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Title

**Social Workers ' Perspectives On Service Users' Access To Mental Healthcare Services In
Hungary And Namibia.**

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ABSTRACT

Objective: This study aimed to explore the social worker's perspectives on service users' access to mental healthcare services in Hungary and Namibia. The study focused on social workers' viewpoints, experiences, and opinions on service users' access to mental healthcare, the challenges and barriers, any specific groups or communities facing higher challenges, and their suggestions to improve access to mental healthcare services in Hungary and Namibia. **Method:** This study incorporated mixed methods with a survey administered questionnaire. The population sample consisted of sixty social workers, with a sample size of thirty professionals from each country, using a targeted snowball sampling method. Data was analysed using an Excel computer program and qualitative thematic analysis. **Results:** Social workers reported better and poor service users' access to mental healthcare services in Hungary and Namibia. Results show that service users' access to mental healthcare services is slightly better in Hungary than in Namibia. Social workers identified barriers such as lack of awareness and understanding of mental health issues, limited availability of adequate mental healthcare professionals, stigma, low income, and cultural beliefs as the leading barriers for service users to accessing mental healthcare services. **Conclusion and recommendation:** Service users' access to mental healthcare is affected by systemic issues such as lack of professionals, lack of proper legislation and funding, and environmental issues such as stigma, cultural beliefs and lack of awareness and understanding of mental health issues in Hungary and Namibia. Improving mental health services requires integration with primary care and general health services. Multiple disciplines and sectors must be involved, including education, media, finance, justice, NGOs, and various medical, nursing, and social work branches.

Keywords: Social workers; Services users; Access; Mental health; Hungary; Namibia.

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CHAPTER 1

INTRODUCTION

1.1 Background and Rationale

Globally, close to five hundred million people suffer from mental illnesses, and mental sicknesses cause various disabilities (Dlouhy, 2014; Koschorke et al., 2021). However, access to mental healthcare services is not the same as that of physical health, and the quality of mental healthcare is still substandard, with lots of gaps observed in many countries worldwide (Kilbourne et al., 2018; Demyttenaere et al. 2004 Whiteford, et al. 2013). Furthermore, the availability and quality of mental healthcare services can vary significantly across different countries and regions (Bährer-Kohler & Carod-Artal Editors, 2017.; Jankovic et al., 2020). Healthcare systems are responsible for identifying potential risks and possible factors that can cause populations to go through mental, emotional, and behavioural problems, and they carefully target interventions to lessen the advance of mental illnesses through coordinated work of different institutions and actions involved and those who are likely to make contact with people who are at high risk. After the risk is known, multidisciplinary care organisations with a combination of social aspects use their sources to address the conditions of people at hazard and their immediate environment.

Social workers are critical in the provision of mental health services around the world; they play a role in prevention through the institutions they work in; they help families and individuals go through treatments and rehabilitation and assist in reintegration and recovery processes to contest the negative social impact of mental illnesses of those exposed to mental illness, or at high risk (Chipare et al., 2020, p. 235; Chiwara; Lombard, 2017, & Fedor & Sárváry, 2021). Clinical social workers endeavour to improve individuals' and communities' social functioning by strengthening meaningful life experiences and providing a broad range of choices for distinct personal behaviours; they assess, diagnose, and treat mental problems and provide individual, group or family therapy. This varies from country to country depending on their specific regulations on treating mental health issues (Fedor & Sárváry, 2021, p.6; Cooper & Lesser, 2002; Saari, 1991, p. 244). Fundamentals of social work include human rights advocacy, social justice, collective responsibility, respect for diversity and trying to change systems that disadvantage and oppress people (Global Definition of Social Work, 2014:1., Hancock et al. 2012, p. 278, Lyons et al. p.566, Chipare et al., 2020).

According to Choudhry et al. (2016), how society thinks, reacts and deals with people suffering from mental health illnesses is influenced by a lot of factors, such as the level of information the person possesses about mental illness, if they have ever socialised with a person living with mental health issues, and modernly is exacerbated by how the media portrays it, how different families deal and cope with their relatives suffering from mental health issues, and restrictions for example, the cost of mental health services or medications.

Furthermore, it has been noted that developing countries have up to 80 % of their citizens unable to access or have easier access to mental healthcare services. In comparison, developed countries have 50 % inadequate access to services (Demyttenaere, 2004). Notably, social labels about mental illnesses and mental healthcare services, the understanding of mental health and the interpretation of mental health varies from nation to nation, which also affects how mental health care is administered and accessed by those who need such services. Based on current literature, it seems evident that social workers' roles in many countries are not so distinct. According to (Fedor & Sárváry, 2021,p.5), social workers have a significant role in assisting in reintegration processes to mitigate the causes and consequences of mental disorders. Social workers promote changes and development by proposing changes in laws, therefore liberating and empowering people with mental health illnesses and mental health services users, as they may experience violence, abuse, discrimination and neglect in their environments (Fedor & Sárváry, 2021,p.5). The roles of social workers in mental health provision include identifying and lessening the direct impact of traumatic events, mobilising and enhancing psychological capabilities, and interpreting and communicating their discoveries to the other hospital staff to be included in diagnosis in their practice (Chipare et al., 2020, p.237, Dominelli, 2012, p. 295).

The most common areas of mental health social work are psychiatric and clinical social workers. Social workers in psychiatric areas provide services for persons with mental disorders, and social workers in clinical social work provide counselling and combine modern psychotherapeutic practices with casework (Kelemen, 2011; Fedor & Sárváry, 2021). For instance, social workers offer counselling services to help patients understand their diagnosis and prescribed medications. They promote continuity of care in hospital settings while treating their clients empathetically and considering their environmental factors (Chitereka, 2010). Social workers have different roles in mental health provisions. In some countries, social workers are licensed to diagnose and provide therapy, while in some countries, they are not, though they have a critical function in mental health prevention, treatment, and rehabilitation. (Fedor & Sárváry, 2021, p. 6., Cooper and Lesser, 2002). Social workers in mental healthcare link patients to needed services, help build

helpful social networks, provide patient education and advice, and make referrals (Connolly et al., 2011).

Access to mental healthcare services is a critical component of public health systems worldwide, yet disparities in access persist, particularly in low- and middle-income countries. In contexts such as Hungary and Namibia, mental healthcare services may face various challenges; understanding the perspectives of frontline professionals, such as social workers, is paramount to enhancing service delivery and addressing barriers to access for service users. Hungary and Namibia represent contrasting socio-cultural and economic landscapes, each with unique healthcare systems and policy frameworks. Despite these differences, both countries might encounter challenges related to mental healthcare service provision, including stigma, resource constraints, and geographical disparities. Within this context, social workers are vital intermediaries between service users and mental health services, often serving as advocates and facilitators in navigating complex healthcare systems.

Access to mental healthcare services is a fundamental aspect of ensuring the well-being of individuals experiencing mental health challenges. Social workers play a crucial role in facilitating and advocating for service users' access to mental healthcare services. Understanding social workers' perspectives in different cultural and social contexts is essential in providing insights into the barriers and facilitators that impact service users' access to mental healthcare. This research study aimed to explore and compare social workers' perspectives on service users' access to mental healthcare services in two distinct countries, Hungary and Namibia. Both countries present unique challenges and opportunities concerning mental healthcare delivery due to differences in healthcare systems, socio-cultural factors, and historical contexts. This study contributes to a broader understanding of mental health service delivery dynamics by amplifying social workers' voices. It underscores the importance of collaborative efforts to promote equitable access to care for all individuals, irrespective of geographical or socio-economic background.

1.2 Statement of the problem

Hungary, a high-income country in central Europe, has undergone substantial healthcare reforms recently and has been striving to adapt mental healthcare services to meet the growing demand (Ács et al., 2019; Cartwright et al., 2017.) According to the World Health Organisation (WHO) Mental Health Atlas (2022), Hungary had a suicide mortality rate per 100,000 citizens of 11.7 per cent, with a mental health research and reporting output of 8.82%. It is reported that there is no

mental health policy, plan or legislation in Hungary. Furthermore, it is stated that Hungary has a child and adolescent mental health policy or plan from the year 2018 only, with this plan said to have a suicide plan strategy. There is insurance for mental healthcare in Hungary, with citizens paying nothing at the point of service use. By 2020, Hungary had mental health workers per 100,00 population of 41.54%. Hungary was rated 2 out of five for integrating mental health into primary healthcare, with 9.37 % of community-based mental health services per 100,000 population. Efforts for mental health promotion and prevention have been rated 2 out of 5 in terms of functioning programs (Mental et al., 2022). A study by Ács et al. (2019) notes that acceptance of mental health clients in the social environment in Hungary is below those of other European states or overseas, and professionals working with these patients are not free from prejudice. Furthermore, they found that there is a lack of workforce and low education of employees in the field, alongside a paternalistic, institution-based approach, and the congestion of old, run-down buildings, which are not favourable to the prospect of rehabilitation and the reversibility of mental illnesses. To add, in Hungary, 58% of medical students had answered a straight "no "after being asked if they could work in a psychiatric department after they finish their studies, according to a survey carried out among BSc nursing students before the onset of their psychiatric clinical training (Ács et al., 2019). The same study by (Ács et al., 2019) concluded that there are many new mental health patients waiting for admission to mental health institutions in Hungary, the resources at hand are said to be limited, and the surrounding social attitudes are not friendly to mental health service users and their recovery journey.

On the other hand, Namibia, an upper-middle-income country located in Southern Africa, faces significant resource constraints and a high burden of mental health disorders (Chipare et al., 2020; Chiwara & Lombard, 2017). The country has a history of its citizens struggling for independence during colonial times. It faces many social problems rooted in high social inequalities, tribal differences, internal migration, and family problems (Ananias et al., 2023). Furthermore, the colonial history of Namibia has left significant marks on the people. The country experienced brutality and oppression from 1884 to 1990, and during apartheid years, social services were racially segregated, and other injustices were inflicted on black Namibians (Ananias et al., 2023). According to the World Health Organisation (WHO) Mental Health Atlas (2022), Namibia has a suicide rate of 13.51 % per 100,000 population of 2.7 million population. It is reported that Namibia has a mental health research output of 4.82%, and there is a mental healthcare policy from 2005 and legislation from 1973. However, Namibia has no child or adolescent mental health policy like Hungary but has a suicide prevention policy. In Namibia, it

is reported that there is no government expenditure on mental health financing available. Mental health is fully insured in Namibia, with a mental health workforce of 0.8 % per 100,00 population. Namibia has a rating of 1 out of 5 regarding the functioning integration of mental healthcare services in primary healthcare, with no community-based mental health services. However, there is a national suicide prevention program in Namibia, jointly implemented by the government and non-governmental organisations. To continue, in Namibia, Kafula, Ugburo, and Kibuule (2020) pointed out that mental illness statistics in Namibia are projected to have risen by 26% by 2021 and are feared to even double by 2025. In different regions of Namibia, there is an increase in deaths related to mental health illnesses (Paavo, 2021). Additionally, few psychiatrists, psychologists, social workers, nurses, and other healthcare professionals are available throughout Namibia to treat mental health issues (e.g., Feinstein, 2002; Haidula et al., 2003; Ruiz-Casares et al., 2009). The Namibian Sun Newspaper (2022) reported that mental health patients receive treatment in dilapidated buildings and a dire shortage of mental health personnel and beds, with a shortage of medications worsening the situation.

Moreover, mental health issues in northern Namibia are associated with madness or being cursed, which carries many stigmas. At the same time, 12-13 % of Namibians endure symptoms of psychosocial or psychological distress, while mental healthcare services are unavailable, especially in Namibia's primary healthcare settings (Bartholomew & Gintz, 2019). According to Shifiona (2014:2), it is a well-known fact in the Namibian community that many families experiencing mental health issues prefer to be treated by traditional healers than hospitals because mental health is associated with witchcraft and sorcery caused by supernatural forces and a loss of protection from ancestors. In northern Namibia, for example, it was found that patients with chronic mental illness are handcuffed, chained, and padlocked to objects and tied to trees' trunks to immobilise them; some are taken to churches for pastors to pray for them (Shifiona, 2014, p. 3). Mental health illness sufferers experience difficulties in accessing basic needs and often experience limited capacity and discrimination (Shifiona, 2014).

From the abovementioned circumstances, ensuring service users' access to mental healthcare services in Hungary and Namibia seems complicated and complex to provide a clear insight into service users' access to mental healthcare services. Hence, there was a need to conduct a research study to explore the social worker's perspectives on service users' access to mental healthcare services in Hungary and Namibia, especially in the absence of adequate mental health professionals, lack of resources, and stigma towards people with mental health issues.

1.3 Research Questions

The research seeks to answer the question: What are social workers' perspectives on service users' access to mental healthcare services in Hungary and Namibia? The other sub-questions to answer the main questions were:

1. What are the social workers' perceptions of current service users' access to mental healthcare services?
2. What are the challenges and barriers for the service users accessing mental healthcare services?
3. Are any specific groups or communities facing higher challenges accessing mental healthcare services?
4. What are the social workers' suggestions for improving access to mental healthcare services?

1.4 Significance of the study

Firstly, this study can provide valuable insights to healthcare professionals, helping them understand the challenges and barriers service users face when seeking mental health care. This understanding can improve healthcare delivery, policies, and practices, resulting in better access to mental healthcare services for service users. Secondly, the study findings can be shared with policymakers and government bodies to inform evidence-based decisions that positively impact mental healthcare policy and funding and lead to developing and implementing policies prioritising and supporting mental healthcare access. Thirdly, the study can benefit service users directly; by comprehending social workers' perspectives, service users can better understand potential systemic issues, advocate for specific improvements, and participate in learnt dialogues beside healthcare providers. The study can promote more equitable, accessible, and effective mental healthcare services for service users by creating a feedback loop between healthcare professionals' policymakers and those seeking help.

CHAPTER 2

LITERATURE REVIEW

2. Literature Review

This chapter reviewed previous literature investigating the concept of mental health and related roles of social workers in mental healthcare. This chapter discusses the overview of mental health, social workers' roles in mental healthcare, mental healthcare in Hungary and Namibia, and healthcare professionals' perspectives.

2.1 Overview of Mental Health

"Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with the universal values of society. Basic cognitive and social skills; ability to recognise, express and modulate one's own emotions, as well as empathise with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent essential components of mental health which contribute, to varying degrees, to the state of internal equilibrium" (Galderisi et al., 2017; p. 3.; Fedor & Sárváry, 2021). According to the World Health Organization (WHO) (2004), Nobre et al. (2023), mental health is a state of well-being in which individuals realise their abilities, can cope with the stresses of life, can work meet their targets effectively, and can contribute to his or her community. (Kleinman 2009; WHO 2016) reviewed that mental health needs must be a worldwide humanitarian and development priority and a primary concern in every country. Mental illness includes when an individual suffers disturbances in perceptions, beliefs, thought processes, irritability, fatigue, concentration, and mood changes (Maloboka & Barandonga, 2011; Bertolote, 2008). Mental health is so vital in all aspects of humankind; Kleinman (2009) and WHO (2016) informs that mental health needs must be much more a worldwide humanitarian and development priority and a primary concern in every country in the world and that in the past a moral failure of communities in all parts of the world existed.

According to Fedor & Sárváry (2021), research in social psychiatry has established that social and traditional relations have a severe effect on the mental health of people. Developed and modern countries are nowadays experiencing a high level of anxiety and depression, which is different in less developed countries, especially where commonality and collectivism are firmer,

and people enjoy their freedoms and fairness, which is less common in developed countries. Moreover, Ashipala (2013) states that the absence of mental illness allows people to feel positive about themselves and other people and promotes emotional and social wellness. Mental health influences how people act, behave, respond to everyday challenges, and cope with events. Mental health involves being productive in the workplace, school, and family, as well as in the overall daily routine work and functioning optimally in their environment (De Haan, 2011).

On the other hand, Fedor and Sárváry (2021) state that mental health is a continuum, not a dichotomy. These emphasise that mental well-being exists on a spectrum rather than in simple categories of "healthy" or "unhealthy." This perspective acknowledges that individuals can experience varying levels of mental health at different times and that it is not a fixed state but rather a dynamic and evolving aspect of the human experience. By viewing mental health along a continuum, researchers and practitioners can better understand the complexity and nuances of mental well-being (Fedor & Sárváry, 2021). This approach allows for a more holistic understanding of mental health, considering factors such as resilience, coping strategies, social support, and personal growth. Other than having severe mental illnesses, many people are living in deficiency of basic needs, are jobless, facing numerous disasters, which can be natural, artificial, intricate crises, experiencing discrimination because they are mid-minority groups, existing with consequences of economic or political unstable situations or societies, having difficulties because of their sexual orientation for whom mental well-being is under serious challenge.

Mental health globally is not satisfactory in all nations; there is a notable gap between the commonness of mental disorders and the number of persons in all countries receiving adequate treatment and care (Mental et al. U.K., 2015; WHO, 2008). Mental disorders cause grave vulnerabilities, and people with severe mental illness are among the most underprivileged people in the public. They experience a weakened ability to function, face discrimination, unemployment, poverty, social isolation, homelessness, limited access to health facilities, high risk for many physical diseases, substance abuse, violence, and maltreatment from time to time, ending with suicide and premature deaths. (Bährer-Kohler et.al, 2017.) The problems caused by mental health disorders are highest in developing countries where there is the highest proportion of mental health sufferers, but the lowest proportion of services are found (Coomer, 2013; Bährer-Kohler et al., 2017).

There are three central ideas for improving mental health. They define mental health as a fundamental part of human health, more than the presence of mental illnesses, and intimately connected with behaviour and health (Herrman et al., 2005). Additionally, mental health is understood differently across cultures; however, it remains the basis for health and effective functioning for a person and their community (Herrman et al., 2005). Individuals' adaptation to multifaceted changes in their physical and social environment can be seen as why mental health is a dynamic state and situations or events that are conducive to mentally ill states are a risk factor. At the same time, other conditions and circumstances that promote development and growth are protective factors (Fedor & Sárváry, 2021, p.17; Mental Well-being, 2019). According to Dlouhy (2014), mental illnesses affect more than 25 % of all people globally at some point in their lifetimes, from urban to rural environments, men to women, from the rich to the poorest, people of all ages, from all countries, mental illnesses do not discriminate and are universal. Mental illnesses can have an unfavourable impact on the quality of life in societies, individuals, and families (Dlouhy, 2014). Fedor and Sárváry (2021) inform that cultural issues, extreme fear of stigmatisation, and deficiency in access to mental healthcare systems are part of the effects of mental health disorders and illnesses that are frequently underreported.

2.2 Roles of Social workers in mental healthcare

The roots of the social work profession and social workers can be traced back many years. Firstly, from the days of the Charity Organization Society (COS), founded in 1876 by Stephen Humphreys, it was known to provide scientific charity to families needing financial help. These friendly volunteers acted as moral role models, attending to each person's needs through moral persuasion and creating an environment that could be regarded as therapeutic today. They rarely gave money directly; instead, they acted as role models (Tosone, 2016). Secondly, Jane Addams 1889 founded the Hull House in Chicago; the movement was known as the Settlement Movement; on the other hand, they believed that poverty was a result of environmental factors rather than a personal moral fault of any one person. Settlement workers decided to live in the same neighbourhood homes as their clients, emphasising community involvement above one-on-one therapy in their professional lives. Put differently, communities rather than specific people were their clients (Tosone, 2016). Moreover, Mary Richmond 1917, wrote *The Social Diagnosis*, as the field was interested in psychoanalysis then, where she emphasised the influence of the client's surroundings on their personality and adjustment, while Freud's emphasis on internal characteristics offered a workable explanatory model for why resistive clients failed to improve with social casework (Cornell, 2006).

According to the National Association of Social Workers (2014), "the primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty and social workers promote social justice and social change with and on behalf of clients". The National Association of Social Workers arranged forums to provide basic definitions of clinical social work and outline the goals, skills, body of knowledge, and the new speciality's connection to the social work field. For example, Grosh (2016) NASW (2022) defines clinical social work as: *"A speciality practice area of social work which focuses on the assessment, diagnosis, treatment, and prevention of mental illness, emotional, and other behavioural disturbances. Individual, group, and family therapy are common treatment modalities. Social workers who provide these services must be licensed or certified at the clinical level in their state of practice. Clinical social workers serve in various settings, including private practice, hospitals, community mental health, primary care, and agencies"*. (Para, 1 & 2.

Social workers play a pivotal character in mental health care, as they comprise a significant portion of the mental health workforce in the United States (Tosone, 2016; Cheng, 2009). Social workers are vital professionals in rendering interventions and services aimed at treating individuals with mental health problems and are adequately capacitated to provide mental health services (Whitaker et al., 2021). Social workers' unique skills and expertise enable them to address the complex social, emotional, and environmental factors that impact mental well-being.

Furthermore, Social workers' roles in integrated care teams include behavioural interventions, care coordination, and intake assessment, and their involvement in integrated care settings has been associated with improved mental health results for patients (Poopedi & Bila, 2023). One of the primary roles of social workers in mental healthcare is to provide counselling and psychotherapy to individuals experiencing mental health issues. Social workers use their training in therapeutic techniques and their understanding of human behaviour to help clients navigate their emotions, thoughts, and behaviours in a supportive and non-judgmental environment. For example, in the USA, according to NASW, 37% of licenced social workers identify as mental health specialists, 45% work in private practice, and 61% engage in direct practice, and they are the majority of healthcare professionals who provide mental healthcare while at the same time, students studying social work learn how to diagnose using The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and about the possible applications and misuses of this guidebook (Tosone, 2016).

In addition, as mental health professionals, social workers enjoy upholding a resilience-based, strengths-based approach to client care (Goldstein, 1995). Through individual and group therapy sessions, social workers help clients develop coping strategies, improve communication skills, and build resilience to manage their mental health challenges effectively. In addition to providing direct counselling services, social workers also play a vital role in advocating for the liberty, freedoms and needs of individuals with mental health conditions. They work tirelessly to ensure their clients access quality mental healthcare services, affordable housing, employment opportunities, and other essential resources that promote their well-being. Social workers collaborate with healthcare providers, government agencies, and community organisations to create a supportive network of care for people with mental health illnesses (Goldstein et al., 2009).

Moreover, social workers practising as clinical social workers, the mental, emotional, and behavioural health of individuals, couples, families, and groups is the main focus of clinical social work. Clinical social work focuses on the client's interaction with their surroundings, and a comprehensive approach to psychotherapy and treatment planning in clinical social work considers the client's relationship with their environment crucial (Raine et al., 2023). Besides, social workers in mental healthcare often serve as case managers, coordinating care and services for clients with complex needs. They assess clients' strengths and challenges, develop individualised care plans together with clients, and connect them to needed resources and support systems. By taking a holistic approach to care, social workers address the mental health symptoms, social causal factors, and circumstances of health that burden their clients' overall well-being (Raine et al., 2023).

Another critical role of social workers in mental healthcare is to provide crisis intervention and support during times of acute distress. According to Mason et al. (2002), Social workers are trained to assess risk factors, de-escalate crises, and connect clients to emergency services when needed. Whether responding to suicidal ideation, domestic violence, or substance abuse issues, social workers are essential in protecting and guarding the safety and well-being of individuals in crisis. Other organisations, such as the American Board of Clinical Social Work ABCSW (2023), inform that clinical social work is a healthcare profession based on theories and methods of prevention and treatment in providing mental health/healthcare services, with a particular focus on behavioural and bio-psychosocial problems and disorders.

Clinical social work's unique attributes include using the person-in-environment perspective, respect for the primacy of client rights and strong therapeutic alliance between client and practitioner. (What is Clinical Social Work, para 1). Social workers are critical in the provision of mental health services around the world; they play a role in prevention and treatment and assist in reintegration processes to contest the negative social impact of mental illnesses (Chipare et al., 2020, p. 235; Chiwara; Lombard, 2017) & Fedor & Sárváry, 2021). Clinical social workers endeavour to improve individuals' and communities' social functioning by strengthening meaningful life experiences and providing a broad range of choices for distinct personal behaviours; they assess, diagnose, and treat mental problems and provide individual, group or family therapy (Fedor & Sárváry, 2021, p.6, Cooper, and; Saari, 1991, p. 244). social workers are indispensable members of the mental healthcare team, bringing a unique set of skills and perspectives to support individuals with mental health challenges. Their roles encompass counselling, advocacy, case management, crisis intervention, and more, all aimed at promoting the mental well-being of their clients and communities. Through their dedication, compassion, and expertise, social workers make a significant impact on the lives of those struggling with mental health issues, helping them lead fulfilling and meaningful lives. Fundamentals of social work include human rights advocacy, social justice, collective responsibility, respect for diversity and trying to change systems that disadvantage and oppress people (Global Definition of Social Work, 2014:1., Hancock et al. 2012, p. 278, Lyons et al. p.566, Chipare et al., 2020).

2.3 Mental Healthcare Services in Hungary

In Hungary, the social services system was established in the 1950s; it provided support for disabled people and establishments dealing with mental health issues, with the states responsible for ensuring personal care for people in such need (Acs et al., 2019). In Hungary, a legislature was introduced for mental health patients in 2003, which targets mental health clients who are not a danger to the public and complex psychosocial rehabilitation is provided in the environment of the patient (Acs et al., 2019). Furthermore, even though the fight against mental illnesses, such as depression, received more attention in the early 1990s in terms of education, health programs, and outpatient and inpatient psychiatric care, depression and psychiatric disorders no longer seem to be top priorities for health policymakers. Policymakers should maintain mental health and patient care as a strategic priority because it has been scientifically shown that improved access to psychiatric care and effective treatments was the primary cause of Hungary's 65% decline in suicide rates between 1985 and 2020. Central Statistical Office Population, (2021). Many patients in Hungary have limited access to publicly funded specialist care due to a lack of specialist and

institutional capacity and insufficient funding (such as capacity limits and lengthy waiting lists). Patients with depression can access a variety of publicly funded health services in Hungary, including general psychiatric examinations, medication therapy, psychotherapy, counselling, and cognitive behavioural therapy (Depression Scorecard for Hungary, 2022).

Additionally, Mental healthcare services are provided at both outpatient and inpatient mental healthcare units. In addition, not-for-profit mental health centres provide treatment to people according to their residence, like primary care centres (Koschorke et al., et al. 2021). Acts et al. (2019) note that acceptance of mental health clients in the social environment in Hungary is below those in other European states or overseas, and professionals working with these patients are not free from prejudice. On the other hand, Hungarian family doctors in primary care centres refer persons with mental illness to mental health centres, where they get outpatient treatment. In contrast, if patients need inpatient treatment, specialists in outpatient mental health centres refer them to hospitals with inpatient psychiatric departments (Koschorke et al., 2021).

According to Depression Scorecard Hungary (2022) In Hungary, 7% of adults over the age of 15 suffer from depression (2021). Monthly, it is stated that there are around 200,000 cases of severe depression in the Hungarian healthcare system. The illness is typically underdiagnosed and undertreated, with years often passing between diagnosis and treatment of the service users needing such services. Furthermore, it is stated that Hungary saw a notable rise in depression and anxiety symptoms as well as completed suicides in 2020 as a result of the COVID-19 pandemic.

In Hungary, Mental health is a serious public health matter and a sector that remains persistently underfunded (Cartwright et al., 2017.) In their study, Cartwright et al. (2017) reported that the quantity of trained mental healthcare professionals is decreasing, so new professionals are not enough to replace older professionals. Psychiatrists close to the exact numbers are needed to meet the client's needs. Additionally, the mental health sector is facing problems such as low wages and poor working conditions, which in turn forces young Hungarian professionals such as social workers and psychiatrists to migrate abroad for greener pastures (Cartwright et al., 2017 Karbouniaris et al., 2022). In other words, underfunding of mental healthcare services reduces access to proper and up-to-date care for those affected role in need and contributes to the exodus of G.P.s from the public healthcare system to the private sector. Comparing Hungary to other European countries, it is found that community-based approaches to the treatment of mental health problems are not so popular and instead, the practice in Hungary is more small-scale

patient-focused approach, which emphasises self-help, mutual support groups and cognitive treatments and a significant number of non-traditional therapies and alternative institutions are primarily found in the capital city (Cartwright et al., 2017). Besides, the treatment of mental health problems relies heavily on prescription medicine, and there is a strict hierarchical treatment relationship between service users and medical doctors (Cartwright et al., 2017). However, When seeking medical attention for their problems, patients in primary care already encounter several difficulties in Hungary. It is said that there is a limited number of general practitioners who prescribe medications to people with mental health issues. Patients who are referred from primary healthcare to specialists for psychiatry care leave the system because of stigma from their environment or lengthy wait times for services. According to psychiatrists' experiences, patients receiving expert care have few or limited visits annually, which results in an enormous percentage of patients terminating treatment and conduct because there is a lack of ongoing follow-ups (Depression Scorecard for Hungary, 2022).

According to Cartwright et al. (2017), mental health illnesses in Hungary mostly have roots in social issues such as inadequate housing, alcohol and substance abuse, lack of employment, family breakdowns, loneliness and different types of addictions. Additionally, the roles of social workers treating clients as partners, participants, and actors are weakening, and the observations of a lack of resources affect the helping relationship in Hungary and mental health services (Patyan, 2015). However, mental healthcare centres are available in Hungary at the community level (Koschorke et al., 2021). Hungary has many primary care centres, all paid for by the insurance company according to the number of registered patients, and no private primary care centres (Koschorke et al., et al. 2021). It is scientifically demonstrated that the most critical factors behind the 65% decrease in suicide rates in Hungary between 1985-2020 were improved access to psychiatry care and effective treatments (Depression Care (E.U.), 2022).

According to Kozma (2010), the ordinariness of mental disorders and substance use disorders was observed to be increasing; around 4% of the Hungarian population experienced depression, but only a few of them had a medical diagnosis around the year 2010. A study found the rate of depression among people attending primary care while the rate of major depressive episodes was observed (Kozma, 2010). The suicide rate in Hungary was known to be the highest in the E.U., even though between 2000 and 2005, the decrease in Hungary's suicide rate was the second largest recorded worldwide (Kozma, 2010). Moreover, in addition to the service provided by transitional institutions, legally defined bodies such as nursing homes and shelters for homeless people, as well as accommodation for people with drug problems and psychiatric patients,

community psychiatric care is also available in Hungary (Kozma, 2010). However, four medical universities in Hungary provide postgraduate training in psychiatry and secondary specialisation in psychotherapy for medical doctors and psychologists (Kurimay, 2010). However, his report concluded that mental health must overcome party politics and become a priority in Hungary's comparatively poor mental health indexes.

2.4 Mental healthcare services in Namibia

Namibia's colonisation history has left a permanent stain on its citizens and their welfare in general. Namibia suffered vicious colonial violence and oppressive rule under German colonial rule from 1884 to 1915. It was re-traumatised by the apartheid rule of a South Africa-led governance from 1915 to attaining its independence in 1990 (Ananias et al., 2023). The Dutch Reformed Church introduced social work in Namibia in the early 1950s. In contrast, state services arose with the expansion of the Pensions Administration and Welfare Administration in the late 1950s (Ananias et al., 2023; Chipare et al., 2020). From 1960, Namibia was subject to apartheid policies under South African rule; when South Africa gained independence in 1960, apartheid policies divided Namibian people along racial and ethnic lines, introduced segregated social services, and inferior black education and healthcare services, forced Black Namibians into settlements and forced labour (Ananias et al., 2023). Namibia's part of an oppressive and racially inequitable apartheid system and the liberation struggle that followed from 1966 contributed to various emotional and cognitive stressors with unpredictable future effects on the people's mental health (Ministry of Health and Social Services, 2005)

Social work in Namibia proliferated between 1970 and 1990 when it attained professional recognition in Namibia (Chipare et al., 2020). Namibia has been discovered to have limited mental health services amid the growing burden of mental health issues within the country. In contrast, the scarcity of resources and lack of investment in treating mental illness has been linked to problems in funding and a lack of attention toward mental healthcare and mental health services (Laubscher, 2016). Namibia is just one of the many nations that struggle to meet the requirements of people with mental health issues and disorders. One of the leading causes of illness and mortality in the nation is mental health disorders. However, there is little information on the prevalence of mental health issues, and the statistics that are provided are frequently very inconsistent (Coomer, 2013). According to Coomer (2013), one cause for the inadequate availability and accessibility of mental healthcare services in Namibia could be the absence of solid evidence concerning the commonness of mental health issues and services available.

From the history of colonial systems, Western European means of treating illness have been developed in Southern Africa. However, Cultures throughout this region have indigenous or culturally constructed ways of healing and explaining distress that are not connected directly to Western diagnostic structures or treatments of mental health issues (Bartholomew & Gentz, 2019). The Mental Health Act of 1973, leading viewpoints of mental health services in Namibia, frames mental health care within a predominantly Western diagnostic that focuses on concepts like depression or anxiety manner (Bartholomew & Gentz, 2019). This legislation serves as a guide for institutions like government-supported psychiatric facilities. Throughout Namibia, few psychiatrists, psychologists, social workers, nurses, and mental health counsellors are available to treat documented symptoms of depression, psychological distress related to HIV, and trauma (Feinstein, 2002; Haidula et al., 2003; Ruiz-Casares et al., 2009). Namibian mental health provision is faced with the main challenge, which is the lack of funding to take on social service activities and interventions. As a result, social workers tend to focus more on assessment and counselling than community-based interventions like awareness campaigns, post-discharge and recovery (Chipare, 2020).

The Namibian Sun Newspaper (2022) reported that mental health patients are treated in dilapidated buildings and a dire shortage of mental health personnel and beds, with a shortage of medications. Mental health in northern Namibia is conceptualised as madness or being cursed, with 12-13 % of Namibians enduring psychological distress, and mental health services are mostly not available, especially in primary healthcare settings. (Bartholomew & Gentz 2019). Mental health centres in Namibia attempt to treat many mental health issues, including substance abuse, anxiety, manic depression, and schizophrenia (Ashipala, 2013).

Moreover, Kafula, Uguburo, and Kibuule 2020; Mthoko et al., 2022)) state that the dominance of mental illness has risen by 26% over the 2021 rate and is to double by 2025 in Namibia, according to mental health research statistics. Namibia Daily News (2021) point out that it is so severe that it has become a day-after-day thing to read about mental health-related deaths, especially among the youth (Paavo, 2021). The most drivers of mental illnesses in Namibia have been attributed to abuse of illicit drugs and alcohol, chronic infections, as well as socio-economic factors, among others (Kafula et al., 2020). WHO (2022) estimates Namibia's suicide rate to be 9.7 in a 100,000 population. Namibia's suicide rate is the fourth highest compared to neighbouring countries such as South Africa, Botswana, and Zimbabwe. The increase in mental health illnesses and conditions is a catastrophe leading to intensification in suicide rates in

Namibia between 2020 and 2021; Namibia reported the highest number of suicides (WHO, 2022).

Mental healthcare services are curative-based, whereby the patients get treatment or are admitted and discharged from care after their condition has improved. According to Ashipala (2013), access to mental healthcare in Namibia was limited because the treatment and follow-up services were only available at regional and district hospitals, even though more than 60% of the Namibian population live in rural areas. If the mental healthcare needs of a country are ignored, sufferers will not be able to make a significant contribution to society (De Haan, 2011). In Namibia, emergency mental health services are provided at district hospitals as part of general wards, and there are no specialist mental health staff in these facilities. Hence, follow-up and a limited range of psychotropic medications are available at some healthcare centres and clinics (MoHSS, 2005). Due to budgetary limitations, mental health services are low on the priority list in Namibia (Curling, 2002; Shifiona, 2014; Chipare, 2020).

Furthermore, according to The Namibian Newspaper (2012:2), the mental health situation is alarming in Namibia, notably in the northern regions where people with mental health issues are relentlessly deserted. A study by Shifiona (2014: 8) informs that it is a permanent fight against stigma and a daily struggle to be a mental health patient in the northern part of Namibia. Individuals with mental health problems reported having difficulties in terms of finding jobs and less support from their family members and friends. Interestingly, her study found that in the northern part of Namibia, people and families with individuals with mental health issues put more faith in traditional healers as they are accessible, even though many know that Western medicine helps them better and has a good healing effect (Shifiona, 2014). Even though people from the northern part of Namibia might utilise healthcare facilities often, some would still seek help from traditional healers in cases of mental illness (Davies, 1994: 22, Shifiona, 2014:8). In addition, in most cultures in Namibia, mental illnesses are associated with beliefs in ghosts, retribution from ancestors and evil deeds (Shifiona, 2014). Oshiwambo-speaking people in Namibia attribute mental illness to possession by ancestral spirits. Sorcery and witchcraft are other strong possibilities since both cause misery and misfortune in their victims. In contrast, for other ethnic groups, mental illness is regarded as a family problem and a shameful condition that is never discussed in public because it is regarded as bringing stigma and shame to the clan or family (Davies, 1994; Shifiona, 2014).

Social workers and nurses mainly provide the backbone of mental health care services in Namibia (Shifiona, 2014). According to her study, it is found that the shortage of trained mental healthcare professionals, poor health facilities, and the increased number of psychiatric patients worsen the problem. These factors together lead to regrettable situations in which only severely sick patients are treated, as patients are sent from their families hundreds of kilometres away to be admitted to the psychiatry unit. In return, people with mental health issues in Namibia mostly lack the reassurance and support of their significant others; in some cases, professionals do not even understand or speak the patient's dialect or language (Shifiona, 2014, p. 10). In addition, the Legal Assistance Centre (2012: 18) reported that in Namibia, public awareness is minimal, and there are few opportunities to access information on mental health. It was found that families complained about side effects of mental health treatment, such as untreated side effects of medication, problems in communicating with medical doctors and limited knowledge of information about mental health medications.

On the other hand, Amathila (2001) recommended that mental health services be provided within communities using available resources. The findings show that individuals with mental health illnesses have to travel long distances for services; they lack financial resources, transportation and family support, which often leads to defaulting and aggravation of the condition. The most common areas of mental health concerns in Namibia comprise, among others, trauma-related mental illnesses, substance abuse, HIV/AIDS-related mental illnesses, as well as domestic violence-related mental illnesses (Shifiona, 2014). Mental health and physical health are said to be very separate in the healthcare services structure, and there is an enormous stigma around mental illnesses (Sibbald, 2012). Additionally, Haufiku (2012:1) alluded that no psychiatric healthcare facilities throughout Namibia are available at the community level in his report "Desperate Need for Mental Health Facilities". However, it was found that the obstacle to community adjustment is stigma, and this is mainly cited by mental healthcare professionals, people with mental illnesses as well as their families (Prince & Price, 2002).

2.5 Perspectives of Health Care Professionals:

A study by (Ori et al., 2022) was conducted in Hungary to study the attitudes of psychiatrists about populations with mental health in the field of stigma from the mental health professions point of view. Their study found that professionals in Hungary hold a positive toward mental illness patients as their score in the study was in the lowest third. For example, the results with Bahrain professionals were much higher. The study suggested less stigmatising attitudes from

Hungarian healthcare professionals. Nevertheless, their study has revealed that 50 % of their respondents, who were professionals, would be hesitant to get help or disclose their mental health problems to their colleagues (Ori et al., 2022). suffering mental illness at the workplace is seen as being less competent, dangerous and unstable and working itself is not considered healthy for people with mental illnesses (Krupa et al., 2009). A study by Cohen and Winstanley, Greene (2016), which reached about two thousand doctors, showed that their concerns were more about being labelled, the feeling of being weak due to a mental illness condition, and a lack of understanding of support structures in place. In addition, it has been found that professionals' negative attitudes towards mental health issues are associated with hopelessness in whether they can help people with their skills, and lack of confidence and/ perceived competence may lead to negative attitudes toward people with mental health issues (Knaak et al., 2014; Gorgenyi-Hegyes et al., 2021). A study by Waugh et al. (2017) from the United Kingdom confirmed that the attitudes of non-psychiatry healthcare professionals about colleagues with mental illness were positive. However, they did report that other colleagues held negative attitudes toward mental health issues.

Healthcare professionals hold diverse perspectives on mental health, shaped by their training, experiences, and the contexts in which they practice. Here are some common perspectives observed among healthcare professionals:

Biopsychosocial Model: According to Engel (1977), many healthcare professionals, including physicians, psychologists, and social workers, subscribe to the biopsychosocial model of mental health, recognising the interplay of biological, psychological, and social factors in shaping mental well-being and illness. This perspective emphasises the importance of a holistic approach to assessment, diagnosis, and treatment, considering biological vulnerabilities, psychological factors (cognition and emotions), and social determinants (family dynamics, socio-economic status, and cultural factors).

Trauma-Informed Care: The Substance Abuse and Mental Health Services Administration (SAMHSA). (2014) informs that a growing number of healthcare professionals advocate for trauma-informed care, which acknowledges the prevalence and impact of trauma on mental health outcomes. This perspective emphasises the importance of creating safe, supportive environments for individuals who have experienced trauma, avoiding re-traumatisation, and integrating trauma-sensitive practices into clinical care and organisational settings.

Recovery-Oriented Practice: Many mental health professionals adopt a recovery-oriented approach to care, which focuses on supporting individuals in their recovery journey, empowerment, and personal growth rather than just managing symptoms or deficits. This perspective emphasises hope, self-determination, and resilience, recognising that recovery is a unique and ongoing process that involves the whole person and extends beyond symptom reduction (Davidson et al., 2005).

Social Justice and Equity: Increasingly, healthcare professionals recognise the role of social determinants of health in shaping mental health outcomes and advocating for social justice and equity in mental healthcare. This perspective highlights the importance of addressing systemic injustices, such as poverty, racism, sexism, and other forms of oppression, which contribute to disparities in access to care and health outcomes. (Mental Health Commission of Canada, 2009).

2.6 Gaps in the Literature

The reviewed literature has shed light on the significance and dynamics of mental healthcare services in Hungary and Namibia. However, less is known about social workers' perspectives on service users' access to mental health services. A gap could appear in the comparative analysis of the role of cultural beliefs and practices in influencing access to mental healthcare services between the two countries. While existing research may have explored cultural factors impacting mental health help-seeking behaviours in either Hungary or Namibia individually, there may be a lack of comparative studies examining how cultural differences between these two countries shape social workers' perspectives on service users' access to mental healthcare. Understanding the influence of cultural beliefs, stigma, and traditional healing practices on attitudes towards mental illness and utilisation of mental health services is crucial for developing culturally responsive and effective interventions. By identifying similarities and differences in cultural perceptions and their impact on access to mental healthcare services, this study could provide valuable insights into the unique challenges social workers face in each country and inform the development of tailored strategies to improve access to care. Hence, there is a gap in research on social workers' perspectives on service users' access to mental health services.

2.7 Theoretical Framework

The study employed the social-ecological model as the theoretical framework theory to investigate social workers' perspectives on service users' access to mental healthcare in Hungary and Namibia. Social-ecological models provide a principal framework, or set of theoretic doctrines, for interpreting the interrelations amongst distinct personal and environmental

circumstances in human healthiness and sickness (Fleury & Lee, 2006). This framework considers various levels of influence on individuals' access to healthcare, including individual, interpersonal, community, and societal factors (Golden et al., 2015). This model allowed for examining how these different levels of influence shape and how they interplay to impact access to mental healthcare services. According to Fleury & Lee (2006, p. 130), the solitary way of conceptualising the interdependence among people, their behaviour and their environment is through social-ecological models. The framework allowed the research to explore the complex interplay between social workers' perspectives, institutional policies, community resources, and societal attitudes to understand the barriers and facilitators of access to mental healthcare in the two countries where the study was conducted. The social-ecological paradigm is deep-rooted in certain core principles or themes concerning the interrelations among environmental conditions and human behaviour and well-being as it describes ecological settings as having several physical, social, and cultural extents that can impact different outcomes (Stokols, 1996; Golden et al., 2015)).

Moreover, the social-ecological model emphasises the dynamic interplay between situational and personal factors and incorporates a variety of concepts from systems theory, such as interdependence, homeostasis, negative feedback, and deviation amplification to understand the dynamic relations between people and their environment ((Stokols, 1996); Golden et al., 2015). In other words, the social-ecological model emphasises the interdependence of environmental conditions within settings and interconnections between multiple settings and life domains (Stokols, 1996). Moreover, the social-ecological model informs that levels of influence between multiple settings are interactive and reinforcing (Golden & Earp, 2012). For example, in this study's context, the environment's social, physical, and cultural aspects can influence service users' access to mental healthcare and affect social workers' perspectives and service users' access to mental healthcare services. Besides, Golden & Earp (2012) allude that the environment is multidimensional since institutions and neighbourhoods are rooted in larger social and economic structures and that the environmental context may influence, for example, the access to mental healthcare services by service users or social workers differently, depending on their unique approaches to service provision, beliefs, and practices given their environment.

Additionally, the social-ecological models are used to clarify the complicated connection between social (for example, social networks) and structural (for example, accessibility of care) influences, personal practices, the physical setting, and health (Baral et al., 2013). Still, the same researchers emphasise that the social-ecological model contextualises individualistic behaviour

using dimensions including intrapersonal, for example for the context of this study (e.g., knowledge, attitudes, behaviour of healthcare professionals), interpersonal or network (for example, social network, social support), community (for example relationships between organisations and institutions) and public policy. (For example, local, state, and national laws) to offer an outline for illustrating the relations concerning these points and how they affect each other (Baral et al., 2013). This theoretical framework was the best fit for the study—healthcare access

CHAPTER 3

RESEARCH METHODOLOGY

3. Introduction

This chapter covers the research design and methods employed in the study, including the analysis method.

3.1 Research Methods and Research Design

This study was designed as an explorative study with a unique mixed lens as a method of inquiry. The investigator was driven by a curiosity to explore and seek an understanding of the experiences of social workers. This phenomenon has not yet been formally explored in the Hungarian and Namibian contexts, making this research a pioneering endeavour.

3.1.1 Research Approach

A mixed methods approach with a comparative strategy method was used in the study, as the core assumption of the study was to combine statistical trends (quantitative data) with stories and personal experiences (qualitative data) to better understand the research problem from both sides of data forms. (Creswell 2015., Maitisa, 2019., & Walter, 2017). The study gathered qualitative and quantitative data, integrated the two, and then drew interpretations based on the combined strengths of both data to understand the research problem” (Creswell, 2015, p. 2 Clark & Creswell, 2007; Abdelhamid, 2021., Du Plessis, 2012).

The survey was cross-sectional, as data was collected at one point. The survey methodology employed in this research study was a questionnaire. It was rational to use in this study and more convenient for respondents, considering that the study has been conducted in two different countries. The survey methodology employed in this research study was an electronically

administered questionnaire. It was rational to use for this study, as it is more convenient for respondents and costs less and more data to be collected (Creswell, 2009., Cohen, Manion, & Morrison, 2007). This was the most suitable study, considering that the study was conducted in two different countries, hence utilising a comparative method strategy.

3.1.3 Research Design

The framework for applying the research approach combined exploratory and descriptive research designs. This made using quantitative and qualitative design components in the research possible. It results from a lack of knowledge in a topic or area of research and is carried out to obtain additional understanding of a phenomenon or society (De Vos et al., 2012).

3.2 Population

The study population was the social workers working in public or private service settings such as government ministries, parastatals, faith-based organisations, and non-governmental organisations. Study participants presently are involved in providing mental healthcare services or are experts in the field and offer such services in urban, semi-urban, and rural areas from any part of Hungary and Namibia.

3.3 Sample and Sampling Technique

The study employed a targeted purposive sampling method, utilising a snowball sampling technique, which comprised 30 respondents as a sample size from each country, making it a total of 60 social workers from Hungary and Namibia.

3.4 Data Collection and Data Analysis

The research data was collected through a survey. A questionnaire was developed from the study's central questions and was distributed online using the Google Forms tool. Google Forms collected responses and generated results. The results were downloaded for further analysis. The quantitative data was generated and converted into pie charts, tables, and bar graphs during analysis. Qualitative parts of the data were categorised and classified into common themes that appeared in the qualitative responses. An analysis process of sorting and categorising the identified codes into themes followed, and the researcher was able to identify themes of significance and those of less significance in line with the research objectives.

CHAPTER 4

RESEARCH RESULTS AND FINDINGS

4. Introduction

In this study, all responses by the participants regarding service users' access to mental healthcare services refer to their own experiences and observations as social workers. The result presented here shows the responses to the research questions, including both quantitative and qualitative data.

4.1 Research Findings

4.1.1 Gender proportion

The study recruited 70 % of respondents from Hungary as females and 30% as males. Meanwhile, Namibia had 80 % female and 20 male respondents. The result may suggest that females dominate as healthcare professionals in both countries.

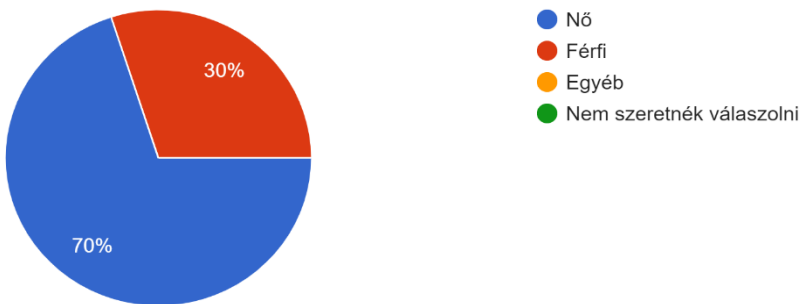
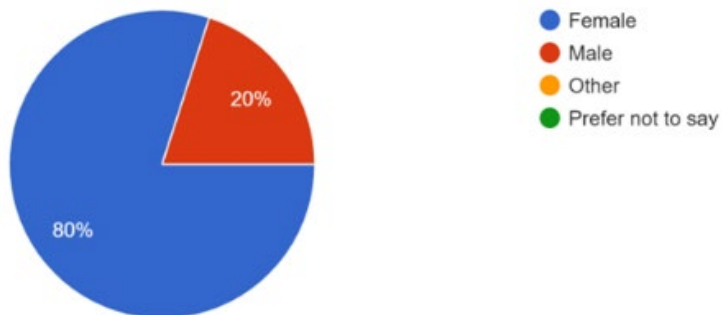


Figure 2. Gender proportion (up) Hungary (down) Namibia



4.1.2 The age group of participants

The second demographic question in the study was to determine the age range of participants. The age range varied from under 25 years to over 65 years old. Hungary's response indicates a middle-aged-dominated, with 50 % of respondents ranging from 35 to 50 years old. Namibia is young-dominated, with 66 % of respondents between 26 and 34 years old.

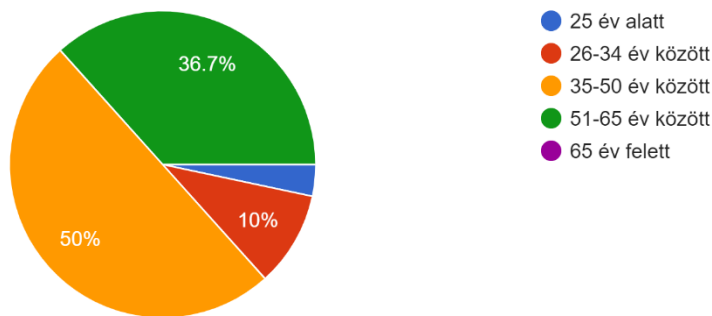
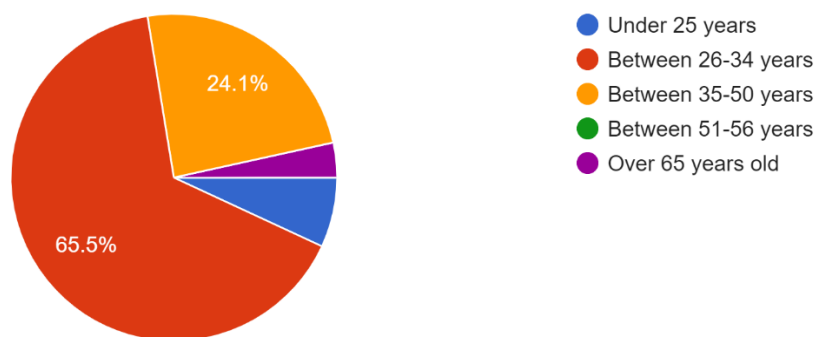


Figure 3. Professionals age groups (up) Hungary, (Down) Namibia



4.1.3 Perceptions of social workers on current services users' access level to mental healthcare services.

Social workers were asked about the current access level rate for services users to mental healthcare services; the access level rate was measured using a scaling question on a scale of 1-5, with one being "very poor" and five being "excellent,". Results show that 47 % of social workers in Hungary perceive the current access as better, followed by 30 % as poor and 23 % indicating good access to mental healthcare services. On the other hand, social workers in Namibia reported slightly lower numbers, with 43% indicating better access to mental healthcare services, 32% being poor, and 17% remarking good.

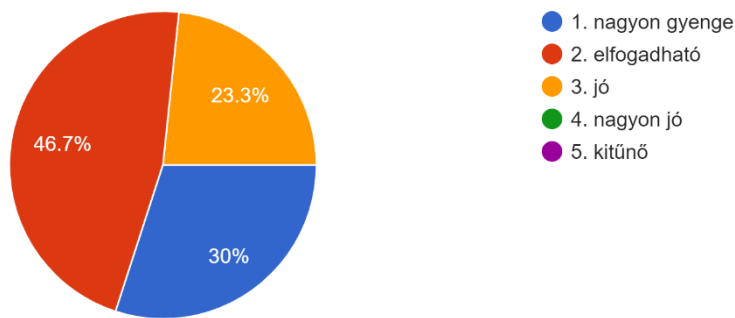
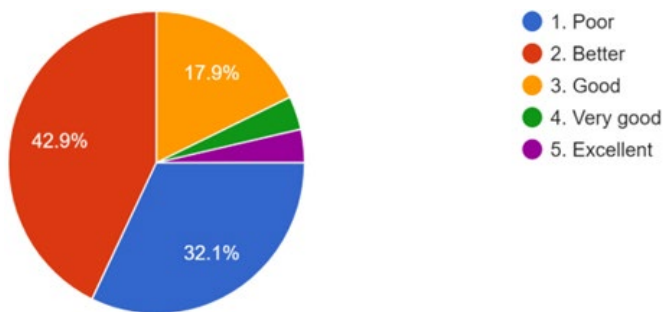


Figure 4. Current service users have access to mental healthcare services in (top) Hungary and (down) Namibia.



4.1.4 Barriers for service users to accessing mental healthcare services

Results show that social workers in both countries registered a lack of understanding about mental health issues as the most significant barrier to accessing mental healthcare services, with 77% of respondents from Hungary and 87% of respondents indicating the same in Namibia. The second significant barrier is the limited availability of mental healthcare professionals, with 83% in Namibia and a lower % in Hungary at 63%. At the same time, in Hungary so, social workers indicated limited access to affordable or accessible mental healthcare services at 73.3 %, which is low in Namibia at 36.7 %. To continue the stigma surrounding mental health issues is high in both countries, with 66% in Hungary and higher in Namibia at 70 %. The results show cultural beliefs as the third highest barrier to users' access to mental healthcare services in Namibia, with 67%. The results show a difference that seems to suggest that mental healthcare services are relatively expensive or unfordable to those who require them in Hungary. In contrast, Namibia seems to have an enormous level of lack of awareness and understanding about mental health issues.

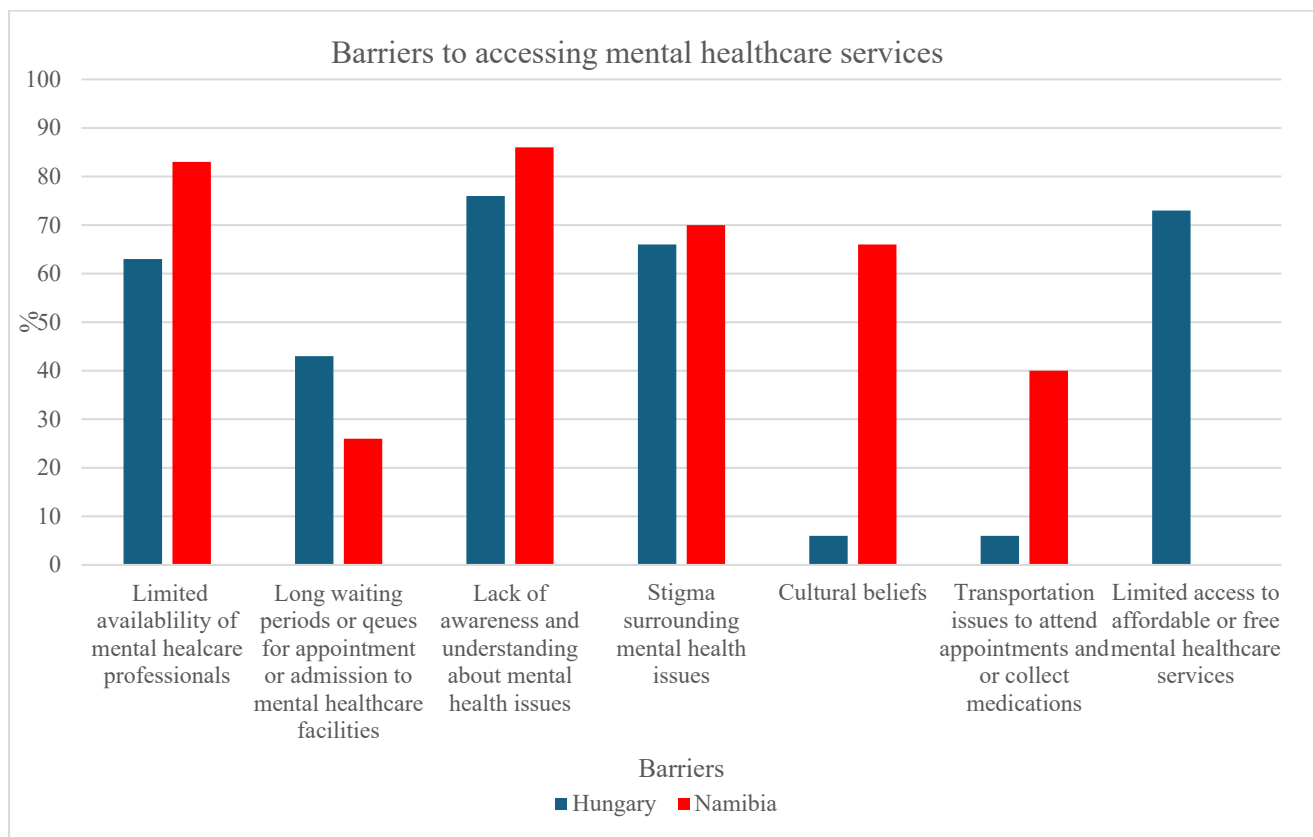


Figure 5. Barriers for service users to accessing mental healthcare services

4.1.5 Groups and communities that face high challenges in accessing mental healthcare services

Several groups or communities that face the most challenges in accessing mental healthcare services have been identified by social workers in Hungary and Namibia as follows;

Hungary

- *Low-income earners*

Social workers in Hungary have identified that those who earn less are likely to have limited access to mental healthcare services compared to other income groups in the country. Their responses are noted below.

“Average earners and those below, because mental health care is expensive and can only be obtained in private services|” (Respondent 3)

“poorer, more uneducated class” (Respondent 7)

“Low-income people, people living in cities, towns, villages or farms, homeless people, psychiatric patients, criminals” (Respondent 28)

“Lower social strata. People with low incomes, limited mobility, families with several children, and the elderly” (Respondent 27).

- *Old aged people*

Social workers mentioned that senior citizens are among the people who are facing high challenges in accessing mental healthcare, especially if they live in isolation.

“A senior citizen living in the countryside|” (Respondent 5)

“Elderly groups who are living alone” (Respondent 23)

- *People belonging to ethnic minorities*

Some social workers stated that people from groups belonging to ethnic minorities face challenges in accessing mental healthcare services.

“Minority groups, Roma” (respondent 10)

“people living in the countryside, belonging to an ethnic minority|” (Respondent 17)

- *Families*

Social workers stated that children, young people, and the elderly can all face challenges in accessing services, such as:

“Kids”(Respondent 11)

“Students in primary, secondary or even college who have much stress from family, private life and school” (Respondent)

“Young employees and middle-crisis people still find their profession to work well in life” (respondent 14)

.

“Young adults around age 20-30 (private life, family and career crisis) and elderly left alone” (Respondent 18)

“All age groups, starting with children being traumatised, young adults dealing with career and or private life matters, or the elderly who do not get enough attention” (Respondent 25)

- *People living outside of cities*

Social workers in Hungary have identified that those who reside outside big cities are mostly the ones who experience challenges accessing services.

“Small villages, due to the need for more information and availability” (Respondent 24).

“Persons with a low level of education, people living in small communities (townships, small villages), people living in segregated areas” (Respondent 21)

“People living in extreme poverty, living in the countryside or slums” (Respondent 30)

Namibia

In Namibia, social workers have identified the following groups as the most susceptible to facing challenges in accessing mental health services.

- *People in rural area communities*

“Yes, Ovambo, Kavango, Wambo communities, northern communities” (Respondent 1

“Remote areas/villages” (Respondent 10)

“Primarily people in rural areas” (Respondent 3)

“Yes, people in remote areas” (Respondent 18)

- *Males*

Males were perceived to be one of the groups in Namibia that face challenges in accessing mental health services. Social workers mentioned as follows:

“Men would instead resort to drinking alcohol rather than seeking assistance. Most men believe counselling is for the weak, especially in the black community” (Respondent 5)

“Specifically males, yes, males in general” (Respondent 8)

- *People living in poverty*

Social workers in Namibia stated that people living in poverty make up the group of those who face challenges in accessing mental health services; they narrated as follows:

“Yes, most community members are impoverished” (Respondent 13).

“Disadvantaged groups, poor people and drug users”(Respondent 25),

“The impoverished communities” (Respondent 21).

“Unemployed people” (Respondent 27)

- *Marginalised communities*

“The marginalised populations such as the Himbas, Zemba, and Nyemba, among others” (Respondent 26)

“Yes, San communities” (Respondent 16)

“People living with disability and older people” (Respondent 5)

4.1.6 Use of telehealth or digital mental healthcare intervention to enhance access

Social workers in Hungary on using telehealth services to enhance access, results show that 43% responded “Yes,” with 50 % deliberating "Maybe" and 7 % indicating this would not help. on the other hand, in Namibia, results are similar, however slightly low, recording 37 % “yes|” and 60 % “maybe”, and 3% indicating that this would not assist the use of telehealth and digital mental healthcare interventions to make a difference in accessing mental healthcare services. Figures 5 and 6 below depict social workers' responses in the two countries under study.

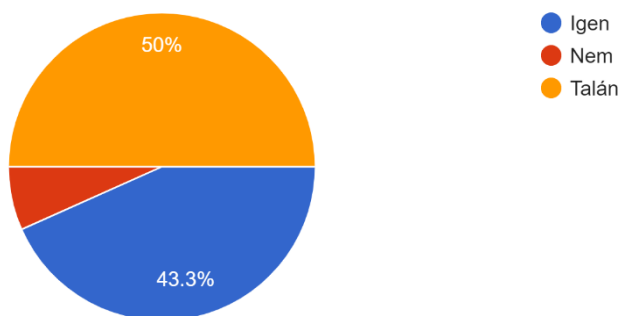


Figure 6

- Hungary

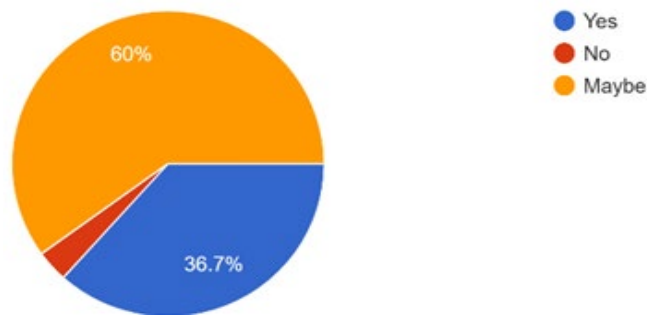


Figure 7

- Namibia

4.1.7 Suggested strategies to improve access to mental healthcare

In this study, the social workers have suggested what they thought was the need to improve service users' access to mental healthcare services in their respective countries from their perspectives and experiences. Three themes arose from the thematic analysis of this study's data.

Suggested strategies to improve service users' access to mental healthcare services in Hungary.

Theme 1.

Training of mental healthcare professionals and remuneration

The participants have reported and suggested that more mental healthcare professionals be trained in Hungary to help improve the service users' access to mental healthcare services. Their responses are recorded below;

“More mental health professionals, available (more) state-funded care options, provision of school psychologists/school mental health professionals as permanent employees, and an organisational mental health specialist at larger workplaces”. {Respondent 1}.

“More professionals, a more extensive supply network”. {Respondent 6}.

“More professionals, more self-promotion”. “{Respondent 8”}.

“Paying the oral hygiene professionals so that they do not leave the field, thus a kind of adverse selection is realised, and the workload of those who remain is infinitely increased”. {Respondent 18}.

“Increase the number of freely available mental hygiene specialists and educate people about awareness of mental hygiene.” {Responded 17}.

Theme 2.

Mental health outreach programs and community education

Respondents' suggestions are recorded below. They suggest the need for more improvement in access to mental healthcare services. There is a need to raise awareness in the country to disseminate information to the general public.

“Sensitisation, informing the Population, early prevention, and expanding the available-free services are necessary.” {Respondent 23}.

“Strengthen the social worker’s networks to support lonely elders more so they can find support and community to speak about their problems.” {Respondent 18}.

“Extensive information! Posters.” {Respondent 15}.

“The appearance of mental hygiene starts with public education; the presence and use of this kind of service should be natural. The Internet can also be a good channel, but it does not often reach those who most need it”. {Respondent 11}.

“Education about mental health and a better free available mental hygiene network would prevent a lot of unnecessary psychological treatments and reduce the prevalence of psychosomatic diseases among the patients seeking medical care; it also could reduce the overload of doctors due to psychosomatic diseases.” {Respondent 21}.

“Education programs in schools make mental hygiene specialists available in all schools.” {Respondent 26}.

“I recommend social education, even targeted, e.g. problems of the elderly, problems of the divorced, problems of parents, problems of adolescents, etc.” {Respondent 19}.

Theme 3

Mental health telehealth and online support

Healthcare professionals have interestingly suggested the importance and use of online consultations, with some responding as follows:

“Online support online consultations help greatly improve the availability flexibly.”{Respondent 22}.

“Online consultations would be great for the young generation. However, physical consultations are also needed to reach out to elders in enormous availability for free, raising awareness of mental hygienic problems and the solutions, available options and support.”{Respondent 26}.

4.1.9 Suggested strategies to improve service users' access to mental healthcare services in Namibia.

Theme 1

Decentralisation of mental healthcare services

It has been found that there is a need for more to be done in Namibia to improve the services users' access to mental healthcare services. The respondents have suggested as follows:

“Decentralised medication to clinics”{respondent 1}.

“Increase the number of mental health care facilities and workers. Employ psychologists in the state, every hospital, and more extensive clinics. Increase the number of Social Workers in the community and the schools. Invest more in awareness campaigns on the services provided and how to access them. Awareness must also include information on early warning signs that people must look out for, as well as families, individuals, and colleagues in the workplace, to identify and act.”{Respondent 2}.

“At every entry of care, any person should receive their mental health care without long referral systems—decentralisation of mental health care services within the country.”{Respondent 8}.

“All the district hospitals need a mental health unit attached to it. Also, to incorporate mental health services into primary health care, all urban and rural clinics must provide access to services by creating the necessary structure and trained qualified professionals.” {Respondent 27}.

“A more comprehensive range of healthcare institutions is needed because, as it stands, only two institutions have qualified professionals in the country. Awareness should be promoted And included in the school curriculum.” {Respondent 5}.

Theme 2

Mental healthcare awareness outreach programs and community education

Social workers in Namibia have indicated that there is a need for awareness-raising and outreach programs to inform communities about mental health illnesses appropriately. Their responses are recorded as follows:

“Creating awareness through the sharing of correct information regarding different mental health issues, an increase in state mental health service providers and facilities” {Responded 11}.

“Combat stigma by raising awareness starting from schools and community” {Respondent 13}.

“Raising awareness campaigns on mental health, facilities that render mental health services to provide transportation for those living in remote areas and have appointments, recruit more mental health practitioners. Inform community members about confidentiality”. {Respondent 18}.

“Awareness campaigns and talk shows that target children and adults and health talks in schools.” {Respondent 15}.

“The Use of mental health clinics and outreach programs in rural areas will go a long way in solving the issue of people accessing mental health services. Advocacy and institutionalisation of mental awareness within schools will do away with the stigma surrounding mental health, and it will also solve the issue of lack of awareness in the country about mental health. However, there are still many areas for improvement in mental health.” {Respondent 26}.

Theme 3

Training of Healthcare professionals

Social workers have alluded to the need for more mental healthcare professionals to be trained in Namibia. Their perspectives are as follows:

"Health professionals need to be given enough training on Mental health. Social workers, psychologists, and healthcare workers must be taught that health is physical and mental health as well..." {Respondent 22}.

"Training more mental health care professionals and building more mental health care facilities." {Respondent 19}.

"Build more mental health care centres since only two more rehabilitation centres are needed |more specialists and psychologists are needed, and Social workers and Medication such as antiparkinsonians are to be made available". {Respondent 24}.

CHAPTER 5

DISCUSSION AND CONCLUSIONS

5.1 Discussions

The study gives an insight into the perspective of social workers on service users accessing mental healthcare services in Hungary and Namibia. The central perceptions that came from the findings here are: first, that mental healthcare service users in Hungary and Namibia have poor to better-accessing services they need. In other words, the two countries have average access to mental healthcare services. However, according to the results, service users' access to services seems better in Hungary than in Namibia. Better to poor access to mental healthcare services might be attributed to what the literature has informed, for example, that mental health remains constantly underfunded (Cartwright et al., 2017; Acts et al., 2019). One of the primary challenges to accessing mental healthcare in both countries is the shortage of mental health professionals, including psychiatrists, psychologists, and social workers. The limited number of mental health professionals relative to the population means that there are long waiting times for appointments, making it difficult for individuals to receive timely care. With the same rhetoric in Namibia that

mental healthcare funding does not exist (Bartholomew & Gentz, 2019; Curling, 2002; Shifiona, 2014; Chipare, 2020).

Social workers in this study show similar major barriers that service users experience in accessing mental healthcare services in Hungary and Namibia: Lack of understanding and awareness about mental health issues, stigma surrounding mental health, long waiting periods to access services, cultural beliefs, limited number of mental healthcare professionals and transportation issues. Firstly, several studies have described barriers to accessing mental healthcare services, such as a lack of understanding and awareness among populations (Salami et al., 2019; Boydell et al., 2006). Moreover, the lack of understanding is slightly high in Namibia; this could be due to few opportunities to access mental health information (Legal Assistance Centre; 2012: 18). Secondly, social workers have identified the stigma surrounding mental health to be high in both countries. The literature has informed that Hungary has a low acceptance rate of mental health clients in social environments (Koschorke et al., et al. 2021; Acts et al. (2019), while in Namibia, stigma is associated with facts such as mental illnesses are regarded as a family problem and a shameful condition that is never discussed in public because it is regarded as Shame to the clan or family (Davies, 1994; Shifiona, 2014). Thirdly, long waiting periods recorded as another barrier; s in Hungary are influenced by the hierarchical nature of care, where medical doctors are responsible for the prescription and referral of clients between outpatient and inpatient departments (Koschorke et al., 2021). The uneven distribution of mental health services across different regions of the country further exacerbates disparities in access to care, particularly in rural areas where services may be scarce. The cultural beliefs as a barrier to accessing mental healthcare services are very high in Namibia. Literature has reported the need to conceptualise mental illness within cultural beliefs (Bartholomew, 2016) and that even though some people might utilise mental healthcare services, some still seek help from traditional healers (Davies, 1994: p. 22, Shifiona, 2014, p. 8, Bartholomew & Gentz 2019). The study revealed the lack of mental healthcare professionals as one of the barriers in both countries. However, literature has shown that there are different reasons. Cartwright et al. (2017) state that Hungarian professionals such as social workers and psychiatrists migrate abroad for greener pastures due to low wages and poor working environments, even though there seem to be enough training Institutions. On the other hand, in Namibia, few professionals are generally available, as only one higher educational institution trains mental health professionals (Chipare, 2020; Feinstein, 2002; Haidula et al., 2003; Ruiz-Casares et al., 2009). The difference in barriers to accessing mental healthcare services between the two countries has been observed in that Hungarian social workers

have indicated a very high limited availability of access to accessible and affordable mental healthcare services. In contrast, social workers in Namibia have indicated firm cultural beliefs. The two barriers are low in the other country and vice versa. Study respondents from both countries have identified similar groups that face challenges in accessing mental healthcare services, with a slight difference in themes identified from the results. Social workers in Hungary labelled groups such as low-income earners, the elderly, ethnic minorities, such as the Roma community, and all those who live in the countryside. Likewise, in Namibia, the group is associated with rural areas, poverty and marginalised communities, such as the San community, Himba and others. The results confirm that underprivileged people in public are primarily among those with mental illnesses (Bährer-Kohler et al., 2017). Addressing stigma through public education campaigns, anti-discrimination policies, and community outreach programs is essential to encourage individuals to seek help without fear of judgment or discrimination. Furthermore, the cost of mental healthcare services can be a significant barrier for many individuals in Hungary, particularly those with limited financial resources. While the national health insurance system partially covers mental health services, out-of-pocket expenses for medications, therapy sessions, and other treatments can still be prohibitive for some individuals. Ensuring affordable and accessible mental healthcare services for all individuals, regardless of their socioeconomic status, is essential to promote equitable access to care in both countries. On the other hand, the reported literature on lack of funding can cause concern to these communities because there might be the highest number of people with, but the lowest proportion of services are found (Coomer, 2010; Bährer-Kohler et al., 2017). Strategies to improve service users' access to mental healthcare services were identified, and social workers from both countries suggested increasing the number of professionals but training more than the current rate, suggesting a significant shortage of mental health professionals (Chipare et al., 2020).

Social workers have recommended extensive outreach programs in all countries, the need to avail mental health services in school settings and, most importantly, the decentralisation of services to remote areas in Namibia. Negative attitudes and misconceptions about mental health conditions contribute to feelings of shame and embarrassment, leading many individuals to suffer in silence rather than reaching out for support. Addressing stigma through public education campaigns, anti-discrimination policies, and community outreach programs is essential to encourage individuals to seek help without fear of judgment or discrimination. Schools and workplaces have also been shown as essential settings for mental health promotion and prevention interventions such as stress reduction programs and awareness-raising activities on alcohol and

drug misuse issues (Petersen et al., 2016). As indicated by Bährer-Kohler et al. (2017), it would not be disbelief that preventive programs and mental health promotion activities can be demanded if service users were aware of such needs and possibilities, and that the role of advocacy for service users should be carried out by opinion leaders of communities, educators, managers and leading figures of media channels (including social media). Additionally, integrating mental health services into primary care settings and using community health workers have helped improve access to care for individuals in remote or underserved areas. Other studies have suggested the following for mental health promotion and prevention. These programs may include the improvement of sports activities and organisations for adolescents at school premises (Liddle et al., 2016), forming school mental health clubs on the prevention of illegal substance use aiming them at those at high risk (Abbo et al., 2016), Concentrating on technological trends to reach youthful generations whose likings are related with this modern type of communication (Hayes et al., 2016), offering tele mental health programs for younger people who may have obstacles to access community care.

5.2 Limitations

The study limitation could include sample size, potentially restricting the generalizability of the findings. Additionally, the study faces limitations regarding the recruitment and participation of social workers only, as some may have been hesitant or unwilling to share their perspectives openly. The nature of the study focusing solely on social workers' perspectives may be a limitation, as it might have yet to capture the full range of factors impacting service users' access to mental healthcare. Moreover, the study may not have accounted for regional or cultural variations within Hungary and Namibia, potentially overlooking essential differences in perspectives and experiences. Lastly, time constraints imposed on the study limited the depth of the findings and the ability to explore the topic comprehensively.

5.3 Conclusions

The results indicate that there is average to poor access to mental healthcare services by service users in Hungary and Namibia; the results suggest that about 70 % seventy per cent of the total study population rated the current access in the two countries below better to poor. Results inform that there is an enormous lack of awareness and understanding about mental health issues, limited availability of mental healthcare professionals, and high stigma surrounding mental health in Hungary and Namibia. On the other hand, there is a difference in that Hungary reported minimal access to affordable or accessible mental healthcare services. At the same time, Namibia noted high cultural beliefs as barriers to mental healthcare services. In both countries, the specific groups that face higher challenges to accessing mental healthcare services are primarily people who are living in the countryside, the poor neighbourhoods and low-income earners. Healthcare professionals have indicated that in hopes of improving access to services, telehealth and digital mental healthcare could potentially improve access to services. In conclusion, access to mental healthcare in Hungary and Namibia remains a complex issue that requires a comprehensive and collaborative approach to address the barriers that prevent individuals from receiving the care they need. By increasing the number of mental health professionals, reducing stigma, and ensuring affordable and accessible services for all individuals, Hungary and Namibia can make significant progress in improving mental healthcare access and promoting the well-being of their population. Policymakers, healthcare providers, and community organisations must work together to create a sustainable and inclusive mental healthcare system that meets the diverse needs of individuals across the countries. People living with mental health issues are viewed as belonging to vulnerable groups. Not only do individuals with mental illnesses face significant risks, but so do those without diagnoses who are impoverished, jobless, experience discrimination, and face various disasters. These vulnerable groups should be taken into consideration by mental health service providers and decision-makers. Improving mental health services requires integration with primary care and general health services. Multiple disciplines and sectors must be involved, including education, media, finance, justice, NGOs, medical, nursing, and social work.

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University/Faculty	Faculty of Humanities and Social Sciences
Major	MA Social Work
Full-time/Part-time	Full-time
Year of thesis submission	2024
Title of the thesis	Social workers' perspectives on service users' access to mental healthcare services in Hungary and Namibia
Name of advisor	Dr. Habil. Erdős Márta, Bognárné Phd.
5 keywords for searching	Social workers; Perspectives; Services users; Access; Mental healthcare; Hungary; Namibia.

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