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Original Research Article

Barriers to mental health services utilization among outpatient clinic attendees at Mathari National teaching and referral hospital, Nairobi City, Kenya

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ABSTRACT

Background: World health organization defines mental health as a state where people realize and recognize their capacities, cope with life stressors, and contribute positively to the society. A gap exists between the need or demand for mental health services and their utilization due to a set of barriers that limit access. The prevalence of mental illnesses is approximately 10%. The study sought to investigate barriers to utilization of mental health services.
Methods: The study used mixed-method research approach that is cross-sectional descriptive and qualitative study design. The study was conducted at Mathari national teaching and referral hospital outpatient clinic. Structured questionnaires and key informant interviews were used to collect data. Study participants comprised 216 caregivers of mentally ill patients and 6 key informants.
Results: Costs of seeking mental health services is a barrier to accessing these services at the MNTRH outpatient clinic. More than half of the participants missed their clinics due to cost of medication, 56% (n=120), consultation costs 55% (n=118), and transport=54% (n=116). Caregivers sought other types of mental health services such as spiritual healing before taking their mentally ill relative for formal care. People with mental illness experienced social stigma 59.3% (n=128).
Conclusions: The cost of mental health service access and stigma are the outstanding barriers to access and utilization of mental health services.

Keywords: Barriers, Mental health, Utilization, Outpatient clinic, Kenya

INTRODUCTION

World health organization (WHO) defines mental health as a state where people realize and recognize their capacities, cope with life stressors and contribute positively to the society.[1] A gap exists between estimated need or demand for mental health services and their utilization due to a set of barriers that limit access.[2] Attitudinal barriers have also emerged as an hindrance to access of mental healthcare and predictor of treatment non-compliance in developed and developing countries.[3] Globally, nearly a billion people experience some form of mental illness. Globally, the prevalence of mental illness is approximately 10.7%.[4] One in every four persons has a mental illness. The problem arises when mental illness affects an individual because most families are not prepared to deal with the realization that their loved one has a mental disorder.[5] In Sierra Leone, for example, the treatment gap for formal mental health services has been estimated at 98.8%.[6] Long waiting time, centralization of

mental care services, and stigma towards the affected individuals and families have been cited as critical barriers.[7] In South Africa attitudinal and structural barriers were preliminary to slow treatment of mental illness cases.[8]

In Kenya, mental disorders account for 5.9% of the country's disease burden.[9] The prevalence of mental disorders in Kenya is approximately 10%.[10] The high index of mental disorders is ascribed to various factors including inadequate mental health professionals, high cost of care and poor facilities. In rural Kenya the ratio of psychiatrists to citizen is approximately 1 per 5,000,000 people compared to globally accepted ratio of 1 psychiatrist serving 10,000 people.[11] Added to this inadequate number of psychiatrists, the mental health burden continues to negatively affect the country.[12] Mathari national teaching and referral hospital (MNTRH) is the largest psychiatric hospital in Kenya that offers in and out-patient mental services. The annual rate of visit to mental health outpatient clinic in Kenya is 14 per 100,000 population compared to the global rate of 1051 per 100,000.[13] MNTRH receives approximately 100 patients seeking outpatient services.[14] This may pose constraints on mental healthcare delivery when correlating the number of psychiatrists with mentally ill patients that MNTRH admits annually. The study sought to establish the multi-factors that Kenyans encounter in search of mental health care services.[15] This, therefore, makes the study very important because it will raise awareness on the key challenges that derail access to available mental health services helping to understand why people do not utilize such services even where they are available.[16,17] The study is necessary because it also seeks to identify barriers that limit mental health services utilization in the facility and recommends ways of addressing them.

Aim and objectives

The study's general objective was to investigate barriers to mental health services utilization among outpatient clinic attendees at Mathari National Teaching and Referral Hospital. The specific objectives; to investigate the association between cost and utilization of mental health services and to examine the association between stigma and utilization of mental health services.

METHODS

Study design

This was a cross-sectional descriptive study, that employed mixed (qualitative and quantitative) methods. Study respondents included both the caregivers of mentally ill patients as well as healthcare providers (clinical officers, nurses, psychiatrists and administrators). Cross-sectional study approach was ideal for this study due to its ability to real-time from the respondents.[18]

Study variables

The independent variables were barriers to mental health services utilization. The dependent variable was the utilization of mental health services.

Study setting

The study was conducted at Mathari national teaching and referral hospital (MNTRH) outpatient clinic. MNTRH was purposely selected for the study due to its ability to deal with all types of mental disorders and access to patients across the country since it is a national referral facility.[19]

Study period

Current study was carried out from 20 March 2021 to 23 June 2021.

Study participants

The study population included caregivers of the patients attending the MNTRH outpatient clinic and healthcare providers serving the patients in the hospital; psychiatrists, doctors, nurses, clinical officers and administrators. The caregivers were the individuals who take care of the mentally ill patients on daily basis.[20]

Sample size determination

Fischer et al 1998 Formula was used for sample size calculation:

$$n = Z2pq/d2$$

Where Z=standard normal deviate, 1.96, p=Population proportion with desired characteristics. q=1–p, d=margin of error 5%. Chow et al. argues that Fisher's formula is a good method of estimating the sample size.[21] The researcher arrived at n=263 and 10% non-response was adjusted, leading to n= 289.

Data collection procedure

The researcher administered questionnaires. Stratified random sampling was employed. The random numbers were auto-generated using Excel's RANDBETWEEN function. MNTRH has seven outpatient clinics and all them were sampled. Each clinic had 42 of its patients' caregivers targeted for sampling randomly. Purposive sampling was used to identify healthcare workers to be interviewed as the key informants. The five key informants are in accordance to Vasileiou et al recommendation that at least five interviews must be conducted in a study to achieve saturation.[21] Interviews with key informants were completed two days after collecting quantitative data.

Data analysis

Quantitative data was coded, cleaned and analyzed using SPSS v.21. Descriptive analysis included statistics such as mean, percentages, frequencies and standard deviation. Pearson Chi-square tests were performed to establish associations between dependent and independent variables. Results were considered significant at $p<0.05$.

RESULTS

Social demographic characteristics of respondents

The study comprised of 216 participants who completed the questionnaires out of expected 289 giving the study a 75% response rate which was considered appropriate, the relatively low response rate was attributed to movement restrictions because of COVID-19 in Kenya. According to Fincham every research should aim at a response rate of above 60% and a survey response rate of 50% or higher should be considered excellent. Majority of the caregivers were females 59.7% (n=129) while males were 39.3% (n=87). Majority of mentally ill patients were males at 50.9% (n=110) while females were 49.1% (n=106). The average age of caregivers was 48.2±13.14 years whereas that of mentally ill patients was 33.8±10.67 years.

Table 1: Participants' demographic characteristics.

Category	N	%
Sex of patient		
Male	110	50.9
Female	106	49.1
Sex of caregivers		
Male	87	39.8
Female	129	59.7
Religion of caregivers		
Christian	166	76.8
Muslim	49	22.7
Indigenous	1	0.5
Education		
None	1	0.5
Primary	45	20.8
Secondary	120	55.6
Tertiary	50	23.1
Income		
<10 000	74	34.2
10 000-50 000	106	49.1
>50 000	36	16.7
Caregiver relationship with patient		
Parents	116	53.7
Siblings	70	32.4
Others/relatives	28	13
Friends/colleagues	2	0.9

With regard to patient relationship with the caregivers 53.7% (n=116) were parents, 32.4% (n=70) siblings, 13% (n=28) relatives/others and 0.9% (n=2) were friends/colleagues. Majority of caregivers were Christians 76.9% (n=166), 22.7% (n=49) were Muslims and 0.5% (n=1) professed African indigenous religion. In terms of caregivers' education, majority 55.6% (n=120) had secondary education, 23.1% (n=50) tertiary, 20.8% (n=45) primary education with 0.5% (n=1) indicating no education. Looking at family income, the study found that majority had a monthly income range of 10,000 to 50,000 at 49.1% (n=106), with 34.3% (n=74) of caregivers reporting family income below 10,000, whereas 16.7% (n=36) reported family monthly income of more than 50,000 (Table 1).

Table 2: Cost of mental health service and missing clinic visits.

Category	N	%
Transport cost		
Missed Clinics	116	53.7
Not Affected by cost	100	46.3
No. clinic missed		
Once	116	53.7
2-4 times	47	21.8
>4 times	23	10.2
Medication cost		
Missed clinics	120	55.6
Not affected by cost	96	44.4
No. clinic missed		
Never	96	44.4
Once	50	23.1
2-4 times	58	26.9
>4 times	12	5.6
Consultation cost		
Ever missed clinic	118	54.6
Never missed clinic	98	45.4
No. clinic missed		
Once	41	34.7
2-4 times	41	34.7
>4 times	36	30.5

Cost and utilization of mental health services

The study assessed whether transport cost affected caregivers' ability to bring mentally ill patients to MNTRH. The study found out that 53.7% (n=116) missed clinics due to lack of transport whereas the rest 46.3% (n=100) were not affected by lack of transport. Majority 53.7% (n=116) have missed clinics at least once whereas 21.8% (n=47) reported missing clinic 2-4 times, and 10.2% (n=23) indicated missing outpatient clinics more than 4 times. The study further examined the influence of medication costs on patient's adherence to clinic appointments. 55.6% (n=120) of respondents said they had missed clinic appointment because of the cost of medication, whereas the rest 44.4% (n=96) reported that they had never missed clinics because of medication cost. 26.9% (n=58) reported missing outpatient clinics 2-4 times, with 23.1% (n=50) had missed once and 5.6%

(n=12) indicating missing clinic visits more than 4 times because of lack of medical fees.

Table 3: Cost of mental health service ANOVA.

Variable	Value	Missed appointment		Chi-square (df); p value
		Yes	No	
Lacked transport	Yes	116	35	29.50 (1); <0.01
	No	25	40	
Lacked consultation fees	Yes	118	38	35.95 (1); <0.01
	No	23	37	
Lacked medication fees	Yes	120	33	40.04 (1); <0.01
	No	21	42	
Total		141	75	-

Consultation fee was also assessed to examine its influence on patients missing clinic appointments at MNTRH. At MNTRH patients are required to pay ksh.50 as consultation fee. When caregivers were asked whether they have ever missed bringing their patients to clinic due to lack of consultation fees, the findings indicated that 54.6% (n=118) said yes while 45.4% (n=98) said no. The study further queried how many times the patient missed clinics because of lack of consultation fee, the report indicated that 34.7 (n=41) have missed once and 2-4 times, while 30.5% (n=36) reported missing over 4 times (Table 2). To establish if various costs of seeking mental health services was significantly associated with patients missing their clinics Pearson's chi-square test of independence was performed. Costs of transport; 29.50 (1); <0.01, consultation 35.95 (1); <0.01, and medication; X^2=40.04 (1); <0.01 were all statistically significantly associated with missing appointments among MH patients at MNTRH. Therefore, the null hypothesis that there is no significant association between cost and utilization of mental health services at MNTRH outpatient clinic was rejected. Forty-eight (22.2%) of study participants were found to be at risk of relapse, based on their adherence to clinic appointments. Only 1 (14.3%) of patients with biweekly appointments was at risk of relapse, compared to 23 (37.1%) those with 1-month appointment and 24 (16.3%) with every 3-month appointment (Table 4).

Stigma and utilization of mental health services

The study assessed the influence of self-stigma and social stigma on influence on utilization of mental health services. The influence of stigma from the community was evaluated in the study.[23] The results found that 59.3% (n=128) of patients with a mental illness experienced stigma from the community while 39.4% (n=85) of the participants noted they had not experienced stigma from the community. Stigma from the community and ceasing to attend clinics by patients at MNTRH were statistically significantly associated $X^2(1)=8.70$, p<0.01. Therefore, the null hypothesis that there is no significant association between stigma and utilization of mental health services was rejected.

Table 4: Mentally ill patient at risk of relapse (calculated at 80% adherence to treatment).

Required psychiatrist visit	Risk of relapse, statistics, N (%)		
	Total	High risk of relapse*	Low risk of relapse
Every 2 weeks	7 (100)	1 (14.3)	6 (85.7)
After 1 month	62 (100)	23 (37.1)	39 (62.9)
After 3 months and above	147 (100)	24 (16.3)	123 (83.7)
Total	216 (100)	48 (22.2)	168 (77.8)

* No of times considered at high risk of relapse: Every 2 weeks (>5 times), After 1 month (>2 times), After 3 months (>1)

Table 5: Associations between stigma and ceasing clinic attendance

Variable	Value	Missed appointment			Chi-square (df); p value
		Yes	No	Total	
Stigmatized in society	Yes	93	35	128	8.70 (1), p<0.01
	No	45	40	85	
Total		138	75	213	-

DISCUSSION

The first objective of the study was to establish the relationship between cost and utilization of mental health services at MNTRH outpatient clinic. There are 3 major categories of costs of seeking mental health services that is cost of transport, drugs, and consultation fees affected patients' ability to seek mental health services.[24] The findings of the study were congruent with those of McCann et al. that established cost of seeking mental health service is the primary cause of patient refusal to seeking mental health services.[25] The results of the study differ with Ali & Agyapong and Priester et al findings where they noted that cost of mental health service was a significant barrier to access mental care.[26,27] Hashem et al argue that stigma, self and social stigma are the major reason why many mentally ill people avoids seeking formal mental health services because of stereotype and other judgmental thoughts.[28] The study established that self-stigma influenced participants with mental illness utilize psychiatric clinics at MNTRH by neglecting themselves and losing hope of getting better. Mental health education and support for patients with mental health problem and caregivers is essential to overcoming self-stigma and promote adherence to mental health interventions.[29] Self-stigma has been linked to slow or underutilization of mental health services.[30]

Over half of the participants in the study were established to have self-stigma. Lannin et al. made similar observations where participants with self-stigma were almost half than those with low self-stigma.[31] Less than one-quarter of the patients were found to be at risk of relapse. This finding is consistent with reports from Kakuhikire et al who indicated that mentally ill patients with psychiatric clinic appointment visits of two weeks are at risk of relapse if they miss more than 5 times within one year.[32] Those scheduled for a monthly psychiatric visit are considered at risk of relapse if they miss psychiatric clinic more than 2 times while those required seeing psychiatrist after every three months and above are considered noncompliant if they miss more than 1 appointment with their psychiatrists.

Limitations

Limitations of current study were; the patients were not considered as respondents due to the ethical concerns hence their input was delegated to their caregivers. The number of mentally ill patients who visit MNTRH outpatient clinic daily could have dramatically reduced due to COVID-19 restrictions during the study data collection period. The movement advisories issued by the Kenyan government may have made potential participants of the study to cut short their clinic attendance at MNTRH.

CONCLUSION

The cost of seeking mental health services at MNTRH is a barrier to access quality mental health services at the institution. The cost of mental health cares was established to influence adherence of mentally ill people to outpatient clinics. Although medical cost was not identified a significant reason for mentally ill patients missing their follow up clinics. Stigma towards mentally ill individuals, their caregivers, and healthcare providers was attributed to supernatural perspective towards mental disorders. Inadequate resources such as inadequate nurses and beds are barriers to provision of mental health services at MNTRH.

Recommendations

The study recommends training of mental care service providers because some form of stigma expressed by healthcare providers is result of stereotypes and ignorance. Similarly, public sensitization at the community level towards mental problem should be done to curtail stigma from the society that have been observed a great obstacle to utilization of formal mental services.

The researcher recommends study of same variables from caregivers at the community level to have a comprehensive view of various barriers that influence mental health service utilization in Kenya.

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