

Follow-up of Mental Care Users by Nurses in the Primary Care Setting in South Africa

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The objective of this qualitative, exploratory, descriptive and contextual research was to explore and describe nurses' experience of follow-up and follow-through care of mental health care users in the primary care setting of South Africa. Thirty clinics were represented in two provinces. A total of 55 nurses took part in the research. Data on nurses' experience of follow-up and follow-through care of mental health care users in the primary care setting of South Africa were collected through open, in-depth interviews and naïve sketches. The data were analysed using a descriptive method of open coding. The barriers impacting on quality follow-up and follow-through care were related to inadequate service provision associated with the availability of resources (human, time, infrastructure); practice system support as well as the attitudes of the mental health care user and the family. Despite indications of pockets of excellence in South Africa's primary care setting, there seems to be a high level of unmet needs related to follow-up and follow-through services.

Keywords: follow-up, follow-through, mental health care, primary care, South Africa

Mental, physical and social health are vital strands of life that are closely interwoven and mutually dependent. According to the World Health Organisation (2001) mental health is critical to the overall well-being of individuals, societies and countries. Neuropsychiatric disorders account for a large portion of years lost to disability (YLDs) to South Africans, and second only to Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS) (Bradshaw, Norman & Schneider, 2007; Norman, Bradshaw, Schneider, Pieterse & Groenewald, 2006). In a recent survey by Williams, Herman, Heeringa, Jackson, Moomal and Kessler (2008), 16.5% of the South African population had experienced a mental disorder in the prior twelve-month period, with 26.2% of respondents with disorder classified as severe cases, and an additional 31.1% as moderately severe cases. The most common disorders were agoraphobia (4.8%), major depressive disorder (4.9%) and alcohol abuse or dependence (4.5%). Twenty eight percent of adults with severe or moderately severe disorder received treatment compared to 24.4% of mild cases. Treatment was mostly provided by the general medical sector, with few people receiving treatment from mental health providers. This finding aligns with the WHO's mental health survey (Wang, Aguilar-Gaxiola, Alonso, & Angermeyer, 2007). Many cases remain undiagnosed and untreated.

Primary Care and the Integration of Mental Health

The South African health system has undergone major transformation. Since 1997, primary care for mental health has been the official policy of the national government. In adopting this national policy, all provinces have been engaged in improving mental health services at community level and integrating mental health at provincial level. The district health system is now seen as the functional unit within which primary care services are rendered. Nurses provide the bulk of primary care services in South Africa (Strasser, London & Kortenaar, 2005).

The South African Mental Health Care Act of 2002 provides for the care, treatment and rehabilitation of mentally ill people in a manner that promotes maximum mental well-being. According to the Act, people with mental problems are regarded as "users", since any individual is a potential user of mental health care services. The legislation has provided the momentum to develop community- and home-based care that focuses on rehabilitation, which is backed by comprehensive protocols, norms and standards at all levels of care (e.g., early detection, follow-up care and social mapping of available supports). This shift towards community care requires preparedness at service levels. A focus on service quality is especially vital where resources are limited. Standards are essential tools for quality assurance, advocacy and rights protection, capacity and management development and dialogue. They should be appropriate, useful and patient-centred, and operationalise local policy and legislation. Mental health standards are a challenge to define, and need to combine both a user- and rights- based approach (Muller, 2005). The primary care for mental health is faced with a number of challenges.

Challenges to the Mental Health Care Services

The lack of a national mental health programme as well as the process of making necessary fiscal, staffing, and structural changes to mental health care services could result in a sub-optimal level of implementation (Jacob, Sharan, Mizra, Garrido-Cumbrera, Seedat, Mari, Sreenivas & Saxena, 2007; WHO, 2008). Sub-optimal levels of care may compromise the efficiency, quality and promptness of care. It carries a major direct cost of increased in-hospital treatment and an indirect cost of user or carer absenteeism from work. These effects are also borne by the family and community (Moosa, Jeenah & Kazadi, 2007). Breen, Swartz, Flisher, Joska, Corrigan, Plaatjies and McDonald (2007) argue that the prevalence of social factors such as the rapid rate of urbanisation, population growth, the

high rate of unemployment, poverty, violence and crime in South Africa, all increase the burden on service delivery and family resources. The lack of financial and human resources in the mental health services as well as communities impact on the ability of the communities to cope with the transition from institutional to community-based mental health care (Thom, 2004).

A challenge to the provision of mental health care services is the availability and quality of follow-up and follow-through care (Solberg, Trangle, & Wineman, 2005). Follow-up care refers to the monitoring of mental health status, the active and collaborative management of aftercare plans (focusing on more than just dispensing medication), initiating action where needed, timely referral, continuous client education and identification of support resources (Craven & Bland, 2006; Roper & Happell, 2007; Solberg et al., 2005). Follow-through denotes providing care, treatment and rehabilitation on a continuous continuum (Jaworoski, Barel & Gropp, 2003; WHO, 2008). Solberg et al. (2005) and Craven and Bland (2006) argued for a pro-active and systematic follow-up and follow-through care for mental health care users (MHCUs); which would improve adherence to treatment. Without early identification and continuing care, MHCUs are precluded from the full benefit of the comprehensive mental health care system (Hagan et al., 1983) and gains made from initial treatment may be lost (Ekendahl, 2007). This in turn fuels the "revolving door" pattern with an increase in recurrence (Parish, 2005; Schwartz, Hiatt, Hargrove & Shaffer, 2007; WHO, 2008) and lower the user's health related quality of care (Klinkenberg & Calsyn, 1996; 1998). Relapse and re-hospitalisation compromise the efficiency, quality and promptness of care by health care staff (Moosa et al., 2007). These effects are not only borne by the mental health service, but also by the family and community, exhausting the limited resources available.

Factors Influencing User Interface with the Mental Health Care Services in South Africa

The quality and continuity of mental health services is an important factor in terms of mental health care access (Wang et al., 2007; WHO, 2008; Williams et al., 2008). Access encompasses a range of dimensions spanning from availability (e.g., geographical distribution of mental health facilities, pharmaceutical products etc.), accessibility (transport, roads, etc.), affordability (cost of treatment etc.) and acceptability (referring to the social and cultural distance between the mental health care systems and their users. This mainly refers to the characteristics of mental health care providers - mental health workers' behaviour, gender aspects, and excessive bureaucracy etc. (Hausmann-Muela, Muela, Ribera, & Nyamongo, 2003).

Allers (cited in SADAG, 2010a) states: "The lack of psychiatrists in South Africa presents a huge problem. At the moment there are about 320 practicing psychiatrists in South Africa, giving a ratio in general of about 150 000 people per psychiatrist. Fifteen percent of the population belong to medical aid and 200 of the psychiatrists work in the private sector. The ratio of psychiatrist to population in this sector is about 33 000 patients per private psychiatrist. Only 120 psychiatrists work in the state sector, giving a ratio of about 440 000 people per state psychiatrist, 13 times more than in the private sector." In the past, psychiatric nurses played a crucial role in managing mental health patients, but now the posts for psychiatric nurses have virtually disappeared (Keeton, 2003). In rural areas, a large portion of the workload is carried by nurses in clinics that are visited by a psychiatrist either weekly or monthly (Uys & Middleton, 2003),

often only at specified times. MHCUs are frequently turned away and asked to return at the scheduled time. Recently though, a number of these clinics have been closed down in favour of primary healthcare clinics (SADAG, 2010a). Nurses are often overworked, demoralised, and they may display a negative attitude. Many present a poor capacity to educated users and this negatively impacts on the provision of continuity of care (Moosa et al., 2007; Uys & Middleton, 2003).

South Africa has seen decades of basic human rights violations, lack of tolerance for differences, and an inequality in the distribution of health care resources (Moultrie & Kleintjies, 2006). Laloo, Smith, Myburgh and Solanki (2004) found that on political level perceptions regarding access to health care in South Africa are largely influenced by race, but at the grass-root level actual access were influenced by socio-economic status.

Woman, especially African, Coloured and rural women are over-represented amongst the poor in South Africa (Moultrie & Kleintjies, 2006). The lives of many women have been characterised by chronic social adversity, race/class and gender oppression, unequal rights in family structures and very limited access to resources and health care. The prevalence of HIV/AIDS is also far higher in woman due to patriarchal culture beliefs and other gender/social inequalities, leaving them more exposed to mental health problems and less able to access resources.

The user-provider interface in primary care settings has often been described by MHCUs as discriminatory, marginalising, abusive and mirroring the social stratifications of society in general (Govender & Penn-Kekana, 2007). In societies marked by deep gender inequities, gender also affects mental health care providers, particularly those at the front-line, who are predominantly women. Where women experience discrimination within the workplace and society at large, the discrimination often spills over into their interaction with the MHCUs.

Most mental health care providers do not belong to the same cultural group as the MHCUs, and often do not speak the same language. Time is frequently limited, there is little privacy or confidentiality, and during the process of interpretation, messages may be confused or distorted (Baumann, 1998). Other markers of poor quality follow-up care are the poor communication between mental health care providers and MHCUs, the failure to communicate medical and health related information fully, and a paternalistic approach which fails to provide MHCUs with the information needed to make informed decisions (Govender & Penn-Kekana, 2007).

Lastly, access to the medication for the treatment of psychiatric disorders is severely limited, making the work of psychiatrists and nurses even more difficult than it already is. Treatment protocols, and guidelines and also the awareness of referral options present a challenge to the mental health care user in obtaining follow-up care. Financial difficulties and the fear of stigmatization are equally responsible for posing barriers to access quality mental health care (WHO, 2001).

Best Practices

There are however, a number of best practice examples in South Africa, as cited in the WHO report on the Integration of Mental Health in Primary Care (2008). These examples provide a description of two models integrating mental health care in the Western Cape Province. In both models nurses are responsible for detecting mental health problems, and managing chronic mental disorders, including dispensing psychotropic medication or recommending medication changes, making referrals, and intervening in crisis situations. The first model utilises a skilled professional

nurse, who sees all clients with mental issues; in the second model, mental disorders are managed as any other health problem and the nurses are trained to assess and treat both mental and physical conditions. Maritz (2009) indicated in a report that there were indications of best practice examples in the primary care setting in South Africa where follow-up and follow-through care occurred frequently. These best practices were typically informed by nurses who have a passion for what they did, and who also had enough time to invest in the care, treatment and follow-up of MHCUs and individual, family and community buy-in in mental health care service. It would be helpful to identify best practices from these examples and transfer the learning to primary care sites where difficulties are experienced.

Goals of the Study

The objectives of this research were two-fold. Firstly to explore and describe nurses' experience of the follow-up and follow-through of mental health care users in the primary care setting in South Africa, and secondly, to describe guidelines for those providing follow-up and follow-through care.

The research questions were:

1. How do nurses experience follow-up and follow-through of mental health care users in the primary care setting in South Africa?
2. What can be done to facilitate follow-up and follow-through care in the primary care setting in South Africa?

Method

Research Design

A qualitative, explorative, descriptive and contextual research design was embraced in order to generate a deeper understanding of nurses' experience of the follow-up and follow-through of mental health care clients in the primary care setting in South Africa. The qualitative design enabled the researcher to build a complex and holistic picture through the analysis of words and the reporting of the specific views of the participants (Corbin & Strauss, 2008).

Participants and Setting

Participants were 55 nurses (50 were black and five were white, all were women, with a mean of five years length of service). Thirty primary care clinics in South Africa were represented. The clinics were situated in two provinces, and across urban, rural and one informal settlement areas. Recruitment was established through professional and social networks. Purposive sampling (Creswell, 2003) was used to ensure that specific elements were included in the sample. This approach employs a considerable degree of selectivity. The snowball technique (De Vos, Strydom, Fouché & Delpont, 2005) was also used to recruit participants so that a nurse helped recruit other participants.

Procedure

Written informed consent was obtained from all participants. Participants were informed of the rationale, recording and safekeeping of audiotaped interviews and transcriptions. Participation was voluntary, and ethical clearance was granted by the University of Johannesburg. Data were collected during normal clinic time.

Instrument

Data were collected using nine semi-structured interviews (lasting between 45 and 60 minutes) and 46 naïve sketches (between one and four pages) as described by Giorgi (1985). Naïve sketches proved useful as face to face data collection were not always available because participants often lived or worked in remote case deprived areas. Data were collected in English, the second language of all participants and the researcher. The interview questions were as follows:

"How is it for you in your clinic regarding the follow-up and follow-through of mental health care users?"

"What are your wishes regarding the follow-up and follow-through of mental health care users?"

Field and observational notes were written as soon as possible after interviews. Triangulation of the data collection methods allowed for a more complete understanding of what was being studied. Multiple methods also revealed different realities (Denzin & Lincoln, 2008).

Data Analysis

Recorded interviews were transcribed and analysed using the descriptive analysis technique described by Tesch (in Creswell, 2003). This is a widely used procedure where units of meaning are underlined for each of the interviews and naïve sketches, and then grouped together in themes and categories. A literature control was employed in order to recontextualise findings, providing a point of reference for comparing and contrasting the themes/ categories of this research with those of other studies.

Results and Discussion

Nurses' experience regarding follow-up and follow-through care of mental health care users where overwhelmingly reported as being fraught with difficulties. Barriers impacting on quality follow-up and follow-through care can be divided into three main categories, namely: inadequate service provision related to availability of resources (human, time, infrastructure); practice system support as well as the attitudes of MHCUs and the family. The theme and categories are discussed below and along with verbatim quotes and a literature control. Nurses' wishes are embedded within the categories.

Inadequate Service Provision Related to the Availability of Resources

The primary health care package for South Africa sets out norms and standards of care. The service seeks to improve the mental health and social well-being of individuals and communities. Although the principles are sound, nurses generally experienced service delivery as "poor", related to a lack of preparedness at service level to implement legislation, norms and standards. One participant observed:

"Mental Health Care Users (MHCUs) are not given proper attention which results in poor service." (participant 46).

"The service is poor; we only rely on clients coming to us. It is only focused on those who were referred and treated at the clinic and their families. Defaulters and those who fall back into the habits are not easily traced or followed up." (participant 11).

South Africa is not unique in its struggles to deal with the painful realities of implementing legislation within poorly resourced and insufficiently prepared circumstance. Burns

(2008) described similar challenges in the United States of America in the 1960's and the United Kingdom during the 1980's, and these are associated with evolving health care systems.

Adequate resources are one of the prerequisites for a well functioning primary health care system (Hering, Dean & Stein, 2008; Jacob, et al., 2007; Thom, 2004). Participants commented on the shortage of human resources to deliver quality follow-up and follow-through care.

"The follow-up of MHCU's is presently difficult due to the fact that nurses are unable to do it effectively because of shortage of staff." (participant 1).

"Follow-ups are done, but not so well due to a shortage of staff." (participant 25).

"The clients always suffer due to shortage of staff." (participant 35).

Inadequate numbers of mental health specialists, such as psychiatric nurses, represent a common problem in low-medium level resource countries such as South Africa. The shortage of human resources impacts negatively on accessible and adequate mental health service delivery to the population in the face of increasing MHCU numbers (Hering et al., 2008; Jacob, et al., 2007; Moosa et al., 2007; Solberg, et al., 2005; Van Hook & Ford, 1998; Wang, et al., 2007; WHO, 2001). According to a participant:

"The follow-up with the fast pace is a problem because of the overpopulation... you know this . . . uprising of the informal settlements it's so difficult it's like when you want to follow a patient; the person was staying at number G2 today, tomorrow he is no longer there." (participant 3).

Primary care nurses are often untrained in mental health care. As a result, the quality of the nurse in terms of knowledge, skills and attitude is deficient. A nurse summarised this fact as follows:

"Many times [users] are mishandled when [nurse] [has no] knowledge of what to do or even [of] the drugs. (participant 3).

Socio-attitudinal barriers also compromise quality of care. A nurse observed:

"I think another reason why some patients don't come to follow-up...the way we handle our patients and sometimes you'll find that we are judgemental...also you don't teach the patient about the condition." (participant 1).

Moosa et al. (2007); Secker, Pidd, Perham and Peck (2000) and Jacob et al. (2007) found in their studies that the factors negatively impacting on treatment adherence and follow-up care include: poorly developed services; poor medication availability and distribution systems; inadequate staff training; overworked health care providers; and an insufficient capacity to educate MHCU's. Thom (2004) and Jacob et al. (2007) added that overcoming negative attitudes and prejudices towards MHCU's is still problematic. Hering et al. (2008) commented on the difficulties in managing acutely suicidal and disruptive psychotic clients together with the frail or medically ill clients. Thom (2004) also alludes to other constraining factors in the implementation of mental health services in South Africa in relation to managerial inexperience and the loss of experienced mental health care practitioners at both management and clinical level.

Nurses also work under considerable time pressure from heavy case loads within the primary care system. Nurses noted that:

"Follow-up care is a tough one [due to] a time factor... And with a fast queue when a patient says 'I have got this', rather than assessing him, they will just give medication... Observations are not taken..." (participant 2).

"They focus on pushing the queue, then saying 'mm 'n, mm 'n, you're taking too much time." (participant 2).

"On arrival in the consulting room they are only be dished up with medications without even asking 'how do you feel . . . ' Observations are not taken." (participant 3).

"They are not given enough opportunity to verbalize their problems." (participant 44).

"Treatment is just issued to them without having enough time to sit with the patient and find out the health problems that they have because the nurse needs to finish and relieve the shortage." (participant 15).

Solberg et al. (2005, p. 5) referred to "busyness, lack of resources, practice system supports and our approach to the care of patients with chronic mental health condition", that impede follow-up and follow-through services. Fairhead (2003) advocated at least 20 minutes for follow-up consultations in order to assess the response to treatment, suicide risk, patient information, education, self-help techniques and medication dispensing.

Infrastructural Shortcomings

Not only do the quantity and quality of resources impact on follow-up and follow-through care, but infrastructural and functional shortcomings exist. A nurse explained:

"You'll find that the nurse wants to refer the client or the patient is violent again. She calls an ambulance; the ambulance would say no, we cannot put her in the ambulance being in this condition she is going to destroy it, or whatever . . . Get the police. Call the police; the police say mm-'n-'n, we do not transport the patient you know. . . . So we leave the patient in an act you know. It's a dilemma! And at the end she sleeps without any intervention because they decide to 'ward' her... she is fine now. Then she goes back to the community. Then it starts all over again. That is my outcry to say really." (participant 2).

The roles of the South African Police Services and Emergency Medical Rescue Services in respect of the management of MHCU's are not clear, and their involvement is often unhelpful (Burns, 2008). Factors leading to the non co-ordination between the services include inadequate liaisons and communication between the two services; representatives being unskilled in the diagnosis of mental illness and decision being based less on psychiatric symptoms but more on the psychosocial and health care institutional factors (Jonsson & Moos, 2008; Wolff, 1998). The lack of intersectoral collaboration affects individuals, practitioners and service delivery as a whole (Thom, 2004).

Transport as an infrastructural support is generally lacking. As the nurses observed:

"Follow-up care is not being done by nurses because of a lack of transport to visit those patients." (participant 40).

"Home visits are happening but at the very smaller scale because sometimes there are even vehicle restrictions and

cost effectiveness in terms of travelling. They are being looked into and then... who remains at the clinic?" (participant 3).

"Home visits are done scarcely - support systems are poor. Staffing also kills us for the home visits." (participant 50).

"It is not easy to make follow-up, sometimes because the clients have no address to make home visits." (participant 3).

Even when transport is available nurses, have personal safety concerns. One participant observed:

"...hijacking problems [abound]. Patients stay in areas that are totally not safe. You will find that the hijackers are on the lookout for this government cars. They say 'after all, it's not yours.' ... nurses [are] in danger Some of them [hijacker] they don't just take the car, they either kill you to take the car or they hack you and cripple you to have the car." (participant 1).

Transport is also a problem for the MHCUs. Participants shared that users did not follow through because:

"Sometimes they default because they do not have money for transport. That is sad because they relapse." (participant 10).

"Most patients are defaulters due to poor transportation if they stay far from the clinic." (participant 46).

"They are referred to a clinic which is 5 km away from the community clinic. This requires that they get transportation which affects compliance to treatment and follow-up." (participant 5).

Nurses have a wish list for improving follow-up and follow through with mental health care. The wish list included the following:

"I wish they would not isolate mental health sites from comprehensive clinics." (participant 4).

"I wish we had user friendly facilities." (participant 36).

". . . that staff and patients know about the available resources and how to utilise them." (participant 6).

"Nurses need to be allowed to have quality time with their client to be able to give quality services." (participant 15).

"A special team should be selected to do home visits, to check patients at least once a month and formulate support like for TB." (participant 19).

"There should be cars available for the officials to move from point A to point B for these cases that really need an expert check-up." (participant 44).

"There should be a space/room where they (MHCUs) can be consulted." (participant 1).

Practice System Support

Practice support refers to well-developed and effective information systems between health care practitioners and facilities. The purpose of information systems is to manage and communicate information that the health care practitioners need to perform their jobs effectively and efficiently. Participants complained about the lack of adequate information and feedback which compromised the continuity and quality of care. Their observations included:

"We are not sure what happens to the people we refer." (participant 9).

"Once you refer, there is no feedback [although] the follow-up care for that patient that you have referred is very important." (participant 2).

"They go to the other clinic for doctor's assessment and we don't get feedback." (participant 35).

Fraser, Allen, Bailey, Douglas, Shin and Blaya (2007) found that effective information systems in developing countries are a recent innovation, and important for supporting and monitoring the care of those with chronic conditions. A particular focus of these systems would be on tracking MHCUs from initial diagnosis to initiation of effective treatments and then to monitor them for treatment breaks or failure to follow-up.

Nurses also expressed a need for:

"...a readily available multi-disciplinary team" (participant 5) and

"...ongoing support from top management." (participant 1).

Attitudes of MHCUs and the Family

The attitudes of MHCUs and the family, as well as taking responsibility for their own mental health, often hamper effective follow-up care. Participants noted:

"They come to collect their medication only. They are not interested in health talks because they don't want to stay in the clinic too long." (participant 14).

"The MHCUs they don't come for their follow-up, they would be talking about the financial issue, 'I don't have money' or 'I wasn't aware of the date.' You know there is an element of irresponsibility." (participant 1).

"Some of them, they run away from the side effects saying 'no I am not going there, they are going to give me this medication.' Some of them also there is a religious issue that counts... because religion doesn't allow it. Others they go for witchcraft, they go to the traditional healer, and they think they give themselves some hope. They stop their medication." (participant 4).

Stein, Kogan, Sorbero, Thomson, Hutchinson (2007) found that individual characteristics, prior experience with the mental health system and discharge planning may contribute to the failure of timely follow-up. Moosa et al. (2007) similarly established that patient-related factors such as forgetfulness, anxiety about side-effects, inadequate knowledge, lack of insight and motivation, fear of being stigmatised and lack of financial resources all increase the risk of non-adherence resulting in failure to follow up.

Cultural Influences

South Africa is home to a variety of cultures in terms of beliefs, norms and traditions. As a result of this diversity, several different approaches to the treatment of mental illness exist, often in conflict with each other (SADAG, 2010b). It is not uncommon for MHCUs or their families to search for other explanations for the disorder, and traditional healers are likely to be consulted, during or after the course of treatment (Moosa et al., 2007).

The family plays an important role in the delivery of primary health care (Burke, 2003; WHO, 2001). The goal is to maintain the MHCUs at home for as long as possible and to ensure high quality care. Family responsibility is an issue that is difficult to resolve in the complex South African society. According to the participants:

"Family involvement is not effective. Families are only dependent on the sisters." (participant 4).

"Families of MHCUs are not present during follow-ups because they are working, as a result they cannot be involved in the care of the user. The user also defaults because the family doesn't supervise the treatment, leading to relapse." (participant 2).

"Some families are only interested in the patient's grant; they don't care. They only keep the patient for the grant." (participant 45).

Adults (18 years or older) who are not able to work due to a mental or physical disability, may receive a monthly payment (R1010.00 or US\$ 100) from the government called a disability grant. A permanent grant is awarded if the disability lasts for more than one year, or a temporary grant if the disability last for between six months and a year (SAGS, 2010).

Primary care nurses are seen as leaders in the community (Strasser et al., 2005). They are often looked to for social support when others such as the family cannot provide the support that is needed (Finfgeld-Connett, 2005). The nurse, acting as a "surrogate family" (Getty, Perese & Knab, 1998, p53), is at risk of becoming overburdened and overtaxed in terms of internal and external resources.

Nurses stated their expectations for families. These included the following:

"A comprehensive approach is necessary especially towards the family because they also hinder the medicine with the use of traditional medicines thinking it is witchcraft." (participant 4).

"Encourage relatives to escort or supervise in taking of medication and follow-up care." (participant 36).

"Advise the family not to chase them away." (participant 50).

Implications for Practice

A balanced approach to care requires a mixed portfolio of services and the blend largely depends upon the resources available. This blend should reflect a genuine collaboration between the health care service, and the health care practitioner as well as the MHCU. The services need to be seen by the community as being client-orientated, assessable and humane (Jaworowski et al., 2003).

Stein et al. (2007, p1568) observed that "no one approach is likely to be effective for all individuals." Successful efforts will require multiple strategies with different approaches to improving follow-up rates and close monitoring among high-risk populations. These efforts may involve interventions that occur before discharge, such as setting appropriate expectations for out-patient and follow-up treatment, enhancing pre-discharge contact with outpatient providers, and enhancing communication between inpatient and outpatient health care practitioners.

A limitation of this research was the recruitment of participants from a limited geographical area in South Africa. Although generalisability is not the purpose of qualitative research, this study could perhaps aid the understanding about what is going on at grass root level in terms of follow-up and follow-through care of mental health care users. Ongoing research is necessary to track the service implementation and the quality of follow-up and follow-through care in the primary care setting in South Africa.

Conclusion

Despite indications of pockets of excellence in South Africa's primary care setting, there seems to be a high level of un-

met needs related to follow-up and follow-through services. Barriers include inadequate service provision related to availability of resources (human, time, infrastructure); practice system support as well as the attitudes of the MHCU and the family. As the South African health system undergoes transformation, primary care services are faced with the important challenge of providing high-quality follow-up and follow-through care for MHCUs.

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