge also helps to identify risk factors and influences awareness of the presentation of mental disorders. Exploring service users' knowledge of mental health and mental health services could shed light on their mental health literacy and provide an opportunity to identify knowledge gaps and address misconceptions.

Sutherland and Chur-Hansen (2014) also found that psychologists working in non-urban areas acknowledge their limitations and understanding of the influence of local culture on clinical presentations. Having a broad and local (clinical) knowledge base that allows the clinician to meet diverse mental health needs is vital to achieving efficient and contextualized clinical

practice in non-urban areas, especially in a multicultural society like South Africa. Given the distinctiveness and complexity of health needs, the disease burden and treatment gap in low- and middle-income countries (LMIC), particularly in non-urban areas requires ongoing attention (Vergunst, 2018). Familiarity with help-seeking behaviours and service preferences in this context are also important for the optimum provision and use of services.

Idriss et al. (2020) highlight that African communities are known for self-reliance in managing mild or less complicated health concerns through traditional knowledge systems, and cultural or religious means. While this approach is also found in other non-urban communities worldwide, Idriss et al. (2020) further found that health-seeking from formal health institutions is often the last resort after other options are exhausted. Similarly, Shai and Sodi (2015) found that the mental health help-seeking behaviour of the South African non-urban community was varied. Traditional interventions were more easily accessible and often preceded or used jointly with western health interventions. The secure and trusting relationships offered by proximity, accessibility and shared cultural understanding of community life earn traditional healers esteemed positions in their communities. (Idris et al., 2020, Zingela et al, 2019). Furthermore, shared beliefs about the spiritual causes or explanations of illness could influence primary consultations with traditional healers before western interventions are considered (Zingela et al, 2019). Interventions from traditional healers are perceived as more accurate and meaningful due to shared worldviews with clients and their families. Traditional healers are also trusted because of the belief by service users that they possess ‘special powers' to provide sought-after explanations and interventions to manage destabilizing health concerns. Lund (2010) noted that in Ghana, the popularity of traditional and faith healers is influenced by shared local beliefs regarding the causes of mental illness, their affordability, accessibility and their availability. According to Hom, Stanley & Joiner (2015), mental health literacy, positive appraisals of services, encouragement from significant others (for example, family and friends), as well as seeking support, are essential factors that influence help-seeking. Hom et al. (2015) referred to these factors as facilitators to care, arguing that the responsibility to (access) care should be a shared endeavour between the service user and their support networks.

Similarly, Labys, Susser and Burns (2016) highlight the value of considering complex local insights in understanding mental illness and help-seeking behaviours in rural KwaZulu-Natal, mainly because some patients do not access Western medicine. Kirmayer and Pedersen (2014),

strongly encouraged the Department of Health to strive for broader health care to acknowledge the vital caring roles played by formal and informal stakeholders in healthcare provision in non-urban communities. Vergunst (2018) also recommends the inclusion of established mental health help-seeking pathways in these contexts to enhance accessibility and equity in the distribution of mental health services in non-urban communities. In his view, the success of task sharing should extend beyond the health sector and prioritize investment in mutual trusting relations between formal and informal health sectors to facilitate cross-referrals between traditional and Western approaches to healthcare. However, there is a paucity of research into non-urban health service user's knowledge and attitudes regarding mental health and related services, which is the aim of the present study.

Purpose of the study

The present study explored the knowledge and attitudes regarding mental health among outpatients referred to clinical psychologists in uMzinyathi, Harry Gwala and uMkhanyakude health districts of KwaZulu-Natal, South Africa. The findings will inform health service authorities and clinical psychologists about service users' needs, understanding of clinical psychologists' roles and mental health care, and also identify knowledge gaps and attitudes regarding referrals for psychological interventions. Furthermore, documenting patients' views and experiences could enlighten clinical psychologists about relevant service delivery in non-urban settings, enhance service acceptance, utilization and adherence, while also developing clinical psychologists' context-specific competencies.

Method

A mixed-methods, descriptive, cross-sectional research design was used. According to (Dawadi et al., 2021) combining both the qualitative and quantitative research designs is based on the belief that both designs have value, are complementary to each other, and that there are benefits that assist the researcher to gain a better understanding of the topic under study, than either design alone. The study was conducted in three non-urban district hospitals in KwaZulu-Natal.

Participants

A convenience sampling method was utilized to access outpatients referred to clinical psychologists in hospitals in the three districts of uMzinyathi, Harry Gwala and uMkhanyakude. The participants were adults above the age of 18 years. Forty participants completed the questionnaire, however, according to the statistician's calculation, the target for the study was 283 participants, resulting in a 14% response rate.

Instruments

A brief self-administered survey questionnaire with closed and open-ended questions was used to collect data. The questions covered demographics, educational level, previous mental health and clinical psychology consultations, understanding of the role of the clinical psychologist, preference for the gender, race, language and age of the consulting clinical psychologists, and participants' expectations of the consultation.

Procedure

Data were collected from three non-urban KwaZulu Natal district hospitals where the targeted sample attended. Participants were given information sheets explaining the purpose of the study and conditions of participation in either IsiZulu or English (according to participants' preference) before consenting to participate. KwaZulu-Natal is predominantly IsiZulu-speaking. The translation was performed by an independent person who is fluent in English and IsiZulu, before submitting the questionnaire for ethics approval. Back translation was done by three colleagues proficient in both languages for clarity and accuracy. Each questionnaire took approximately 30 minutes to complete. Participants were given an information brochure describing the purpose of the study, conditions of participation, a consent form, and a self-administered questionnaire. In addition, the researcher provided verbal explanations and answered clarifying questions. Participants were requested to omit identifying details to facilitate anonymity.

While the response rate is low, the views and experiences of the responding participants provide valuable insights. The following reasons could have contributed to a low response rate

- limited familiarity with research in remote non-urban settings,
- being more focused on getting treatment,
- concerns about missing public transport while completing the questionnaires

Ethical considerations

Participants were asked to omit identifying data to facilitate anonymity and confidentiality. Participation was voluntary and prospective participants were assured that non-participation will have no adverse consequences. Ethics clearance for the study was obtained from the University of Kwa-Zulu Natal Biomedical Research Ethics Committee BE 199/15.

Data analysis

SPSS version 27, descriptive statistics were used to analyse quantitative data and thematic analysis was used to analyse qualitative data. Coding was performed by the researcher and corroborated by a colleague who is familiar with qualitative research.

Results

Quantitative findings

Forty patients participated in the study and most participants were females (52.5%). Table 1 below presents the demographic profile of the sample. Table 2 presents awareness (of clinical psychology services), utilization of services and help-seeking pathways. Table 3 presents participants' clinical psychology service and practitioner preferences.

Table 1: Sample demographics

	N	%
Age (years)		
20-35	22	55
36-55	15	37.5
56+	-	-
Missing data	3	7.5
Gender		
	21	52.5
Female	13	32.5
Not stated	6	15
Male		
Highest level of education		
No formal education	-	-
Primary	3	7.5
Secondary	11	27.5
Matric	14	35
Tertiary	5	12.5
Missing data	7	17.5
Occupation		
Skilled	4	10
Post Matric qualification	11	27.5
Unemployed	19	47.5
Missing data	6	15
Home language		
IsiZulu	19	47.5
IsiXhosa	10	25
English	7	17.5
Afrikaans	2	5
2 or more language(s)	4	10
Missing data	2	5
Referred by		
Doctor	25	62.5
Nurse	2	5
Social Worker	4	10
Occupational Therapist	4	10
Self	2	5
Parent	2	5
Missing data	1	2.5
Previous consultations		
Doctor	11	27.5
Mixed consults	7	17.7
Traditional healer	6	15
Social worker	4	10.7
Occupational Therapist	3	7.5
Nurse	2	5
Missing data	14	35

Seven (17.7%) participants indicated that they had previously consulted two to four health professionals before the clinical psychologist.

Table 2: Awareness, service utilization and help-seeking pathways

Question	Yes	%	No	%	Unsure	%
Do you know why you were referred to the clinical psychologist?	25	62.5	3	7.5	5	12.5
Have you had any previous contact with mental health professionals (e.g. psychologist, psychiatrist)	22	55	15	37.5	-	-
Would you suggest mental health consultation to someone else?	34	85	5	12.5	-	-
Have you consulted a clinical psychologist before?	24	60	16	40	-	-
Do you agree that you need a psychologist?	32	80	5	12.5	-	-
Would you ever disclose to others that you have consulted a psychologist?	25	62.5	11	27.5	-	-
Would you ever tell your traditional healer that you have consulted a psychologist?	17	42.5	12	30	-	-

Table 3: Participants' clinical psychology service and practitioner preferences

	N	Yes	%	No	%
Gender preference	40				
Male		1	2.5		
Female		15	37.5		
It does not matter		23	57.5		
Age preference					
Young		2	5		
Older		10	25		
It does not matter		26	65		
Race preference	40				
Black		4	10		
White		5	12.5		
It does not matter		29	72.5		
Own language preference					
Yes		19	47.5		
No				1	2.5
It does not matter		18	45		

Qualtitative findings

The thematic areas emanating from the responses to the open ended questions are presented below.

Anticipated benefits from clinical psychology consultation

The participants' expectations of the psychologist's consultation included relief from the presenting health concerns, healing, support, development of hope, empowerment, cathartic space, regaining control and coping better with their symptoms as stated by the following participants:

"To be cured and not experience any sort of anxiety attacks" (Participant 9)

"To relieve stress or mental illness that makes my life difficult" (Participant 38)

Some participants expected medication:

"It is to get help for my illness and get suitable medication". (Participant 18)

"To get medication and getting better /healed through the help I receive". (Participant 1)

Others indicated that they wanted direction and affirmation from the clinical psychologist:

"A change of mindset, more confident, strong and knowing that I have a right to be happy". (Participant 29)

"In order to discover what is wrong before it gets worse". (Participant 2)

Reasons for mental health consultation

Participants were asked to state reason(s) for the current consultation to assess their understanding of their mental health needs and the following themes were identified:

<u>Resolve personal distress:</u>

"I was thinking of dying with my children because I saw the way that I was experiencing abuse". (Participant 27)

"To get help in the illness [that] I have, my mind is not working as it should, I am forgetful". (Participant 34)

Coping with difficult experiences

"I went to get help because I could not get over what happened to me". (Participant 19)

"2014, I had a complication with my pregnancy and lost the baby, [I] needed direction". (Participant 10)

To obtain help for family

"I brought my child who told me that he hears noises in his ears and he was also very energetic". (Participant 25)

*"My child displayed behavioural problems at school and was aggressive to others. Behavioural problems lessened once I got help." (*Participant 15)

Somatic complaints

"I had painful blood vessels and headache". (Participant 1)

"I had a persistent headache, sharp chest pains and flatulence". (Participant 20)

Unsure but referred

"I do not know why because I was sent by the doctor to see the psychologist". (Participant 18)

"4 days ago, the doctor asked me whether I would like to see a psychologist, I say yes and transfer to psychologist today". (Participant 2)

Insight/ needing answers:

"I agreed (to see the psychologist) because I was sick and I did not know what was wrong" (Participant 24)

"Clarity of direction of my life". (Participant 2)

Participants' understanding of the clinical psychologists' role

The following themes were identified from the participants' understanding of the clinical psychologists' role:

Helping & healing:

"They (clinical psychologists) help, they work with you to address your problem until it is resolved because you fail when you face them alone" (Participant 8)

"(The clinical psychologist) heals one mentally and gives options on how to deal with issues etc." (Participant 1)

Diagnosis & assessment:

To identify what is going wrong in someone's mind or body" (Participant 7)

"Assess what help patients need to deal with their mental health issues" (Participant 11)

Being referred and willingness to consult a clinical psychologist

Participants were asked whether they would agree when someone suggested that they should consult a clinical psychologist, the following areas influenced their responses supporting the referral:

Trusting the referral source:

"A friend advised me to see someone because she could see that I was not coping". (Participant 29)

"That will mean there's a lot a (referring) person has gained and he/she wants to share that experience". (Participant 1)

Confidence in the psychologists' competence:

"I agree because I have confidence that you leave having received help and healed". (Participant 16*)*

"I need to see them, you know, when I have seen my psychologist, I feel happy because I even tell her my worries". (Participant 17)

Participants' understanding of the difference between social workers and clinical psychologists

The same or a small difference

"Psychologist is an informer & a healer, the social worker is a solver they are almost common". (Participant 1)

"On my own, I don't see any difference they helped". (Participant 3)

"*I do not know, I think they do the same work, there is a small difference".* (Participant 24)

Psychologist relies on psychometric tools to diagnose

“She is doing a great job because she test[s] him first”. (Participant 1)

"A psychologist is the one who tells you what is wrong because she tested". (Participant 4).

Area of intervention

"Psychologist helps with heart matters, a social worker helps with welfare." (Participant 6)

"The social worker deals with home/domestic-related matters while the psychologist deals with how the behaviour/mind is." (Participant 9)

"Psychologist deals with mental and cause of (illness) and social worker assist in social issues". (Participant 12)

"Psychologist specialises in treating the mind, the social worker has a broader scope in the hospital and community." (Participant 16)

Level of education

Some participants used the psychologists' level of education as an identifying factor, as expressed by the following participants:

"A psychologist has studied further than a social worker". (Participant 10)

*"A psychologist is a doctor qualified to diagnose and prescrib*e". (Participant 11)

Consulted Psychologists’ age, gender and race preferences

"I would be happy to get an older person because they do their job carefully and they have a lot of experience". (Participant 19)

"I like the older person because they may have experienced a similar problem to mine". (Participant 27)

"Because she talks like a parent". (Participant 40)

Gender preference and gender loyalty

"A female psychologist would easily understand me, and I am at ease when I talk to her”, (Participant 13)

"It is not easy to talk to a male because I was abused by a male". (Participant 28)

"Female to female, there is more understanding and I would feel comfortable".

(Participant 29),

“*Because I'm female."* (Participant 31)

"Because they understand a lot of things about female problems". (Participant 36)

Psychologists' race and qualities

"A white person is patient and understands love and kindness". (Participant 38)

"*I prefer black people because they'll understand my language better and my problem*". (Participant 27)

"Does not matter, as long as they have compassion for people". (Participant 35)

Psychologist's practice, qualifications and qualities

"I do not mind, anyone can help me, they all work the same way, as long as I get help". (Participant 17)

"*I have no race preference, I only need help*". (Participant 25)

"As long as they are qualified". (Participant 30)

"Psychologist helps with heart matters, a social worker helps with welfare". (Participant 6).

"The psychologist is the person who works with the mind, but the social worker deals with people's welfare at home". (Participant 19).

Discussion

The finding that most participants were younger could indicate the youth's growing awareness and utilization of psychology services. Further, the finding that the majority of participants were female is consistent with the higher help-seeking behaviour of women (Mackenzie et al., 2006). It was surprising to find that all participants had some level of formal education, contrary to an earlier investigation showing that 68.9% of rural mental health service users had no formal education or only primary education (Pillay et al., 2009). This may reflect the positive shifts in education attainment over the years. The unemployment rate in the present study is considerably higher than the national unemployment rate of 36.5% and may reflect the greater stresses posed by unemployment and associated deprivation (Statistics South Africa, 2020). Given that close to three-quarters of the participants cited an African language as their main language, clinicians' proficiency in these languages should be a priority. This is critical to facilitate optimal service delivery, especially considering psychology's reliance on language as the medium of intervention and clinicians' current reliance on translator services to communicate with their patients (Elkington & Talbot, 2015). Cano-Ibáñez et al. (2021) highlight the importance of attention to language concordance in ensuring optimal patient-centred health care.

The higher referral rate from medical doctors is consistent with the findings of Kravitz et al. (2006) and may be due to doctors' knowledge and experience with psychotherapy, low confidence in managing the mental illness themselves, or less time spent providing direct patient care. It must also be remembered that medical doctors are the practitioners primarily responsible for diagnosing and treating the facilities' patients and, therefore, refer more than other disciplines.

Considering earlier research, the finding that only 15% of the participants reported first consulting traditional healers is a little surprising, particularly in non-urban communities (Idriss et al., 2020; Shai & Sodi, 2015). However, under-reporting of this form of health intervention could be due to anticipated disapproval by health professionals, resulting in reluctance to disclose. Moreover, the gap between the percentage of referrals by doctors (62.5%) and the reported previous consultations with doctors (27.5%) may indicate that previous sources of help were not accurately reported. That mixed consultations accounted for 17.5% of the sample is in line with the research showing support for collaborative health consultations in non-urban areas (Idriss et al., 2020).

That almost two-thirds of the participants knew the reason for the clinical psychologist referral is contrary to an earlier finding in the same context, that most patients do not know why they are referred to clinical psychologists (Siyothula, 2019). This could relate to the current finding that more than half (55%) of the participants reported previous mental health consultations. No referral to mental health professionals was cited as one of the reasons for the absence of previous mental health consultations. This speaks to the importance of health professionals' awareness of available mental health services to appropriately refer patients. Dube and Uys (2016) found that most nurses in public health facilities were not familiar with mental health care, which is a concern as nurses are at the frontline of primary health care.

Most participants (85%) stated that they would suggest mental health consultations to someone else. Their reasons included personal mental health service experience and identifying the need for mental health intervention in someone else's life. This is encouraging considering that research in non-urban communities indicated low awareness of mental health conditions among non-urban residents, a high level of mental health stigma and a limited ability to identify psychological distress (Idriss et al., 2020; Rudasa, 2015; Uddin et al., 2019).

The finding that 80% of the participants would support referral to a clinical psychologist suggested by someone else was encouraging, denoting trust in the assessment or judgment of the person suggesting the referral. This is consistent with findings from Hom et al. (2015) who identified encouragement from significant others to seek support as one of the facilitators to care.

That almost two-thirds (62.5%) of the participants would disclose consulting a clinical psychologist to others is also encouraging, as it reflects a lesser stigma concern than might be expected. Participants' autonomy to disclose psychologists' visits (in their terms) could be liberating and empowering for the service users. Non-disclosure (by over one-quarter of the participants) is consistent with an earlier study showing that almost one-third of participants would not disclose their anxious/depressive or psychotic symptoms to anyone in their social networks (Pigeon-Gagné et al., 2017). Interestingly, almost half of the participants stated that they would disclose their clinical psychology consultations to their traditional healers. This may indicate a trusting relationship between patients and their traditional healers, which is also a positive sign (Idris et al. 2020; Zingela et al, 2019).

A quarter of participants preferred consulting older psychologists and valued their experience, knowledge and careful execution of their job. Kessler et al. (2020) found that young patients' preference for a psychologist was influenced by the nature of the presenting problem. For example, older psychologists were preferred for universal problems like dealing with a friend's death or effects of natural disasters. While younger psychologists were preferred for 'young problems' like cyberbullying or relationship problems. According to Kessler et al. (2020), the preference of the psychologist's age is associated with the perceived relevance of the psychologist's life experiences to the presenting problem. That only 2.5% of participants preferred their clinical psychologists to be male is an interesting finding. Those who preferred female clinical psychologists (37.5%) reported feeling understood and the ease of relating to a female psychologist as the rationale. For participants with sexual trauma experiences, the similarity of the psychologists gender to that of the perpetrator was regarded as a potential trigger of the trauma and influenced their preference of a female psychologist (Landes et al., 2013).

The finding that almost half of the participants indicated that they prefer their psychologist to speak their language is understandable, considering that language and culture are intertwined

(Quigley et al., 2019). Jackson et al. (2019) note that words that describe emotions are different across languages. Therefore, patients should feel comfortable communicating in their language of choice to accurately articulate emotional distress or source of vulnerability impacting their mental health. Thus, the clinicians' understanding of the local language where they practice is important. That almost three-quarters of participants stated that the race of the psychologist does not matter, focusing instead on the need for help and the psychologists' qualifications and professional qualities, is interesting. The extent to which the race preference response was influenced by social desirability responding must be considered, especially in a country like South Africa where race was used to segregate and discriminate. Avoiding discussion regarding race could be construed as a safe approach in most discourses in South Africa and elsewhere (Nogueira, 2013), and may account for the present finding. Political correctness could also influence denying the relevance of race. Interestingly, more participants (12.5%) preferred white psychologists based on perceived elevated qualities of a white psychologist, which speaks to the effects of colonialism that brought such ideas to all subjected nations. The lovely story by the late Archbishop Desmond Tutu about being on a plane when turbulence hit (and worried about not having a white pilot on board), is an excellent example of how colonisation affected the psyche of black people (Braw, 2011). The preference for black psychologists (10%), which was perceived as relevant to the service users' context, is surprisingly low, this finding was unexpected as the majority of the KZN non-urban population is black.

Although neutral responses are often criticized for giving an easy way out to participants who are reluctant to engage with sensitive topics or respond in a socially desirable manner (Johns, 2005; Krumpal, 2014), it is believed that participants engaged with the questions and responded in a manner relevant to them and their non-urban contexts of service deprivation. Furthermore, participant responses reflected their greater concern about getting help, with variables like age, gender and race being of lesser importance. Therefore, the finding that most participants chose a neutral option when asked about their preferences mirrors their understanding of the reality of the South African history of scarce resources and lack of choice in non-urban health services (De Kock & Pillay, 2017). When participants were asked whether they would prefer their clinical psychologist to speak their language, there was a margin of only 2.5% between those who preferred own language and those who stated that the language does not matter. This was not an unexpected finding, because patients in these settings are accustomed to receiving health care from professionals of a different culture, who do not speak their language and rely on the services of translators to communicate with them (Elkington & Talbot, 2015).

Interestingly, 50% of the sample differentiated the roles of clinical psychologists and social workers, based on perceived intervention areas and demonstrated a reasonable understanding of the two professions. This is encouraging, especially considering the historical deficiencies in specialist health service provision in non-urban areas (De Kock & Pillay, 2017; Siyothula, 2019; Vergunst, 2018).

Limitations of the study

While the information gathered from this study contributes valuable insights into non-urban community members' understanding of clinical psychology services, the sample size limits the extent to which the results can be generalized.

Conclusion

Participants demonstrated a reasonable understanding of a clinical psychologist's role and most of their expectations were in line with the clinical psychologist's scope of practice. Generally, participants reported that the clinical psychologists' age, gender and race did not matter, suggesting that their need for help was a greater priority. This is understandable given the insufficient mental health service provision in the areas under study and other resource-constrained areas. Therefore, LMICs remain in need of a devoted buy-in from the collective decision-makers to redress the inequitable mental health service distribution between urban and non-urban areas (De Kock & Pillay, 2017). Like their urban counter parts, non-urban communities deserve access to quality mental health services (Mathews & Van Wyk, 2018) that uphold their cultural identity, without limiting their options and contributing to them forfeiting their preferences to get help. Research highlights that encouraging participation and allowing service users to exercise their preference(s) in their health care plays an important role that contributes to positive health outcomes (Bombard et al., 2018; Rackers, 2018; Vahdat et al., 2014). Consideration of the voices of non-urban mental health service users can contribute to the provision of relevant mental health services that considers the context of the community. Given South Africa's history of oppression and marginalisation, the time has long arrived for equity in mental health care, and the upliftment of non-urban communities.

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Chapter 7 presented the findings from the study that explored service users' mental health knowledge and their understanding of the role of clinical psychologists in the three KZN non-urban health districts. Their preferences regarding practitioner demographics and related consultation variables are also presented. Chapter 8 presents the synthesis, study limitations and recommendations.

CHAPTER 8

DISCUSSION, IMPLICATIONS AND CONCLUSIONS

In this final chapter, the researcher seeks to synthesize the findings from the 2 published papers and the submitted manuscripts that comprise this thesis. It draws conclusions, makes recommendations, and suggests possible future research in the integration of clinical psychology services in non-urban areas of KZN and the rest of South Africa.

Previously, mental health care was provided in stand-alone clinics and tertiary psychiatric hospitals. This meant that mental health service users had to visit different health care facilities depending on the specific health problem, which also entrenched the stigma of mental illness. The notion of integrated health care comes from the need to ensure comprehensive health care to all service users, instead of the historically fragmented health care, that still exists in some contexts. Furthermore, (Sartorious, 2013), notes that the comorbidity of mental and physical illness will continue to rise in the future, and the management thereof becomes more complex, with the LMICs hardest hit by the impact of poorly managed mental illnesses (Kumar & Kumar, 2020). While the integration of mental health services into primary health care dates back more than four decades to the Alma Ata Declaration, its progress continues to be slow despite the conference consensus that proclaimed health as a human right, based on the principles of equity, community participation, social determinants and social justice (Rifkin, 2018).

The integration of clinical psychology services into primary health care, particularly in the non-urban areas of KZN, remains a challenge (De Kock & Pillay, 2017; Siyothula, 2019; Vergunst, 2018). In the study that explored the distribution of clinical psychology services in the three non-urban areas of KZN (presented as Paper 1 in this thesis), Siyothula (2019) found that the distribution of mental health services and the ratio of clinical psychologists to the population remain inequitable. This reflects the access difficulties in KZN non-urban areas, which seriously disadvantages the non-urban communities in terms of mental health care. Further, this continued inaccessibility to mental health services compromises communities' health, human rights and perpetuates the social injustice that had its roots in apartheid and colonisation.

Almost three decades of democracy have not produced the anticipated health care equality that non-urban communities hoped for.

The second article explored the experiences and views of clinical psychologists working in non-urban areas of KZN. The researcher recognizes that input from clinical psychologists working in these settings provides valuable insights into their experiences and the nature of psychological service provision in non-urban areas. While the prevalence of mental disorders in urban and non-urban areas is not different on a geographical basis, researchers highlight differences between the health care needs and health-seeking behaviours between these communities (Idriss et al., 2020; Sutherland & Chur-Hansen, 2014; Vergunst, 2018; Zingela et al., 2018). The following are some of the highlighted differences; the causal narratives, complex care seeking behaviours of non-urban communities, timing of presentation to care, socio-cultural beliefs that influence access to care, resource constraints (human and infrastructure), combined care-seeking strategies that include traditional and biomedical approaches, formal and informal health service providers, as well as ethical challenges (De Kock & Pillay, 2017; Idriss et al., 2020; Shai & Sodi, 2015; Siyothula, 2019; Sutherland et al., 2017; Vergunst, 2018). In this study, participants reported a significant lack of basic resources that are required to render optimal clinical psychology services in non-urban areas of KZN. Furthermore, more than half of the participants reported that the traditional clinical psychology training did not equip them with the skills that they need to work confidently in resource constrained non-urban areas.

Findings from the study that explored referral agents' experiences and expectations from clinical psychology services in non-urban areas of KZN affirm the view that clinical psychology services play an important role in mental health care, especially within the public health services. This was reflected in the majority of participants' responses about referring patients to clinical psychologists and being pleased with the outcomes of such referrals. Considering that health care requires a team effort, the finding that health professionals in this study expressed the need for more mental health knowledge indicates the learning areas and needs that should be taken seriously by the health training institutions, tertiary mental health care institutions and the provincial Department of Health. Investing in regular mental health training workshops, in-service training, and optimal supervision and support should form an

important part of staff empowerment in these settings. The absence of dedicated investment in this health resource could mean a missed opportunity to equip staff at the forefront of health care to accurately identify mental health needs and make timely referrals of needy service users. This need was also noted by Dube & Uys (2016) who found that the majority of nurses at primary health care facilities are unable to identify mental illness. Participants in the study of referral agents, like those in the study of clinical psychologists in non-urban areas of KZN, emphasized the non-conducive environments in which patients received mental health care and clinical psychology interventions. The concern about the environment in which non-urban patients receive mental health care is not limited to the present study. Similar concerns have been raised by research elsewhere (Mulaudzi et al., 2020) and the WHO Mental Health Atlas 2017 which proposed massive scale-up of mental health resources as a necessary condition to meet global targets (WHO, 2018). The previous director of the WHO's Department of Mental Health and Substance abuse (Dr Saxena) warned that failing to invest in mental health and treating it with the urgency it deserves will have health, social and economic costs on an unprecedented scale, and the repercussions will be far-reaching (WHO, 2018). This means that governments can no longer afford to ignore mental health if they want to prevent the pending devastation from failure to heed this warning. Freeman (2022) calls on decision makers in health care, in collaboration with other pillars of governance, to change the status quo to achieve optimal outcomes. Furthermore, stakeholders' investment in mental health care could aid in improving access to mental health services and bridging the mental health gap, a concern that continues to dominate the mental health discourse (Wainberg et al., 2017a).

The final study of this thesis explored mental health knowledge and preferences of patients referred to clinical psychologists in non-urban areas of KZN. Research highlights that the prevalence of mental illness is not different between the urban and non-urban areas (Idriss et al., 2020), however, researchers indicate the unique clinical presentations, resource constraints, challenges in accessing services and the needs of non-urban communities among the issues needing our attention (Idriss et al., 2020; Sutherland & Chur-Hansen, 2014; Vergunst, 2018). These elements require clinicians to be equipped with context-based skills and competencies to meet mental health care needs and challenges faced by non-urban communities. In this study, participants' knowledge of clinical psychology services and their preferences were assessed by asking them to share their understanding of clinical psychology services. (Knaak et al., 2017) stated that hearing the voices and experiences of health care of people living with mental illness

validates them. It is also valuable in identifying and addressing the barriers to services and could enhance health outcomes when patients feel that their views matter. Knowledge about the service to which patients are referred can also influence whether they engage with or avoid the treatment process. Key findings from this study indicated that most patients have a reasonable understanding of clinical psychology services. Furthermore, their need for help took precedence over their preferences regarding the age, race and gender of the clinical psychologist who served them. Although a similar proportion of participants preferred their clinical psychologist to speak their language (47.5%) compared to those who stated that language did not matter (45%), this should remain a concern because the psychological consultation is a language-based intervention. The first democratically elected president of South Africa emphasised the importance of language, in his quote***: "If you talk to a man in the language he understands, that goes to his head. If you talk to him in his own language, that goes to his heart." (Nelson Mandela)***.

The role of South Africa's apartheid history in the disadvantages faced by non-urban communities, in terms of poor access to services, should not be ignored. It is important to understand that these communities' experiences force them to adapt and survive in the system that perpetuates inequality between communities on the basis of race, class, geographical residential areas, and other sociodemographic variables. Finding that almost three decades of democracy have not yielded the anticipated equality among citizens of this country is discouraging. Awareness of the harsh reality faced by non-urban communities is necessary for the profession of psychology to transform its training and practice in order to enhance access to quality mental health services by all South Africans. The profession also needs to advocate for these marginalised communities.

Limitations of study

The sample size and relatively low response rate, particularly in the patient sample does limit the extent to which the findings can be generalized to all non-urban communities in South Africa. Nevertheless, it is hoped that the findings from the health service providers and patients contribute to the better understanding of the participants needs from their respective perspectives, and could aid the Department of Health, the training institutions and the mental health fraternity to continue their investment in improving mental health services in non-urban

areas. Another limitation to this study is that instruments used to collect data from the three sample groups was developed by the researcher with the assistance of the supervisor and contextualized to acquire specific information for the study. Therefore, pre-testing of the instruments used to collect data and subsequent adjustment adaptation of the instruments was not done. As the instruments are novel, it is hoped that they can be used in future research and modified as required by studied phenomenon.

Recommendations

As a means of continually assessing the progress of the integration of mental health services into primary health care, the commitment of the Department of health, in collaboration with the relevant stakeholders, is vital. There needs to be demonstrated evidence of change in the current state of mental health services in the KZN non-urban areas as suggested by the findings of this study, the WHO recommendations in Alma Ata, and other research. It is necessary to address the issues of inequitable distribution of mental health services, mental health human resource constraints and the infrastructure should be at the standard that meets the mental health care needs of service users. Regular monitoring, evaluation and support, informed by the feedback from all stake holders could aid the process of integration, and ensure optimal health coverage as proposed by the WHO.

If integrating mental health into the primary health care is to show progress, addressing the expressed knowledge gap by training institutions is necessary. Future research that regularly assess the training curricula of clinical psychologists and health professionals could aid training institutions to invest in equipping all health trainees with knowledge and competencies that prepare them to render mental health services confidently in diverse settings.

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APPENDICES

Appendix A

Please note: the translated versions of the information leaflet, consent document and the questionnaire, as well as the gatekeeper approvals are grouped under one appendix.

Information leaflet to be given to out-patients referred to clinical psychologists

Study Title: The challenges in developing and integrating community clinical psychology services in non-urban areas of KwaZulu Natal (KZN).

Dear participant,

E.B. Siyothula is a PhD student at the University of KwaZulu Natal, supervised by Prof A.L Pillay.

We are conducting a survey of all patients attending the outpatient department who are referred to clinical psychology consultations. We would like to understand your needs and expectations from a clinical psychology consultation as well as your understanding of mental health. Gathered information will provide valuable information that can help to improve service delivery. The questionnaire consists of a few questions and the information you provide will be treated confidentially. Since you will not write your names, we will not know who answered the questionnaires.

The questions will take between 15-20 minutes of your time while you are waiting to see the clinical psychologist. Questionnaires are written in both isiZulu and English to make it easy for you to fill it in. There are people who can assist if you have difficulty with filling in the questionnaire. **Should you choose to participate, please indicate your consent and that you have read and understood this information sheet by ticking the appropriate box on the top of the completed questionnaire**. This will ensure that you do not include any identifying

details in your completed questionnaire. Please post the completed questionnaire in the marked box in the waiting area in OPD. Since there will be no name on the questionnaire, we will not know who returned the questionnaire. Your participation is entirely voluntary and anonymous, and you may choose not to participate without such a decision having any consequence for you. You may also withdraw from participating at any time.

Following receipt of the completed questionnaires; the results will be analysed and this will help us understand your needs and views. The results may also be communicated to the relevant stakeholders in the department of health and published in a scientific journal. The data will be stored securely in the department of Psychology at Fort Napier Hospital and destroyed after 5 years.

Should you have any queries or wish to receive the results of this survey; please feel free to contact us.

Sincere thanks from:

Ms E.B. Siyothula, Clinical Psychologist, Fort Napier Hospital & Department of Behavioural Medicine, Nelson R Mandela School of Medicine, University of KwaZulu Natal, P.O. Box 370, Pietermaritzburg 3200 (Tel: 033 260 4300 ; busi.siyothula@kznhealth.gov.za

Professor Anthony Pillay, Principal Clinical Psychologist, , Fort Napier Hospital & Department of Behavioural Medicine, Nelson R Mandela School of Medicine, University of KwaZulu Natal, P.O. Box 370, Pietermaritzburg 3200 (Tel: 033 260 4300; anthony.pillay@kznhealth.gov.za

Appendix B

Consent document

Dear Participant

E.B. Siyothula is a PhD student at the University of KwaZulu Natal, supervised by Prof. A.L Pillay.

You have been asked to participate in a research study.

Title of the study: Challenges in developing and integrating community clinical psychology services in non-urban communities of Kwa-Zulu Natal

This is an anonymous survey aimed at exploring the needs and expectations of both mental health service providers and service users. The gathered information will provide valuable insight that can enhance service delivery and utilization of mental health services. It will further assist in identifying potential threats which can interfere with relevant and optimal service delivery.

You have been informed about the study by----------

You may contact E.B. Siyothula at 033 260 4350 or email at busi.siyothula@kznhealth.gov.za any time if you have any questions about the research.

You may contact the **Biomedical Research Ethics Office on 031 260 4769 or 260 1074 or** Email BREC@ukzn.ac.za if you have questions about your rights as a research participant.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop at any time.

If you agree to participate, you will be given a signed copy of this document and participant information leaflet which is a written summary of the research. The original copy will be kept separately from your completed questionnaire to ensure anonymity.

The research study, including the above information, has been described to me orally. I understand what my involvement in the study means and I voluntarily agree to participate. I have been given an opportunity to ask any questions that I might have about participation in the study.

---------- ----------

Signature of Participant Date

…… ……

Translated by Date

Appendix C

Questionnaire to be administered to out-patients referred to clinical psychologists

Title: The challenges in developing and integrating community clinical psychology services in non-urban areas of KwaZulu Natal (KZN).

Thank you for agreeing to complete this anonymous survey. Please **do not** write your name on this form.

I have read and understood the information sheet about this study and hereby consent to participate (please tick this box) ☐

Age……. years Male/ Female Level of education…… Occupation ……

Home Language: English/isiZulu/ isiXhosa/Afrikaans/Other…….

Referred by: Doctor/Nurse/Social work/ OT/Self/ Parent/Other……

Do you know why you have been referred to see the psychologist? Yes/No/ Unsure

What do you hope to benefit from this consultation?.....

……..

Have you previously consulted: indigenous healer/ medical doctor/ Nurse/ Social worker work/Occupational Therapist

Have you had any contact with mental health professional (e.g. psychologists, psychiatrists) before? Yes/No

If yes, briefly describe the nature of your contact

….……

……

In your understanding, which health needs can be addressed by mental health care?

……..

…….

Would you suggest a mental health consultation to someone else? Yes/No

Explain…….

Have you consulted a clinical psychologist before? Yes/No

If yes, when and why……

If not, when would you consider seeing a clinical psychologist?

Explain…….

What do you think a clinical psychologist does?

.....

What kind of treatment does a clinical psychologist give?

…….

If you are referred by someone else to see a clinical psychologist, do you agree that you need to see a psychologist? Yes/No

Explain.....
.....

Would you prefer your psychologist to be a Male/ Female/ Does not matter

Explain…….
…….

Would you prefer your psychologist to be a Male/ Female/ Does not matter

Explain…….
…….

Would you prefer your psychologist to be Young/ Older/ Does not matter

Explain…….
…….

Would you prefer your psychologist to be Black / White /Does not matter

Explain…….

…….....

Would you prefer your psychologist to speak your language? Yes/No/ it does not matter

Would you ever disclose to others that you have consulted a psychologist? Yes/No

Would you ever tell your indigenous healer that you have consulted a psychologist? Yes/No

In your understanding, what is the difference between a psychologist and a social worker?

……

Additional comments about mental health needs/ expectations (which you consider to be important)

……

……

Thank you for your time

Appendix A

<u>Incwajana echaza ngocwaningo</u>

Incwajana yolwazi eyonikezwa iziguli ezingalalisiwe ezithunyelwe kubeluleki bezengqondo

Isihloko: Izinselelo ekuthuthukiseni nokuhlanganisa (ukudidiyela) izinsiza kusebenza zabeluleki bezengqondo emiphakathini esezindaweni ezisemakhaya aKwa Zulu Natal (KZN)

Siyakubingelela, (Mhlanganyeli othandekayo)

u E.B. Siyothula ungumfundi we PhD e Nyuvesi yaKwa Zulu-Natali, owelulekwa u Prof A.L. Pillay.

Senza inhlolovo kuzo zonke iziguli ezibonwa emnyangweni wabangalalisiwe abathunyelwa kubeluleki bezengqondo. Singathanda ukuqonda izidingo zakho kanye nalokho okulindele kithi uma uzosibona njengabeluleki bezengqondo kanjalo nokuthi kuyini okuqondayo ngempilo yengqondo. Ulwazi esizoluthola luyoba neqhaza elikhulu futhi luyosiza ukuthi senyuse izinga esisisiza ngalo abantu. Kunohla lwemibuzo embalwa kanti imininingwane nolwazi osinika lona kuzogcinwa kuyimfihlo. Njengoba ungeke ulibhale igama lakho, ngeke sazi ukuthi ubani ophendule uhla lwemibuzo.

Imibuzo izothatha imizuzu eyi 15 kuya kwengama 20 yesikhathi sakho ngenkathi usalinde ukubonwa wumeluleki wakho wezengqondo. Imibuzo ibhalwe ngesiNgisi kanye nangesiZulu ukuze kube lula kuwe ukugcwalisa loluhla lwemibuzo. Kukhona abantu abangakusiza uma uthola kulukhuni ukugcwalisa lenhlolomibuzo (i fomu yohla lwemibuzo). **Uma ukhetha ukuba yingxenye yalenhlolovo, sicela ukhombise imvume yakho nokuthi uyifunde ngokuqonda lencwajana yolwazi ngokufaka uphawu ebhokisaneni elifanelekile ekhoneni elingenhla lohla lwemibuzo eligcwalisiwe**. Lokhu kuyoqinisekisa ukuthi awufaki minininingwane echaza ukuthi uwubani. Sicela ufake uhla lwemibuzo olugcwalisiwe ebhokisini elibhaliwe elikhona endaweni yokulinda eOPD. Njengoba ungeke ulibhale igama lakho, ngeke sazi ukuthi ubani oyigcwalisile lenhlolovo. Ukuzibandakanya kwakho kuwuzikhethela futhi akunazinkomba zokuthi uwubani (kuyimfihlo), Kanjalo ungakhetha ukungazibandakanyi

okungeke kukubangele izinkinga (ngeke kube namthelela kuwe) mayelana nosizo lwezempilo oludingayo. Ungayeka ukube yingxenye nanoma ngasiphi isikhathi.

Emva kokugcwaliswa kwawo wonke amafomu, imiphumela iyocwaningwa lokhu kuyoselekelela ukuba siqonde kahle izidingo zakho nemibono yakho. Imiphumela kungenzeka futhi yethulelwe iziphathimandla ezifanelekile emnywangweni wezempilo iphinde ishicilelwe ezincwadini zocwaningo olunzulu. Lonke ulwazi oluqukethwe kulelifomu namanye luyobekwa endaweni ephephile emnyangweni wakwa Psychology esibhedlela e Fort Napier, iyobe ke seyicekelwa phansi emva kweminyaka emihlanu.

Uma unemibuzo noma ufisa ukwazi ngemiphumela yalenhlolovo; khululeka ukusithinta.

Ukubonga nokukhulu ukuzithoba kuqhamuka kulaba:

Ms E.B. Siyothula, Clinical Psychologist, Fort Napier Hospital & Department of Behavioural Medicine, Nelson R Mandela School of Medicine, University of KwaZulu Natal, P.O. Box 370, Pietermaritzburg 3200 (Tel: 033 260 4300 ; busi.siyothula@kznhealth.gov.za

Professor Anthony Pillay, Principal Clinical Psychologist, , Fort Napier Hospital & Department of Behavioural Medicine, Nelson R Mandela School of Medicine, University of KwaZulu Natal, P.O. Box 370, Pietermaritzburg 3200 (Tel: 033 260 4300; anthony.pillay@kznhealth.gov.za

Appendix B

Incwadi yemvume

Siyakubingelela (Mhlanganyeli Othandekayo)

u E.B. Siyothula ungumfundi we PhD e Nyuvesi yaKwa Zulu Natali, owelulekwa u Prof A.L. Pillay.

Umenywe ukuba yi ngxenye yocwaningo.

Isihloko: **Izinselelo ekuthuthukiseni nokuhlanganisa (ukudidiyela) izinsiza- kusebenza zabeluleki bezengqondo emiphakathini esezindaweni ezisemakhaya zaKwa Zulu Natali**

Lena yi nhlolovo engadaluli muntu (eyimfihlo) ehlose ukuphenya ngezidingo kanye nokulindelwe abasebenzi nabasebenzisa izinsiza-kusebenza zempilo yengqondo. Ulwazi oluyotholakala luyobamba iqhaza eliyokwelekelela ukwenyuseni izinga lokunikeza kanye nokusetshenziswa kwezinsiza -kusebenza zempilo yengqondo. Luyophinda futhi lwelekelele eku dalulenii lezozinto ezinga phazamisa ukunikezwa kosizo olufanele nolusezingeni eliphezulu.

Waziswe ngalolucwaningo ngu----------

Ungathinta u E.B. Siyothula kulenombolo yocingo: 033 260 4350 noma I imeyili ethi: busi.siyothula@kznhealth.gov.za noma nini uma unemibuzo noma eluhlobo luni ngalolucwaningo.

Ungathinta ihhovisi le **Biomedical Research Ethics kule nombolo 031 260 4769** noma I imeyili ethi: BREC@ukzn.ac.za uma unemibuzo ngamalungelo akho njengomuntu oyingxenye yalolucwaningo.

Ukuzibandakanya kwakho kulolucwaningo kuwukuzikhethela, futhi ngeke ujeziswe noma ulahlekelwe usizo okumele uluzuze uma wenqaba ukuba yingxenye noma unquma ukuyeka (ukuba yingxenye) nanoma kunini. Uma uvuma ukuzibandakanya, uyonikwa ikhophi esayiniwe yale ncwajana (yemvume) kanye nencwajana yolwazi enikwa abayingxenye (yocwaningo), eneminingwane efinyeziwe yocwaningo. I khophi eyi original iyogcinwa

endaweni eyehlukene naleyo okuyogcinwa kuyo inhlolomibuzo (uhla lwemibuzo) ephenduliwe ukuze kuqinisekiswe ukuthi igcinwa iyimfihlo (ingadaluli ukuthi uwubani).

Lolucwaningo kanye no lwazi olungenhla ngiluchazelwe ngomlomo. Ngiyaqonda ukuthi kusho ukuthini ukuzibandakanya kwami kulolucwaningo futhi ngizivumela ngokwami ukuba yingxenye. Ngilinikiwe ithuba lokubuza noma yimiphi imibuzo ebengingaba nayo ngokuba yingxenye yalolucwaningo (ngoku zibandakanya kulolu cwaningo).

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Ishicilelwe (isayinwe ngozibandakanyayo) Usuku

Appendix C

Inhlolovo (uhla lwemibuzo) eyonikezwa iziguli ezingalalisiwe ezithunyelwe ukuzobona abeluleki bezengqondo

<u>Isihloko</u>: Izinselelo ekuthuthukiseni nokuhlanganisa (ukudidiyela) izinsiza kusebenza zabeluleki bengqondo emiphakathini esezindaweni ezisemakhaya aKwaZulu-Natal (KZN)

Siyabonga ngokuvuma ukugcwalisa lenhlolovo ngaphandle kokuveza igama lakho. Siyacela ukuba **ungalibhali** igama lakho kuleli fomu.

Ngiyifundile futhi ngayiqonda yonke imininingwane ngalolucwaningo. Ngishicilela imvume yo kuzibandakanya (sicela ufake uphawu kulelibhokisana)☐

Izinga lokukhula ……. (iminyaka) ubulili: isilisa/ isifazane izinga lokufunda…… Uhlobo lomsebenzi……

Ulimi lwasekhaya: isiNgisi/ isiZulu/ isiXhosa/ isi Bhunu/ olunye ulimi:
…….

Uthunyelwe ngu: Dokotela/ uNesi/ uSonhlalakahle Occupational Therapist (OT) owaseTheraphi/ Uzizele wena/ Umzali/ Omunye……

Uyazi yini ukuthi uthunyelelweni ukuzobonana nomeluleki wezengqondo/ nesazi sokusebenza kwengqondo na? Yebo/ Qha/ Angazi kahle

Yini ofisa/ owethemba ukuthi uzoyizuza kulokhukuhlangana/ukubonana kwenu na?

.....
…….
…….

Usuke waya yini ngaphambilini kulaba abalandelayo na?: Umelaphi wendabuko/ uDokotela (umelaphi ngokwasentshonalanga / uNesi/ uSonhlalakahle/ Occupational Therapist (owase Theraphi)

Usuke waxhumana/wabonana yini nalaba abasebenza emkhakheni wezempilo yengqondo: njengo: meluleki wezengqondo/ / nesazi sokusebenza kwengqondo (psychologist) umelaphi/uDokotela wezengqondo(psychiatrist) ngaphambili na? Yebo/ Qha

Uma sekuke kwenzeka, chaza kafushane (ukuthi wawuyokwenzani)

…..
…….
…….

Ngokwakho ukuqonda,yiziphi izidingo zempilo okumele zisukunyelwe ababhekelele impilo yengqondo.

……
……
……

Ungamkhuthaza/ungamgqugquzela yini omunye umuntu ukuba axhumane nababhekelela impilo yengqondo na/ Ungasenza yini isincomo sokuthi omunye umuntu abonane nomunye wabasebenzi ababhekelela ukuphila ngokwengqondo? Yebo/ Qha

Chaza

……
……
……

Usuke wabonana yini nomeluleki wezengqondo/ nesazi sokusebenza kwengqondo ngaphambilini na? Yebo/ Qha

Uma uvuma kwakunini futhi kwakungasiphi isizathu/ kwakwenzenjani?

……
……
……

Uma uthi qha, kungaba sizathu sini esingenza ukucabange ukuyo bonana nomeluleki wezengqondo/ isazi sokusebenza kwe ngqondo/ kungaba yinini lapho unga cabangela ukuyobonana nomeluleki wezengqondo/ nesazi sokusebenza kwengqondo na?

Chaza

……
……
……

Ngokucabanga kwakho, senzani isazi sokusebenza kwengqondo na? / Ucabanga ukuthi uyini umsebenzi womeluleki wezengqondo na?

.....
.....
……..

Sinekeza luphi uhlobo lokwelapha isazi sokusebenza ngengqondo na? Welapha ngandlelani umeluleki wezengqondo na?

……
……
……

Uma uthunyelwe omunye umuntu ukubona isazi sokusebenza kwengqondo/ umeluleki wezengqondo, uyavuma yini ukuthi uyadinga ukubonana nesazi sokusebenza kwengqondo/ umeluleki wezengqondo na? Yebo / Qha

Chaza

.....
.....
.....

Ungakhetha yini ukuthi isazi sokusebenza kwengqondo sakho sibe ngumuntu wesilisa noma wesifazane noma akunandaba ukuthi ubani na? Ungathokozela ukuba umeluleki wakho wezengqondo abe owesilisa/ owesifazane/ noma awukhethile (awunandaba nobulili bakhe

Chaza

……
…….....
……

Ungakhetha yini ukuba isazi sezengqondo sakho kube umuntu omncane noma omdala noma akunandaba ukuthi ungakanani na? Ungathokozela ukuba umeluleki wakho wezengqondo abe umuntu osemusha/osekhulile/ noma awukhethile (awunandaba nobudala bakhe)?

Chaza

……
……
……

Ungakhetha yini ukuthi isazi sokusebenza kwengqondo sakho sibe mnyama noma sibe mhlophe noma awunandaba na? Ungathokozela ukuba umeluleki wakho wezengqondo abe Mnyama/ abe Mhlophe noma awukhethile/ awunandaba nobuzwe /ibala lakhe?

Chaza

……
…….....
……

Ungakhetha yini ukuthi isazi sokusebenza kwengqondo sakho sikhulume ulimi lwakho na? (Ungathokozela ukuba umeluleki wakho wezengqondo akhulume) ulimi lwakho na? Yebo / Qha/ Akunandaba.

Chaza……
…….
……

Ungabatshela yini abanye ukuthi ubuyobona isazi sokusebenza kwengqondo (umeluleki wezengqondo) na? Yebo / Qha

Ungamtshela yini umelaphi wakho wendabuko ukuthi ubonene nesazi sokusebenza ngezengqondo (umeluleki wezengqondo) Yebo / Qha

Ngokwazi kwakho, yini umehluko phakathi kwesazi sokusebenza kwengqondo (umeluleki wezengqondo) kanye no Sonhlalakahle na?

……
……
……

Amaphuzu ongawenezezela/ongawaphawula ngezidingo zempilo yenqqondo kanye nokulindelekile (ocabanga ukuthi kubalulekile).

……
……
…….

Siyabonga ngesikhathi sakho

Appendix D

Information leaflet for health service providers who refer patients to clinical psychologists

Title: The challenges in developing and integrating community clinical psychology services in non-urban communities of KwaZulu-Natal (KZN).

Information leaflet

Dear Colleague,

E.B. Siyothula is a PhD student at the University of KwaZulu Natal, supervised by Prof. A.L Pillay.

The World Health Organization has proposed that mental health services should be integrated into primary health care in order to improve access to services. This is a relatively new move from the previous approach where services were provided at the tertiary level by psychiatric hospitals and 'stand-alone' psychiatric clinics. This study aims to assess the progress of the integration by looking at the distribution of mental health services in KZN non-urban areas, the needs, expectations, experiences and challenges of both service providers and service users. As you will see, the attached questionnaire asks a few questions in this regard. The gathered information will provide valuable insight that can enhance service delivery and utilization of mental health services. It will further assist in identifying potential threats which can interfere with relevant and optimal service delivery.

The questionnaire involves mainly yes/no answers and brief explanations where necessary. It will take about 15-20 minutes of your time. The information you provide will be treated confidentially. **Should you choose to participate, please indicate your consent and that you have read and understood this information sheet by ticking the appropriate box at the top of the completed questionnaire**. This will ensure that you do not include any identifying details in your completed questionnaire. Please post the filled in questionnaire in the marked box in the waiting area in OPD. As there will be no name on the questionnaire, we will not know who returned the questionnaire. Your participation is entirely voluntary and anonymous,

and you may choose not to participate without such a decision having any consequence for you. You may also withdraw from the participation process at any time.

Following receipt of the completed questionnaires; the results will be analysed and this will inform the proposed study. The results may also be communicated to the relevant stakeholders in the department of health and published in scientific journals. The data will be stored securely in the department of Psychology at Fort Napier Hospital and destroyed after 5 years.

Should you have any queries or wish to receive the results of this survey; please feel free to contact us.

Sincere thanks from:

Ms E.B. Siyothula, Clinical Psychologist, Fort Napier Hospital & Department of Behavioural Medicine, Nelson R Mandela School of Medicine, University of KwaZulu Natal, P.O. Box 370, Pietermaritzburg 3200 (Tel: 033 260 4300; busi.siyothula@kznhealth.gov.za

Professor Anthony Pillay, Principal Clinical Psychologist, Fort Napier Hospital & Department of Behavioural Medicine, Nelson R Mandela School of Medicine, University of KwaZulu Natal, P.O. Box 370, Pietermaritzburg 3200 (Tel: 033 260 4300; anthony.pillay@kznhealth.gov.za

Appendix E

Consent document

Dear Participant

E.B. Siyothula is a PhD student at the University of KwaZulu Natal, supervised by Prof. A.L Pillay.

You have been asked to participate in a research study.

Title of the study: Challenges in developing and integrating community clinical psychology services in non-urban communities of Kwa-Zulu Natal

This is an anonymous survey aimed at exploring the needs and expectations of both mental health service providers and service users. The gathered information will provide valuable insight that can enhance service delivery and utilization of mental health services. It will further assist in identifying potential threats which can interfere with relevant and optimal service delivery.

You have been informed about the study by----------

You may contact E.B. Siyothula at 033 260 4350 or email at busi.siyothula@kznhealth.gov.za any time if you have any questions about the research.

You may contact the **Biomedical Research Ethics Office on 031 260 4769 or 260 1074 or** Email BREC@ukzn.ac.za if you have questions about your rights as a research participant.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop at any time.

If you agree to participate, you will be given a signed copy of this document and participant information leaflet which is a written summary of the research. The original copy will be kept separately from your completed questionnaire to ensure anonymity.

The research study, including the above information, has been described to me orally. I understand what my involvement in the study means and I voluntarily agree to participate. I have been given an opportunity to ask any questions that I might have about participation in the study.

---------- ----------

Signature of Participant Date

Appendix F

Questionnaire to be administered to health service providers who refer patients to clinical psychologists

Title of the study: The challenges in developing and integrating community clinical psychology services in non-urban areas of KwaZulu-Natal (KZN).

Thank you for agreeing to complete this anonymous survey. Please **do not** write your name on this form.

I have read and understood the information sheet about this study and hereby consent to participate (please tick this box) ☐

Age……. years Male/ Female

Profession: Nursing/Medical/Social Work/ Occupational Therapy

No. of years in the profession……. years

No. of years working in the non-urban setting……. years

Full-time: Yes/No part-time: Yes/No weekly/monthly/other (specify)……

Did your training prepare you adequately for working in a non-urban setting? Yes/No

Explain……
……
……

Do you get satisfaction from working in a non-urban setting? Yes/No

Explain……
……
……

Do you work in the mental health care division? Yes/No

Do you feel you have sufficient knowledge of mental health care? Yes/No

Explain……
……
……

Do you feel you have a clear understanding of the role of a clinical psychologist? Yes/No

Briefly explain the role of the psychologist in your words

……
……
……

Have you referred patients to clinical psychologists? Yes/No

If yes what types of presenting problems do you refer?

.....
.....
.....

What do you usually expect/ need from the clinical psychologist when you refer patients to him/her?

……
……
……

Have you been pleased /displeased generally with the clinical psychologists' involvement with your patients?

Explain.....
.....
.....

If you have not referred patients to clinical psychologists, what has (have) been your reason(s) for not referring patients to clinical psychologists?

.....
.....

Do you feel that your clinical setting is conducive to meeting the mental health needs of the patients?

Explain……
……

What challenges have you faced whilst rendering mental health services in a non-urban setting?

List the 3 most important needs that can contribute to your job satisfaction whilst rendering mental health services in your clinical setting.

1. …… 2. ……
3……

Additional comments:
……
……

Thank you for your time.

Appendix G

Information leaflet for clinical psychologists working in non-urban areas of KwaZulu-Natal

Title of the study: The challenges in developing and integrating community clinical psychology services in non-urban areas of Kwa Zulu Natal (KZN).

Information leaflet

Dear Colleague,

E.B. Siyothula is a PhD student at the University of KwaZulu Natal, supervised by Prof. A.L Pillay.

The World Health Organization has proposed that mental health services should be integrated into primary health care to improve access to services. This is a relatively new move from the previous approach where services were provided at the tertiary level by psychiatric hospitals and 'stand-alone' psychiatric clinics. This study aims to assess the progress of the integration by looking at the distribution of mental health services in KZN non-urban areas, the needs, expectations, experiences and challenges of both service providers and service users. As you will see, the attached questionnaire asks a few questions in this regard. The gathered information will provide valuable insight that can enhance service delivery and utilization of mental health services. It will further assist in identifying potential threats which can interfere with relevant and optimal service delivery.

The questionnaire involves mainly yes/no answers and a brief explanation where necessary. It will take about 15-20 minutes of your time. The information you provide will be treated confidentially. **Should you choose to participate, please indicate your consent and that you have read and understood this information sheet by ticking the appropriate box at the top of the completed questionnaire**. This will ensure that you do not include any identifying details in your completed questionnaire. Please post the filled-in questionnaire in the marked box in the waiting area in OPD. As there will be no name on the questionnaire, we will not

know who returned the questionnaire. Your participation is entirely voluntary and anonymous, and you may choose not to participate without such a decision having any consequence for you. You may also withdraw from the participation process at any time.

Following receipt of the completed questionnaires; the results will be analysed and this will inform the proposed study. The results may also be communicated to the relevant stakeholders in the Department of Health and published in a scientific journal. The data will be stored securely in the Department of Psychology at Fort Napier Hospital and destroyed after 5 years.

Should you have any queries or wish to receive the results of this survey; please feel free to contact us.

Sincere thanks from:

Ms E.B. Siyothula, Clinical Psychologist, Fort Napier Hospital & Department of Behavioural Medicine, Nelson R Mandela School of Medicine, University of KwaZulu Natal, P.O. Box 370, Pietermaritzburg 3200 (Tel: 033 260 4300; busi.siyothula@kznhealth.gov.za

Professor Anthony Pillay, Principal Clinical Psychologist, Fort Napier Hospital & Department of Behavioural Medicine, Nelson R Mandela School of Medicine, University of KwaZulu Natal, P.O. Box 370, Pietermaritzburg 3200 (Tel: 033 260 4300; anthony.pillay@kznhealth.gov.za)

Appendix H

Consent document

Dear Participant

E.B. Siyothula is a PhD student at the University of KwaZulu Natal, supervised by Prof. A.L Pillay.

You have been asked to participate in a research study.

Title of the study: Challenges in developing and integrating community clinical psychology services in non-urban communities of Kwa-Zulu Natal (KZN)

This is an anonymous survey aimed at exploring the needs and expectations of both mental health service providers and service users. The gathered information will provide valuable insight that can enhance service delivery and utilization of mental health services. It will further assist in identifying potential threats which can interfere with relevant and optimal service delivery.

You have been informed about the study by----------

You may contact E.B. Siyothula at 033 260 4350 or email at busi.siyothula@kznhealth.gov.za any time if you have any questions about the research.

You may contact the **Biomedical Research Ethics Office on 031 260 4769 or 260 1074 or** Email BREC@ukzn.ac.za if you have questions about your rights as a research participant.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop at any time.

If you agree to participate, you will be given a signed copy of this document and participant information leaflet which is a written summary of the research. The original copy will be kept separately from your completed questionnaire to ensure anonymity.

The research study, including the above information, has been described to me orally. I understand what my involvement in the study means and I voluntarily agree to participate. I have been given an opportunity to ask any questions that I might have about participation in the study.

---------- ----------

Signature of Participant Date

Appendix I

Questionnaire to be administered to clinical psychologists working in non-urban areas of Kwa Zulu Natal

Title of the study: Challenges in developing and integrating community clinical psychology services in non-urban communities of KwaZulu Natal (KZN).

Thank you for agreeing to complete this anonymous survey. Please **do not** write your name on this form.

I have read and understood the information sheet about this study and hereby consent to participate (please tick this box) ☐

Age……. years Male/ Female

Designation: intern clinical psychologist/community service clinical psychologist / independent practice clinical psychologist

Experience ……years

Duration of your involvement in the non-urban community setting……years

Full-time: Yes/No part-time: Yes/No

How often do you work in a non-urban community setting? Weekly/monthly/
other……

Did your training prepare you adequately for working in a non-urban community setting? Yes/No

Explain……
……
…….....

Do you get satisfaction from working in a non-urban community setting? Yes/No

Explain……
……
……

Do you feel that other professionals understand your role as a clinical psychologist? Yes/No

Explain……
……
…….

Do you feel that clients referred for psychological intervention understand your role? Yes/No

Explain.....
.....
.....

What do you expect/ need from professionals who refer clients for psychological consultation?.....
……
….……

What has been your experience when you see (consult) clients referred for psychological intervention?.....…
……
…….

Do you feel that your clinical setting provides you with resources that help you to meet the mental health needs of the patients?

Explain……
……
……

What challenges do you face in the non-urban clinical setting that impact service delivery?
.....
.....
.....

List the 3 most important needs that can contribute to your job satisfaction in your clinical setting

1. …… 2. ……
3…….

Where do you see your career in the next 3-5 years?

……
……
……

What do you find most challenging when working with patients in the non–urban setting…….....
.....
.....

What do you find rewarding?

……
……
…….....

Would you want to continue working in non-urban areas? Yes / No

If yes, explain: ……

……
……

Additional comments:

……
……
……

Thank you for your time

Appendix J: Approvals

a) BREC Approval.

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

06 October 2015

Mrs ETB Siyothula (202511457)
School of Nursing and Public Health
busi.siyothula@kznhealth.gov.za

Dear Mrs Siyothula

Protocol: Challenges in Developing and integrating community clinical psychology services on non-urban areas of KwaZulu-Natal.
Degree: PhD
BREC reference number: BE199/15

EXPEDITED APPLICATION

A sub-committee of the Biomedical Research Ethics Committee has considered and noted your application received on 13 April 2015.

The study was provisionally approved pending appropriate responses to queries raised. Your responses received on 28 September 2015 to queries raised on 27 May 2015 have been noted by a sub-committee of the Biomedical Research Ethics Committee. The conditions have been met and the study is given full ethics approval.

This approval is valid for one year from **06 October 2015.** To ensure uninterrupted approval of this study beyond the approval expiry date, an application for recertification must be submitted to BREC on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research Ethics Guidelines (2015), South African National Good Clinical Practice Guidelines (2006) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx.

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

The sub-committee's decision will be **RATIFIED** by a full Committee at its meeting taking place on **10 November 2015.**

We wish you well with this study. We would appreciate receiving copies of all publications arising out of this study.

Yours sincerely

[redacted]ka-Gwegweni
Chair: Biomedical Research Ethics Committee

cc supervisor: pillayb@ukzn.ac.za
cc postgrad: ramlalm@ukzn.ac.za

Biomedical Research Ethics Committee
Professor J Tsoka-Gwegweni (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 2486 **Facsimile:** +27 (0) 31 260 4609 **Email:** brec@ukzn.ac.za
Website: http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx

b) Gatekeeper approvals

i) Department of Health Province of KwaZulu Natal

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM199/15
NHRD Ref.: KZ_2015RP34_794
Enquiries : Ms G Khumalo
Telephone : 033 – 395 3189

Dear Mrs E B Siyothula

Subject: Approval of a Research Proposal

1. The research proposal titled **'Challenges in developing and integrating community clinical psychology services in non-urban communities of KwaZulu-Natal'** was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

The proposal is hereby **approved** for research to be undertaken at Harry Gwala, Umzinyathi and Umkhanyakude Districts.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

[redacted]

Dr E Lutge
Chairperson, Health Research Committee
Date: 07/09/15

ii) uMkhanyakude Health District

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Umkhanyakude Health District Office
Dr C H Vaughan Williams
Medical Manager, Senior
Private Bag X 026, Jozini 3969
Tel: 035 5721327, Fax: 035 5721251
Cell: 072 584 3472
Email:hervey.williams@kznhealth.gov.za

Reference :
Enquiries : Dr CH Vaughan Williams
Telephone : 035-5721327 Ext 114

8 June 2015

Dear Mrs B Siyothula

I have pleasure in informing you that permission has been granted to you by the District Office to conduct research on in this district, entitled:

'Challenges in developing and integrating community clinical psychology services in non-urban communities of KwaZulu-Natal'

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Sincerely,

[redacted]

C H Vaughan Williams
Family Physician, Umkhanyakude Health District Office

iii) uMzinyathi Health District

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

UMZINYATHI DISTRICT OFFICE DC 24
Private Bag X2052, Dundee, 3000
34 Wilson Street, Dundee, 3000
Tel: (034) 299 9100, Fax.: (034) 212 4800
Email: charlotte.vanross@kznhealth.gov.za
www.kznhealth.gov.za

OFFICE OF THE DISTRICT MANAGER

TO	:	***MRS. E.B. SIYOTHULA***
FROM	:	***MR. J. MNDEBELE*** **DISTRICT MANAGER**
DATE	:	**18TH JUNE 2015**
RE	:	**REQUEST FOR STUDY APPROVAL**

Umzinyathi Health District Office supports your request to conduct research for "Challenges in Developing and Integrating Psychology Services in non- urban areas of KwaZulu Natal."

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District / our facilities will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the district office.

Thank you

[redacted]
Mr. J. Mndebele
District Manager
Umzinyathi District Health Office (DC24)

iv) Harry Gwala Health District

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

HARRY GWALA HEALTH DISTRICT
Private Bag X502 Ixopo, 3276
111 Main Street, Ixopo, 3276
Tel.:0398348280/8200, Fax.0398342950/1301
Email.:lindiwe.zuma@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Miss N.M. Myoli
Date: 26/06/2015
Ref 2 /6/3

Mrs ETB Siyothula
School of Nursing and Public Health

Dear Mrs Siyothula

RE: RESEARCH ON CHALLENGES DEVELOPING AND INTEGRATING COMMUNITY CLINICAL PSYCHOLOGY SERVICES ON NON-URBAN AREAS OF KWAZULU-NATAL

I have pleasure in forming you that permission has been granted to you by the district research committee to conduct a research on challenges developing and integrating community clinical psychology services on non-urban areas of KwaZulu-Natal.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District office /Facility will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Research Committee and the District Management Team.

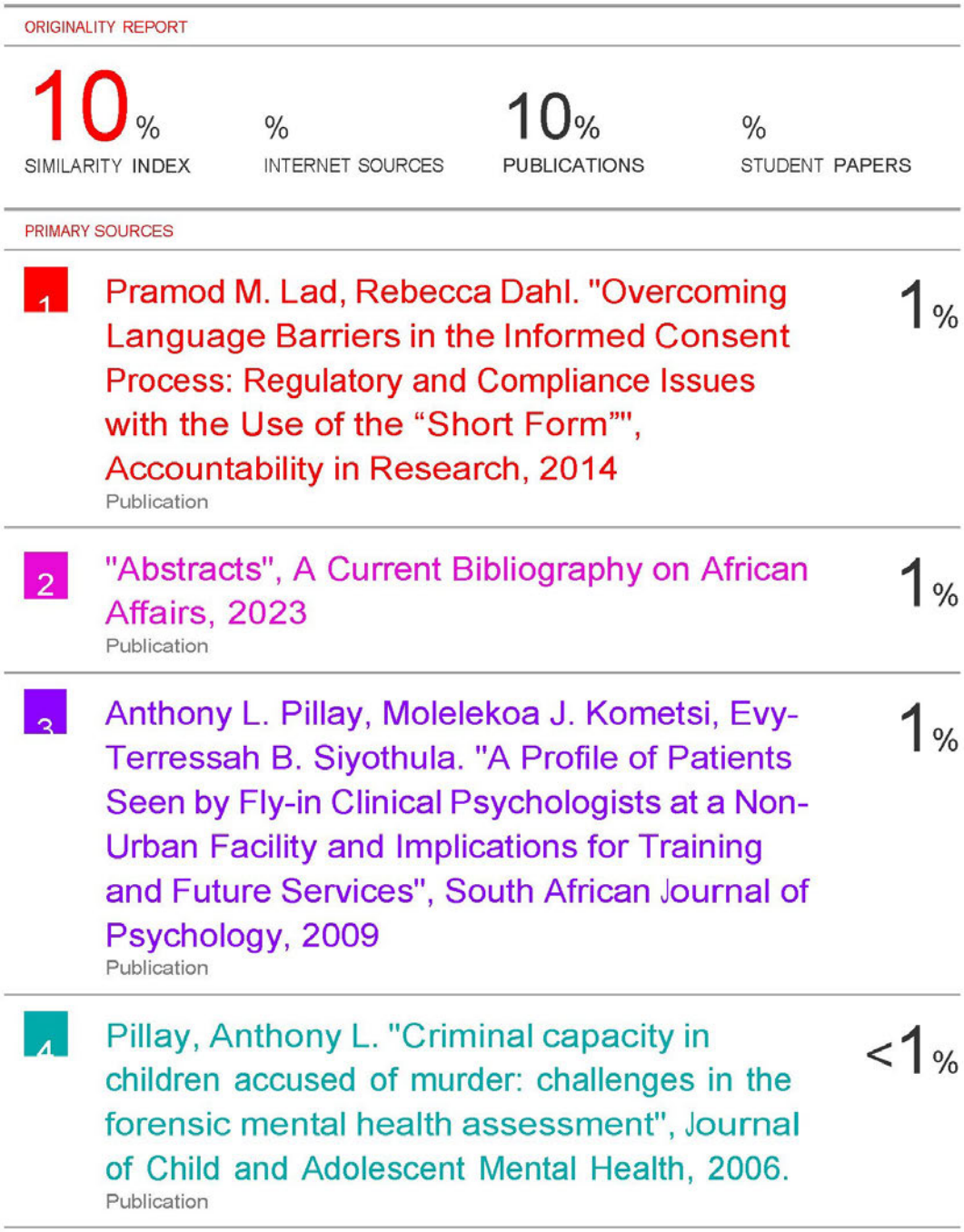
Thanking you
Sincerely

[redacted]

MRS G.L.L. ZUMA
CHAIRPERSON: HARRY GWALA HEALTH DISTRICT RESEARCH COMMITTEE

APPENDIX K

v) TURNITIN REPORT



ORIGINALITY REPORT

10%	%	10%	%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	Pramod M. Lad, Rebecca Dahl. "Overcoming Language Barriers in the Informed Consent Process: Regulatory and Compliance Issues with the Use of the “Short Form”", Accountability in Research, 2014 Publication	1%
2	"Abstracts", A Current Bibliography on African Affairs, 2023 Publication	1%
3	Anthony L. Pillay, Molelekoa J. Kometsi, Evy-Terressah B. Siyothula. "A Profile of Patients Seen by Fly-in Clinical Psychologists at a Non-Urban Facility and Implications for Training and Future Services", South African Journal of Psychology, 2009 Publication	1%
4	Pillay, Anthony L. "Criminal capacity in children accused of murder: challenges in the forensic mental health assessment", Journal of Child and Adolescent Mental Health, 2006. Publication	<1%

systematic review", South African Journal of Psychology, 2022
Publication

12	"Caring on the Frontline during COVID-19", Springer Science and Business Media LLC, 2022 Publication	<1%
13	Konstantinos N. Fountoulakis. "Psychiatry", Springer Science and Business Media LLC, 2022 Publication	<1%
14	Yemisi Okikiade Oyegbile, Petra Brysiewicz. "Exploring caregiver burden experienced by family caregivers of patients with End-Stage Renal Disease in Nigeria", International Journal of Africa Nursing Sciences, 2017 Publication	<1%
15	"Improving Mental Health Care", Wiley, 2013 Publication	<1%
16	N Chabani Manganyi. "On becoming a psychologist in apartheid South Africa", South African Journal of Psychology, 2013 Publication	<1%
17	Winnie Baphumelele Cele, Euphemia Mbali Mhlongo. "Health Professionals' Perceptions of the Integration of Mental Health Into HIV	<1%