A Mixed-Method Study of Mental Health Practices and Policy among practitioners in Southern Nigeria

Godlene Osokam Ugbaja[1,] Mamodesan Tudjegbe Okumagba[1], Florence Konye Igweh[2] and Osagie Mike Odigie[3*]

[1]*Department of Community Medicine, Faculty of Clinical Sciences, Delta State University, Abraka, Delta State, Nigeria.* [2]*Department of Business Administration, Faculty of management and Social Sciences, University of Delta, Agbor, Delta State, Nigeria.* [3] Department of Physiology, Faculty of Basic Medical Sciences, Edo State University, Uzairue, Edo State, Nigeria.

ABSTRACT

Background: The Community Mental Health Model (CMHM) is suggested by the World Health Organization as appropriate for effective delivery of mental health care. However, the state of Nigeria's mental health care is precarious. This is particularly traceable to the lack of awareness, stigmatization, inadequate or poor services, as well as ineffective government policies. **Objectives:** The goal of this study was to investigate mental health practices and policy implementation among mental healthcare practitioners in Southern Nigeria. **Materials and Methods:** The mixed-method research leveraged on quantitative and qualitative data which used a total population and purposive sampling respectively. Data collection was via a researcher-administered questionnaire, and in-depth interviews. **Results**: Data analysis using SPSS Version 20 and NVivo 12 revealed that the mental healthcare model in the study area is a combination of out-patient, in-patient, and CMHM. Participants showed a good level of awareness of CMHM. They also identified barriers to mental healthcare, including stigmatization and financial constraints. While most participants acknowledged the adoption of the Nigerian mental health policy of 2013, its implementation was notably inadequate. **Conclusion:** A strong necessity to reform Nigeria's existing mental health care with proper policy guide is imperative in this study. This will tilt the nation towards international standards and global best practices, and guarantee the most efficient and effective mental health service delivery to the Nigerian people.

Keywords: Assessment; Mental Health Practices; Mental Health Policy; Mental Healthcare Practitioners; Nigeria; Mixed-Method.

INTRODUCTION

The World Health Organization defines mental health as "a state of well-being in which each individual realizes his or her own potential, can cope with everyday stresses, can work productively and fruitfully, and is able to contribute to her or his community". [1] There is a mental health epidemic happening all across the world. A mental illness or drug use problem affects about one in ten people, or 792 million people, and accounts for 10% of all diseases in the globe. [2] Despite the massive worldwide burden,

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Correspondence:

G O Ugbaja. Department of Community Medicine, Faculty of Clinical Sciences, Delta State University, Abraka, Delta State, Nigeria.

Telephone number: +23470368444554

Email: odigie.mike@edouniversity.edu.ng

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governments barely allocate 2% of their health resources to mental health,[3] and in low- and middle-income nations, 76–85% of those suffering from mental diseases are left untreated. [1,4]

The state of Nigeria's mental health services is appalling. [5] According to statistics, nearly 80% of Nigerians who suffer from severe mental health problems are unable to access the care they require because of negative cultural perceptions of mental illness, widespread stigma and discrimination, inadequately furnished services, a lack of a coordinated system of treatment, a shortage of trained mental health professionals, and a lack of funding. [6,7] In January 2023, Nigeria successfully passed the national mental health bill, replacing the outdated Lunacy Act of 1958. This significant milestone comes after years of unsuccessful attempts to amend the law since the initial creation of the national mental health policy document in 1991. [7, 8] Currently, Nigeria has 27 multi-specialty hospitals controlled by the federal and state governments as well as 12 regional mental hospitals, all of which are located in large centers and provide psychiatric care to the country's 213 million residents. [9-11] The most severe patients can only be treated in mental in-patient facilities or improvised institutions due to a lack of community-based and primary healthcare services, while the majority (roughly 70%) of mental health services are provided by religious organizations and traditional healers. [12]

Community engagement is one of the creative mental health treatment strategies that has been put into place as a result of the widespread prevalence of mental illness. The community mental health model (CMHM) is endorsed by the World Health Organization as an effective strategy for delivering mental health services. [13, 14]

The rationale of this study is based on the urgency to reform Nigeria's mental health policy and its current model of care for individuals with mental illness, which will result in the development of an evidence-based protocol for the development, implementation, monitoring and management of adequate mental healthcare practices and policy.

Therefore, this study aims to assess mental health practices and policy implementation among mental healthcare practitioners in Delta and Edo states, Nigeria; with specific objectives to determine: the current model of mental health care in Nigeria, level of awareness of mental health practitioners about the new model of care (the community mental health model), barriers to improvement of mental health care in Delta and Edo states, and the implementation of the current mental healthcare policy in Nigeria.

MATERIALS AND METHODS

This study adopted a mixed-method research; integration, or "mixing," quantitative and qualitative studies within a single investigation or sustained program of inquiry. The basic premise of this is that such integration permits a more complete and synergistic utilization of data than separate quantitative and qualitative data collection and analysis. [15] The study was conducted at one federal tertiary institution in Edo (Federal Neuro-psychiatric hospital, Benin-city), one federal tertiary institution in Delta (Federal medical center, Asaba) and two state tertiary institutions in Delta (Central Hospital, Warri and Delta State Teaching Hospital, Oghara) states, Nigeria.

The study population comprised of all public mental healthcare practitioners; psychiatrists, psychiatric nurses, clinical psychologists, behavioral therapists, social workers, neuro physiotherapists, occupational therapists, medical officers at the selected study sites. Non-public mental health clinicians, persons without knowledge of mental health services or who do not work directly with mentally ill patients were excluded from the study. The quantitative study utilized a total population sampling method, which is a form of purposive sampling technique. On the other hand, the qualitative aspect employed purposive sampling.

A researcher administered 23- itemed questionnaire was used for data collection in the quantitative study. The questionnaire comprised of the bio-data to elicit respondents' demographic details, while the subsequent four (4) sections were designed with questions to elicit responses that captures the

research objectives. The qualitative study data collection process was by conducting a one-on-one in-depth, semi-structured interview at the selected mental health facilities after contacting the participants who consented all interviews were audio-recorded and conducted in English language. Data analysis for the quantitative study was conducted using the Statistical Package for Social Sciences software (SPSS version 20), then presented with descriptive statistics in frequency and percentage; using tables and bar charts only. While for the qualitative study, the transcripts were organized and managed using NVivo 12 to find patterns that were present in one interview or multiple interviews.

RESULTS

Quantitative study results

Demographically, the quantitative study results revealed that the majority of respondents were between the ages of 30 and 39 years (37.3%), with a higher proportion of females (54.2%) than males (48.8%). Most respondents were married (33.1%) and identified as Christians (93.2%), while Bini (31.4%) was the predominant ethnicity. The highest educational qualification was a Bachelor of Science in Nursing (BSN) with 45.8%, followed by a Bachelor of Medicine and Bachelor of Surgery (MBBS) with 39.0%. The majority of respondents were employed at a federal tertiary health institution in Edo state (87.3%), with psychiatric nurses (39.8%) being the most common designation, followed by psychiatrist with 24.6%. See Table 1

Current model of mental health care in Nigerian hospitals.

Findings from this study revealed that out of the four (4) known models of mental healthcare (out-patient, in-patient, community mental health and combination of the three), the combination model was the most popular, with 56.8% of respondents indicating they offer it (Figure 1). This was followed by the out-patient model, which was selected by 16.9% of respondents. The in-patient model was chosen by 13.6%, and the least popular option was the community mental health model (CMHM), which was chosen by 9.3% (See Table 2).

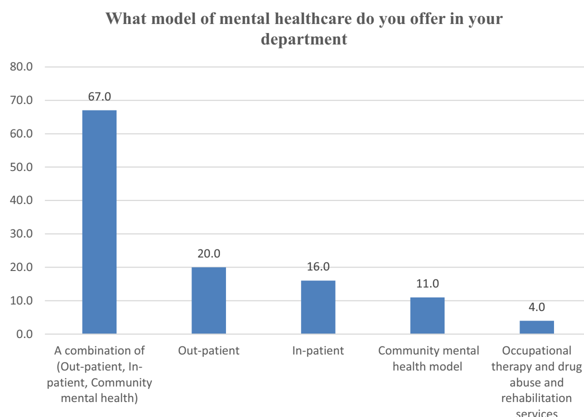

Figure 1: Bar chart showing distribution of models of mental healthcare practiced in the study institutions.

Table 2. Model of mental healthcare offered in mental healthcare facility
MENTAL HEALTHCARE FACILITIES

What Model Of Mental Healthcare Do You Offer?	Fnph Benin-City	Fmc Asaba	Central Hospital, Warri	Delsuth, Oghara	Total
A combination of (out-patient, in-patient, community mental health)	67	0	0	0	**67**
In patient	16	0	0	0	**16**
Community mental health model	11	0	0	0	**11**
Out-patient	4	6	6	4	**20**
Unknown mental health model	4	0	0	0	**4**
Unknown mental health model (Occupational therapy and Drug abuse rehabilitation)	4	0	0	0	**4**
Total	**102**	**6**	**6**	**4**	**118**

Level of awareness about the new model of care: Community mental health model (CMHM).

In this study, a significant majority (94.9%) of respondents were aware of the community mental health model (CMHM), while a small percentage (5.1%) had no knowledge about it. Among those who knew about CMHM, more than half (n=89; 79.5%) had a sufficient understanding of this model. The main sources of information about CMHM were research papers and the internet (53.6%). A smaller percentage of respondents acquired information from colleagues (22.3%) and television (2.5%). See Table 3.

Table 3: Participants knowledge, level of awareness and source of information about the new model of care (Community mental health model).

Variable	Frequency	Percentage (%)
Knowledge about the new Model of care (CMHM) (n= 118)		
Yes	112	94.9
No	6	5.1
Level of awareness of CMHM for those indicated yes (n=112)		
Excellent	16	14.3
Very good	31	27.7
Good	42	37.5
Fair	20	17.9
Poor	3	2.7
Source of information (n=112)		
Radio	3	2.7
Television	6	5.4
Newspaper or bulletin	1	0.9
Research papers or journals	30	26.8
Internet	30	26.8
From a colleague	25	22.3
Others	7	15.2

Barriers to improvement of mental healthcare.

In this quantitative study, 89.8% of respondents acknowledged barriers to mental healthcare services in their states of practice, with 10.2% reporting no barriers. The primary barriers identified were stigmatization (15.1%) and financial constraints (13.2%) (Table 4a). In addition, respondents suggested solutions such as public education on mental illness (31.1%) and increased public awareness (19.8%) with regards to the barriers (Table 4b).

Current state of implementation of mental health policy.

Majority of respondents (69.5%) reported familiarity with the Nigerian mental healthcare policy titled "National policy for mental health service delivery, 2013." Additionally, 59% of respondents were aware that this policy had been adopted in their current mental health department. However, opinions on the level of implementation varied, with 37.3% considering it fair and 35.6% perceiving it as poor.

Table 4a: Barriers to the provision of mental healthcare services.

Variable	Frequency	Percentage (%)
Barriers to the provision of mental healthcare (n= 106)		
Stigmatization (for both professionals and patients)	16	15.1
Financial constraints/ high cost of treatment	14	13.2
Ignorance/ Inadequate information about mental illness	12	11.3
Lack of public awareness of mental illness	10	9.4
Cultural belief	9	8.5
Poor government funding	9	8.5
Limited number of mental health workers	8	7.6
Accessibility/Availability	5	4.7
Religion	5	4.7
Inadequate facilities	4	3.8
Public misconception	4	3.8
Poor health seeking behavior	3	2.8
Outdated mental health laws	2	1.9
Political will	2	1.9
Poor social support	2	1.9
Limited federal institutions	1	0.9

Table 4b: Possible solutions to barriers affecting provision of mental healthcare services.

Variable	Frequency	Percentage (%)
Possible solutions (n= 106)		
Public enlightenment on mental health	33	31.1
Public awareness/ education	21	19.8
Health care insurance/ Subsidized treatment	12	11.3
Government funding and NGO's collaboration	10	9.4
Creation of rural mental health clinics in primary health centers	9	8.5
Modern mental health facilities	7	6.6
Recruitment and training of new and old mental health professionals.	7	6.6
Community involvement in rehabilitation/ follow-up care of mentally ill	3	2.8
Co- involvement of traditional/ religious leaders in care of mentally ill	2	1.9
Implementation of updated mental health laws	2	1.9

Suggestions for improving mental health policy implementation in Nigeria included providing legislative support for effective policy implementation (23.8%), increasing awareness among policymakers (19.0%), and implementing the policy across all levels of healthcare (19.0%). See Table 5.

Table 5: Knowledge, adoption, level of implementation and measures to improve mental health policy in Nigeria.

Variable	Frequency	Percentage (%)
Knowledge the Nigerian mental healthcare document? (n=118)		
Yes	82	69.5
No	36	30.5
Adoption of the policy (n=100)		
Yes	59	59.0
No	41	41.0
Level of implementation of the policy (n= 59)		
Poor	21	35.6
Fair	22	37.3
Good	10	16.9
Very good	6	10.2
Measures for improvement (n=21)		
Government should provide legislative backing for effective implementation	5	23.8
Creating more awareness among policymakers	4	19.0
Implementation of mental health policy at all levels of healthcare	4	19.0
Increase mental health service reach through the help of rural mental health personnel	3	14.3
Re-evaluation of the policy and periodical reporting	3	14.3
Adequate funding to build better mental health facilities	1	4.8
Training of more mental health professionals	1	4.8

Qualitative Study Results

Five key informant interviews (KII) were conducted, four participants were from a federal tertiary healthcare institution while one of the participant was from a state tertiary healthcare institution. The socio-demographic characteristics of the participants are outlined in Table 6, which shows that four of the participants were male and one was female. Additionally, three of the participants were psychiatrists, one a clinical psychologist, and one a medical officer.

Table 6: Qualitative Socio-demographic characteristics of participants.

Code Of Informants	Age (Years)	Gender	Role	Hospital	Highest educational Level
IDI_01	38	Male	Medical officer	FTI	MBBS
IDI_02	40	Male	Psychiatrist	FTI	MEDICAL FELLOWSHIP
IDI_03	35	Female	Clinical psychologist	FTI	M.SC MEDICAL
IDI_04	42	Male	Psychiatrist	FTI	MEDICAL FELLOWSHIP
IDI_05	50	Male	Psychiatrist	STI	MEDICAL FELLOWSHIP

**FTI- Federal tertiary institution, **STI- State tertiary institution*

The results of the KIIs are presented in themes as follows:

Current model of mental healthcare in the hospital

Most participants (3) reported employing a combination model of mental healthcare, including outpatient, inpatient, and community mental health models. One participant mentioned solely offering the outpatient model in their healthcare institution.

Level of awareness about the new model of care: Community mental health model (CMHM).

The majority of participants were aware of the new model of care, the Community Mental Health Model (CMHM).

Barriers to Improving Mental Healthcare.

Participants identified barriers to providing mental healthcare services in their respective states, including stigma, lack of political support, and financial constraints. They suggested potential solutions such as establishing mental health services in rural areas, raising public awareness, improving mental health facilities, and expanding health insurance coverage.

Current state of implementation of mental health policy.

Participants noted the absence of specific state-level mental health policies and acknowledged the utilization of the National Mental Health Policy of 2013.

They emphasized the importance of policy implementation at the primary healthcare level, government sensitization, policy review, increased mental health budget, and inclusion of traditional and religious leaders in the policy to enhance mental health policy in Nigeria.

DISCUSSION

Summary of key Results

Findings from this study revealed similarities in results from qualitative and quantitative investigations which suggest that the current model of mental healthcare practiced is the combination model (out-patient, in-patient and community mental health model). Additionally, there is also a good self-reported level of awareness of the community mental health model among participants. Furthermore, there are numerous barriers to mental healthcare provision as indicated by participants in their states of practices, which included stigmatization, financial constraints, inadequate information, cultural beliefs, and lack of political will. Lastly, the level of implementation of the National Policy for Mental Health Service

Delivery (2013 document) was inadequate, although the majority of respondents acknowledged its adoption.

Interpretation / Generalization

The World Health Organization-Assessment Instrument for Mental Health Systems (WHO-AIMS) report highlighted the limited availability of community-level mental health services, with a strong focus on curative psychiatric care offered by regional psychiatric institutions and state tertiary hospitals. [16] Past studies have similarly shown that relying solely on hospital-based models of care fails to adequately address access barriers and ensure consistent support for individuals with long-term disabilities.[17] Consistent with these findings, this study reveals that Nigerian hospitals predominantly adopt a combination of outpatient and inpatient models, while the community mental health model (CMHM) received less preference. This suggests that mental health services in Nigeria continue to favor institutionalized models of care and do not consider community mental models as the sole viable option for delivering mental health services.

Furthermore, this study highlights a commendable level of self-reported understanding and familiarity with the Community Mental Health Model (CMHM) among participants. This positive outcome can be attributed to the diverse range of informative resources they had at their disposal, such as academic articles, the internet, and insights from peers. However, continuous professional development and training for mental health practitioners are crucial for enhancing their comprehension of the CMHM. In settings with a shortage of mental health professionals, it is imperative for primary health care unit employees to undergo comprehensive training in various aspects, including identification, referral processes, prescription practices, and psychotropic medication management.

Additionally, this study investigates various barriers to the delivery of mental health services, including stigmatization, cultural beliefs, financial constraints, and inadequate government funding. These barriers align with previous research, which has also identified cultural belief systems, limited information, and lack of public awareness as contributing factors to the stigma surrounding mental illnesses. Consequently, this stigma leads to adverse emotional and social consequences such as social isolation, unemployment, and abandonment. [18] Financial constraints further exacerbate the situation, as mental health treatment often incurs high out-of-pocket expenses, resulting in inequitable accessibility. The lack of government support in terms of social welfare for individuals seeking mental health services contributes to poorer mental health outcomes. [19 -23] Inadequate government commitment to prioritizing mental health services, due to ambiguous objectives, personnel challenges, insufficient legislation, and funding limitations, has also hindered their expansion of mental health services. [24 -27]

This study supports the 2006 World Health Organization-African Regional Office Mental Health Action Plan (WHO-AIMS) Report, indicating that Nigeria's inadequate policy implementation hinders the provision of satisfactory mental health services. [16] Another study highlights the challenges arising from the absence of effective mental health policies, poor enforcement, and political disregard, particularly in basic healthcare and existing mental health facilities in Nigeria [28-29]. In order to address these challenges, it is crucial to establish a legislative framework that ensures effective policy implementation, appropriate resource allocation, and robust monitoring of health information systems across all levels of healthcare, particularly in primary healthcare. The recent national mental health bill of 2019 provides an opportunity to rectify previous policy limitations and enhance the provision of mental health services. By giving utmost priority to the adherence of the provisions delineated in the bill, it becomes feasible to attain efficient allocation of resources and successful implementation of the bill across all healthcare levels [30].

The study's strength lies in its mixed-method research design, which enhanced its validity and reliability through data triangulation. This approach yielded comprehensive insights of the research problem resulting in a robust body of evidence. However, limitations include a smaller sample size in the qualitative component due to time constraints (5 out of 15 intended participants).

In summary, this study emphasizes the significance of adopting the community mental health model to ensure efficient delivery of mental health services. It explores the challenges faced in delivering mental health services and proposes solutions like public education, awareness campaigns, and subsidized care. Furthermore, it underscores the importance of reassessing the national mental health policy by establishing a legislative framework and implementing mental health services at the primary healthcare level, highlighting the importance of comprehensive and easily accessible care.

CONCLUSION

This research investigated mental health practices and policy implementation in the southern region of Nigeria. The results indicated that the existing mental healthcare model incorporates outpatient, inpatient, and community mental health approaches. Participants exhibited a commendable level of familiarity with the community mental health model. Moreover, they highlighted various obstacles to delivering mental health services, including stigmatization, financial constraints, limited awareness, cultural influences, insufficient government funding, and a lack of political dedication. Additionally, the study found the implementation of the mental health policy to be inadequate.

To improve mental healthcare in Nigeria, several key actions are recommended: The Federal Ministry of Health (FMOH) should collaborate with other health agencies (public and private) to coordinate public health education campaigns focused on mental health. NGOs and professional associations should expand mental healthcare services towards prevention-oriented approaches to increase mental health awareness. State governments should integrate mental health care into primary health centres to enhance accessibility, prioritize human rights, and improve health outcomes. The FMOH should also provide specialized training to address the shortage of mental health professionals. Lastly, strict compliance with the provisions outlined in the recent national mental health bill is crucial for efficient resource allocation and effective implementation of mental health policies and practices across all levels of healthcare.

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Data availability: The data used to support the findings of this study are available from the corresponding author [OMO], upon reasonable request

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Ethical approval: The study was approved by the institutional ethics committee at DELSUTH, Oghara, and FNPH, Benin-city..

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