



Opinions and experiences of tertiary-level mental health providers regarding the down-referral of patients: A qualitative study



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Background: Down-referral of patients from tertiary psychiatric hospitals to primary healthcare (PHC) is central to South Africa's National Mental Health Policy, which advocates for decentralised, accessible and sustainable mental healthcare. This process supports continuity of care, reduces pressure on specialist services and promotes community reintegration. Despite these benefits, challenges such as limited PHC resources, poor medication supply, inadequate staffing and stigma undermine effective implementation. This study explored the opinions and experiences of mental health providers at Weskoppies Psychiatric Hospital, a tertiary psychiatric facility in Pretoria, South Africa, to better understand these challenges, perceptions and potential strategies.

Methods: A qualitative, exploratory design using grounded theory was employed. Purposive sampling was used to recruit 12 healthcare professionals who worked at the outpatient department and were involved in the down-referral process, with data collection continuing until theoretical saturation was reached. Semi-structured interviews were conducted. Data were analysed thematically.

Results: Five key themes emerged: (1) The importance of early planning for discharge and down-referral but inconsistently applied; (2) patient resistance, often driven by fear, stigma and distrust of PHC, complicates transitions; (3) perceived challenges at PHC included staff shortages, long waits and poor medication availability; (4) perceived stigmatisation; and (5) recommendations for improving the down-referral process including better communication, dedicated referral coordinators, use of outreach teams, improved documentation and dedicated mental healthcare providers at the PHC level.

Conclusion: Down-referral is necessary but challenged by systemic and relational gaps. Down-referral can be enhanced by improving PHC capacity, standardising discharge planning and reducing stigma. Patients and their families should be included in care decisions.

Contribution: This study provides insight into the lived experiences of healthcare providers managing down-referral from tertiary to PHC services. It highlights barriers and practical strategies that can inform policy implementation and strengthen community-based mental healthcare.

Keywords: down-referral; MHCUs; PHC; stigma; discharge; WHO; challenges.

Introduction

Down-referral of mental healthcare users (MHCUs) from specialised psychiatric hospitals to primary healthcare (PHC) facilities is a part of effective healthcare delivery. A functioning referral system allows for continuity of care across different tiers of health services and is central to achieving universal health coverage.^{1,2} For referral systems to operate optimally, all levels of the healthcare delivery framework must function effectively. The World Health Organization (WHO) has long advocated for the integration of mental healthcare into primary care, a stance first articulated in its 1975 Expert Committee report on the *Organising of Mental Health Care Services in Developing Countries*.³ Subsequent WHO collaborative studies, including the *Psychological Problems in General Health Care* project, demonstrated that both common mental disorders, such as depression, anxiety and somatoform disorders and more serious psychological conditions, such as schizophrenia, bipolar disorder and severe forms of major depressive disorder associated with psychotic features can be effectively identified and managed within PHC settings across diverse cultural and resource contexts.^{4,5} These findings highlighted that mental disorders, ranging from

mild to severe forms associated with marked functional disability, frequently present in primary care and can be treated effectively when appropriate systems and training are in place. This evidence further reinforced global recommendations to integrate mental health into PHC as a means to improve accessibility, continuity and comprehensiveness of care.⁶

According to the Referral Policy for South African Health Services,¹ patients may be down-referred to their originating health establishment or another facility for further treatment after receiving necessary interventions at a higher level of care.¹ Despite evidence supporting the inclusion of mental healthcare in PHC, this goal remains largely unrealised in many countries.^{7,8,9}

Hattingh et al.¹⁰ highlighted the challenges faced by MHCUs during down-referral. Participants in that study expressed that the perceived disadvantages of referral to PHC centres often outweighed the perceived advantages. Common concerns included unavailability of medications, lack of specialised care, loss of established relationships with familiar healthcare providers, mistreatment by nursing staff at PHC facilities, longer waiting times and increased stigma.¹⁰ In contrast, Mukora et al.¹¹ identified several advantages to down-referral, including improved accessibility through proximity to clinics and reduced transport costs for patients. Participants in their study also noted that being treated at local clinics saved time, reduced the need to take leave from work and helped alleviate overcrowding at tertiary hospitals by allowing specialist services to focus on more acutely ill patients. Some even perceived down-referral as an altruistic act, enabling others with greater needs to access tertiary-level care. Other studies have similarly shown that down-referral can decrease waiting times, enhance continuity and retention in care and promote more efficient use of limited specialist resources, thereby reducing the overall cost burden on the health system.^{6,11}

Mental healthcare providers face numerous challenges when down-referring MHCUs. Many patients refuse down-referrals because of perceived fears,¹⁰ leaving tertiary-level providers overwhelmed with MHCUs who could be effectively treated at the primary level.^{12,13} Although most patients were discharged to public PHC, a small number were down-referred to private facilities, but participants' responses were related to the public sector PHC, and no participant mentioned down-referral to the private sector.

In South Africa, human resources limit the attainment of a well-functioning referral system. The limited availability of specialised mental health professionals hampers timely and comprehensive care. This scarcity highlights the need for increased investment and resources in mental healthcare to ensure access and optimal outcomes for down-referral systems.^{14,15,16,17,18,19,20}

Despite healthcare providers facilitating the down-referral of patients, little is known about their experiences and challenges.^{13,16,21} Understanding their perspectives is essential

for identifying factors influencing referral decisions and the impact of these decisions on treatment outcomes.

Madlala et al. explored the experiences of mental healthcare providers at a public hospital in KwaZulu-Natal and noted that a shortage of mental health professional nurses increased the pressure on already overburdened healthcare workers. Successful integration of mental health into PHC would require more PHC staff to alleviate this burden.¹² The WHO has also indicated that shortages of professional nurses have become a global phenomenon.^{3,4,7,22,23}

Exploring the experiences and opinions of mental health care providers may offer insights into the broader implications of down-referral on PHC systems. By examining their perspectives, we can better understand the support needed to ensure sustainable solutions for integrating mental health into PHC frameworks.

Research methods and design

Setting

This qualitative, exploratory study was conducted at Weskoppies Hospital (WKH), a tertiary psychiatric hospital in Pretoria, South Africa.

Study population and sampling

The study cohort comprised 12 tertiary-level healthcare professionals employed at WKH, who were actively engaged in the down-referral of MHCUs to PHC settings. This multidisciplinary sample included registrars ($n = 6$), community service medical officers ($n = 2$) and psychiatric nurses ($n = 4$), representing all the clinical roles responsible for care transition decisions in the institution.

Participants were selected through purposive sampling²⁴ to ensure inclusion of professionals with direct experience in down-referral processes and at least 6 months in their current position. Before enrolment, all eligible candidates received comprehensive information about study objectives and data handling protocols, with written informed consent obtained from each participant in accordance with institutional ethical guidelines.

Interviews

Participants were interviewed using a semi-structured interview guide that was developed by the first author. It was based on a review of the relevant literature on down-referral, mental health integration into primary care and patient and provider experiences.¹⁰ The interview guide comprised seven questions organised into four domains: clinical prerequisites, implementation barriers, patient experiences and process optimisation.

Interview guide structure

- **Clinical decision-making:** Participants were asked to describe their recommendations for determining

appropriate down-referral timing, including clinical indicators, such as symptom stability and functional capacity ('In your opinion, when is it appropriate to down-refer a MHCU from the outpatient department to PHC?').

- **Implementation barriers:** These questions explored challenges at the patient and system levels. Providers reflected on obstacles encountered during referrals ('What challenges have you faced while down-referring MHCUs?') and institutional barriers affecting colleagues ('Are you aware of challenges faced by other providers?'). A spatial analysis question identified disparities across care tiers: 'At which level (district hospitals, community health or clinics) do patients report the most challenges after referral?'
- **Patient-centred factors:** The guide probed drivers of refusal through the question: 'What factors contribute to MHCUs refusing to be down-referred?'
- **Process improvement:** The final questions focused on solutions: 'What recommendations would enhance the down-referral process?' and 'Which strategies have effectively facilitated referrals?'

Inclusion and exclusion criteria

Eligible participants had to be 18 years or older, capable of providing informed consent, and currently employed as healthcare providers at WKH, specifically within or having previous experience in the outpatient department.

Exclusion criteria included healthcare providers who did not meet these requirements or who declined to participate in the study.

Methodology

This study employed a qualitative research design using grounded theory as outlined by Charmaz and discussed in Flick.²⁵ The goal was to generate a theory grounded in the lived experiences of mental healthcare providers at a tertiary facility, specifically regarding the challenges associated with the down-referral of MHCUs to PHC facilities. This approach allows for theory to emerge directly from the empirical data rather than being shaped by a prior hypothesis.²⁶

Study design and data collection

The estimated sample size was approximately 20 to 25 participants. However, the aim was qualitative, not quantitative, and thus recruitment continued only until theoretical saturation was achieved, that is, when no new themes or insights emerged from subsequent interviews. In this study, saturation was reached after 12 interviews, and no further participants were recruited thereafter.

Semi-structured interviews were conducted with 12 participants. Interviews were primarily conducted in English, although participants were given the option to respond in Afrikaans or isiZulu, based on their preference.

The interviewer was fluent in all three languages, which facilitated open communication. Each interview lasted approximately 30 min to 45 min.

In addition to the interviews, basic demographic data were collected using a brief data sheet, and field notes were taken during each interview to capture contextual observations and supplementary information. With participants' written informed consent, all interviews were audio-recorded and later transcribed verbatim by the interviewer for in-depth analysis. Strict adherence to confidentiality and ethical standards was maintained throughout the research process.

Data analysis

The analysis included open coding, axial coding and selective coding as described by Silverman.²⁶ During open coding, the interviewer identified text meaningful to the study from the transcripts and 'coded' them by capturing into related concepts. This was followed by axial coding, where the relationships between categories were explored and reconstructed in meaningful ways. Finally, selective coding was used to identify and refine the core categories, culminating in the development of an emerging theory.²⁶ Throughout the process, the study supervisors provided guidance and confirmed the coding approach and category development, ensuring consistency and rigour, although no formal multiple-coder triangulation was performed.

Microsoft® Word and Excel were used for manual coding, ensuring close interaction with the data. Reasoning during the coding process was guided by both induction, where inferences are drawn from the empirical accounts of participants and abduction, which involves searching for the most coherent and comprehensive explanations of the observed phenomena.²⁷

Ethical considerations

Ethical approval was obtained from the University of Pretoria's Faculty of Health Sciences Research Ethics Committee (Reference no. 612/2023). Informed consent was secured from all participants, and data were anonymised to ensure confidentiality. Audio recordings and transcripts were securely stored, accessible only to the research team.

Results

Participant demographics

A total of 12 healthcare professionals participated in the study. The sample included 10 women and two men, aged 26 years to over 40 years (majority 31–40 years). Clinically, the sample comprised six psychiatry registrars, two community service medical officers and four professional nurses. Years of service ranged from 3 to over 10 years, with most having 6–10 years' experience (see Table 1). This diverse sample provided perspectives across different professional roles and experience levels relevant to the down-referral process.

TABLE 1: Demographic data of participants.

Demographic	Number
Sex	
Male	2
Female	10
Age (years)	
26–30	2
31–40	7
Older than 40	3
Clinical category	
Psychiatry registrars	6
Community service medical officers	2
Professional nurses	4
Years of service	
3–5	2
6–10	7
> 10	3

Themes

Five themes emerged from the data regarding the down-referral process in this tertiary psychiatric hospital. These include the need for early discharge planning, patient resistance rooted in distrust and prior experiences, systemic challenges at PHC, such as understaffing and long waiting times, the impact of stigma on care acceptance and provider-suggested solutions. These themes point to critical areas for intervention to support a more effective and patient-centred referral system.

Theme 1: Early planning for discharge and down-referral

Participants mentioned that down-referral should occur because:

'[I]n my opinion, a tertiary institution is to stabilise the patient. So, once you've reached to an optimal management plan, [and the] patient is stable on a certain medication, that is the indication to step down' (Participant A, psychiatry registrar, 34-year-old, female)

Patients must be prepared:

'[W]hen the patient is admitted so that they are mentally and emotionally ready for it, [thus] it must not be ... a last-minute decision.' (Participant B, psychiatric nurse, 39-year-old, female)

Families should be prepared too:

'Families need to be prepared, too. If they don't understand the process, they won't support the patient's transition [to PHC], and that makes everything harder.' (Participant B, Psychiatric nurse, 39-year-old, female)

Thus, patients and family should be informed that the integrated treatment plan involves admission, follow-up at the Out Patient Department (OPD) and finally, down-referral. Preparation should include psycho-education and family engagement.

By following these steps, patients and families are prepared and ready. Inadequate preparation may result in patients completely misinterpreting their down-referral; they may feel that *WKH* rejects them, for example, 'we feel like you are chasing us away from your institution.' (Participant C, psychiatric nurse, 28-year-old, male)

Theme 2: Resistance to down-referral

Participants were concerned about resistance to down-referral, for example, 'I've had patients who were very resistant to being down-referred.' One participant said:

"We have cases whereby we have down-referred certain patients, but they did not even attempt to even visit those local clinics" Some patients were so reluctant that "[they] have threatened to default on purpose, even some others have faked an acute psychosis in the office with us to try and be retained at *WKH* instead of being down-referred." The reluctance seems to be underpinned by "... issues of service delivery, waiting time, time constraints, familiarity or unfamiliarity with the nursing staff that are there, which makes them very reluctant to even go there." (Participant D, community service medical officer, 41-year-old, male)

Theme 3: Challenges at primary healthcare facilities

Participants expressed concerns regarding systemic and structural challenges within PHC settings, which participants believed hindered effective down-referral. This included perceived lack of appropriate medication, stigmatisation, mental health not being a priority, problems with service delivery, issues about familiarity with PHC staff and familiarity with *WKH* staff and challenges with communication between tertiary-level psychiatric services and PHC:

"As a doctor, it is really frustrating because you send a patient down to PHC with a proper plan, but then they come back saying the medication is not available." Participants experienced a limited availability of psychiatric medication at the PHC level, "... over and over ..." The shortage of essential medication was troubling for participants as it '... affects their [the patients'] stability'. Participants heard frequent reports of essential psychotropic medications being unavailable, leading to disruptions in treatment continuity. This is so "... despite [the medication] being one that's on an EDL." Thus, participants heard patients complaining, "... the clinic says they can't help me or the clinic doesn't have the medication that I need ..." (Participant E, Psychiatry registrar, 35-year-old, female)

Theme 4: Perceived stigma

Stigmatisation plays an important role in patients' reluctance to accept down-referral to PHC facilities. According to participants, many MHCUs feel unwelcome, misunderstood or judged at the PHC level, which directly affects their willingness to transition from tertiary services. As one participant explained:

'I think one thing that we have realised is that the stigmatisation around mental health as a concept still remains something that is very alive.' (Participant C, psychiatric nurse, 28-year-old, male)

Participants explained that stigma originates from other patients, the broader community and even PHC staff, for example:

'It's something that is not only attributed to staff, not only attributed to patients that are mentally ill, but even staff members who are actually afraid of a psychiatric patient.' (Participant C, psychiatric nurse, 28-year-old, male)

As a result, many mental health patients feel neglected and uncared for:

'Patients come back saying they waited for hours only to be told to go somewhere else.' (Participant F, psychiatric nurse, 41-year-old, female)

The situation may be even more acute for state patients, who are patients referred by a court of law after being deemed unfit to stand trial because of mental illness. One participant shared an account from a state patient who said:

'[T]he nurse that was attending me was actually afraid of me because I am a so-called state patient.' (Participant C, psychiatric nurse, 28-year-old, male)

Consequently, MHCUs prefer to remain in tertiary facilities, where they feel more accepted:

'They say they'd rather come all the way to Westkoppie because at least here they are treated with respect.' (Participant G, psychiatric nurse, 42-year-old, female)

Furthermore, healthcare professionals, empathising with their patients' concerns, also expressed scepticism about the feasibility of down-referral:

'[Y]ou're setting your down referrals up for failure.' (Participant E, psychiatry registrar, 35-year-old, female)

Concerns were raised regarding whether mental health is regarded as being on an equal footing with other medical conditions at the PHC level. For instance:

'The reality is that mental health is not prioritized at PHC level.' (Participant A, psychiatry registrar, 34-year-old, female)

Service delivery: Service delivery in PHC facilities appears to be hindered by resource constraints, insufficient training and concerns regarding the safety of clinic locations. In many cases, there are simply not enough medical practitioners to meet the high demand:

'But I do think there is a huge play there in resources. Like from my personal experience, there's one doctor seeing all the patients on the clinic that day. The clinic is massively overbooked.' (Participant E, psychiatry registrar, 35-year-old, female)

In some instances, patients make multiple attempts to access care, only to be turned away:

'[Patients] would report that they went to the clinic twice or three times and they were told the doctor is not available.' (Participant A, psychiatry registrar, 34-year-old, female)

Because of such shortages, the time allocated per patient at PHC clinics is minimal, with one participant reflecting on her PHC rotation experience:

'[W]e've got three minutes to see them.' (Participant E, psychiatry registrar, 35-year-old, female)

Participants suggested that PHC workers may lack specialised training. This lack of training may exacerbate stigma, particularly when healthcare workers are confronted with challenging patient behaviours:

'When health care workers that are not trained in psychiatry experience such aggressive patients, they start being prejudiced towards all MHCUs and paint them with the same brush.' (Participant G, psychiatric nurse, 42-year-old, female)

These generalisations contribute to stereotyping MHCUs as dangerous, undermining the trust required for therapeutic relationships. Ironically, some PHC clinics are located in potentially dangerous areas, dissuading MHCUs from attending:

'Certain clinics are situated in 'dangerous' neighbourhoods or neighbourhoods where drug abuse and gangsterism is high ...' (Participant G, psychiatric nurse, 42-year-old, female)

When patients are down-referred, they leave familiar and trusted spaces for facilities where providers are new or disliked. Thus, reluctance to accept down-referral may be influenced by:

'[F]amiliarity or unfamiliarity with the nursing staff that are there ...' (Participant C, psychiatric nurse, 28-year-old, male)

Participants highlighted communication breakdowns between tertiary and PHC facilities, which threaten continuity of care. The issue was said to be present on both sides.

Theme 5: Recommendations for improving the down-referral process

Participants recommended possible solutions, including improving communication, integrating PHC with tertiary-level care and prioritising mental health at the PHC level.

Improving communication: Communication can be enhanced by appointing coordinators, improving the quality of down-referral documentation and appointing specific contacts at the PHC level. Coordinators should be appointed to assist with proper administrative support and promote a more responsive referral system:

'[C]oordinators should be allocated to assist with the smooth functioning of the down-referral process.' (Participant B, psychiatric nurse, 39-year-old, female)

Participants suggested holding regular interdisciplinary meetings to strengthen collaboration and ensure continuity of care:

'Currently WKH is holding ... we call them cluster meetings. We invite all the primary level facilities and also secondary ... We hold meetings, I think, every three months to see on how we can help as a tertiary level.' (Participant B, psychiatric nurse, 39-year-old, female)

Clear, detailed documentation during referrals was viewed as essential. Referral letters should include the patient's full clinical history, triggers for previous admissions and early warning signs to support ongoing care.

Integrating primary healthcare and tertiary-level services: Although services are in place at the PHC level, participants felt that service delivery to MHCUs could be improved through better integration with tertiary institutions:

'Certain things are already on the ground but they're underutilized ... we need to make use and start to integrate the community-based care or health service to our tertiary institution and not isolate ourselves because there are trained mental health care coordinators that I know of that do outreach and make sure the patient showed up at clinic.' (Participant A, psychiatry registrar, 34-year-old, female)

Integration was also seen as a potential strategy to address staff shortages and training gaps. Rotating staff between the tertiary and PHC levels was suggested:

'[D]octors and nurses should rotate to PHC.' (Participant B, psychiatric nurse, 39-year-old, female)

Prioritisation of mental healthcare: Participants consistently voiced concerns that mental health services at PHC levels are underfunded, resulting in staff shortages and a lack of essential medications:

'PHC should be prioritised when allocating budgets, to facilitate increase in HCWs and medication.' (Participant E, psychiatry registrar, 35-year-old, female)

Beyond staffing and medication needs, participants proposed practical service delivery reforms, such as setting aside specific days or dedicated spaces for mental health services in PHC facilities. These changes could enhance access and reduce stigma associated with psychiatric care:

'Let us segregate psychiatry from other services.' (Participant C, psychiatric nurse, 28-year-old-male)

Creating a separate, focused environment for mental health was seen as a step towards more respectful, patient-centred care.

However, previous studies have recognised that segregating psychiatric services from other general services could inadvertently increase stigma, noting that while the integration of mental health into general healthcare can normalise care and reduce stigma, separate or highly visible psychiatric services may reinforce negative perceptions of mental illness.^{28,29}

The diagram (Figure 1) illustrates the interconnected factors contributing to resistance within the down-referral process from tertiary to primary care. At the centre is the 'Resistance block', representing the barriers that hinder smooth

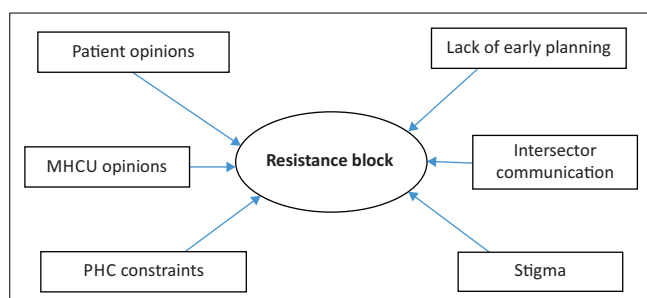


FIGURE 1: Need for down-referral - Barriers influencing resistance to discharge to primary healthcare.

transitions of MHCUs to PHC facilities. Surrounding this core are six key influences: the lack of early planning, intersector communication challenges, stigma, PHC constraints and the opinions of both patients and MHCUs. Limited early planning and poor coordination between sectors often create uncertainty and mistrust, while stigma perpetuates negative perceptions of PHC services. Tertiary psychiatric hospitals to PHC constraints, including inadequate staffing and resources, further fuel patient and MHCU reluctance to accept down-referral. Collectively, these factors reinforce one another, sustaining a cycle of resistance that impedes continuity of care and delays reintegration of stable patients into community-level services.

Discussion

This study highlights the complexity of down-referral in mental healthcare within a resource-constrained context, such as South Africa. Similar findings have reported the importance of early preparation of MHCUs to facilitate successful down-referrals from tertiary to PHC services.^{10,11,12} Structured discharge planning reduces readmission rates and improves long-term outcomes.^{28,30,31,32} Accordingly, planning for down-referral should begin early during admission.

Early preparation for down-referral extends beyond clinical management to include psycho-education, family engagement and proactive communication.^{33,34,35} Similarly, our participants stated that early planning helps manage patient and family expectations, enhances continuity of care and reduces the sense of abandonment often expressed by MHCUs during transitions.

Despite agreeing on its importance, early discharge planning seems to be inconsistently implemented at WKH. Participants emphasised the importance of initiating down-referral planning early in the admission process, rather than waiting until the outpatient stage. Delays in planning were believed to contribute to patient unpreparedness, resulting in resistance, confusion or emotional distress during discharge. Patients may misinterpret the lack of timely preparation as a form of abandonment or rejection. These observations support existing research underscoring the importance of early discharge planning and structured transitions in mental healthcare.^{36,37} Without standardised processes, patients may disengage from follow-up care or develop mistrust in the system. Participants argued that discharge and down-referral should be a part of routine care, with consistent communication and family involvement. These practices align with the principles of coordinated care transitions, which prioritise predictability, continuity and preparation to reduce unnecessary reliance on tertiary services.^{38,39}

A major barrier to effective down-referral, according to participants, is the ongoing strain on PHC capacity. Overcrowded clinics, long waiting times and insufficient human resources, especially the lack of psychiatrically

trained professionals, were identified as significant constraints. These conditions mirror national and global findings on the chronic under-resourcing of mental health services in low- and middle-income countries.^{12,15,32} Staffing shortages lead to provider burnout, rushed consultations, incomplete assessments and a lack of continuity of care.⁴⁰ These factors collectively undermine MHCUs and tertiary providers' trust in PHC systems.

Participants highlighted gaps in the quality and completeness of referral documentation. They noted that referral letters frequently lacked essential clinical information, such as psychiatric history, treatment trials or early warning signs of relapse. These omissions were seen to compromise follow-up care and, in some cases, result in inappropriate medication substitutions or missed signs of deterioration. To address this, participants recommended improving referral documents and appointing specific coordinators at PHC facilities. Coordinators are professional nurses who are ideally placed to liaise directly with tertiary and primary care clinicians, ensure receipt of referrals and clarify care plans when necessary. They also ensure that state patients who are conditionally discharged follow up at their local clinics and adhere to the conditions of their discharge. Additionally, coordinators can assist in cases where certain state patients abscond.

In our study, participants noted that many patients were resistant to being down-referred. Participants described instances of patients refusing referral, exaggerating symptoms or threatening to discontinue medication in an effort to remain at, or return to, the tertiary facility. These behaviours may be driven by fear of perceived substandard care at the PHC level, past negative experiences or the comfort and familiarity associated with tertiary-level staff. Similar findings have been reported elsewhere, namely that MHCUs are often reluctant to transition to PHC because of perceived quality deficits and fear of relapse.^{10,29,41,42,43} This reflects a lack of trust in receiving facilities. Viewed through the lens of the Health Belief Model, such resistance occurs when perceived barriers outweigh perceived benefits.⁴⁴ Patient resistance will remain a major obstacle to effective down-referral unless trust is built by improving the system.⁴⁴

While less tangible, stigma emerged as a factor influencing patient behaviour. Participants observed that many MHCUs experience stigma from both PHC staff and community members, leading them to avoid follow-up care altogether. Stigma was primarily directed at MHCUs, with participants reporting that patients often felt unwelcome, misunderstood or even feared by PHC staff. In some cases, staff members were described as being afraid of psychiatric patients, particularly state patients, resulting in patients being reluctant to attend local clinics. Structural stigma refers to institutional practices, policies and norms that contribute to the marginalisation of vulnerable groups, including those with mental illness.^{10,11,22,29,45}

Participants emphasised the need for continuous psycho-education throughout the admission and follow-up process to ensure that patients are adequately informed about the purpose and benefits of down-referral, which in turn would reduce reluctance and reinforce acceptance by addressing underlying stigma. In this context, psycho-education can serve as a clinical tool and as a form of empowerment, helping patients to understand their condition, the rationale for down-referral and the resources available at the PHC level.^{22,45}

To address the various challenges, participants recommended strengthening PHC systems. These include increasing PHC staffing, rotating psychiatrically trained nurses and doctors to local clinics, improving medication supply and enhancing collaboration between tertiary and PHC providers via regular cluster meetings. These suggestions are in line with previous literature advocating for integrated mental healthcare models and greater community-based service provision.^{12,22,43,46}

Thus, the study's findings highlight that strengthening PHC systems must occur alongside addressing the relational and procedural barriers embedded in the down-referral process. The grounded theory analysis positions 'early planning and managing expectations' as the central process through which providers attempt to overcome a broader 'resistance block' arising from interconnected factors such as PHC constraints, stigma, inadequate intersector communication and patient or MHCU attitudes. By conceptualising these dynamics together, the study highlights that successful down-referral depends not only on patient readiness but also on coordinated system-level planning and proactive communication across the continuum of care. Addressing the resistance block through structured early engagement and cross-sector collaboration can strengthen trust, reduce stigma and ultimately enhance the continuity and quality of community-based mental health services.

Strengths and limitations

The study was conducted at a single tertiary institution, limiting the generalisability of the findings to broader contexts. As this was a qualitative study, the findings represent the views of the participants. We did not incorporate the perspectives of MHCUs or their families, which are essential for a comprehensive understanding of the down-referral process. The inclusion of these perspectives could have provided valuable insights into the experiences and challenges faced by MHCUs and their families. Future studies could include these perspectives to gain valuable insights into the experiences and challenges faced by MHCUs and their families. Reflexivity was carefully considered as the researcher conducted interviews, transcribed data and performed the analysis. Strategies such as reflective journaling and discussions with supervisors were used to manage potential bias and ensure interpretations remained grounded in participants' narratives. Despite these limitations, this qualitative research provides an in-depth insight into the lived experiences of mental healthcare workers involved in the down-referral process.

Conclusion

This study highlights structural and relational challenges in down-referral from tertiary to primary mental healthcare. Although essential for continuity and resource use, the process is weakened by poor planning, limited communication, stigma and under-resourced PHC services. Patients and families are often unprepared, partly because of the absence of standardised protocols. Consequently, improved discharge planning, stronger PHC capacity and better coordination are needed. Designating coordinators and fostering inter-facility collaboration may support smoother transitions. Future efforts should include MHCU and family perspectives to ensure responsive reforms in South Africa's mental health system.

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Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

CRedit authorship contribution

Nomthandazo S. Tjiana: Conceptualisation, Formal analysis, Funding acquisition, Investigation, Methodology, Writing – original draft. Maseqhala P. Nkondo-Ndaba: Supervision. Pierre Joubert: Supervision. All authors reviewed the article, contributed to the discussion of results, approved the final version for submission and publication and take responsibility for the integrity of its findings.

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Data availability

The interview transcripts and field notes generated during this study are securely archived at the Department of Psychiatry, Weskoppies Hospital. In accordance with institutional policies, the data will be retained for a period of 15 years from the date of publication. These data may be obtained from the corresponding author, Nomthandazo S. Tjiana, upon reasonable request.

Disclaimer

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