Abstract

In their systematic review of community mental health care in Africa, published in *World Psychiatry,* Hanlon et al [1] point out that ñin the low-income countries of the Africa region, community mental health care is largely restricted to mental health care delivered by primary care workers, with specialist mental health workers (usually psychiatrists and psychiatric nurses) tending to provide care through hospital-based outpatient clinicsò. An article by McDaid et al [2], also published in the journal, notices that non-governmental organizations can support primary care by ñbuilding on social capital in communitiesò. A hidden face of community mental health care in Africa, however, is specialist care from private providers, especially psychiatrists and psychiatric nurses. A good example is Kenya, where three quarters of doctors and two thirds of nurses work in the private sector [3].

We administered a structured interview, between July and September 2012, to 11 private mental health specialists (8 psychiatrists, 3 psychiatric nurses), sampled using snow-balling. Five of them were from Nairobi and six ï including all nurses ï from central province. Three of them were women. Their average age was 46 years, and time in private sector 9.2 years. Respondents had a mean active case load of 128 mental health patients, and the mean number of mental health patients seen per clinic day was 5.

The leading diagnosis for which 55% of people attended private clinics was common mental disorders, while 25% had severe mental disorders, 15% substance use disorders, and 5% epilepsy, child mental disorders or mental retardation. Slightly over half (56%) were women, representing a departure from psychiatric hospitals, where the majority are men affected by psychosis [4]. In a context where the term ñmentalò is associated with psychotic behaviour, a private clinic in the community may offer a less stigmatizing option of care. Privately owned clinics are also more ñprivateò to clients in that care can be sought with greater confidentiality.

Private clinics operated on average 24 hours per week (range 12-40), and specialists saw their patients for an average of one hour on the first visit (range 50-90 minutes) and half an hour at follow-up (range 15-45 minutes). Typical wait time was 20 minutes (range 3-60 minutes). Patients were followed up on average monthly (maximum every 8 weeks). In the previous month, respondents referred a mean of 13% of clients for hospitalization. Two out of the three psychiatric nurses ran general health clinics, with only 5% of patients seen for mental health reasons. The third ran an exclusively mental health clinic.

The mean fee of Int$ 13.0 (Ksh 500) charged by psychiatric nurses represents approximately 2.5 days work by an unskilled agricultural labourer [5] ï a significant, but not unattainable sum. The average psychiatrist fee of Int$ 55.3 (Ksh 2,100) (higher in Nairobi than the province) represents one month's salary for the same agricultural worker, making it inaccessible to most. Nearly two thirds of respondents modulated fees, based on session length and ability to pay, judged in part by patient occupation.

We found a large cross-over between private and public sectors: eight out of the eleven private specialists split their time with the public sector. Six of them said the care they offered in private practice was different ï mainly with a greater choice of drugs, especially atypical antipsychotics.

One respondent noted: ñAt government clinics, prescriptions are dictated by the available medicationsò. Continuity of care was also highlighted: ñI am able to constantly follow the clientò. In a context of under-paying public health providers, private employment may be seen as cross-subsidizing public health care.