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MENTAL HEALTH EDUCATION AND ACCESS TO MENTAL HEALTH CARE UTILIZATION IN SOUTHWEST NIGERIA

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Abstract

Background: The psycho-social burden of mental health disorders is enormous as evidenced by a low level of knowledge about the cause and course of mental illness, scarcity of mental health personnel and stigmatization within the community. Hence individual living with mental illness continue to suffer inhumane form of treatment and lack access to formal mental health service.

Aim: The aim of this study was to determine whether mental health education program would yield access to mental health service (MHS) utilization in Ibadan, Nigeria.

Method: In this mixed-method approach (quantitative and qualitative), mental health education program was carried out in selected religious places, markets and also the media using a Radio/Television program in Ibadan. The proportion of respondents who responded via telephone calls and later accessed treatment reported was analyzed. The Composite International Interview (CIDI 7.0) was used to allocate ICD 10 and DSM IV diagnosis to respondents who had contact with MHS. A Focus Group Discussion (FGD) was conducted among a heterogeneous population to determine their knowledge and attitude to mental illnesses. Analyses were by Chi Square test and by thematic analysis.

Results: In all 12.1% made telephone calls, 33.0% of those who made telephone calls had contact with mental health facility. In all, 426 subjects had contact with mental health service post mental health literacy program. Of these 426 participants, 348 (81.7%) had an ICD 10 disorder, and the most prevalent was anxiety disorder (30.0%). Focus group discussion yielded further information on respondents view about aetiology and treatment of mental disorders.

Conclusion: Mental health literacy program is a feasible method of increasing access to formal mental health services in Nigeria

Key Words: Mental health literacy program, Telephone, Church, Islamic Congregation, Access to Care.

Introduction

Mental disorders are usually associated with a huge personal and societal burden worldwide most especially in low and middle-income countries,¹and there are indications that there is a substantial treatment gap in these countries.²For example, the results of the World Mental Health Survey showed that in Nigeria, only 9.0% of those with any 12-month DSM-IV disorder had received treatment. While none of those with substance use disorders had ever used a mental health service.²The scarcity of specialist mental health personnel, low level of knowledge about the cause of mental illnesses, stigma is some of the reasons for the widespread lack of access to formal mental health care.^{2, 3}As a consequence, people with mental illness in Nigeria seek alternative methods of care including religious or Faith Based Organizations (FBOs)⁴.

The use of other formal health care structures, including non-specialist health workers in the form of task sharing, is widely advocated for the scale up of mental health interventions in settings with limited resources.⁵For example, the World Health Organization (WHO) Mental Health Gap Action Program (mhGAP) advocates that mental health should be integrated into primary care in order to address the unmet mental health needs in low and middle income countries.⁶In Nigeria, a substantial effort has been used in aligning with the mhGAP, focusing on the expansion of mental healthcare across the country through integration into primary care^{7, 8}.

Despite the biomedical approaches in addressing the treatment gap of mental

disorders, there are indications that a much broader and pluralistic approach is required. Based on research findings that in Nigeria, the alternative practitioners such as the spiritualist and religious practitioners constitute the first port of call by individuals with mental disorder,⁹it is conceived that effective public health initiative aimed at increasing mental health literacy should be population based and embrace different settings of which Faith Based Organizations are a very useful tool¹⁰.

Thus, in response to poor National Health Service profile of Nigeria, and poor knowledge about understanding of etiology of mental illnesses,¹¹a mental health awareness program in Ibadan Nigeria was set to determine the response to mental health education across various settings.

Objectives

The aim of this study was to determine the impact of various mental health education programs on willingness to seek treatment for any mental health problem among residents in Ibadan, Nigeria.

Specifically, we set to determine the proportion of respondents who would seek contact with us by telephone calls. We also determined the proportion of those who made telephone calls and also sought access to care. In addition, we assessed the profile of ICD 10 mental disorders among those who accessed care at the designated center for such.

Finally, we conducted quantitative assessment to determine respondents' knowledge about causes, symptoms and treatments of mental disorders.

Methods

Study design

This was a mixed method follow-up study that accesses the pathway of mental health education to access mental health services.

Setting

The study took place in Ibadan, the capital of Oyo state, Nigeria with a population of 3.5 million people¹² and was carried out between March and July 2018.

Sample size estimation

We obtained a minimum sample size of 384, from the sample size estimation formula: $n = z^2pq/d^2$, where z is 1.96 (a statistical constant), p = prevalence of those who sought mental health service following a mental health promotion in Nigeria from previous studies (50%, a statistical assumption was used because of lack of data on this), $q = 1-p$, $d = 0.05$ (the precision expected at 95% CI). We, however, increased this minimum sample size of 384 by 10% because of an anticipated non-response making the final minimum sample of 418.

Sampling technique for the research Study

Stage 1: Mental health education

Stage 2: Telephone call to designated lines

Stage 3: Evaluation of the effect of mental health literacy based on willingness to access treatment

Sampling technique for the education Program

The study employed a multistage random sampling.

Stage 1: Four out of eleven local government areas in Ibadan were randomly selected

Stage 2: 1 Church, 1 Muslim congregation, one marketplace and a radio station were selected from each of these 4 local governments.

Stage 3: 1 Pentecostal church, 1 Anglican church, 1 Baptist church and 1 Christ Apostolic Church (CAC) were randomly selected from the four selected local governments, while 1 Ahmadiyya sect, 1 Sufi sect, 2 Sunni sects were selected from the Islamic congregations.

Sample size

In the religious centers, we obtained the number of those that attended to services from the respective wardens. In the market places tallies were allocated to participants that clustered round the research team.

The Radio/TV (media) was a universal intervention; therefore, the number of listeners/viewers was difficult to assess.

In each of the study sites, the session commenced after obtaining permission from the head of religious organization, followed by a brief introduction of the research team, the head of which gave the mental health education in Yoruba. Each session lasted about 40 minutes, followed by another 30 minutes of debriefing.

Instruments of data collection

1. Sociodemographic questionnaire

The sociodemographic questionnaire yielded information on age, sex, employment of the patient, marital status, religion, years of education, previous knowledge about mental illness.

2. World Health Organization Composite International Diagnostic Interview, Version 7.0 (WHO – CIDI 7.0)

Diagnoses of the patients were made using the CIDI version 7.0. This instrument yields diagnosis using both ICD 10 and DSM IV criteria and has been validated and used in Nigeria in previous studies. The instrument is a fully structured diagnostic instrument for psychiatric conditions that can be administered by lay interviewers¹³.

1. Focus Group Discussion Guide

A focus group discussion guide was used to kick start the FGD and contains items such as definition of mental illnesses, causes of mental illnesses, symptoms of mental illnesses, complications of mental illnesses, treatment of mental illnesses and relationship between physical illnesses and mental illnesses.

2. Contents of mental health education

The content of the mental health education was same as the focus group guide.

Quantitative method

We carried out a mental health education program in both English and Yoruba languages in public places such as the church, the mosque, the marketplaces and over the media. The structured mental health education was in accordance with the WHO mhGAP training manual in mental health. Prior to the commencement of the mental health education, adverts were placed at the venues of the program, so also were media announcements made.

Mental health education

Churches/ Mosque Methodology

Members of the research team visited the designated church or mosque, the Pentecostal church had 385 congregations, the Anglican Church (400), the CAC (400 congregations), the Baptist Church (480 congregations), the Ahmadiyya sect had 415 congregation, Sufi comprised of 503 congregations and the two Sunni sects had 1070 congregations.

These religious places were visited on one same Sunday. Sunday was chosen because Christians attend their churches on Sundays so do Muslims also congregate on Sundays.

Community (major markets from 11 local governments in Ibadan).

Four major market (Bode, Oje, Aleshinloye and Ojoo markets) were consecutively visited on market days. These markets were randomly selected out of the major markets in the 11 local governments in Ibadan. Selected participants were approached through respective head of market and consent obtained. A conservative estimate of about 1000 attendees were present at each of the major markets.

The research team comprised of a community psychiatrist, a mental health nurse and a community health extension worker. With the support of their respective head, traders, transporters and people in the community were gathered.

Briefly stated, the team leader introduced himself and proceeded to give a short talk on mental health talk in Yoruba language. This was followed by a brief question and answer period.

Participants were thereafter informed to consult the attending physician through telephone calls if they felt they required any further attention. Participants were assured that the exercise was strictly for public awareness and screening for mental health problem. Leaflets were thereafter distributed.

Television phone program

The media program was carried out exclusively by the psychiatrist and was a telephone call radio/television program. The psychiatrist has formal training in community medicine and health promotion. Serial sensitization announcements were made few days to each program.

On each program day, introduction of speaker was done and objective spelt out to all listeners.

Mental health education commenced. The whole media program lasted 4 weeks and each session lasted one hour. The Program was a mixture of Yoruba and English language.

Outcome assessment

The outcome was the number of clients who after receiving mental health education had contact with the designated mental health facility.

At the designated mental health facility, information was obtained about the sociodemographic characteristics of the clients, source of mental health awareness program, following which diagnosis was allocated to each participant using Composite International Interview (CIDI 7.0) to make ICD 10 and DSM IV diagnosis¹⁴.

Qualitative assessment

Three sessions of a rapid situation analysis using a focus group discussion (FGD) was carried out among some stakeholders, comprising of individuals who sought contacts with MHS, their caregivers and some service providers. In all, 10 individuals were involved in each of the 3 sessions of the FGD. This was in accordance with MacIntosh¹⁵. This heterogeneous composition was carried out to unitize diverse opinion about etiology, symptom profile, treatment and consequences of mental disorders. Participants were enrolled into the FGD by snowballing and data collection was stopped when teams were satisfied that core cultural beliefs had been represented when no new information was found (data saturation)¹⁶.

Methodology of the Focus Group Discussion

All participants were formally contacted in writing and were duly informed of the location, date and time of the focus group. Three sessions were held every other day for a week. Timing was such that it did not interfere with their work or other private issues. Written consent was obtained from each participant and a short sociodemographic survey was carried out and coded in the provided forms. Each session commenced by welcoming all participants and appreciating them for participating. This was followed by the introduction of the moderator and his assistant. The moderator was the principal researcher. The purpose of the discussion was explained to the members of the group so were the ground rules.

FGD Guide

1. What are mental illnesses
2. Causes of mental illnesses
3. Symptoms of mental illnesses
4. Complications of mental illnesses
5. Treatment of mental illnesses
6. Relationship between physical illnesses and mental illnesses

Each question on the FGD guide was discussed. The ground rules were: participants did the talking, there were no yes or no answer, information divulged was to be confidential, and all activities were to be tape recorded. All the sessions and other activities including body languages and other subtle clues were recorded by the assistant moderator who was silent during the sessions. Snacks were served at each session. Immediately after all participants left, the moderator and his assistant debriefed while the recorder was still running. All tapes and notes were labeled with date, time and name of group

Ethical approval

Ethical approval was obtained from the Oyo State Ministry of Health Research Ethics Committee and informed consent obtained from all participants.

Data analysis

For the quantitative analysis, analysis was essentially by Chi Square statistics and was performed using SPSS version 17.0 software¹⁷.

In the case of the focus group discussion, data analysis commenced during the period of data collection and each session was recorded. Thematic analysis was carried out by the researcher initially collating all information into broad themes in a matrix

and at the end of each day transcribed these broad themes to identify emerging themes for further exploration during subsequent focus groups. Two independent analysts carried out further thematic analysis aimed at unitizing the data. The two analysts reconciled their data and came to a consensus opinion on issues of discussion. Quotes were also reported after the data collection.

Results

Willingness to interact with the researchers and attempt at accessing formal mental health service is shown in table 1. In all 1,289 respondents made telephone calls, 426 (33.0%) of which had contact with mental health facility (Table 1).

Table 1: Study sites and contact with mental health facility

	N (4110)	Telephone calls		Contact with mental health service		χ^2	p
		N	%	N	%		
Markets	2000	188	9.2	41	21.8	41.3 (df 8)	< 0.001
Churches							
Pentecostal	385	48	17.7	32	66.7		
CAC	400	61	15.3	28	45.9		
Baptist	480	56	11.7	21	37.5		
Anglican	400	91	22.8	45	49.5		
Moslem Sects							
Ahmadiyya	415	95	23.0	49	51.6		
Suffi	503	132	26.2	60	45.5		
Sunni	1070	281	26.3	128	45.6		
Media	5,000	337	6.7	22	6.5		
Total	10,653	1,289	12.1	426	33.0%		

Of the 426 participants, 348 (81.7%) had an ICD 10 disorder. Of the 348 subjects with an ICD 10 disorder, the prevalence of a disorder reduced with increasing age, $\chi^2=28.9$, $p<0.001$. A significantly higher proportion of them were men, $\chi^2 = 7.8$, $p < 0.005$. A higher proportion of them was

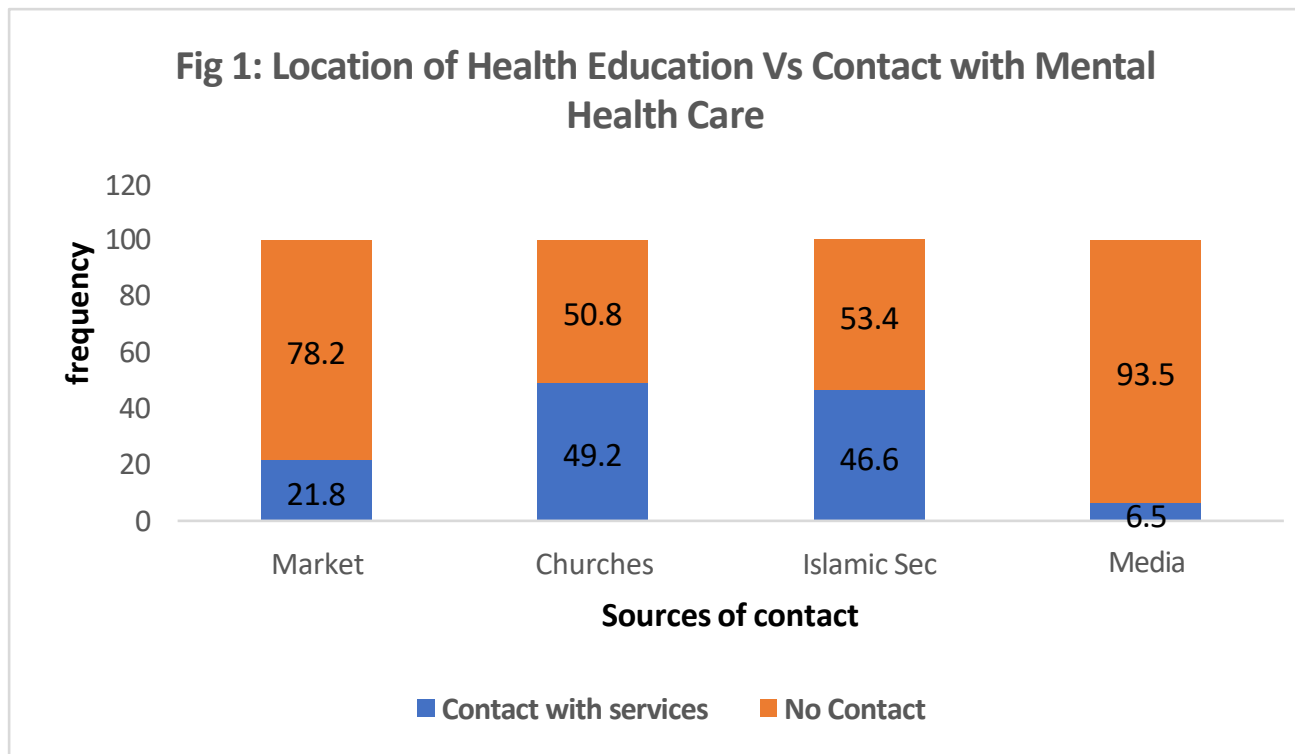
unmarried, $\chi^2 = 17.5$, $p < 0.001$ and unemployed, $\chi^2 = 5.2$, $p = 0.02$ (Table 2). Receiving an ICD 10 diagnosis was also significantly associated with no previous knowledge about causes and treatment of mental illnesses and being unemployed (Table 2).

Table 2: Sociodemographic characteristics of respondents, contact with mental health facility and ICD 10 disorder

Sociodemographic characteristics	Contact with mental health facility N (426)	Any ICD 10 disorder N (348)	%	χ^2	p
Age					
<25	150	140	93.3	28.9	< 0.001
25-34	115	100	86.9		
35-44	97	71	73.2		
45-54	43	26	60.5		
>54	21	11	52.4		
Gender					
Male	243	210	86.4	7.8	< 0.005
Female	183	138	75.9		
Years of education					
0	46	39	84.7	8.7	0.03
1-6	205	173	84.4		
6-12	158	120	75.9		
>12	25	16	64.0		
Marital status					
Married	160	114	71.3	17.5	< 0.001
Unmarried	266	234	87.9		
Previous knowledge about mental illness					
Yes	42	27	64.3	8.2	0.004
No	384	321	83.5		
In employment					
Yes	124	110	88.7	5.2	0.02
No	302	238	77.7		

When all the churches were grouped together and the Islamic sect also grouped together and compared with the market and the media, A significantly higher proportion of respondents who received literacy

awareness in the churches (49.2%) or the Islamic congregations (46.6%) had contact with mental health facility when compared with either the market (21.8%) or the media (6.9%) (Figure 1).



²
 $\chi^2 = 69.7, p < .001.$

The most prevalent ICD 10 disorder was anxiety disorder 128 (30.0%) and the least, substance use disorder 15 (3.5%), (Table 3).

Table 3: ICD 10 Disorders post mental health education

ICD 10 disorders	N	%
Anxiety disorder	128	30.0
Bipolar disorder	33	7.7
Depressive episode	51	11.9
Dementia	18	4.2
Mental & behavioral disorder with onset in childhood and adolescent	37	8.70
Schizophrenia	22	5.2
Somatization disorder	22	5.2
Substance use disorder	15	3.5
Psychotic disorder unspecified	22	5.2
No ICD diagnosis	78	18.2

Focus Group Discussion (FGD)

All the sessions took place at the Department of Community Medicine, College of Medicine, University of Ibadan. The choice was to create a neutral environment to enable debriefing of participants' diverse opinion. Ten participants were present on two of the three sessions and nine on the third session.

Composition was heterogeneous to allow diversity of view and opinion, present were stakeholders, comprising of individuals who sought contacts with MHS, their caregivers and some service providers.

The researcher was the moderator assisted by a mental health Nurse. There were 3 sessions in all. Each question on the FGD guide was discussed. On the causes of mental illness, a patient commented: *"mental illnesses are caused by smoking cannabis"*. Another patient: *"mental illness is caused by curse"*. An artisan commented, *"mental illness is the handwork of people of darkness"*. A patient relation said: *"mental illness is caused by spiritual forces"*.

About symptom profile, a patient said, *"mental illness has no symptoms"*. A relation said *"misbehavior is the most common symptom and murmuring of words"*. A religionist said: *"mental illness is the wage of sin"*.

About treatments, a relation said, *"spiritual issues can only be given spiritual treatment"*. A patient, *"herbs is good for madness"*.

About complications of mental illness, a religionist commented: *"people with mental illnesses do not any physical illness; they are immune to all diseases and have high resilience to infections"*.

Discussion

In this study aimed at deriving the most appropriate mental health education approach to enable residents in Ibadan, Nigeria have adequate mental health education, briefly stated, the results show that the media was the commonest forum for such and that about 4 in every 5 participants who made telephone calls either by self or by proxy met criteria for a mental disorder. It was also found that media contact was significantly associated with more contact with mental health service as compared with face-to-face contact. The results also show that although a higher percentage of telephone calls were received from those that had face to face contact with the researcher; significantly less proportion of them had contact with mental health service. These results substantiate the societal deeply ingrained prejudice towards mental illness, and its sufferers¹¹, thereby perpetuating a lot of secrecy about it¹⁸. For example, in a community study of attitude of people to persons suffering from mental illness in Nigeria, it was found that people generally had negative views about mental illness and its sufferers to the extent that they are generally avoided, people fear having conversation with them nor wanting to contract marriage with them¹¹. For this, lay people would not want to discuss issues about mentally ill person openly.

This result shows that there were interdenominational differences in the response of participants to mental health education. For example, members of the Baptist denomination, Christ Apostolic Church and Pentecostal church reported fewer telephone calls. This could suggest

some reluctance from these sects in responding to mental health education, because some of what is considered as psychopathologies from mental health perspective could be regarded as religious experiences by them. Indeed, Dein and Co-investigator had reported that psychopathologies and religious experiences occupy a continuum that is often indistinguishable by “lay people”.¹⁹ Paradoxically, in terms of treatment seeking, the highest proportion of those that sought contact with MHS was from the Pentecostal sect. Another finding is that media and market mental health education were consistently associated with low level of telephone calls and contact with MHS. Nevertheless, when all Christians were merged together and the various Islamic sects merged accordingly, there was no significant difference in their treatment seeking behavior. The reason for this is difficult to give. For example, in a report, it was found that Islam seems to have a clear taxonomy that distinguishes mental illness and the causes thereof from „spiritual illnesses“. ²⁰This however does not equate Islamic sect not having theological considerations in illness and suffering. ²¹For example, similar to the Catholics, among the Yoruba tribe of Southwest Nigeria, the native Muslim diviners had for long adopted divination with rosary and sand with resultant high degree of hybridization in a healing custom²².

The sociodemographic profile of those that sought psychiatric intervention is similar to previous reports²³. This study supports the findings of a study where it was reported that mental illness starts early in life²⁴. Lack

of enabling laws in Nigerian to protect the rights of individuals living with mental illness in regard to treatment, employment, rights and privileges make many of them unemployed and with poor education.

The finding that anxiety disorders and depressive episodes were the most commonly reported mental disorders supports the report from the World Mental Health Survey in Nigeria²⁴. It may be implausible to explain the high prevalence of somatoform disorder as reported in this study as a reflection of the tendency of African patients to present their psychological distress with somatic symptoms as it has been reported that there is no cultural variation in somatization²⁵. However, this high rate of somatization may suggest a path way to more severe mental disorders.

Our aforementioned associations are somehow corroborated by the results of the focus group discussion. We found that the participants of the focus group discussion generally have limited knowledge about etiology and treatment of mental illness. Despite the high prevalence of anxiety and depressive episodes in this study, none of the focus group participants“ have knowledge about these disorders constituting part of mental health disorders. Unlike in some developed countries of the world²⁶, participants from this study had poor level of knowledge regarding causes of mental illnesses. This corroborates an earlier report in Nigeria¹¹. It was also found that some participants were able to associate cannabis with mental illness. This we found a very promising road to further exploration

regarding psychoactive substances use and mental disorders health.

However, the idea that mental illness is a reflection of sin which holds in some religious communities¹⁹ was reported in our focus group discussion. Thus, some participants opine that the treatment of mental disorders is “restitution and prayers”. However, the report from some participants that mental illnesses could be treated using herbs sounds very promising regarding treatment of mental disorders.

The participants were generally of the opinion that individuals living with mental illness enjoy good physical health, are not afflicted by physical illnesses and that is responsible for their vagrant way of lives. This finding contrasts with well documented evidences on increased risk of medical illnesses among mentally ill persons²⁷.

This study highlights the usefulness of mental health awareness programs in mental health literacy. This is very relevant in Nigeria where the majority of people have poor knowledge about mental illness¹¹, where a substantial proportion of mentally ill do not have access to formal mental health care²⁸ and where a substantial proportion of mentally ill first utilize alternative practitioners before formal mental health care⁹.

The present study deserves merit by utilizing the “hidden” power of mental health education in recruiting 426 people for mental health assessment of which 338 has a mental health problem. This is a very useful and important epidemiological method of determining psychiatric „cases“.

This study was limited by a number of factors. First our method of sample size

selection could have created a selection bias and may not be representative of true population of those in need of mental health attention. Also, the estimate of those who listened or viewed the media program could not be ascertained, hence a rough estimate of 5,000 people, which could have either been a gross underestimation or overestimation.

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