



What factors influence engagement with primary mental health care services? A qualitative study of service user perspectives in rural communities of Mexico

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ABSTRACT

Background: Low engagement with mental health treatment, including a lack of help-seeking and low subsequent attendance to treatment, are important challenges to the provision of mental healthcare. In settings with high levels of poverty, such as rural Mexican communities, low engagement may be aggravated by the limited availability of mental health services and existing barriers to access these services. This qualitative study was conducted to investigate factors that influenced engagement to a primary care mental health service programme in Chiapas, Mexico.

Methods: We conducted 30 semi-structured interviews with adult service users diagnosed with depression or anxiety who had received mental health services at 10 primary care clinics in rural communities in Mexico. Interviews were analysed through the framework analysis approach to understand service user perspectives on factors influencing: (a) help-seeking, and (b) subsequent treatment attendance.

Results: Lack of attribution of symptoms to a mental illness, the perception that symptoms could be managed without treatment, and stigma hindered help-seeking. Perceived need for care, prompted by strong feelings of desperation and severe somatic symptoms, along with advice from trusted sources about the availability of relevant services at the primary health care clinics, were key incentives for service users to make their first contact with the clinics. An ongoing desire for symptom alleviation and satisfaction with services (e.g. due to the positive impact of treatment) improved subsequent attendance, while feeling that treatment was no longer necessary and structural barriers led to non-attendance.

Conclusions: Strategies to enhance understandings between service users and health care providers are necessary to improve the extent to which the needs and preferences of service users are met by healthcare services. Further improvements in the mental health of communities are likely to require interventions outside the health setting that tackle social risk factors affecting mental health.

1. Background

Common mental disorders (CMDs) – a term encompassing both depressive and anxiety disorders – represent a critical public health concern on a global scale (Goldberg, 1994; World Health Organization, 2017). Many individuals in need of mental healthcare are neither seeking nor receiving treatment. Less than 50% of individuals with a mood or

anxiety disorder reported seeking help within the first year of onset (Christiana et al., 2000). This stark discrepancy between the high number of people needing mental healthcare and the low number of people receiving it comprises the so-called treatment gap (Kohn et al., 2004).

Evidence of the treatment gap has led to extensive calls within the field of global mental health for the scaling up and increasing of access to mental healthcare worldwide, particularly via actions such as training

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human resources, integrating mental health services into primary care, and advocating for mental health to be prioritized on a governmental level (Eaton et al., 2011; Organization, 2008, 2013; Patel et al., 2018; Patel and Thornicroft, 2009). Although these efforts are undeniably important, focusing on supply-side factors is insufficient for addressing the treatment gap. Even in high-income countries that have universal health coverage, a considerable proportion of individuals with CMDs do not contact healthcare services (Wang et al., 2007). It is therefore necessary to expand our understanding of why, when and how people engage with treatment, by investigating the demand-side factors – individual, household or community characteristics (Peters et al., 2008) – that influence this.

In Mexico, depressive and anxiety disorders have been reported to affect 4.2% and 3.6% of the population, respectively (World Health Organization, 2017). However, only 20% of those affected by a mental health condition ever seek treatment (Gorn et al., 2013). The median delay in seeking care for those experiencing an anxiety disorder has been recorded at 30 years; 13 years for those experiencing depression (Borges et al., 2007). Furthermore, research in Mexico has shown that mental health treatment dropout rates are often high (Torija and Muñoz, 2002; Velázquez et al., 2000). There is therefore a need to understand why people choose to seek help or not, and the factors that influence subsequent attendance to treatment, to improve mental health service delivery and engagement. It is important to account for both these steps, as only understanding whether people make initial contact with a service, explains little about whether people actually then go on to receive care (Kohn et al., 2004).

Both delays in help-seeking and low rates of subsequent attendance to mental health treatment can have detrimental consequences for service users. Delaying first contact with mental healthcare services can worsen the prognosis of the mental health condition, aggravate existing comorbidities, or lead to the development of new comorbid disorders (Altamura et al., 2008; Ambaw et al., 2018; Kessler and Price, 1993). Non-attendance may lower treatment effectiveness by altering the intended dose of an intervention or influencing adherence to pharmacological treatments, consequently worsening individuals' health outcomes (Killaspy et al., 2000; McQueenie et al., 2019; Mitchell and Selmes, 2007).

Globally, multiple factors have been identified as negative influences on help-seeking behaviour, e.g. stigma, low mental health literacy, or the idea that symptoms are temporary, not severe and can be managed without treatment (Roberts et al., 2018; Andrade et al., 2014; Berkman et al., 2011; Cabassa et al., 2006; Jorm et al., 2006). Even when individuals recognize their need for care and are willing to initiate treatment, certain structural barriers may also deter individuals from accessing services, such as geographical constraints, lack of available services, competing priorities or the cost of treatment (Andrade et al., 2014; Clement et al., 2015; Galván et al., 2017a; Schnyder et al., 2017). Indeed, studies that have investigated barriers to engagement with mental health services in low- and middle-income countries have identified that symptom severity (Adelufosi et al., 2013), distance to services (Adelufosi et al., 2013; Chatterjee et al., 2008; Jordans et al., 2016; Petersen et al., 2017; Shidhaye et al., 2015), long waiting times (Chatterjee et al., 2008), financial constraints (Adelufosi et al., 2013; Petersen et al., 2017; Shidhaye et al., 2015), transportation costs or loss of wages due to time required to access services (Chatterjee et al., 2008; Jordans et al., 2016; Petersen et al., 2017; Shidhaye et al., 2015), dissatisfaction with services (Adelufosi et al., 2013), medication side effects and the perception that treatment is no longer necessary or helpful, are related to low engagement (Chatterjee et al., 2008; Jordans et al., 2016; Jenkins et al., 2013). On the other hand, positive relationships with providers, the perception that treatment would be helpful, perceived positive impact of treatment, flexible appointments, receiving reminders, free treatment, family support, ease of transport and short waiting times have been identified as facilitating factors (Chatterjee et al., 2008).

1.1. In context: *Compañeros en Salud* in the Sierra Madre region of Chiapas, Mexico

Located in southern Mexico, Chiapas is the country's poorest state – almost 75% of its 5.2 million inhabitants live in poverty (Consejo Nacional de Evaluación de la Política de Desarrollo Social, 2012), with limited educational and career opportunities (Belló et al., 2005; Elliott et al., 2019). In the rural areas of the state, people with mental disorders face numerous barriers to accessing mental health services, e.g. the geographical barriers posed by the mountainous landscape of the region, poor communication infrastructure, high levels of poverty and a lack of trained healthcare workers (Lozano et al., 2013). In 2011, *Compañeros en Salud* (CES), a non-governmental organisation, partnered with the local Ministry of Health to increase access to quality care through 10 primary health care (PHC) clinics located in the a rural area of Chiapas. At these clinics, a mental health programme is delivered by medical doctors. Services within the programme include diagnosis, pharmacological treatment and talk-based interventions. Through a community health programme run by CES, community health workers (CHWs) also provide community-based *acompañamiento*, i.e. care delivered via home visits. This involves reminding service users to take their medication and attend clinic appointments, as well as providing psychoeducation, and psychosocial support (Newman et al., 2018). The majority of service users receive care for a common mental disorder (CMD), and about 5% for psychotic or alcohol use disorders (en Salud, 2017). The CES mental health programme is a unique example of mental health service integration in PHC services in Mexico and will therefore provide a case study for this work.

There is international consensus that integrating mental health services into community PHC systems has the potential to provide greater access to mental healthcare and reduce the treatment gap (Patel et al., 2018). Although efforts to take on this approach have been attempted for decades in Mexico (Xavier et al., 2008), the CES mental health programme is one of few examples of programmes that have been successfully implemented at the primary care level. In a previous evaluation, it was found that low attendance to follow-up consultations is a key issue for this programme (Miguel-Esponda et al., 2020). As such, qualitative research was conducted with the aim of investigating the factors related to engagement with the services delivered by CES, including help-seeking and subsequent attendance.

2. Methods

2.1. Setting

The current study was conducted in 10 rural *comunidades*, hereafter referred to as communities, in the mountainous Sierra Madre region of the state of Chiapas, Mexico. These remote communities can only be reached from the state capital by travelling for several hours along largely unpaved roads. Each community has at least one pre-school, one primary school, a small shop, two churches, and a PHC clinic which is supported by CES. There is no access to mobile networks, and telephone and internet connection is limited. Inhabitants of these communities must travel to the nearest town (2–4 hours away) to access banks, markets, and secondary health services. Tertiary health services, including for mental health, are located 6–8 hours away in the state capital. Each community has 1000 to 2000 inhabitants, none of whom belong to indigenous groups. Coffee farming is the main economic activity in the region. Most inhabitants in these communities live below the poverty line (Instituto Nacional de Estadística y Geografía, 2017).

2.2. Study design

This is a qualitative study of data collected from service users. Qualitative methods were deemed appropriate for this study as they

allow for the exploration of phenomena as experienced and interpreted by the population of interest (Ormston et al., 2014). Additionally, these methods are not overly prescriptive and; new concepts can arise during the research process (Spencer et al., 2003). Both features of the research were central to the aim of this work, which was intended to understand the subjective experiences of participants.

2.3. Sample and recruitment strategy

A purposive sample was used to include service users who (a) were 18 years of age or older, (b) had been diagnosed with a CMD, (c) had attended the clinic at least once between December 2016 and December 2017 to receive services for a mental health complaint, and (d) were available for an interview at the time of data collection. The exclusion criteria were service users who (a) were diagnosed with psychosis or had experienced psychotic symptoms, since their treatment needs are significantly different compared to those of service users with CMDs; (b) who were known to have experienced domestic or intimate partner violence, to protect the safety of both participants and interviewers; and (c) those who were not able to provide written consent due to a lack of understanding of the study purposes or emotional or physical impediments.

Service users were recruited during their visits to the clinics. After attending a mental health consultation, service users were invited to the study by medical doctors (MDs). MDs explained the purposes of the study and introduced service users to a member of the research team. MDs did not inform the research team about service users who were not interested in participating. Researchers explained the study in detail to interested service users and requested informed consent before conducting interviews. A total of 30 service users were included in the qualitative data collection.

2.4. Data collection

Qualitative data were collected between May 2017 and February 2018 through semi-structured interviews. The data collection and topic guide (Appendix 1) was developed based on the Consolidated Framework for Implementation Research (CFIR), which was created through an extensive review process through which the authors identified elements that conceptually or empirically had been found be associated with effective implementation of a programme (Damschroder et al., 2009). Effective implementation includes engagement, acceptability and appropriateness of a programme according to relevant stakeholders, such as service users (Proctor et al., 2011). Table 1 shows the subset of CFIR factors that are particularly relevant to our study, hence incorporated into the interviews. Topic guides were kept broad to enable any relevant

Table 1
Domains and factors used to inform the data collection (extracted from the CFIR).

Domain	Factor	Definition
Service user needs and resources	Service user needs and preferences	Extent to which service user needs and preferences are known; extent to which needs and preferences are prioritized or addressed through the programme or intervention; barriers and facilitators to meet those needs or preferences.
	Patient-centred approach to services	Extent to which (a) service users are provided with choices, (b) barriers to engagement with services are addressed, (c) complexity of service is minimized, (d) costs are minimized, (e) service users are satisfied with services and can provide feedback.
	Service user resources	Resources required to access services, including financial resources, time requirements, transportation, and others.

factors influencing help-seeking and engagement with services not considered in the selected framework were identified.

Before being interviewed, participants were reminded that participation was voluntary, that their decision whether to participate or not would have no impact on the services they received at the clinic, that participation could be stopped at any moment and that any information that they provided would remain confidential and would be fully anonymized for its analysis and dissemination. Interviewers were two Spanish-speaking, experienced qualitative researchers with post-graduate education and a middle-class background. They conducted all of the interviews, which took place in the clinics or residences of participants, according to their preference and depending on the availability of a private space. Interviews were audio recorded if participants consented. Fifteen participants did not consent to being recorded, potentially due to concern that the recordings would be shared with others – in these cases, detailed notes were taken instead. All audio-recordings were transcribed verbatim for analysis by bilingual researchers. GME checked the quality and accuracy of these transcriptions.

2.5. Data analysis

Framework analysis was utilised to analyse the qualitative data. This method follows a systematic approach that allows team discussions to ensure both context and individual interpretations are considered. The following steps were followed: (a) data familiarisation, (b) coding, (c) development of an analytical framework, (d) framework application and (e) interpretation (Gale et al., 2013). The resulting analytical framework contained two major codes (i.e. help-seeking and attendance), within which multiple-sub-codes were used to identify challenges and drivers. All interviews were independently double-coded by two researchers using this framework, who also engaged in discussions to identify emerging themes from each of the sub-codes. The analysis was conducted in Spanish. Two bilingual researchers translated the relevant quotations to English, and three researchers familiar with the sociocultural context of rural Chiapas assessed the accuracy of the translations.

2.6. Ethics

This study received ethical approval from the London School of Hygiene & Tropical Medicine (11955/11955-1) and the Chiapas State Ministry of Health (5033/1800).

3. Results

Twenty-eight of the 30 service users included in the qualitative study sample were female. This gender distribution is representative of people with CMDs who use services in this area. Participants were between 18 and 60 years old. All participants had received mental health services, for more than a year before the start of data collection, including at least one course of pharmacological treatment. Half of the participants were only receiving talk-based treatment at the time of the study.

A summary of all emerging themes can be found in Table 2. We present a narrative of important themes in each of the major analytical domains: help-seeking and subsequent attendance. These analytical domains are used to distinguish two different stages of engagement with services. First, the help-seeking stage includes the experiences that lead to seeking services for the first time at PHC clinics. Then, once a person has attended a consultation in which a diagnosis is allocated and treatment is prescribed, the subsequent attendance stage includes the experiences that affect attendance to follow-up consultations at the PHC clinics.

3.1. Help-seeking mental health services at PHC

3.1.1. Symptom experience and attribution

Participants described experiencing symptoms commonly associated with mental illness, e.g. sadness, irritability, low energy, physical pains,

Table 2
Summary factors delaying and promoting help-seeking and subsequent attendance at mental health primary care services.

	Factors delaying help-seeking and subsequent attendance to services	Factors promoting help-seeking and subsequent attendance to services
Help-seeking	<ul style="list-style-type: none"> • Lack of attribution of symptoms to a mental health condition requiring care • Non-biomedical understandings of mental health • Stigma towards mental illness, in particular from family members • Delays due to perception that symptoms could be self-managed or that symptoms would subside over time • Reliance on informal care, e.g. prayer • Cost of treatment 	<ul style="list-style-type: none"> • Trusted advice or information from family members or community members who had, in some cases, previously sought care at the clinics • Company of family members while seeking health services • Desire to recover for family members • Positive interactions with healthcare providers either inside or outside clinics • Urgent need for external help driven by feelings of desperation or presence of severe symptoms
Subsequent attendance	<ul style="list-style-type: none"> • Perception that treatment is no longer helpful or necessary given that symptoms have been alleviated • Poor communication skills from healthcare providers • Lack of trust in healthcare providers due to concerns about confidentiality • Need to constantly rebuild relationships with healthcare providers due to personnel turnover • Concerns regarding the usefulness and long-term use of pharmacological treatment • Long waiting times and costly journeys to clinics, often resulting in loss of productive time 	<ul style="list-style-type: none"> • Desire for symptom alleviation or relapse prevention • Perception that treatment is helpful or necessary • Positive interactions with healthcare providers

and sleeping difficulties. However, almost half of respondents suggested that their initial delay in seeking help was rooted in a lack of attribution of their symptoms to a mental health condition: “[...] my headaches started, neck pain, ear pain [...] sometimes you say, it's the heat, or it's just pain [...] one doesn't [consider] it's another illness.” (P25, female). Participants recalled being very aware of their symptoms but unable to pinpoint what it was they were experiencing: “I honestly didn't know. I didn't know [that it was depression]. I simply acted in the way that, about anything, I would get angry, I would start crying” (P31, female). Almost half of participants described symptoms of a somatic nature, including neck, heart, chest, body, ear, foot, or head pain. A participant described his high blood pressure as intrinsically linked to his depression: “it's just the depression of the heart, [it] is almost the same as the sadness thing” (P34, male). Indeed, high blood pressure and depression were spoken about almost interchangeably amongst multiple participants when discussing their early symptoms, possibly rooted in the similarity of the words in Spanish (*presión* and *depresión*) but also in that these conditions are often comorbid (Li et al., 2015).

Participants also referred to their depression with terminology unaligned with biomedical vocabulary, which may have made mental health consultations a less relevant option to them. For example, one participant reported being told by a doctor that she had the “*malaise of the dead*” (P6, female), referring to the fact that bereavement was the source of her distress. Various participants reported experiencing *nervios* (nerves); *nervios* has been described as a culture-bound syndrome in Latin America, characterized by episodes of severe anxiety or sadness, associated with a variety of somatic symptoms such as fatigue or insomnia

(Nogueira and JdJ Razzouk, 2015). Others referred to their condition as “the illness of sadness” (P21, female) and to their medicine as “sadness pills” (P31, female).

Symptoms were perceived as negative, given their significant impact on participants' relationships with family members and on their capacity to perform daily household activities like cleaning or childcare: “When I fell into depression [...] I felt really sad. Really lonely. My head hurt. I got frustrated, I used to get angry with my daughters for anything. There were moments where I did not feel like doing anything, no housework, nothing. [...] When someone came to visit me, I would not pay attention and just close the door.” (P31, female)

Despite the impact of symptoms on participants' lives, delays in contacting health services ranged from two months to over 20 years.

3.1.2. Perceiving that symptoms could be managed independently

Many participants reported that, rather than accessing formal healthcare, they tried to alleviate their distress alone: “I didn't even know what I had, [...] but I thought that I would be able to feel good by myself. Without the need for treatment, without the need for doctors, without the need for anything” (P8, female). One participant reported thinking that time would take away her sadness: “I didn't feel well. But I thought that it would pass, because it was a sadness I already had [referring to the death of her husband]. For a long time, I said, it will pass” (P25, female). Prayer was repeatedly reported as a mechanism of self-care, which may have contributed to alleviating participants' distress to a certain extent, but created delays in seeking healthcare: “I had been managing all these symptoms for years, I had insomnia for years, I had no interest in things, two times I had tried with pills, once with liquid [referring to suicide attempts]. I saw that I got a little better when I started going to church. [...] I asked a lot, a lot of God [...] I would cry, I would pray.” (P27, female)

3.1.3. The influence of the social environment

The main factor mentioned as facilitating participants' help-seeking were interactions with their social networks, including family members, healthcare providers or other community members.

Several participants reported that having a family member offer to take them to the clinic was instrumental in their decision to approach the clinics. Family members also acted as a source of information; relatives who had experience with services were able to inform participants about care options: “Because I felt like that, with a headache and all these things, I told my mother, and my mother told me it was depression. That she was also feeling like that. And she told me to come here [to the clinic] because she was also in treatment.” (P5, female). Additionally, participants' accounts hinted at a sense of commitment to becoming well for their family members, particularly in terms of parenting: “it was a lot of things. And mainly, my son, [...] I would say my son doesn't deserve this. My son doesn't deserve to have a mother like this.” (P15, female).

Sometimes, advice from other community members led to participants accessing healthcare services: “They [other community members] would say to me, “No. You get up. Bathe yourself. Get ready. [...] You can't stay like this. Show some interest in your kids.” And they told my husband, “Take her to the clinic.” And from then on, I started going. My husband took me to the clinic.” (P4, female)

Various participants spoke about informal encounters with CES healthcare providers, outside of the formal healthcare environment, as the event that had motivated their first visit to a CES clinic: “here, [the doctor] would come for lunch. And then she would say, “if you can come down [to the clinic], you'll see, we're going to have a small [psycho-education] workshop” (P31, female). Several other service users reported having known about CES clinics beforehand because of family members or friends or having attended the clinics in the past for other healthcare needs, “yes, I'd gone before when I was pregnant or when my children got sick” (P4, female). Information about the clinics from trusted sources or previous positive interactions with healthcare providers were instrumental in making people more likely to access CES clinics.

However, various participants referred to stigma amongst their social networks when describing what discouraged their help-seeking. Mostly, participants spoke of not having felt comfortable speaking to anyone about their mental health, in fear of being judged, laughed at, criticized or gossiped about: *"After you tell [people in the community] something [...] everybody finds out about what is going on with you. Actually, my family doesn't know what I have [referring to her depression]."* (P2, female). Family members were most commonly mentioned as the source of stigma: *"my husband would say: 'You're crazy.' Well, maybe. Maybe I am crazy, right?"* (P4, female). Participants recalled these instances with sadness: *"That's a little bit difficult, that the family doesn't understand. That's the hardest thing [...]."* (P6, female)

3.1.4. Perceiving a need for external help

Many participants expressed that it was the perception of a need for external help that eventually prompted them to seek treatment. Many verbalized this perception as being driven by a feeling of *desesperación* (desperation) – of no longer knowing how to or feeling able to, handle the situation: *"I would always feel a worry of, oh I don't know, desesperación. I don't know, I felt like crying, like screaming. And because of that, I started going [to the clinic] to see if they could help me"* (P23, female). This feeling was spoken about in relation to the severity of participants' symptoms, mainly somatic symptoms. When asked why she had decided to seek care, one participant said: *"The pain I had. Because I didn't feel well. [...] My body hurt. [...] Everything, everything. And I couldn't sleep"* (P18, female). For one participant, his *desesperación* stemmed from realizing the illness was preventing him from working: *"I started feeling symptoms of desesperación, [...] I felt like I could no longer work. I made every effort to get some money and go to the doctor"* (P34, male).

Suicidal thoughts were also mentioned in several instances as individuals' turning point in understanding that they needed to seek external help: *"I had lots of problems, and well there was then one situation that was, as they say, the last straw, right? And I felt, well, bad, sad, about to commit suicide"* (P2, female).

3.1.5. Cost of treatment

Several participants expressed struggling to find the financial means to access treatment: *"I made every effort to obtain money and go to the doctor"* (P34, female). Participants reported visiting four types of providers: CES clinics, GPs (outside of CES), mental health specialists (including psychologists, psychiatrists and neurologists), and alternative medicine providers (including naturopaths and traditional healers called *curanderos*). For those individuals who accessed private GPs, discontinuation of treatment often related to cost. These participants suggested they ended up choosing CES clinics because the diagnosis received was the same, but the CES clinics were free. One participant, when discussing how she would consider improving CES clinics, said: *"Honestly the clinic, I would like it to grow more, and that more of us would get better because here in the Sierra, one needs the medicine. There are no resources to go with the private doctors."* (P31, female)

3.2. Subsequent attendance at mental health follow-up consultations

3.2.1. A desire to alleviate symptoms

Half of participants reported that the primary motivator for attending mental health consultations, was the desire to alleviate symptoms that were debilitating and detrimentally affecting interpersonal relationships: *"If I had not wanted to get better, maybe I would have let some appointments pass. But no, I was very constant with my [attendance], and whatever date the doctor said, I would be there. Because I wanted to get out of there. It is not nice to be sad, or angry, or anxious, or scared."* (P6, female)

Similar to the way understandings of mental illness influenced help-seeking, expectations of services during treatment seemed to be closely shaped by service users' understanding of mental illnesses. Some participants expected treatments provided at the clinics would help with symptom control and others expected it would *cure* or *heal* them: *"[I*

would like] *to be healthy, [for the treatment to] take away all that I feel, to be good in one moment, be happy, be cheerful, be fine, and not thinking every day that I am sick, and wondering whether I will heal."* (P25, female) These differences in expectations seemed to be related to whether depression and anxiety were understood as chronic or acute conditions. A desire for a *cure* seemed to motivate attendance but when expectations were not met, participants seemed to grow less motivated and disillusioned, and ultimately they would abandon treatment.

Participants' perceived need to receive treatment or support continued to be a key factor in accessing care; service users seemed to adhere to pharmacological treatment and attend mental health consultations if they felt that they required them: *"[...] it is possible to come out of depression. Sometimes you cannot do it on your own. It needs medication and family support. [...] These past months I have not been to the clinic because I have felt calmer, and I haven't used more treatments."* (P6, female)

3.2.2. The role of service satisfaction

Positive and negative experiences with the services provided at the clinics, or by health care providers, influenced participants' decision whether to attend follow-up consultations.

Service users perceived positively that providers were good listeners, gave agreeable advice, demonstrated understanding and were empathetic. These characteristics contributed to service users' acceptability of the services offered at the clinics, in turn influencing attendance: *"It is normal that we go to talk to the doctor about what happens to us. It is like she says, 'that is what we are for, to care for you, to talk, to listen.' Thankfully, when I go to see the doctor to talk, she pays attention."* (P4, female)

However, about a quarter of participants reported negative experiences with service providers as reasons for not attending mental health consultations at the clinic. Negative experiences were mainly reported in relation to communication issues, including limited explanations about diagnosis and treatment: *"She gave me the same pills and I didn't get better and that's why I went to [urban area]. [...] She would never tell me what it was [referring to the depression]. I explained everything to her. But she didn't tell me."* (P10, female) Various participants mentioned not trusting that providers would maintain confidentiality: *"This doctor has not made me feel that trust. I have not talked to him. In comparison, the [previous] doctors tried to talk to me in the park, would remind me when I had not gone to my appointments, or motivated me. They made me feel that trust."* (P23, female)

A few participants were doubtful of the usefulness of pharmacological treatment or expressed concerns about side effects or its long-term use. Perceptions such as pills making people feel *"very hot"* (P19, female), causing insomnia, or damaging other organs such as the stomach or the liver were common. These perceptions hindered the acceptability of treatment and also engagement with services: *"When the doctor told me to come, I said I was not going to because I was not going to take treatment for a year. My husband tells me off, and people tell me that it is bad, that it damages the liver."* (P7, female)

3.2.3. Long waiting times and potential loss of income

All participants reported having to wait for their consultations, even when they came to their appointments on time. Although waiting times varied, waiting for several hours was not uncommon, as the clinics were often overburdened. Service users reported feeling impatient and frustrated as a result of this: *"Sometimes I come on the date of my consultation and see that there are a lot of people, and I feel very exasperated."* (P5, female) For participants who reported having to travel long distances to attend the clinics, long waiting times were an added obstacle that led to frustration: *"[I would like to change] that we have to wait. [...] And it is worse when you come from far away."* (P29, female)

Long travelling and waiting times resulted in loss of productive time. Participants reported not being able to attend consultations due to other commitments or responsibilities. These included school meetings and cash transfer programme meetings, absences which could result in financial penalties. Women also missed appointments due to housework

and caregiving duties (e.g. taking care of children or ill family members), of which they are primarily responsible in these communities.

Finally, a few participants also reported that they travel often, either to the bigger towns to see family, for business, to collect payments from a government the cash transfer programme, or to the plantations during the harvesting season. These sources of income were prioritized over attendance to healthcare services.

4. Discussion

The current study explored factors associated with help-seeking and subsequent attendance to mental health services delivered in primary care clinics in rural Mexico. Perceived need for care, prompted by strong feelings of desperation and severe somatic symptoms, emerged as key drivers of help-seeking and subsequent attendance. Notably, when participants did not understand their experiences as symptoms of a mental illness requiring care or did not feel treatment from the PHC clinic would help them, they did not engage with services. Endorsement by family and community members enabled help-seeking at the PHC clinics. However, loss of income due to time spent travelling to the clinic or long waiting times were important barriers for engagement. The availability of free treatment at PHC clinics facilitated subsequent attendance alongside satisfaction with providers and services. In turn, dissatisfaction with services due to unmet expectations of treatment hindered attendance.

Lack of attribution of symptoms to a mental illness requiring biomedical treatment emerged as a prominent barrier to help-seeking. Importantly, participants frequently described their depression with terms differing from traditional biomedical vocabulary or rationalized physical ailments such as hypertension as intrinsically linked to their psychological distress. This finding points towards a mismatch between understandings of psychological suffering used by the local community, such as *'nervios'* or *'malaise of the dead,'* and those used by medical providers, whose understandings and language related to mental distress is largely determined by the medical training they have received in institutions located in urban settings using manuals and diagnostic criteria developed in the Global North. Understanding the idioms of distress used within a context – defined as alternative modes of expressing distress that reflect personal experiences rooted in a particular culture and social environment (Desai and Chaturvedi, 2017) –, and thus defying the universalism of biomedical vocabulary, is increasingly recognised as central to being able to improve and/or develop treatments and interventions that can mitigate communities' distress (Cassaniti, 2019; Mendenhall et al., 2019). Idioms of distress are often embodiments of political, social, and somatic experiences which may require more nuanced, or alternative, forms of mental healthcare than those offered by common medical services (Mendenhall et al., 2019). We call for a further analysis of the narratives of mental health used within the communities of Chiapas, and the complex meanings embedded within these terms.

The current study also found that service users' engagement with mental health services was associated with the extent to which they perceived they were having experiences for which they required medical treatment, or that they could not manage symptoms alone. The association between perceived need for care and help-seeking and attendance has been widely documented (George and Rubin, 2003; Issakidis and Andrews, 2004). According to findings from the World Mental Health survey, about 60% of participants diagnosed with a disorder in the previous 12 months reported low perceived need for professional treatment, which prevented them from seeking services and also contributed to dropping out of services (Andrade et al., 2014). The participants of the current study also reported doubting the benefits of medical treatment, which may be partly due to the fact that often symptoms were not labelled by participants as a mental health condition requiring medical support. However, in a region where poverty, violence and other forms of trauma are highly prevalent (Aguerebere Gomez Urquiza, 2018), this may point to the importance of considering the social determinants of

health when designing interventions. It is increasingly recognised that people living with CMD who face socioeconomic adversity doubt the impact that intervention will have on their lives, if said intervention does not lead to a change in their social or economic circumstance (Roberts et al., 2022). Ultimately, these themes support current movements to shift the focus of mental health treatment from one which is purely medical to one based on the social context of affected individuals, their understanding of their illness and preferences for treatment (Patel et al., 2018). They hint at the potential of working towards a recovery-based approach to care in Mexico, where centrality is given to the individuals' definition of their distress and their desired approach to treatment (Patel et al., 2018; Leamy et al., 2011), and to address the social realities that may be driving the psychological distress of individuals. To address these social realities, social interventions linked to the health sector, as part of a comprehensive and integrated system of care, are likely needed to improve outcomes of people with mental disorders (Burgess et al., 2020). Integrated systems of care, implemented across various relevant platforms (e.g. health clinics, schools, community centres, social services) have the potential to facilitate help-seeking and improve engagement with services by ensuring people with mental disorders can access the support they need (Patel et al., 2013).

Stigma was reported to hinder help-seeking, in accordance with previous literature across contexts (Clement et al., 2015; Martinez et al., 2016). Family members were the primary source of stigma, highlighting the mixed blessing of families for individuals with mental health conditions in Mexico (Mora-Ríos and Bautista, 2014). Although family involvement in treatment has received little attention from Global Mental Health researchers (Hinton et al., 2019), it is important that this is not overlooked. The delivery of psychoeducation through family workshops or the participation of family members in home visits and initial consultations may be key not only in reducing stigma and facilitating access to health services, but in maximizing the role of family members in providing practical and emotional support to individuals during the wider recovery process (Hinton et al., 2019).

Finding treatment helpful or not has an important role in facilitating or hindering use of services (Chatterjee et al., 2008; Jenkins et al., 2013; Dilgul et al., 2018). The expectations that service users have of treatment might affect the extent to which this is found to be useful, and therefore their attendance to services. Previous research related to mental health and other chronic conditions has noted that people who experience such conditions seek a cure or permanent alleviation of their symptoms (Read, 2012; Aikins, 2005; Polak, 2017). Service users' acceptability of long-term treatment for chronic conditions is an ongoing challenge for the delivery of health services. The stigma associated with long-term reliance on pharmacological treatments (Polak, 2017), and other issues, such as side effects, need to be acknowledged and considered in the delivery of mental health services (Read, 2012). To improve communication, understanding and trust between service users and providers, approaches and practices like patient-centred care and shared decision-making, where the service users are actively involved with the health providers in defining their recovery and jointly selecting a treatment plan, could be adopted (Shay and Lafata, 2015; Barry and Edgman-Levitan, 2012). Beyond improving relationships between providers and users, these approaches and practices have shown to improve satisfaction with services, promote service user autonomy, understanding of service user needs and the extent to which healthcare meets those needs (Barry and Edgman-Levitan, 2012). Such approaches can also result in improved clinical outcomes and efficient use of resources (Anderson, 2002; Little et al., 2001). Primary care service users, especially those with low-income and increased symptom severity, have expressed preference for the mode of communication, partnership and health promotion engendered by this model (Anderson, 2002; Little et al., 2001).

Service users often reported experiencing more than one practical challenge in accessing services, suggesting individuals requiring care may not access and engage with clinics unless their perceived need for

care overrides the practical challenges in accessing services. This may be of particular importance in poor and rural settings where health service infrastructure is scarce, and challenges to accessing them are greater which contributes to inequity in healthcare access and outcomes (Baraza-Lloréns et al., 2002). Service users had difficulty accessing the clinic for the first time if they lived far away and could not afford transportation. Once engaged in services, many participants stopped attending because they had other commitments that their livelihood depended upon, such as travelling to tend to the coffee crop, attending school meetings (which they must pay a fee for if they are absent), or taking care of their families. Health systems strengthening is essential to improve access to care and health equity, particularly in low resource, rural and remote contexts (Semrau et al., 2015). To this end, strategies to improve leadership, governance, financing, availability of human resources and quality of services need to be urgently implemented (Semrau et al., 2019).

4.1. Strengths and limitations

The researchers conducting qualitative interviews were either native of Mexico or had lived in the participants' communities for an extended period, which is an important strength of the current study. This will have contributed to reducing perceived researcher-participant power imbalances and increasing trust (Råheim et al., 2016), facilitating participant disclosure and helping achieve a comprehensive account of experiences. However, important power imbalances between researchers and participants from these rural communities largely affected by poverty need to be acknowledged. Firstly, researchers were highly educated individuals with a middle-class socioeconomic background, who were born and raised in urban settings. More significantly, researchers were linked to the organisation that had enabled access to free healthcare in these communities. Despite assurances for confidentiality, it is possible that participants might have felt an obligation to take part in this research project or speak somewhat positively about the service provided. Nevertheless, the qualitative design of this study is an important strength of this study that enabled us to gain insight into the attitudinal factors influencing participants' experiences of the healthcare, within a field in which structural barriers have been more widely focused on using quantitative methods (Roberts et al., 2018).

There are limitations to the generalizability of the current findings. All but two included participants were female. This has been a reported limitation of research conducted in Mexico (Mora-Ríos and Ito-Sugiyama, 2005), reflecting that women are more frequent users of healthcare (Galván et al., 2017b) and more likely to be diagnosed with CMDs (World Health Organization, 2017). Research to understand the mental health needs and experiences of other underserved population groups, such as men, is also necessary to improve services. Additionally, this study used a clinic-based sample. Therefore, this study's findings elucidate only one part of a complex story. Findings overemphasize the idea that individuals eventually reach formal healthcare services; it gives no account of individuals who never reach services, or of those that discontinued their treatment before reaching included clinics or chose to receive treatment from other providers. It also magnifies the importance given to formal care in these communities. Particularly in rural communities where access to formal care may be geographically and financially beyond reach (Salgado-de Snyder et al., 2003), it is important to thoroughly understand informal sources of care used by individuals, to ensure that informal carers are included and supported. Future research should consider using a community-based sample and exploring the use of informal care to provide a more comprehensive understanding of phenomena. Finally, we excluded women who experienced Intimate Partner Violence (IPV). A recent study in one of the communities where we conducted this study found 66.4% of women had experienced IPV, and of these 16% presented significant symptoms of depression (Aguerebere et al., 2021). Future studies should also include women affected by IPV.

5. Conclusions

The current study investigated service users' perspectives of factors influencing engagement with mental health services delivered at primary care clinics in rural Mexico, both in terms of initial help-seeking and subsequent attendance. Our findings indicate that perceived need for care, influenced by a variety of factors, was instrumental to engagement with services. The social environment, with different roles played by family members, the wider community and clinicians, and the extent to which users were satisfied with services also influenced engagement. Practical challenges relating to treatment cost, waiting times and physical access emerged as important barriers to service use. These findings hold several implications, including the need to work towards an increased alignment between the community's understanding of mental health and that held by service providers, to increase collaboration with informal sources of care and to capitalize on the social interconnectedness of individuals in these communities. Given the reported practical difficulties accessing care this study highlights the important role that providing mental healthcare at the community level has in rural Mexico and the need to search for forms of mental health care that account for the social realities of the community at hand. This work provides a valuable contribution towards understanding why and how individuals in rural Mexico engage with mental healthcare, from a service user perspective.

Quality mental health services are necessary to meet the health needs of people with depression and anxiety in these communities. However, it is unlikely that better health services will, on their own, lead to significant improvements in the mental health of populations. Increasingly, evidence supports the need to address the social risk factors that lead to poor mental health outcomes (Patel et al., 2018; Burgess et al., 2020). In contexts with extremely high levels of poverty, economic insecurity, IPV and limited access to education, social policies and interventions to tackle these issues are essential. Addressing social risk factors by developing comprehensive systems of care across multiple relevant platforms (e.g. health clinics, schools, community centres, social services) is necessary to improve the health and mental health of people whose distress is rooted in social rather than health factors.

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Credit author statement

Georgina Miguel Esponda conceptualised the research study, designed the methodology, conducted most of the data collection, led the analysis of data, and prepared the manuscript for publication. June Pastor made significant contributions to the data analysis and preparation of the manuscript. Sara Hartman contributed to the data collection, analysis and reviewed multiple drafts of the manuscript. Fatima Rodriguez Cuevas contributed to the conceptualisation of the study, provided advice during the data collection stage and reviewed multiple drafts of the manuscript. Alex Cohen and Ritsuko Kakama made significant contributions to the conceptualisation of the study, provided extensive advice during the collection and analysis of data, and reviewed multiple drafts of the manuscript. All authors reviewed a final version of the manuscript before submission.

Declaration of competing interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: Fatima Rodriguez Cuevas reports a relationship with *Compañeros En Salud* that includes: employment.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ssmmh.2022.100125>.

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