

Participation of psychiatric nurses in public and private mental healthcare in Kenya

Victoria Pattison de Menil¹ and Martin Knapp²

¹PhD student, London School of Economics and Political Science, London, UK, email v.p.de-menil@lse.ac.uk

²Director, Personal Social Services Research Unit, London School of Economics and Political Science, London, UK, email m.knapp@lse.ac.uk

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We studied the rate of participation of psychiatric nurses in mental healthcare in Kenya. A simple questionnaire was delivered to 50 nurses attending a mental health meeting of the National Nursing Alliance of Kenya in April 2012. Of the 40 nurses with psychiatric nursing qualifications, 19 worked specifically as psychiatric nurses; among those employed as general nurses, half their case-loads were mental health patients. Ten per cent of psychiatric nurses had run a private clinic (75% of them general clinics) and 15% were doing private locum work alongside salaried employment. Kenya would need to increase the number of psychiatric nurses 20-fold in order to achieve an internationally recommended ratio (for low-income countries) of 12 psychiatric nurses per 100 000. It appears psychiatric nurses are migrating internally to nursing positions in other areas of healthcare, aggravating the 'brain drain' in mental health.

A loss of psychiatric specialists in Africa is frequently attributed to outward migration to wealthier countries (Jenkins *et al*, 2010a; Padmanathan & Newell, 2012) and less attention is turned to migration internally, to other fields of health. Kenya's Ministry of Health estimates there are 500 practising psychiatric nurses nationally (Kiima & Jenkins, 2010); however, because of the shortfall of general nurses – estimated at 66 782 (Rakuom, 2010) – not all psychiatric nurses work in mental health. Psychiatric nurses in Kenya have prescribing rights and therefore can, and do, perform the functions of a psychiatrist and of a general doctor – as they do elsewhere in Africa (Chetty & Hoque, 2013).

Mental healthcare is designed to be delivered through trained primary care providers in outpatient settings in Kenya, as in higher-income countries. Reliance on psychiatric nurses to deliver specialist mental healthcare is greatest in rural provinces, where there averages one psychiatrist per 3–5 million (Kiima & Jenkins, 2010).

From a health systems perspective, it is essential to know the rate of participation of psychiatric nurses in mental healthcare, not only in public health services but also in private practice, since two-thirds (63%) of enrolled nurses are estimated to work in the private sector (Barnes *et al*, 2010). We therefore set out to establish the participation of psychiatric nurses in mental healthcare in Kenya (Kohn *et al*, 2004).

Method

A simple tool was designed and piloted for the study. The Mental Health Nursing Questionnaire, a 25-item multiple-choice numerical answer survey developed by the first author (available on request), was delivered to all psychiatric nurses attending the annual meeting of the mental health chapter of the National Nursing Alliance of Kenya (NNAK) in April 2012. The purpose of the tool was to determine the proportion of psychiatric nurses working in mental health and the rate of participation of psychiatric nurses in the private sector.

Membership of the NNAK mental health nursing chapter stood at approximately 80 nurses, 50 of whom attended the annual general meeting. The response rate was 100% (all 50 attendees). Ethical approval was given by Kenyatta National Hospital's Ethics and Research Committee (P450/10/2011).

Results

The mean age of the sample was 46 years (s.d. 6.5); 54% were female and 40% worked in Nairobi. Forty nurses had a psychiatric nursing qualification (33 a diploma and 7 a certificate), eight had none (two of whom did have a general nursing qualification and another two a midwifery qualification) and two did not respond (Fig. 1). A quarter of those with a psychiatric nursing qualification ($n = 10$) had at least one other nursing qualification: 12.5% ($n = 5$) in community health, 7.5% ($n = 3$) in midwifery and 5.0% ($n = 2$) in two or more specialties.

Half of those with psychiatric nursing qualifications ($n = 19$) worked specifically as mental health nurses, while the remainder of the sample were employed as general nurses ($n = 8$), as other specialist nurses ($n = 6$), in administration ($n = 5$) or as nursing teachers ($n = 2$) (Fig. 2). Among those employed as non-psychiatric clinical nurses, half (46%) their case-loads were mental health patients. The eight nurses without a psychiatric nursing qualification worked mostly as general nurses ($n = 5$), but also as administrators ($n = 2$) or teachers ($n = 1$).

Among the 47 psychiatric nurses in clinical practice, all but one held a public sector job (Table 1). Over two-thirds ($n = 27$) worked exclusively in the public sector, while over a quarter ($n = 11$) worked partly in the non-state sector. Those in non-state care worked for not-for-profit hospitals, for-profit facilities or a combination of providers.

Five nurses, including four with psychiatric nursing qualifications, reported ever having managed a private clinic and three currently did so. All private practice nurses also worked in the public sector.

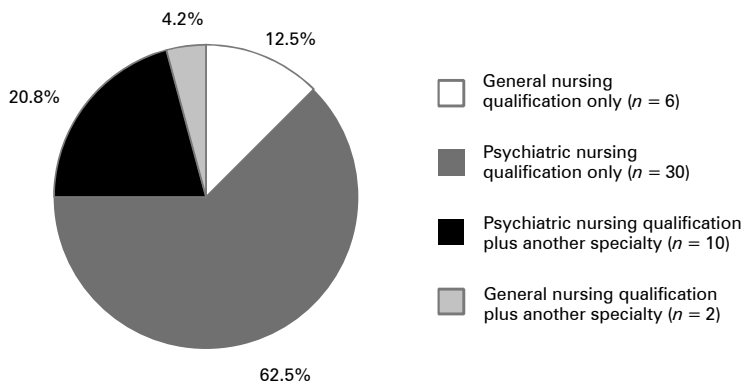


Fig. 1
Nursing qualifications held by the sample

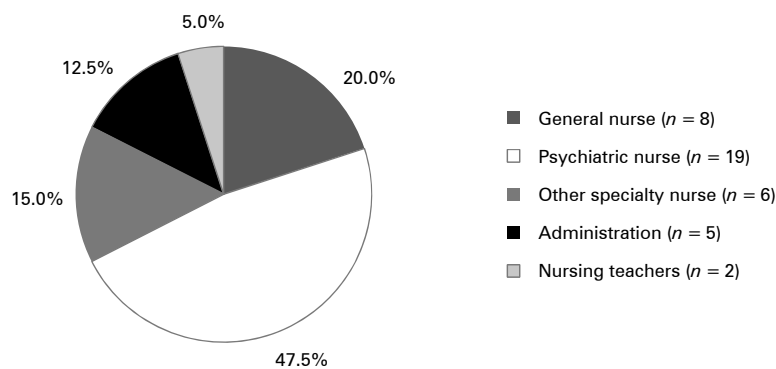


Fig. 2
Employment positions of those with psychiatric nursing qualifications

Private clinics operated on average 2 days (14 hours) per week. The majority ($n = 4$) operated general health clinics rather than mental health clinics. On average, five mental health patients were seen each week (range 3–10), representing a quarter of the patient case-load.

Outside of private clinics, psychiatric nurses also participated in private practice, doing locum work at for-profit hospitals or non-governmental organisations (NGOs). Seven reported doing private locum work in the previous month, largely ($n = 5$) in for-profit hospitals. Only one locum was employed for mental health services. The amount of time spent in locum work differed widely across respondents, from a minimum of a 0.5 day to a maximum of 9.5 days in the previous month.

Table 1
Employment of those with psychiatric nursing qualifications

	Psychiatric nurse		Non-psychiatric, clinical		Non-clinical		Total	
	%	n	%	n	%	n	%	n
Sampled	100	19	100	14	100	7	100	40
Employed by the public sector	40	13	33	12	17	5	75	30
Employed by the public sector only	44	12	37	10	19	5	68	27
Participating in the non-state sector	64	7	36	4	0	0	28	11
Doing additional locum work	0	0	100	6	0	0	15	6
Private practice, ever	50	2	25	1	25	1	10	4

Discussion

The study demonstrates one way in which the mental health treatment gap in Kenya is adversely affected by the overall health treatment gap, as rare skilled labour is being drawn away from the practice of psychiatry to other areas of health. We found that half of those with psychiatric nursing qualifications in Kenya are employed for functions other than delivery of mental healthcare – a finding consistent with previous estimates (Kiima & Jenkins, 2010). A contributing factor is that a quarter of those with psychiatric nursing qualifications also hold other specialty nursing qualifications, especially in community health and midwifery. It should also be noted that not all nurses who have worked in a mental health setting have psychiatric nursing qualifications, as was the case of 17% of our sample.

If the sample of nurses participating in this modest survey is representative, the results would imply that only 238 of the estimated 500 practising psychiatric nurses in Kenya work specifically with mental health patients, which amounts to a ratio of 0.62 psychiatric nurses per 100 000. Though low, this nonetheless amounts to higher than the average for low-income countries, which are estimated to have an overall mean of 0.42 (World Health Organization, 2011). Moreover, in response to the demand for mental health services, roughly half of the people on the case-loads of psychiatric nurses in general practice are patients with mental health needs. The training of a nurse is often known by colleagues, as a result of which a psychiatric nurse will commonly be referred psychiatric cases, even when employed for other functions.

Kakuma *et al* (2011) argue in *The Lancet* that the necessary ratio of specialist human resources to achieve desirable coverage for mental disorders in low-income countries is 22.3 health workers per 100 000 population: 6% psychiatrists, 54% nurses in mental health settings and 41% psychosocial care providers. This works out to a ratio of 12 mental health nurses per 100 000. To achieve that ratio, Kenya would need 4650 nurses working in mental health settings – 20 times the estimated number of psychiatric nurses practising full-time mental healthcare. Policy efforts to address this wide gap in human resources focus on two strategies: task-shifting counselling to lay health workers (Kakuma *et al*, 2011); and integrating mental health into

primary care by training clinical officers (Jenkins *et al.*, 2010b, 2013). A stepped-care strategy also applied in settings with higher densities of specialised providers.

The findings from our survey point to a significant role played by psychiatric nurses in the private sector – through private out-patient practice, in-patient locum work and with NGOs. One nurse noted that the Ministry of Health has a policy prohibiting simultaneous work in public and private facilities, out of concern that private work compromises public work: 'If people work two jobs, they do it quietly.' Nonetheless, 14% of nurses reported doing locum work. A further 10% had managed a private practice and a quarter of their patients came seeking mental health services. Clinics run by psychiatric nurses tend to operate outside Nairobi, as the competition from private psychiatrists is high in the capital. The participation rate of psychiatric nurses in private practice was found to be lower than in other types of nursing (Barnes *et al.*, 2010), though still significant.

A limitation of this study is the potential for sampling bias, as the sample represents only those attending the annual general conference on mental health. Those with psychiatric nursing qualifications who are no longer practising mental health would be less inclined to attend a mental health meeting. It is also possible that those in private practice would be less likely to attend the meeting, since there is a separate chapter of the NNAK for nurses in private practice. If this is the case, then our estimate of the shortfall of psychiatric nurses is conservative, as is our estimate of their participation in private practice. In addition,

the questionnaire did not address wider inter-sectoral roles held by psychiatric nurses, including supervising primary care.

In conclusion, it appears that psychiatric nurses are migrating internally to nursing positions in other areas of healthcare, aggravating the existing 'brain drain' for mental health.

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SPECIAL
PAPER

SUNDAR: mental health for all by all

Vikram Patel

Professor of International Mental Health and Wellcome Trust Senior Research Fellow in Clinical Science; The Centre for Global Mental Health, London School of Hygiene and Tropical Medicine; Sangath; and Centre for Chronic Conditions and Injuries, Public Health Foundation of India

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This article describes the rationale and principles for the SUNDAR approach adopted by Sangath, an Indian non-governmental organisation: to use lay people, with appropriate training and supervision, to deliver psychosocial interventions for a range of mental health conditions. This approach has been evaluated in a number of randomised controlled trials and is now being scaled up. At the core of this innovation is revisiting the questions of what constitutes mental healthcare, who provides mental healthcare and where mental healthcare is provided. In doing so, SUNDAR offers a vision for a mental healthcare system which is empowering, inclusive, equitable and effective.

The rationale

Even by the most conservative prevalence estimates, about 50 million people are affected by mental health problems in India. In contrast to this high burden, the country has only approximately 5000 mental health professionals. It is obvious then that the strategies to address mental healthcare need to rely on alternative human resources if the country is to meet more than a tiny fraction of the needs of people affected by mental health problems. It is in this context that Sangath (<http://www.sangath.com>), an Indian non-governmental organisation (NGO) headquartered in the state of Goa and now working in several states around the country, began shaping its approach to using lay people to