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Mental Health Service and Access in Nigeria: A Short Overview

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Abstract

Nigeria as a former British colony has attempted over the years to provide Western method of mental health services and access. This has not been quite impressively successful and mental health services and access remains and will for a long time to come will continue to remain abysmally poor. Local adaptation from African perspective of existing mental health service styles will be needed to bridge the gap of the unmet needs of the huge number of the Nigerian population with mental ill health.

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Introduction

Mental health problems are common and incur great costs- socially, economically, psychologically, physically and financially [1]. In this paper, I will present a brief overview of mental health service and access in Nigeria, the most populous black nation on earth, with about two hundred million people. First, I will present a summarized history of Nigerian mental health service and access and thereafter take a short peep into the current status and then I will conclude with a suggestion.

A brief history of mental health service and access in Nigeria is helpful in appreciating where Nigeria currently stands in the stream of time.

As in other parts of the world, it is doubtless that persons with severe mental disorders in Nigeria during much of the 18th and 19th centuries had no access to any formal Western model of mental health service [2]. The first asylum was established in the southern city of Calabar in 1904 and Yaba Psychiatric Hospital was established in Lagos in 1907 as Yaba Asylum with medical officers providing mental health care for few persons.

It would appear that modern mental health service and access actually took a serious turn in the 1950s.

Lantoro is a community in the current Ogun State, South Western Nigeria. This small rural community was a colonial (British) local government prison but in 1944 was transformed into an asylum to accommodate and provide mental health service for soldiers with mental disorders who were repatriated from the Burma war front during the World War II [3].

History has it that when some Nigerian soldiers came back from the Burma War, thirteen health attendants were transferred from Yaba (Lagos) Asylum to open a care institution in Lantoro. A prison in Lantoro was then taken over by the Colonial Medical Department and converted to a mental asylum [3].

Civilians with mental disorders were also later allowed to access mental health service in the Lantoro facility, which led to an overpopulation of the facility necessitating its expansion and the building of a better facility [3].

The first Nigerian trained psychiatrist, Thomas Adeoye Lambo came back from the United Kingdom in the early 1950s and established the popular Aro Village system of community psychiatry in 1954 with the aim of making use of traditional sociocultural resources of the community in the treatment of persons with mental disorders [3].

Figure 1 shows the Psychiatric Hospital, Aro, and Abeokuta.

In a country that has about 924 square kilometers of land space, mental health service and access of a necessity had to be limited essentially to the South Western region of Nigeria, even though a few persons with mental disorders from other regions had to travel to Aro.

In the Mid Western region, the Nervous Diseases Clinic, later called Uselu Psychiatric Hospital, started in 1964, providing more avenues for access to mental health care to Southern Nigeria.

Figure 2 shows the picture of the old Uselu Nervous Clinic, now Psychiatric Hospital, Uselu, Benin City, Edo State, Nigeria.

The three Psychiatric Hospitals at Aro (Abeokuta), Yaba (Lagos) and Uselu (Benin City) had a common Board of Management starting in 1979 as enacted by the Federal Government.

In the late 1990s the Federal Government of Nigeria established/ acquired five more Psychiatric Hospitals at Maiduguri (North East Nigeria), Kaduna (North Central Nigeria), Kware, Sokoto (North West Nigeria), Calabar (South South Nigeria) and Enugu (South East Nigeria).

The 1999 Nigerian Constitution (as amended) puts health care in the concurrent list meaning that both Federal and State Governments can establish all levels of health care facilities [4]. A few states (out of the entire thirty-six) have ill equipped mental health facilities. As Ayorinde, Gureje and Lawal [5] observed, the bulk of psychiatric service in Nigeria is provided by the eight regional psychiatric hospitals and the departments of psychiatry in a few medical schools with some general hospitals also providing some sort of psychiatric services.

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Figure 1: Picture of the New Psychiatric Hospital, Aro, Abeokuta.

Figure 2: Picture of the New Uselu Hospital, Benin City.

Three Issues to Consider

Many factors may be associated with mental health services and access. In respect of Nigeria, I would want to briefly mention three issues, not because others are less important but simply for the fact that these are key issues.

These three issues include the burden of mental health problems, the availability of mental health professionals and the health care system.

There is sparse if any current information on these matters in Nigeria.

The literature is dotted here and there with few, most times not robust studies of isolated mental health problems in small areas within or outside the health institutions in Nigeria.

Although it may be feasible to carry out a meta-analysis of the prevalence of mental disorders in different studies in Nigeria, the actual, and perhaps only nationally representative (involving close to seven thousand participants scientifically selected in five regions of Nigeria), population based survey of mental disorders in Nigeria was done by Gureje, Lasebikan, Kola and Makanjuola and was later expanded with the inclusion of other Nigerian researchers [6].

In the first phase survey, Gureje, Lasebikan, Kola and Makanjuola [6] reported that 12.1% of the sample had had at least one lifetime DSM-IV disorder and 5.6% had experienced at least one of the disorders in the prior twelve months. Specific phobia was the most common disorder, occurring in 5.4% ever in lifetime and in 3.5% in the prior twelve months. According to the authors the lifetime prevalence of major depressive disorder was 3.3% while that of alcohol abuse was 2.8% and most (94.4%) of those with twelve -month disorders had only one disorder, two twelve-month disorders were identified in 0.3% of the sample, and three disorders in 0.1%.

In the representative national population survey, by Gureje, Lasebikan, Kola and Makanjuola [6] it was reported that less than 10% of those with mental disorders, irrespective of whether the disorder was serious or mild, had received any form of treatment for their mental disorders any time in the twelve-month period. The authors reported that the majority of those receiving treatments were doing so from general practitioners and from non-mental-health specialists. The authors stated that only about 0.6% of those with serious mental disorders had received treatment in a specialist setting; conversely, almost 2% had been in the care of alternative or traditional practitioners. The authors further reported that of those with no DSM–IV disorder (many of whom might nevertheless have had symptoms of psychological distress), 0.7% were in treatment, with a substantial proportion (0.4%) receiving treatment from alternative or traditional health practitioners.

It has been over a decade when this landmark study was done. In the absence of a more recent replication of such national representative survey, it is impossible to be certain what the exact situation may be but one can guess that rather than improve the situation may have worsened, considering the growing population and ever-rising poverty and continuous lowering of social economic circumstances.

In 2006, the World Health Organization (WHO), Country Office for Nigeria in collaboration with WHO, Regional Office for Africa and WHO Headquarters [7] used the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) to collect information on the mental health system of Nigeria. The project was led by Gureje and his team at Ibadan [7].

The WHO-AIMS study reported that at the time of that study ninety-five percent of psychiatrists in the surveyed areas worked only for government administered mental health facilities and five percent worked only for Nongovernmental Organization (NGOs), for profit mental health facilities and private practice. Though physicians were found to be coordinators of the primary health care centers (PHC) located within local government areas, and such centers were run by non-physicians but physicians in PHCs are allowed to prescribe psychotropic medications without restrictions. Non-physicians working at primary care levels can sometimes prescribe but only in situations of emergency. Emergency means for example that a person has become very violent and would require immediate sedation with simple benzodiazepine. It was reported that family and patient associations focusing on mental health issues did not exist in the surveyed areas (and possibly in the entire country). The WHO -AIMS report was based on data collected from six states: Lagos (south-west), Calabar (south south), Enugu (south-east), Kaduna (north central), Maiduguri (north-east), and Sokoto (north-west) which in all represent about 17% of the total Nigerian population.

The conclusion of that assessment showed a gloomy picture of very low numbers of mental health professionals, poverty of mental health facilities, non-availability of common medications used in mental health and general poor access to formal mental health service.

It was shown that Nigeria has a ratio of mental health bed of 0.4 per 100,000 persons, 4 psychiatric nurses per 100,000 persons, 0.09 psychiatrists and 0.02 psychologists and social workers per 100,000 persons and a total public health expenditure of far less than 5% of the country's budget [7]. Although a later WHO information note [8] indicates that there are only eight psychiatric hospitals in Nigeria, with a total of 4000 beds giving a rate of 0.005 hospital per 100,000 population and 2.528 beds per 100,000 population, this is an incomplete picture and has not taken account of Federal Medical Centres, state psychiatric hospitals and General Hospitals where mental services are available. The eight psychiatric hospitals as already stated belong to the Federal Government of Nigeria; however, teaching hospitals and Federal Medical Centres also provide some mental health services in most of the thirty six states of the federation.

There is no evidence however that that the situation has become any much better since the 2006 WHO-AIMS survey. In fact in recent times a paradoxical phenomenon has developed. Despite the fact that mental health professionals are few and do not match the WHO recommended ratio in Nigeria, many trained mental health professionals have no jobs especially in the public health system. The result is that currently the majority of mental health professionals are migrating in droves out of Nigeria to the West (especially the United Kingdom, Canada, Australia and other developed countries) [9,10]. Nigeria now seems like an exporter of the few specialist mental health professionals produced in the country. This has drastically reduced mental health service and access in Nigeria.

Even though Nigeria first produced a mental health policy in 1991 and later revised it, there is no evidence of its implication or impact in the general population. Therefore both the health system and availability of mental health professionals have contributed to poor mental health service and access in Nigeria.

For a number of reasons, the majority of persons with mental health problems do not have access to formal care.

In Nigeria, some researchers have reported that there are paucity of mental health services for children and older adults (the so called elderly), with a differential in service utilization in all age groups. Here I provide a few examples.

Small scale epidemiological studies in selected areas in Southern Nigeria indicate that more men than women utilize mental health services in Nigeria, perhaps for sociocultural reasons [11]. Olawande et al. [12] examined gender differentials in the availability of mental healthcare services among the Yoruba of Ogun State, Nigeria and reported that in respect to awareness on primary healthcare services, only 8.9 percent of female respondents were aware compared to 19.7 percent of the men but only 14.5 percent of the male respondents were aware of the secondary healthcare service when compared to 25.4 percent of their female counterparts. Although, this may or may not be related to mental health service use, it has been demonstrated that male Nigerian adolescents have poorer knowledge of mental health problems compared to their female counterparts [13]. Tunde-Ayinmode [14] however has argued that even though child psychiatric disorders are highly prevalent in Nigeria, mental health service availability and utilization in this group is very poor. Van Heerden, Uwakwe and Potochnick [15] have shown that older adults in Nigeria and South Africa, and indeed the African continent have poor mental health service attention, even though some bit of progress appears to be on the horizon.

In general, specialist services are scarce and the field is as good as unregulated.

The porous nature and poverty of psychotropic supply/ acquisition control, has left the market open and charlatans are having a field day.

An interesting observation is the free use of long acting psychotropic medications by religious and other non-health professionals without regard to whatever specific mental health problems people may have. Sometimes this practice can be quite frighteningly dangerous as we have sometimes observed in our mental health care facility.

One example is in South Eastern Nigeria, where there is a community called Osina. Here, a purported medical practitioner gives long acting psychotropic medication to everyone who visits the centre. Probably to avoid people knowing the name of the medications and failing to sustain their patronage, the "practitioner" gives a prescription that could last for three or more years at a go, putting the parenteral / injectable long acting injections inside Ethylene diamine tetraacetic acid (EDTA) bottles and labeling the dates on which each injection would be taken.

Figure 3 shows a snapshot of some EDTA bottles and dates given to one patient at once to last for four years and when the patient developed uncontrollable tardive dyskinesia he was brought to our mental health clinic at Nnamdi Azikiwe University Teaching Hospital, Nnewi, Anambra, South East, Nigeria in 2018.

Some Nigerian studies have shown that there are a number of barriers to mental health service care. In a state University Teaching Hospital in Lagos, Nigeria, Olugbile, Coker and Zachariah [16] reported

Figure 3: Long acting psychotropic injections in EDTA bottles to be given at stated dates for four years.

that apart from distance to mental health facility, social stigma, cultural beliefs, attitudes and taboos, cost was a major barrier to accessing mental health care in that facility. In a qualitative study to assess barriers to mental health care in the Niger Delta region of Nigeria, Omi Jack-Ide and Uys [17] reported that physical, financial and cultural constraints were the major barriers to mental health care. Absence of service in rural communities, poor knowledge of mental health services, stigma, transportation problems, waiting time at the facility and cost of service were in the front as barriers.

Adeosun, Adegbohun, Adewumi and Jeje [18] assessed the pathways to mental health care among patients with schizophrenia at their first contact with mental health services at the Federal Neuro-Psychiatric Hospital Yaba Lagos, Nigeria. The authors reported that close to 70% of the patients had initially contacted traditional and religious healers and those service users who first contacted nonorthodox healers (such as spiritualists and herbalists) made a greater number of contacts in the course of seeking help, eventuating in a longer duration of untreated psychosis. According to the authors, the delay between the onset of psychosis and contact with the first point of care was shorter in patients who patronized nonorthodox practitioners. They suggested that collaboration between orthodox and nonorthodox health services could facilitate the contact of patients with schizophrenia with appropriate treatment, thereby reducing the duration of untreated psychosis.

Uwakwe and Otapkor [19] had argued that bridging the gap between mental health needs and available services in developing countries needs to incorporate traditional healers, who are ubiquitously available, easily accessible, and acceptable to the natives despite the barriers in forging collaborations between traditional and biomedical mental health care providers. They contended that even though the present WHO mhGAP is meant to be used by low cadre health care professionals, yet it is an opportunity to bring traditional and faith healers on board of the mental health service system in developing countries recognizing that for a long time to come, there will hardly ever be sufficient western method of mental health service and access.

Uwakwe and Otapkor [19] stated that with adapted training using the mhGAP intervention guide, it should be possible to get some traditional/faith healers to understand the core principles of some priority mental health problems identification, treatment, and referral and this will be one possible way of bridging the treatment gap and closing the inequity and inequality chasm in mental health care.

Gureje, Abdulmalik, Musa, Yasamy and Adebayo [20] are of the view that pragmatic solution is to improve access to care through the facilities that exist closest to the community, via a task-shifting strategy. Over eighteen months, they implemented a programme to integrate mental health services into primary health care in eight selected local government areas (LGAs) in Osun state of Nigeria, using the WHO Mental Health Gap Action Programme Intervention Guide (mhGAP-IG). They reported that a total of one hundred and ninety eight primary care workers, from sixty eight primary care clinics, drawn from eight LGAs with a combined population of 966,714 were trained in the detection and management of four mental health conditions: moderate to severe major depression, psychosis, epilepsy, and alcohol use disorders, using the mhGAP-IG. The authors reported that following training, there was a marked improvement in the knowledge and skills of the health workers and there was also a significant increase in the numbers of persons identified and treated for mental health disorders, and in the number of referrals. They concluded that it is feasible to scale up mental health services in primary care settings in Nigeria, using the mhGAP-IG and a well-supervised cascade-training model.

Conclusion

In conclusion, mental health service and access in Nigeria is quite poor owing to a number of political, cultural, social and other sundry factors. The situation will likely remain the same for decades to come. Before the country matures to boast of full and optimal mental health services and access, there will continue to be the need to use culturally appropriate and acceptable stop gap approaches, such as home grown local adaptation of the WHO mhGAP in addressing and scaling up provision and utilization of mental health services in Nigeria. Galvanizing all the few professionals including social workers, occupational therapists, psychiatrists and (clinical) psychologists will be a step in the right direction. These various professionals can mobilize the cooperation and assistance of their colleagues both within Africa and internationally for a joint fast tracking of the increase and improvement in mental health service and utilization in Nigeria. Such Global social work, concerned with bigger issues, such

as how to effectively intervene, ameliorate and solve local problems and life difficulties experienced by people around the world will be an added advantage to whatever Nigerians themselves are able do to enhance mental health service delivery to the teeming population in need.

Competing Interests

The author declare no competing interests.

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