The challenges faced by mental health care users in a primary care setting: a qualitative study

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Abstract

Over the past two decades, the value and benefits of integrated mental health care services have been increasingly recognised. Despite the potential benefits, barriers exist at primary care level to receiving mental health care services, interfering with continuity of care. We conducted semi-structured interviews with mental healthcare users at a primary care clinic in South Africa, to explore their experiences of receiving mental health care services. A convenience sample of 15 participants identified challenges such as limited infrastructure, organisation, medication, services in local communities, allied mental health care services, communication and long waiting times. Mental health care users felt uncared for and disrespected, especially if they were treated by unskilled and overworked staff. Mental health care users described clinic visits as stressful and frustrating. Mental health care users described marked challenges in mental health care service provision in a South African primary health care setting..

Introduction

In South Africa, as in many low and middle income countries, mental health care has been neglected in terms of budget, infrastructure and human resources.[1] Of the South African national health budget, 4.6% is spent on mental health services, with only 7.9% of the mental health care budget being spent on primary health care mental health services.[2] With an estimated 0.31 public sector psychiatrists available for every 100 000 population and great urban/rural and interprovincial disparities in South African health care provision[3], primary health care providers have been called on to render mental health care services at local primary health care clinics. Access to community mental health care is important for preventative and long term care[4], while inaccessibility may contribute to treatment noncompliance and increased relapse rates. Treating mental health care users with severe or acute mental disorders at primary care level is complicated for a number of reasons, including limited training and inadequate support for primary health care nurses and doctors.[5] Nurses and doctors who are not adequately trained to treat mental health users may struggle to diagnose and treat mental disorders,[5] which may lead to common mental disorders remaining undetected and untreated at the primary health care level. In South Africa, three out of every four individuals with a common mental disorder remains untreated.[6-7]

Globally, over the last two decades, traditional institutionalised mental health care has shifted towards a decentralised and integrated community based care approach. [5,8-10] Community based services are advocated globally as they potentially improve accessibility, destigmatisation and efficiency of mental health services by leveraging already existing resources, since individuals with comorbidities can access treatment at a single facility.[1,7] The value and benefits of integrated mental health care hold promise for a resource constrained South African mental health care system. New legislations and policies have been developed to assist the formation of integrated mental health care.[8,10-11] With the promulgation of the Mental Health Care Act No 17 of 2002 in 2004, South Africa reformed its outdated mental health legislation and adopted the global decentralised mental health care model, a vision that was further detailed in the South African National Mental Health Policy Framework (MHPF) and Strategic Plan 2013-2020.[8] The MHPF aligned itself with the World Health Organisation's Mental Health Gap Action Plan (mhGAP) in promoting task sharing and integrating mental health care into primary care.[12] The process is ongoing as South Africa continues to integrate mental health care into primary health care services, which are rendered at local clinics and general hospitals.

Although decentralised and integrated mental health care is supported in theory, certain challenges are preventing the process from taking place. Numerous studies, both from South Africa and elsewhere, have investigated mental health care services at the primary care level. South African studies have identified barriers that prevent individuals from receiving optimal mental health care at primary care level in different parts of the country.[4,13] We know that mental health care users' experience during clinic visits are important in strengthening therapeutic alliance, improving treatment compliance and outcome overall. To our knowledge, no studies have qualitatively explored mental health care users' perceptions of the challenges they face during primary health care visits through individual, in-depth interviews in South Africa. We explore the challenges that mental health care users face when receiving mental health care services in a primary care setting. The researchers further aimed to determine what mental health care users think about receiving mental health care services in a primary care setting, as well as what they perceive as barriers to adequate and appropriate mental health care in a primary care setting.

Methods
We conducted a qualitative study at Skinner Clinic, a primary health care clinic in Gezina, a suburb on the outskirts of Pretoria central business district, South Africa. Skinner Clinic is a primary health care clinic that provides specialised mental health care services to users suffering from anxiety, mood, psychotic and substance use disorders. Mental health care users are referred to Skinner Clinic by primary health care workers, as well as mental health care users who were down-referred from psychiatric hospitals. Services are mostly provided by one to two professional nurses with supportive services rendered by psychiatrists and psychiatric registrars on selected days. One clinical psychologist is available to render psychotherapeutic services at the clinic. Newly referred mental health care users are assessed and treatment is prescribed by a psychiatrist or psychiatric registrar during their first consultation. Approximately 600 mental health care users consult at the clinic on a monthly basis. The investigators chose a qualitative research approach to uncover the nature of a person's experience with a phenomenon in context specific conditions. A qualitative approach was best suited for this study as allowed researchers to explore, uncover, describe and obtain a deeper

understanding of health and illness as perceived by the individuals themselves, rather than from the researchers' perspective.[14-15]

The study was approved by the University of Pretoria, Faculty of Health Sciences Research Ethics Committee and the Tshwane Research Committee.

The principle researcher conducted 16 once-off, individual, semi-structured interviews with mental health care users attending the clinic. Study participants were sampled by convenience, and were all users who attended Skinner Clinic between July and October 2017 to receive treatment for a mental health condition. Participants were included if they were 1) between the ages of 18 and 70 years 2) able to communicate in English and 3) able to provide informed consent. Each participant's ability to provide consent was assessed according to guidelines recommended by Van Staden and Krüger.[16]

Written informed consent was obtained from all individual participants. We used participant codes to preserve anonymity. No names or identifying details of mental health care users were recorded or used during reporting. Basic demographic data were collected from mental health care users' clinical files and captured on data collection sheets. The interviewer took additional field notes during interviews to assist the investigation.Each interview lasted approximately twenty minutes. Interviews were audio recorded and transcribed verbatim for further analysis.

Semi-structured interviews are the most widely used interviewing format for qualitative research and revolve around a predetermined set of four open-ended questions, with other questions often emerging from the dialogue between the interviewer and interviewee.[17] Some of the open-ended questions used during this study included "how do you feel about receiving mental health care services at your clinic?" and "what advantages or disadvantages have you experienced with receiving mental health care services at your clinic?" A semi-structured interview format allowed for a flexible framework to provide rich descriptions, while providing uniformity among interviews without prompting or influencing the participants' expressed opinion. It further allowed participants to develop trust in the interviewer, and put the participants at ease, allowing them to disclose and elaborate on opinions they otherwise would have been uncomfortable with.[18] Through in-depth, face-to-face individual interviews, the researchers were able to delve deeply into the challenges mental health care users face while also making descriptive observations which further contributed towards formulating an understanding of the mental health care users' problems. Through this framework, researchers were able to explore health care users' experience of receiving mental health care services at their clinic, advantages and disadvantages of receiving mental health care services at their clinic as well as their perceived challenges at the clinic.

South Africa is a multilingual country with 11 official languages. To prevent language barriers and miscommunication during interviews, we only participants conversant in English. Interviews were conducted outside of official clinic hours to ensure the availability of space, non-interference and privacy during interviews.

Data were analysed concurrently during data collection and was performed by the principle investigator. Initially, the researcher carefully studied transcriptions and field notes. This was

followed by initial coding, a process where researchers assign labels to similar data.[19-20] Similar or related codes were grouped together into categories or themes.[15] Through constant comparative analysis, a central principle of grounded theory research, emerging themes were constantly re-evaluated, theories were continually redefined and used to inform subsequent interviews.[20] Codes were collated into tentative themes and re-analysed before the final themes were defined and named. This iterative process of data collection and analysis ultimately led to a point where no new themes emerged, indicating that data collection was complete and saturation had been reached.[17] All data and analyses were reviewed again in collaboration with an expert in the field.

The trustworthiness of this study is supported by the random sampling of study participants, maintaining participant anonymity and confidentiality, collection of data by means of interviews with patients as well as observations and field notes made by the principle investigator.[21-22] Together with peer collaboration, previous research was also examined to contextualize the current research.[22]

The inclusion of typical or illustrative quotations by mental health care users during the interview process supports the trustworthiness of this study.[15] The quotations reflect mental health care users' descriptions of their experience of attending a primary health care clinic to access mental health care services.

Results

Data from 15 interviews were included in the study, as one interview could not be completed in English.

The demographic data and emergent themes are illustrated in Tables 1 and 2 respectively.

Table 1 Demographic information of mental health care users attending Skinner Clinic, Pretoria, South Africa (2017).

Gender	
Female	12
Male	3
Age	
18-30	0
31-40	2
41-50	2
51-60	5
61-70	6
Diagnosis	
Schizophrenia spectrum and other psychotic disorders	3
Bipolar and related disorders	6
Depressive disorders	4
Anxiety disorders	1
Other	1

From the data collected, the following themes emerged and are illustrated in table 2.

Table 2 Themes and subthemes identified in interviews with mental health care users at Skinner Clinic, Pretoria, South Africa, 2017

Theme 1: Challenges involving infrastructure, services and organization

Subthemes:

- Limited infrastructure
- Poor organization and inconsistency in service
- Shortage of medication
- Limited services in local communities
- Long waiting times
- Limited allied mental health services

Theme 2: Staff challenges

Subthemes:

- Poor communication and information
- Staff shortages
- Limited training and skills
- Staff wellbeing
- Lack of respect and dignity
- Not feeling cared for
- Not seeing doctor frequently/desire to see doctor more frequently

Theme 3: Mental health care user experience

Subthemes:

- Stress of coming to clinic
- Avoiding clinic visits if possible
- Embarrassment
- Vulnerability
- Irritability, aggression and dissatisfaction

Overview of themes and subthemes

Theme 1: Challenges involving infrastructure, services and organization

Subtheme 1.1 Limited infrastructure Numerous participants identified that clinic visits were negatively influenced by limited adequate infrastructure, especially in terms of shelter while waiting outside the clinic, as well as seating arrangements in and around the clinic. Participants reported arriving at the clinic long before opening to be assisted first or to be in time for work afterward. Participants are required to stand and wait outside while being exposed to extreme temperatures and natural elements until the clinic opens. Participants expressed great discomfort while standing for long periods of time, waiting to be assisted.

"For example, maybe it's the infrastructure. Instead of like, they don't let people in. We have to stand from six o'clock outside and wait. And by the time people get in, they are huffing and puffing and they just want a... a seat... But normally there is a non-caring attitude that if you don't get a chair, you just stand and wait." (Participant J)

Also, this clinic only has two consultation rooms where mental health care users can privately and confidentially consult with mental health care providers. The mental health care unit is situated next to the paediatric and tuberculosis units, which could pose potential risks in terms of infection control and aggravation of vulnerable mental health care users.

Subtheme 1.2 Poor organization and inconsistency in service Participants reported a poorly organized system as a challenge to receiving treatment. The procedure to follow on arrival, was described as being "chaotic", with "no order" and "not user friendly". Participants did not know where to go, where to queue or who to ask once they arrived at the clinic, since these procedures are not clearly marked or would change from the previous month. Participants reported experiencing frustration because they did not know what to expect from their clinic visit and expressed the need for an effective and consistent system that would facilitate smooth clinic visits. One participant also reported frequent changes to the nursing staff at the clinic, causing disruptions and inconsistency in clinic services.

 "… there's a lot of chaos sometimes. Chaos, because you come then you're not sure where in the system you fall." (Participant B)

"They have problems, like every month there's a new setup. It's not the way they did it last month. Then you sit outside like they tell you to wait for two, three hours. Then you should've gone for your blood pressure because this is also now a new system that comes this side. And once you've been here they say no sorry you must come back this side, it's no longer there, it's no longer that… It's always a problem to come here every month and things' changed. It's not the same every month." (Participant G)

Subtheme 1.3 Shortage of medication Numerous participants reported that their medication was often out of stock at the clinic pharmacy and that they would sometimes go for months without their correct medication. Some participants made an effort to return to the clinic a week later in the hope that their medication would be in stock, just to find that their medication was still out of stock. Participants reported that there was no replacement medication if their specific medication was unavailable. Some participants reported feeling mentally unwell because they had not received their correct treatment for months.

 "Sometimes there is no medication. They tell you the medication is not enough… they don't have enough medication. So, there are times where you don't get all the medication because they said there's not enough medication. Then you would have to wait probably a month to get your entire medication that has been prescribed for you. Like for instance, if the doctor prescribes five items for you, five items medication, the clinic will tell you that we don't have enough medication and give you only three items…So then the two items you don't take. You don't have. You only got the three items because there's not enough medication. It's a disadvantage to us because we don't drink our medication properly at all." (Participant C)

Subtheme 1.4 Limited services in local communities One participant lived outside of the clinic's referral area, in contrast to most of the participants who lived close to the clinic. This participant had to travel approximately 50 kilometres to the clinic every month to attend or collect medication as their local community clinic was unable to provide adequate mental health care. This participant reported personal transportation issues and financial implications that affected the whole family.

 "So we're spending more on transportation because you have to come frequently and the distance is very far. It would've been an advantage to me if we had these services close to where I live. It's a small clinic that doesn't have much compared to a hospital. And it's not open most of the time… They cannot look after my needs. If they could, I would be very happy

because then it would be closer for me… So now when I'm travelling from far, I even have to ask family members to please take me…" (Participant C)

Subtheme 1.5 Long waiting times Most participants reported long waiting times as a challenge to clinic visits. Participants could spend up to seven hours at the clinic on a day, from time of arrival until leaving with their prescribed medication.

 "You come in at about half past five in the morning and you get into there… let into the building or the place where you can come and sit down at about half past seven… So by the time you get out it could be about twelve, half past twelve and then for an elder person it can be quite tiring." (Participant B)

Subtheme 1.6 Limited allied mental health services One participant reported that it was nearly impossible to consult with a psychologist at the clinic as there was only a single clinical psychologist available with a long waiting list of mental health care users awaiting appointments. The participant expressed concern over mental health care users mostly receiving pharmacological treatment and that alternative or complementary forms of treatment were mostly unavailable at the clinic.

"I think they can improve a bit because right now they're taking an approach where we're being treated by psychiatrists. There should be also psychologist and psychotherapy along with medication." (Participant J)

Theme 2: Staff challenges

Subtheme 2.1 Poor communication and information Participants reported feeling dismissed by clinic staff when they had questions or queries. They reported that their questions were often answered very abruptly or even ignored. Some participants were reluctant to ask any questions and would rather not ask because of the type of response they anticipated from the staff. One participant reported feeling that treatment was not properly explained to mental health care users, for example medication and potential side effects.

"Well, disadvantages I do say, there are. Some of the sisters and security that aren't very nice with a person. Well, like the security we have here. When he does speak to you, when you want to ask him a normal question, the answers he gives you or he just tells you straight ag man keep quiet I'm busy. And to me, why? He can speak to you really nicely. Ant to the sisters also, you can speak to them and they say man, just please… just leave me alone, I'm busy. Or you know, maybe it's just coming for the new date. You knock on the door. The sister says man, just sit down, I will help you when I can… And to me, why doesn't she just ask you, can I help you? What is it you want? Why does she have to be so rude? And to me, that isn't very nice." (Participant E)

Subtheme 2.2 Staff shortages Participants reported that there were not enough staff members to assist with service delivery at the clinic including nursing staff, doctors and pharmacists. Participants felt that staff shortages resulted in longer waiting times, slower service delivery, frustration for themselves and mounting pressure on the staff rendering services.

"They got a bulk (of patients) and a lot of times they don't have staff. When you come here, they'll tell you sorry there's only two people here today. They're short staffed. And it's not their fault, I mean, that's how it is. They, they've got to cope with it." (Participant O)

Subtheme 2.3 Limited training and skills Several participants expressed concern over the level of training and skills of staff working at the clinic. Some participants specifically felt that personnel were not well trained or equipped to deal with stressful, high volume environments and demanding patients.

"So, it's just I think, it's just a matter of maybe you know, training the staff in a certain area specific to you know, their job role." (Participant F)

Subtheme 2.4 Staff wellbeing One participant reported that nursing staff were under a significant amount of pressure to deliver services in an understaffed and overburdened clinic environment. Participants felt that this pressure was responsible for staff feeling overwhelmed and becoming rude, abrupt and impatient towards them.

"… It's just that you know, the nurses get under pressure. Especially when there's a lot of people and then they get terribly impatient and rude… I don't blame them." (Participant A)

Subtheme 2.5 Lack of respect and dignity Several participants were concerned over the lack of respect and dignity with which mental health care users are treated at the clinic. One participant started crying whilst being interviewed, and was clearly upset by past events that took place at the clinic. Participants used words such as "rude", "animals" and "inhumane" to describe how clinic staff treated them. Participants reported that this treatment negatively affected their mental state.

"I think that if the personnel might just be trained in such a way that although they have their stress situations, they might, because you know what, they might just have to realise that they've got to do with people, especially mental… I sometimes get tear in my eyes because I get epilepsy and I have been very ill in my neuro illness stages of my life, but I've never been as ill as some of the people that come here. And if you see with how little integrity they treat these people, it's heart-breaking. So if these people might be trained to handle these and treat these people with a bit more dignity, I think that would be a good idea." (Participant B)

Subtheme 2.6 Not feeling cared for Participants expressed a need to feel cared for during clinic visits; since they rarely felt cared for during clinic visits. Participants reported experiencing that clinic staff did not care about their well-being or comfort.

"The last time that I came here, they (nursing staff) mixed up the cards. The patients were unhappy because it resulted in people who came here at six's clock in the morning, they were standing on the outside, they had to fall in at the end of the queue. So they were very upset about it. But the sisters didn't seem to care that they did that and jut the treatment of the patients… inhumane… They didn't really care that they did that… But normally there is a non-caring attitude that if you don't get a chair, you just stand and wait… I think definitely what can improve it is, a more caring attitude towards people... If they (nursing staff) had to like show a more caring attitude towards patients, that would help. It would go a long way." (Participant J)

Subtheme 2.7 Not seeing doctor frequently/desire to see doctor more frequently Participants reported inconsistent availability of doctors at the clinic. One participant reported not seeing a doctor in eight months, while some reported not seeing a doctor in as long as a year. Some participants saw a doctor more frequently, at least once every six months or more when they needed to. There seemed to be a gap in the system that allowed mental health care users to fall

through the cracks and miss out on opportunities to revise and optimise their treatment. Some respondents also expressed a desire to see a doctor more frequently.

"I feel alright. I get my medication, everything but I haven't seen the doctor for a long, long time. It's about eight months now… It's going on eight months. That's out… I'm supposed to see the doctor today and they told me that he or she came on Tuesday and they swop times, one week Tuesday and one week Thursday. One week Tuesday, one week Thursday, so I'm not sure when exactly am I to see the doctor again." (Participant M)

Theme 3: Mental health care user experience

Subtheme 3.1 Stress of coming to clinic Participants reported experiencing clinic visits as "tiring", "stressful" and "unsettling". One participant found clinic visits to be exhausting. Another participant explained that clinic visits triggered emotional upset.

"I must tell you, I don't have a problem being a clinic patient but knowing that it's the day I need to come to the clinic, is an ordeal for me… In the way that it's very stressful." (Participant B)

Subtheme 3.2 Avoiding clinic visits if possible Participants reported that the clinic's pharmacy sometimes issued two months' worth of medication to mental health care users at a single visit. One participant reported feelings of gratitude when this happened, as he or she could avoid the clinic for one month, and avoid being mistreated. Another participant reported specifically avoiding the pharmacy by requesting a private prescription from the doctor, allowing them to collect medication from a private pharmacy at their leisure, but at their own cost.

"If I, you know, sometimes I do get medication at the pharmacy for two months and then I'm glad I'm away here for the next month before I come the month after that." (Participant E)

"The wait at the pharmacy is, it's what makes people don't want to come… because you may sit there by the chairs for an hour and a half, waiting for medication… That's a very long time. So some people feel it's a disadvantage. They go to the, to the pharmacies where you buy. They don't come to the clinic or the hospital. They go to other pharmacies where you have to buy medication." (Participant C)

Subtheme 3.3 Embarrassment One participant reported that going to a government facility felt degrading, since she had previously used private mental health care services. She was dissatisfied with how the clinic functioned and felt uncomfortable with receiving treatment at the clinic. This participant reported not having any other options for accessing treatment.

"It's, it's not very good because I was used to a medical aid and then some things happened and so we are without medical aid. So I have to rely on the medicines from, from the clinic… It's, it's half degrading... Because for a human being that's been, that's been having a medical aid and suddenly you don't have nothing, it, I find it very degrading but well, I have to keep my mouth shut, my eyes front and just move along with everything. They don't listen to me." (Participant K)

Subtheme 3.4 Vulnerability Participants were very aware of their mental illnesses and how mental illness impacts their daily lives. Participants were aware of their dependence on the

services rendered at the clinic. They expressed a need to be heard, a need for help and a need for adequate treatment to optimise their daily functioning.

"Thank you. I think it's about time somebody actually took an interest in what is going on..." (Participant A)

Subtheme 3.5 Irritability, aggression and dissatisfaction Most participants had experienced or witnessed frustration and irritation at the clinic. Occasionally, mental health care users would become so frustrated, that they would resort to aggressive behaviour.

"...I can sometimes see a lot of frustration on these people's attitude and that sometimes make them quite aggressive... I can see on the patients because they are brushed off and they don't always understand why. I can and some other patients who are not on certain medications and in a certain stage of illness, state of illness, can withstand but they don't always. And then they can get aggressive because they're frustrated or because of the medications they use. So, I think that can, that can exterminate some of those conflicts, you know. Because the sister gets upset, the patient gets upset and, and it causes quite a bit of eruption sometimes. But because of these emotions that gets out of hand sometimes, but that you can understand due to the circumstances." (Participant B)

Discussion

In this study, we qualitatively explored the challenges mental health care users experience when visiting a primary health care clinic for mental health care and treatment. Mental health care users identified various interrelated challenges to their clinic visits. From their perspective, clinic visits were negatively influenced by limitations in infrastructure, organisation, medication, services in local communities, allied mental health care services and communication at the clinic. Mental health care users complained about long waiting times. Participants felt that many of their negative experiences were exacerbated by staff shortages, especially poorly trained and unskilled staff. Those staff members who were there, were over-worked, under pressure and stressed. Participants also reported not feeling cared for or respected, while they described clinic visits as stressful and frustrating. The information gathered during our research highlights the paucity of services and resources in mental health in South Africa.

In primary health care, services are provided by general practitioners, nurses and other allied health care professionals. Primary health care is regarded as the first point of entry into the health care system and allows for early diagnosis and treatment, with relevant referrals being made to secondary and tertiary levels of healthcare. When compared to the Apartheid era, access to primary health care in South Africa has improved, but the successful implementation of primary health care is limited by resource constraints, unequal staff distribution, low skill level, low staff motivation and managerial capacity.[23-24]

Reports of limited infrastructure is not a new challenge faced by primary mental health care in South Africa.[4-5,7] Limited physical infrastructure is associated with long and uncomfortable waiting times, creating a suboptimal treatment environment for sensitive mental health care users. Long waiting times and lengthy clinic visits also contribute to dissatisfaction among patients attending health care facilities, which could contribute towards patients failing to follow up or attending health care facilities outside of their area of referral.[25] Shortages of medication, often for months at a time, posed a significant challenge to mental health care users

in our study, putting them at risk of relapse and admission. Shortage of medication is a frequently encountered problem in primary health care clinics in South Africa.[5,26]

Similar to previous research[13,27], our participants reported poor organisation and inconsistency in service delivery within the clinic. Participants also complained about the inconvenience of not being able to consult with the same mental health care practitioner during follow-up appointments, which may be detrimental to the therapeutic alliance and continuity of care. A study done by Shariff[13] describes disorganised mental health care service delivery in South Africa, which was highlighted by mental health care users expressing frustration and anger. A similar problem of organisational capacity in the health care sector has previously been reported to be a barrier to implementing the Mental Health Care Act.[4]

Access to allied mental health care services, such as psychology, is also a challenge in the primary health care sector and even more so in rural settings.[28] Group and cognitive behaviour therapy have shown promise in treating mild depression in the primary health care setting, but with limited access to clinical psychologists, implementation seems nearly impossible.[28]

The shortage of resources in the primary health care system, is intensified by limited human capacity. Staff shortages are a significant barrier to providing adequate mental health care services in primary health care[4,12-13], both from the perspective of the health care provider and the health care user. In South Africa, human resources in mental health care have steadily declined over the past two decades. In 1997, there were 19.5 total mental health staff, 0.4 psychiatrists and 15.6 nurses per 100 000 population. Since then, these figures have dropped to 0.31 psychiatrists and 9.3 total mental health staff per 100 000 population.[3,8,29] In South Africa, great discrepancies in human resources for mental health care exist between urban and rural areas, with 3.6 times as many psychiatrists working in urban areas than rural areas per 100 000 population.[24] Effective mental health care cannot be sustained in primary health care without the support of specialist mental health care professionals.[30] Despite our study clinic being located in an urban area, mental health care users reported that their visits were negatively affected by a shortage of staff, including doctors, at the clinic. Mental health care users were also concerned about poor quality of training and skills amongst staff, a concern similar to what was found in a study done by van Deventer et al.[13] Primary care nurses need to be trained and gain experience in mental health care before mental health care can be integrated into primary care.[12] Inexperienced and untrained nursing staff may be more prone to low self-confidence, further reducing their ability to identify, diagnose and treat common mental disorders.[7,27] Poor staff well-being has also been associated with poor physical and mental health, substance abuse, high staff turnover rates and poorer quality of mental health care.[31] Overworked and stressed nurses are less likely to have empathy and time for their patients. Staff incompetence may be perceived by patients, which could lead to higher rates of treatment noncompliance among persons with mental disorders.[7]

In our study, mental health care users felt that there was not enough communication at the clinic, leading to feelings of confusion, not being heard and feeling unimportant, putting them at risk of stopping clinic visits, defaulting treatment and relapsing. Similar complaints were raised during a study by van Deventer et al.[13] A study by Marais et al. found "a breakdown in communication", coordination and collaboration within the mental health care sector stood in the way of successful service provision and continuity of care.[12] Mental health care practitioners should provide mental health care users with the necessary information and psychoeducation needed to make collaborative and informed decisions regarding their

treatment. This does not always seem to be the case[27], since mental health care users, including those in our study, do not always receive the necessary information.

Limitations
The study was conducted at a single primary health care clinic in urban South Africa, which makes it difficult to generalise to other provinces or contexts, especially to rural primary health care clinics where resources are known to be more constrained. Transferability is further limited by the age and sex profile of the sample. English was chosen as the language of communication, thereby excluding individuals who were not conversant in the language.

Conclusion
Notwithstanding its limitations, this study adds to the literature of mental health care user experience regarding mental health care in the primary care setting. Dissatisfaction with numerous aspects of mental health care service provision including limited of infrastructure, organisation, medication, services in local communities, allied mental health care services and communication, as well as long waiting times, staff inadequacy and shortages were expressed by 15 mental health care users. Mental health care users suffer as a result of a broken mental health care system, and their concerns and views very often remain unheard.

Recommendations
Our research opens up avenues for further investigation. The authors recommend further research be done pertaining to the specific challenges mental health care users face in different clinic settings and contexts in order to inform policy changes and improve mental health care service delivery in South Africa and globally.

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