POLICY IMPLEMENTATION: IMPLICATION ON CAREGIVING EXPERIENCES OF FAMILIES AND PERSONS LIVING WITH SERIOUS MENTAL HEALTH PROBLEMS IN NIGERIA

BY

IZIBELOKO OMI JACK-IDE

A Thesis submitted to the School of Nursing, Faculty of Health Sciences, University of KwaZulu-Natal

In fulfillment of the requirements for the degree of Doctor of Philosophy (Nursing)

Supervisor: Leana R. Uys

Co-Supervisor: Lyn E. Middleton

2012

DECLARATION

I hereby declare the sole ownership of this dissertation

POLICY IMPLEMENTATION: IMPLICATION ON CAREGIVING EXPERIENCES OF FAMILIES AND PERSONS LIVING WITH SERIOUS MENTAL HEALTH PROBLEMS IN NIGERIA

This research thesis has been submitted for PhD in Nursing (Mental Health) at the University of KwaZulu-Natal, Durban, South Africa on the merits of its originality, through observation of the scientific process of academic writing, tremendous input from my supervisors. It has never been submitted for any degree or examination in any institution. Work used and cited in this dissertation has been appropriately acknowledged both within the text and in the reference list.

Signature……………………………………….Date………………………………

Name: Izibeloko Omi Jack-Ide   Student Number: 209527704

This study has been approved for submission by the Supervisors

Prof Leana R. Uys and Dr Lyn E. Middleton

Signature.…………………………………….. Date…………………………….

Signature…………………………………….Date………………….…….......

DEDICATION

This work is dedicated to persons and families living with mental health problems and to God Almighty for His love and mercies in my life

ACKNOWLEDGEMENTS

First and foremost I give thanks to God Almighty who gave me life and the privilege to embark on this PhD journey and saw me through to the end of my study and residence in Durban, South Africa.

Special thanks and appreciation

There are many people without whom this dissertation could not have been accomplished. With a grateful heart I express my thanks and appreciation to the following persons who, in no small measure, contributed greatly through financial, physical, emotional and spiritual support to the successful accomplishment of this project work. I humbly wish to acknowledge the contributions of the following persons to whom I am greatly indebted.

Prof Leana R. Uys

My indefatigable and amiable supervisor for helping me develops passion for academic writing and the value for research. Who has been a pillar of my success, your dynamism and enthusiasm has led me on even during very stressful time. Thanks Prof for accepting to supervise me and provided an intellectually enriching experience in the area of mental health research which enhanced this study in a very unique manner. Your supervision was tremendous, and is greatly cherished. Without which this project work would have been consigned to oblivion. I am "here" because you made this dream come true. Thanks Prof!!

Dr Lyn E. Middleton

My co-supervisor, for helping me develop appreciation for the value of research in mental health nursing specialty. Thanks for your time and the light you ignited that cultivated a deep interest for academic writing and for providing a rich wealth of practical experiences that enhanced this study in a knowledgeable manner and for this; your supervision was excellent and greatly appreciated. Thanks so much!!

My loving family

Thanks to my children Ivy and Miriam, stepchildren Etimekize and Amelia, my adopted son Peter alias AA and my grandchildren Ekiye Junior alias J-boy, Sini and Gbavieme for their unending love, support and encouragement in my ongoing pursuit of my goals and most especially my beloved husband, Hyacinth Ben Ide "Dearest" never stopped believing in me and reminded me many times of what I am able to accomplish. I cannot thank you enough for your never ending patience, kindness and love, you have always been, and continues to be, a source of love and strength.

To my relatives

My elder brother, Chief Boma Spero Jack "Daddy" Thanks for your fatherly support and holding forth the home front, your enormous financial and emotional support. To my mother Mrs. Fanny Gwegwe Jack and my sisters, may God replenish and keep you all in good health.

Prof Musa Kola Jinadu

Words are not enough to express my heartfelt gratitude for your great initiatives, to secure my admission into University of KwaZulu-Natal. This story began with you and for this, you are greatly appreciated. Thanks so much for all!!

Niger Delta University (NDU)

My sincere thanks and appreciation for granting me study leave to pursue further studies in the hope that I return home to serve the institution and the young Faculty of Nursing as a foundation staff, Bayelsa State and my country on completion.

Neuro-Psychiatric Hospital

Thanks to the management and staff of the Neuro-Psychiatric Hospital, Rumuigbo, Port Harcourt, Rivers State, Nigeria for the support during data collection. I will always cherish your hospitality, eagerness and assistance in all. Sincere thanks!!

Study Participants

To all of you, who volunteer to take part in this study, my heart is full of thanks and appreciation for providing useful and relevant information needed for this study.

University of KwaZulu-Natal (UKZN)

Thanks for granting me admission to pursue higher education in a stimulating and serene environment that reflect academic scholarship. The academic and support staff, School of Nursing, UKZN, Durban, for your dedication to duty and willingness to assist and support

during the time of my study. Thanks for your wise counsels and support throughout my stay in Durban, South Africa.

My friends

Prof Adeleka A. Ojo, Theresa Obi, Akeghyifa Diffa, Prayer Solomoba Hogan, Mmoni Ndibo Tabengwa and my Durban family Bro Swana Munduku and wife Sister Steve Munduku. I appreciate your care and support, the special phone calls you make to know how I am faring in Durban, and they were of great support. Thanks for being there!!

My Classmate and Friend

Mrs. Penehafo Angula, we met first week of arrival in Durban at School of Nursing. You also came from afar (Namibia), we bonded together and our friendship became a beacon of strength. We cried together when the cloud of academia became gloomy and we also laughed and rejoiced together during times of successes. Thanks!!! You were more than a friend "You are a Sister"

TABLE OF CONTENTS

SECTION ONE: INTRODUCTION

SECTION TWO: ARTICLES AND POLICY BRIEF

SECTION THREE: CONCLUSION

ANNEXURE

LIST OF TABLES

LIST OF FIGURE

POLICY IMPLEMENTATION: IMPLICATION ON CAREGIVING EXPERIENCES OF FAMILIES AND PERSONS LIVING WITH SERIOUS MENTAL HEALTH PROBLEMS IN NIGERIA

SECTION ONE

1. INTRODUCTION

Mental health is an integral and essential component of health (Prince et al., 2007), with mental health problems constituting 14% of the global burden of disease and being one of the leading causes of disability world-wide (World Health Organization (WHO), 2008a). Prince et al. (2007) argue that this burden of mental illness is likely to have been underestimated because of the inadequate appreciation of the connectedness between mental illness and other health conditions. Furthermore, many individuals with mental health problems remain untreated although effective treatments exist (Kohn et al., 2004; Wang et al., 2007). It is therefore anticipated that by 2020, mental health problems will constitute 15% of the global burden of disease (Kohn et al., 2004) and account for 37% of all healthy life years lost through disease (Wang et al., 2007).

Almost 30% of the total burden of non-communicable disease is due to disorders most frequently associated with mental health problems (WHO, 2008a). These disorders are often co-morbid with, or act as risk factors for, non-communicable diseases (e.g. cardiovascular disease and cancer), communicable diseases (e.g. HIV/AIDS and tuberculosis), maternal sexual and reproductive health problems (e.g. increased gynaecological morbidity, sexual violence and maternal depression) violence and road

1

traffic accidents (WHO, 2008a). Cardiovascular diseases and cancer are the main contributors to disability and mortality within the non-communicable diseases aside from neuro-psychiatric disorders. Coronary and stroke account for 21% of disability adjusted life-years in this group and cancer for 12%. Endocrine disorders (primarily diabetes) account for 3·7% of the disability-adjusted life-years and this proportion is predicted to rise sharply to 5 4% by 2030 (Prince et al., 2007). According to the WHO's estimates, neuropsychiatric disorders account for 21 million deaths every year (WHO, 2008a). Approximately, about 877 000 die of suicide yearly, 86% of whom are in low-income and middle-income countries, and more than half of whom are aged between 15 and 44 years (Prince et al., 2007).

Community-based epidemiological studies have estimated that the worldwide lifetime prevalence rates for mental disorders in adults ranges from 12.2–48.6%, with a twelve month prevalence rate of between 8.4 and 29.1% (WHO, 2008a). The extent of the burden and prevalence of psychiatric disorders is of serious concern for national health systems and for psychiatric service delivery in developing countries in particular (Jacob et al., 2007; Chisholm et al., 2007). A WHO report shows that developing countries have a higher proportion of persons with serious mental health problems than developed countries due to poor resource environment, and that between 76–85% of persons with mental health problems in developing countries received no treatment in the previous 12 months compared to 35-50% in developed countries. In a WHO (2008a) review of the world literature on mental health, WHO found treatment gaps to be 32% for schizophrenia, 56%

for depression, 50% for bipolar, 56% for panic disorders and as much as 78% for alcohol use disorders.

Reports of mental health service utilization over a period of 12 months illustrate the seriousness of the situation for both developing and developed countries. For example, only 2% of persons with mental health problems in Nigeria, compared to 18% of persons in the United States of America used a mental health service in the preceding year, while only 11% of persons in China received care on first service contact, compared to 61% in Belgium. Follow-up treatment is higher than service utilization in developed countries e.g. 70% follow-up rate in Germany compared with 10% in Nigeria (Wang et al., 2007).

Currently, primary and community-based mental health care is the global approach to care (WHO, 2001; 2008b; 2008c; Amorim & Dimenstein, 2009). The primary purpose of this approach is to provide affordable, effective mental health and physical care in tandem to people at the community level, closest to where they live and with minimal disruption to family life (Saxena et al., 2007). This approach has been well described in a number of global documents for mental health in developing and developed countries, most notably "Mental Health Gap Action Programme: Scaling Up Care for Mental, Neurological and Substance Use Disorders" WHO, 2008a; "Integrating Mental Health into Primary Care: A Global Perspective" World Health Organization and World Organization of Family Doctors (WONCA), 2008; "Treatment and Prevention of Mental Disorders in Low-income and Middle-income Countries" Patel et al., 2007; "Mental Health: New Understanding, New Hope" WHO, 2001. These documents set out priorities, opportunities and challenges

for mental health care service delivery for both developing and developed countries (Jacob et al., 2007). Among these priorities are developing mental health policies and legislation, integrating mental health services into primary health, ensuring the affordability of primary care for mental health, and providing human resource for service delivery. Mental health is central to values and principles of the Alma Ata Declaration which states that primary health care (PHC) is the key to the attainment of Health for All (HFA), that health is a fundamental right, to be guaranteed by the state, that people should be the prime movers in shaping their health services, using and enlarging upon the capacities developed in their societies, and that health services should operate as an integral whole, with promotive, preventive, curative, and rehabilitative components (WHO, 2008c).

Primary and community-based mental health care have been adopted, with varying degree of success, by a number of countries across the developing (Brazil, India, South Africa) and developed (Australia, United States, Britain) world (Jacob et al., 2007). The extent to which health systems are able to integrate mental health care into psychiatric care is influenced by a number of challenges. Many developing countries in Africa (e.g. Guinea-Bissua and Somalia) are required to provide integrated care without mental health legislation and policies to direct their mental health programs and within the context of scarce financial, human and infrastructure and treatment resources for mental service delivery (WHO, 2001; Jacob et al., 2007; Patel et al., 2007). A World Health Organization survey found that only 50% of African countries have a mental health policy compared to 70.5% in developed countries (WHO, 2005a). Within sub-Saharan Africa, South Africa is

rated highest in the provision of essential components of mental health care service and human resources and has a mental health legislation, policy and plans in place.

With respect to mental health financing, 47% of developing countries spend less than 1% of their total health budgets on mental health, compared to 6-8% spent by developed countries (WHO, 2005a). In 2007, Nigeria spent 5% of the GDP (gross domestic product) on health (Jacob et al., 2007) with approximately 3.3% of this health budget being allocated to mental health. Ninety percent of this mental health budget was allocated to big mental health hospitals in the country (World Health Organization-Assessment Instrument for Mental Health Services Report on Mental Health in Nigeria (WHO-AIMS), 2006) for the maintenance of structural facilities and to pay specialists. The limited financial resources for mental health is often compounded by lack of commitment from public health policy makers and inefficient use of resources (Tomlinson et al., 2009), all of which contribute to poor delivery of services and to the suffering in people with mental disorders (Jacob et al., 2007).

The shortage of skilled mental health professionals has been identified as a critical issue for mental health service provision in developing countries. For example, the median number of psychiatrists in high income countries is 200 times greater than that in low-income countries. There are approximately 1800 psychiatrists for 702 million people in Africa compared to 89 000 psychiatrists for 879 million people in Europe (WHO, 2005b). Similar inequalities are evident for all other mental health professionals, such as psychiatric nurses, psychologists, social workers, occupational therapists (Gureje & Alem, 2000; WHO-AIMS,

2006; Patel, 2007; Lund et al., 2008). For example, Nigeria has a ratio of four psychiatric nurses, 0.09 psychiatrists, 0.02 psychologists and social workers per 100 000 persons. South Africa has 7.5 psychiatric nurses per 100 000 people, 1.2 psychiatrists per 100 000 people and 4.5 mental health bed. Ghana is slightly worse off than Nigeria, with 2 psychiatric nurses per 100 000 people, and 0.08 psychiatrists per 100 000 people (Jacob et al., 2007). With regard to mental health services, Nigeria has 0.4 mental health beds per 100.000 persons, South Africa 4.5 mental health beds and Ghana, 0.4.

Social, individual and family poverty is an additional global challenge, with approximately 1.4 billion people world-wide being affected, equating to over one fourth of all people in developing countries living below the poverty datum line (Chen & Ravallion, 2008). The most recent global declaration of the Millennium Development Goals (MDG) for education and social development emphases, the relationship between health, poverty and individual productivity, social stability and national economy. The relationship between poverty and mental illness has been described as 'complex, bi-directional and dynamic' (Patel et al., 2007). Mental disabilities result in substantial burdens for individuals and families, particularly in developing countries where out-of pocket expenditure is the dominant form of mental health care financing (Funk et al., 2009).

Challenges notwithstanding, some African countries have made some progress towards integrating mental health care into primary health care in community settings using community mental health teams and outreach clinics (Jacob, 2001; Seloilwe & Thupayagale-Tshweneagae, 2007; Lund et al., 2008) For example, the care of persons with

serious mental health problems in Botswana is provided by a central psychiatric hospital with a follow-up care offered through psychiatric outpatients clinics attached to the district hospitals. These clinics are run by psychiatric nurses with a psychiatrist visiting on monthly basis (Seloilwe & Thupayagale-Tshweneagae, 2007). South Africa also uses community mental health teams and outreach clinics to bring treatment services closer to users and for community based mental health promotion and illness prevention activities (Lund et al., 2008). For example, in the Moorreesburg District of the Western Cape, the general primary care nurse provides regular basic and daily mental health services and is supported in this, by different mental health professionals. The mental health nurse visits the clinic once a month, a regional psychiatrist visits clinics once every three months, a psychologist sees patients for eight hours per week and a medical officer is available daily at the clinic. Complex cases are managed through joint consultations with the primary care worker and in this way, knowledge and skills can be imparted and supervision offered. http://www.who.int/mental_health/policy/services/SouthAfrica.pdf

The benefits of integrating mental health into community-based primary care services in developing countries is illustrated in a number of recent studies which have shown that this approach not only makes mental health care local and accessible, but is also able to address the multiple social needs of individuals and families such as sheltered housing, employment, welfare payments and subsidized cost for treatment, which promotes rehabilitation, empowerment and community integration (Browne & Courtney, 2005; Gavois et al., 2006; Wang et al., 2007). For example, integrated primary mental health care enhances access to mental health services, and brings services closer to their homes, thus

maintaining the clients and their families' well-being. Primary care for mental health also facilitates community outreach and mental health promotion therefore minimizes stigma and discrimination and removes the risk of human rights violations that can occur in large mental hospitals. Primary care services for mental health are less expensive for patients, communities and governments. In addition, it results in a reduction on patients and families indirect costs associated with seeking specialist care in distant locations and promotes good mental health outcomes when linked to social network services in the community.

These facilities in the community have resulted in numerous financial and other forms of support for persons with serious mental health problems and their families (Saxena et al., 2007; Langeland & Wahl, 2009). Saraceno et al. (2007) argues that this approach has the potential to reduce stigma, to improve early detection and treatment, and to partly offset limitation in mental health resources through the use of community resources.

With a shift in emphasis in most parts of the world from institution to community family care, the role of the family in the care of persons with serious mental health problems has increased (Ohaeri, 2002; Schulz & Matrie, 2004; Chang & Horrocks, 2006; Seloilwe & Thupayagale-Tshweneagae, 2007; WONCA, 2008). The totality of the experience of caring for relatives or friends with serious mental health problems, affects the physical, psychological and socioeconomic wellbeing of families as well as their capacity to cope with and adjust to those circumstances (Cuijpers & Stam, 2003; Foldemo et al., 2005; Rossler et al., 2005). The family faces numerous challenges, including the daily stressors of unpredictable and bizarre behaviors of their mentally ill relatives, the cost of treatment

(McDonell et al., 2003; Saunders, 2003; Shibre et al., 2003), and stigma that leads to social withdrawal and hinders their integration into the community (Corrigan et al., 2001; Ohaeri, 2001).

Caregiving experiences of families living with persons with serious mental health problems in developed countries such as the United States of America, Canada, Sweden and United Kingdom have been well described (Gallagher & Mechanic, 1996; Magliano et al., 2000; Veltman et al., 2002; Foldemo et al., 2005). These studies in developed countries shed light on the stress and burden of families experiencing caregiving in a developed and even more resourced context. They suffer both subjective and objective burdens which are found to be strongly associated with overall poorer functioning of their health and wellbeing. Patel, (2007) and Shibre et al. (2003) argue that given the human resource, financial and service delivery challenges faced by most developing country health systems, the demand for family care-giving will increase, and that this requires support from health care systems and nongovernmental organizations as a whole.

1.1 FORMAT OF THE STUDY

This thesis is presented in three sections: Section one being the introduction and background to the study, section two detailing the articles and section three conclusion, it presents the discussion and findings, addressing the six research questions, application of the theoretical framework, relevance of the study to nursing knowledge and practice, limitation and implications. The study is by research papers for publication in peer review journals and was conducted in five phases as stated below:

PHASE ONE: A comparative study of mental health services in two African countries: Nigeria and South Africa (Theoretical review).

This phase involved a comparative policy analysis of the current mental health care acts, mental health policies, service planning documents and country health and human resource profiles of two middle in-come African countries i.e. Nigeria and South Africa. The purpose of this analysis is to identify the crucial policy differences and similarities with respect to their strength and weaknesses in delivering equitable, affordable and accessible mental health services. These core elements will inform the potential for policy improvement in Nigeria.

PHASE TWO: Caregiving experiences of families of persons with serious mental health problems in the Niger Delta Region of Nigeria (qualitative analysis).

This phase dealt with in-depth individual interviews with family caregivers living with relatives with serious mental health problems. Qualitative data analysis was done to explore the caregivers' experiences in terms of the components of the theoretical framework describing the health service environment. After the data analysis, a focus group discussion was held with family caregivers to validate the conclusions reached from the results.

PHASE THREE: Clients with serious mental health problems experiencing care within the current mental health policy in the Niger Delta region of Nigeria (qualitative analysis).

Phase three explored clients' experiences of being recipients of mental health services within the current policy environment in Rivers State, Nigeria. To understand the progress and successes of mental health service delivery requires empirical data, which could only

be attained by asking the clients about their lived experiences, to learn what had propelled them forward in recovery as well as what had held them back. The interview deal with current service use experiences, their care pathway in order to assess accessibility and acceptability of services, and their everyday life of living with mental illness. A focus group discussion was held after the data analysis with clients to confirm findings.

PHASE FOUR: Mental health care professionals' experiences of providing mental health services within the current policy environment in the Niger Delta region of Nigeria (qualitative analysis).

This phase explored mental health care professionals' experiences of providing mental health care services to families/clients with serious mental health problems, as to provide insight and identify the challenges of mental health care provision in Rivers state, Nigeria. After data analysis a focus group discussion was held to validate the conclusions reached from the results.

PHASE FIVE: Policy brief development

This phase involved development of policy briefs from results of the theoretical analysis and qualitative studies. Title of brief "Increasing access to mental health services through primary health care in Nigeria" This document was prepared and presented to policy-makers in Nigeria to suggest mental health policy reforms. This is based on international and African best practices and on the contextual reality of the Nigerian health and financial status.

1.2 THE NIGERIAN MENTAL HEALTH CONTEXT

Nigeria is situated on the west coast of Africa. It has a population of over 140 million people (NPC, 2006) and covers an area of 924,000 square kilometers. It is a country of ethnic diversity with over 200 local languages with English being the common official language. The country has 36 states with the Federal Capital City (FCT) Abuja situated in Niger State. It has sustained its democracy for fourteen years and has a federal system of government, with constitutional responsibilities allocated to the various tiers of government; central, state and local. There are predominantly two main religions, Islam in the north and Christianity in the south. According to Gureje, (2003) traditional religions are still practised by some people (idols or ancestral worship). The family system is an extended or communal type, with members of the family living closely together and sharing the duties of nurturing and training its members collectively.

According to the World Bank, Nigeria is rated as a middle-income country (WHO, 2005a). Approximately 170 out of every 1000 children die before the age of five years and life expectancy is 46.8 years for men and 48.2 years for women (WHO, 2000). Nigeria is an oil producing country and yet the majority of the population is very poor. The bulk of the nation's oil wealth comes from the Niger Delta region and Rivers State is one of the states in the Niger Delta. The Nigerian public health system is developed around the primary health care approach to care. This approach was introduced into the country in 1981 with the adoption of the Declaration of Alma Ata conference in 1978. A National Mental Health Policy and Action Plan were formulated as a policy document in 1991 (Federal Ministry of Health (FMOH), 1991), in order to integrate mental health into primary health care. By

promulgating this policy, mental health became the ninth component of the nation's primary health care service. Primary health care is rendered as the first tier of care, followed by secondary care and lastly tertiary care. Since the formulation of the mental health policy over 30 years ago, no formal assessment or revision has been done to ascertain the extent of mental health implementation (Gureje, 2003; WHO-AIMS, 2006),

Although the development of the health system is centrally directed, its implementation is coordinated by the various States and Local Government Authorities. Authority for service delivery is devolved to various state Ministries of Health with different states ministries being responsible for each level of care. Tertiary hospitals are under the portfolio of the Federal Ministry of Health, secondary care falls under the Ministry of Health of each state, while primary health care being the responsibility of the Local Government Authority. These different functions are coordinated at a central level by the Federal Ministry of Health which has the overall responsibility for the implementation and improvement of the national health care service (FMOH, 2004). The Federal Ministry of Health sets the general goals, priorities and directions for development of health services and activities while state and local authorities are responsible for implementation.

Mental health care in Nigeria has not been implemented at the community level, a process that presents a number of challenges, most of which are shared by other resource-poor low to middle income countries. The first of these relates to legislation and implementing the mental health policy. The existing Mental Health Policy in Nigeria is the first policy document addressing issues of mental health (WHO-AIMS, 2006). It reinforces the

principle that communities and individuals have the right and duty to participate in the planning and implementation of health services. It also envisages that mental health services be scaled-up at community level to create accessibility and affordability, to enable essential treatment, including psychotropic medications, to be available to those in need in the community, and to ensure that services are delivered by trained primary health workers, with coordinated supervision provided by specialist mental health professionals (FMOH, 2004). However, a new draft of Mental Health Legislation is being prepared by the Federal Ministry of Health to be passed into law by the National Assembly, as a previous mental health bill presented by two private Senators did not get the approval of the National Assembly in 2004. The Bill, when passed, will protect the rights of people with mental illness in the country.

Mental health legislation is the basis of mental health service provision because it consolidates the fundamental principles, values, aims, and objectives of mental health policies and programs (WHO, 2001; Lund et al., 2008). It provides a legal framework to prevent violations, promote human rights, equity in health and address critical issues that affect the lives of people with mental disorders (Lund et al., 2008; WHO, 2008b). The human right protection of persons with serious mental health problems from unjust discrimination is not explicit in Nigeria. The country has no specific external monitoring activities to ensure human rights of persons living with mental health problems are protected (WHO-AIMS, 2006). Reflecting on the nature of patients' contacts with service it is reported that, 51% of all admissions to community-based inpatient psychiatric units and 64% of all admissions to the mental hospitals are involuntary, that is, initiated by the

families and resisted by the patients (WHO-AIMS, 2006). The human rights of persons with serious mental health problems must be given prominence with relevant legal provisions, while the safety and well-being of the society are to be protected.

Psychiatric care is generally, hospital rather than community based, and is concentrated in urban areas. The mental health needs of the entire population are served by eight Federal government funded psychiatric institutions and six State funded hospitals located in various parts of the country, totaling 14 facilities serving a population of over 140 million people. Four of the eight federally funded facilities are located in the South West of the country, three in the North, one in the East and two in the far South of the country. This provision is skewed, as 50% of the facilities serve only 17% of the total population (WHO-AIMS, 2006). Primary mental health care services are delivered in these psychiatric facilities located in urban cities rather than through community-based PHC centers in Nigeria. However, both specialized and tertiary services are delivered through big psychiatric hospitals, while primary and secondary care is provided in the same facility in psychiatric units of teaching hospitals (WHO-AIMS, 2006). These specialized services are usually located in urban cities far from the rural communities, thereby creating inequity of access for rural and remote village dwellers (Gureje, 2003). This means that rural people have to travel great distances for specialized care and are frequently hospitalized lengthy periods of time, separated from home, family and place of employment (Lund & Flisher, 2006).

A further challenge to the delivery of mental health services is the shortage of human resources. Mental health care does not depend on advanced technology and equipment,

rather relies on professionals such as psychiatric nurses, psychologists, psychiatrists, and social workers to render effective care (WHO, 2008a). The shortage of mental health professionals and facilities has placed the family as a primary caregiver and many of these family caregivers lack understanding and skills related to mental illness, are unable to recognize early signs of relapse or the adverse effects of psychotropic drugs, and lack any professional support and resources (Adewuya & Makanjuola, 2005; Gureje et al., 2006). Families and patients are often discriminated against by negative public perceptions and misconceptions (Kabir et al., 2004; Adewuya et al., 2006), which hinders the integration of persons with serious mental health problems into their community (Ohaeri, 2001).

For a better understanding of the plight of client and families, policy makers within the region were engaged through consultation/deliberations, and one of the benefits of democracy is that individuals or groups voices can be heard on issues concerning their wellbeing through constituency representatives or various House committees of State House of Assembly (Legislators). Recommendation from the study in the form of policy briefs were disseminated and discussed with policy makers through the House Committee on Health, National and State House of Assemblies and health organizations for possible policy improvement and implementation.

1.3 PROBLEM STATEMENT

With a shift in emphasis in most parts of the world from institution to community care, the role of the family in the care of persons with serious mental health problems has increased (Chang & Horrocks, 2006; Seloilwe & Thupayagale-Tshweneagae, 2007). This role of the

family and the burdens associated with it are likely to increase, given the policy and implementation challenges facing mental health systems in general, and Nigeria in particular (Shibre et al., 2003; Epping-Jordan et al., 2004; Patel, 2007). Families need support from mental health services to cope and adjust to challenges of managing symptoms of mental illness and to know when and how to seek professional assistances. Persons with serious mental health problems experience difficulties in performing the activities of daily living and depend largely on family members for assistance with these activities from managing dressing and personal hygiene to managing the more complex activities of dealing with psychiatric symptoms, medication administration and social relationships (Dangdomyouth et al., 2008).

While there is a growing understanding of the needs of families of persons with serious mental health problems and the caregiving experiences in developed countries (McDonell et al., 2003; Kung, 2004; Awad & Voruganti, 2008), very little is known about the nature and extent of caregiving experiences or the needs and outcomes of policies on caregivers in most developing countries (Martin et al., 2006). The experiences of service users and their families with the implementation of policies, such as providing essential drugs, integrating mental health into general health care services at all levels of care, providing appropriate training of mental healthcare personnel, intersectoral collaboration, eliminating stigma, and funding mental health related research (FMOH, 1991; 2004) have not been studied.

There is very little information about how the family as the primary site of care, experiences caregiving under the current policy in Nigeria. Mental health care services are

not provided at primary centers in the communities (WHO-AIMS, 2006) where clients and families can receive help and support during time of crisis. A lack of professional mental health services to support families may likely increase the financial burden of the illness (Adewuya & Makanjuola, 2009). Additionally, the family caregiving experiences in a well resourced policy environment might not be the same in a poorly resourced one (Chang & Horrocks, 2006).   The family context in Nigeria differs substantially from a Western context yet little is known about the implications of policy on the experiences of families and persons living with serious mental health problems, their needs, available resources and network support systems (Gureje & Alem, 2000). The focus of caregiving research in the Western world may be quite different due to the type of legislation and policies that drives their mental health services and programs. This situation necessitates an understanding of the implications of the current mental health policy on families and persons experiencing serious mental health problem in developing appropriate programs and interventions to address their needs (Ohaeri, 2001). With the shift in paradigm of care, family caregiving seems to be an alternative approach to care and understanding it cannot be overemphasized.

1.4 AIM OF THE STUDY

The aim of this study is to explore families' caregivers experiences of caring for persons with serious mental health problems, clients' experiences of receiving care within the current mental health policy environment, mental health care professionals experiences of providing mental health care services for families/clients with serious mental health

problems, and to identify the difficulties/challenges of providing these services, the intention being to engage policy makers and suggest policy reforms.

1.5 RESEARCH OBJECTIVES

The objectives of the study were to:

1. Compare the Nigerian mental health care system with that of South African.

2. Explore the caregiving experiences of families living with persons with serious mental health problems in terms of the policy and health systems environment.

3. Explore the experiences of clients with serious mental health problems in terms of the policy environment.

4. Explore the experiences of health care providers of providing mental health care services within the current policy environment.

5. Describe the pathway for engaging regional policy makers in policy improvement.

6. Explore strategies for policy improvement in terms of international/African best practice and the World Health Organisation principles of equity, sustainability and affordability

1.6 RESEARCH QUESTIONS

The following six research questions guided this research:

1. How is the mental health system in Nigeria organized and how are services delivered compared to that of South Africa?

3. What are the caregiving experiences of families within this policy and health system environment?

4. What are the experiences of clients receiving care within this policy environment?

5. What are the experiences of mental health care professionals providing mental health services within the policy environment?

6. What is the pathway to be followed in engaging state policy makers in policy improvements?

7. What policy improvements will ameliorate the burden on clients and the families of those experiencing serious mental health problems?

1.7 SIGNIFICANCE OF THE STUDY

The study has significance for mental health policy development, as mental health care needs and services have been systematically excluded from Nigeria's primary health care approach. Maintaining the current centralization of mental health care services of sequestering people with mental illness from public life and public view reinforces commonly held lay beliefs that psychiatric patients are social outcasts and should be quarantined until judged to have returned to normal (Kabir et al., 2004; Adewuya & Makanjuola, 2005; Jegede, 2005). These views continue to fuel stigma and discrimination and in so doing, prevent people from seeking help, and policy makers from ensuring that those in need receive the necessary services.

Mental health professionals, particularly psychiatric nurses, continue to be trained to provide curative care in large psychiatric hospitals rather than community-based, preventive and promotive facilities, and mental health care services are therefore not provided at primary care centers, nor are health professionals with psychiatric training

stationed at these sites to support families and persons with mental illness. The lack of demand for services as a result of the associated stigma negates the perceived need for their provision, many mental health conditions that could be prevented and treated therefore remain undiagnosed, denying people the opportunity for improved mental health (Alem et al., 2008; Erinosho, 2010). Policy makers need to show strong political will and be committed to the importance of delivering effective and affordable mental health care starting at primary care level. This will make mental health care more accessible and affordable to clients and their families, and ensure that everyone in need has access to the mental health care services.

1.8 CONCEPTUAL FRAMEWORK

1.8.1 INTRODUCTION

The conceptual framework for this study is based on the assumptions of health policy analysis and specifically, on the framework for mental health policy development developed by Townsend et al. (2004). The WHO, (2001) emphasizes that, one of the critical health challenges for low-income countries such as Nigeria is to increase access to mental health care, through integration into the primary health care service. Mental health care that is based on the principles of primary health care means care that is accessible, affordable, uses of appropriate technology, emphasizes community participation, health promotion and intersectoral collaboration. The principles of primary health care will be used to evaluate functioning in each domain of the mental health policy template of Townsend et al. (2004). Mental health policy analysis is a mechanism for assessing

progress in the processes of service delivery and how well mental health policy, legislation and programs have been implemented and integrated into primary health care (Peterson et al., 2009).

1.8.2 TOWNSEND ET AL'S (2004) MENTAL HEALTH POLICY TEMPLATE

Townsend et al's (2004) mental health policy template outlines the domains and associated elements that need to be considered in developing, refining and or reviewing mental health policy. The model therefore provides a framework template for systematic policy data collection and evaluation. The template consists of four domains namely context, resources, provision, and outcomes. Each domain considers a number of elements that can be used in policy assessment as well as program implementation (Townsend et al., 2004). These domains and their elements are illustrated in the table 1 below. This framework is discussed in detail in the literature review.

TABLE 1: MENTAL HEALTH POLICY TEMPLATE

CONTEXT	RESOURCES	PROVISION	OUTCOMES
1. Societal Organization and Culture	5. Financing	10. Personal Mental Health Services	13. Health Population Individual
2. Public Policy	6. Human Resources	11. Population Based Mental Health	14. Service Outcomes
3. Governance	7. Physical Capital		15. Economic Outcomes
	8. Consumables	12. Intersectoral Linkages	
4. Population Need and Demand	9. Social Capital		16. Social Outcomes

Source: Townsend et al. (2004)

1.8.3 THE CONTEXT DOMAIN (ITEMS 1-4)

The context domain describes the prevailing social, economic, cultural and political contexts that impact on mental health and in which mental health policy is to be formulated or reviewed. It also considers issues of governance, population need and demand, and the environmental factors that influence the health of the population and within which

interventions are delivered. Context includes factors outside as well as within the health systems that might influence the health of the general population.

1.8.4 THE RESOURCES DOMAIN (ITEMS 5-9)

The Resources domain includes all specific health and non-health elements that are inputs to the mental health system. Higher-level issues, such as access, can be determined by considering the availability of these inputs or resources. This domain comprises five elements: namely financing which considers how health and mental health services are financed; human resources including professionals and non-professional staff, complementary and religious or traditional healers and non-governmental organizations as well as families and caregivers; physical capital including all health and non-health social infrastructure directly related to improving mental health; consumables including non-reusable consumables related to mental health; and social capital. Social capital covers the features of social organization such as civic participation, norms of reciprocity and trust in others that facilitate corporation for mutual benefit

1.8.5 THE PROVISION DOMAIN (ITEMS 10-12)

The Provision domain includes all mental health and related services that are or should be provided to the community in order to prevent and treat mental illness and promote mental health and well-being. It comprises three elements including personal mental health services for individual prevention, treatment, rehabilitation or health promotion and well-being. Population-based mental health services comprise services provided for the population at large. It includes not only population-directed mental health education,

promotion and literacy, but also strategies relating to non-human phenomena such as the erection of a structure to prevent suicide from a public building or bridge. Intersectoral linkages describe the relationships between mental health services and those social services that influence individual mental health outcomes and general well-being. These services include: welfare, religious, educational, rehabilitation, vocational, employment, accommodation, correctional, police and other services required by people with mental illness and disability.

1.8.6 THE OUTCOMES DOMAIN (ITEMS 13-16)

Outcomes are indicators of the impact of the mental health services applied at both individual and population level. Outcome measurement has the potential to provide policy makers with reliable data on the efficiency and effectiveness of services and interventions. This domain comprise of five elements.

1. Mental health outcomes: These are considered to be changes in functioning, morbidity and mortality that are attributable to the treatment and care received. These outcomes can be considered at the population or individual level.

2. Population outcomes: This element is concerned with changes in the mental health status of the whole population that may be considered to be attributable, at least in part, to the range, quality and type of mental health services available to the community. In contrast, individual outcomes are changes in an individual who has accessed a mental health intervention that can be attributed wholly or partly to that intervention. Individual outcomes include mental health status, functional status (social and vocational), quality of life and satisfaction with access and interventions.

3. Economic outcomes: These are the economic consequences of mental health intervention, or lack of intervention, to the community as a whole as well as the individual, their family and other carers. Four key sub-elements are considered in assessing the economic outcomes of a mental health policy and service system implementation namely direct and indirect costs, individual's acquired and innate capacities for productivity, externalities (unanticipated outcomes of interventions) and poverty in the individual and population.

4. Service outcomes: This element is concerned with the overall health system performance and impact of service provision on end-users. The focus is on the efficiency and effectiveness of service provision in responding to the needs of the people mental health services are funded to serve. These outcomes are measured at an aggregate rather than individual level. Measures of service outcome can provide critical information to assist policy makers in resource allocation and service development. The indicators of service outcome include five sub-elements: efficiency, access and equity, appropriateness, quality and effectiveness.

5. Social outcomes: This is used to monitor overall changes in the social environment, changes in the relationships between individuals and changes in the relationship between the individual and the environment resulting from improved mental health and well-being.

1.8.7 NON-RECURSIVE RELATIONSHIPS

The template is a non-recursive as opposed to linear. It is not prescriptive in terms of actions to be taken but rather, it identifies those elements that are crucial and need to be considered for policy formulation, implementation or evaluation. The information collected

in the outcomes domain serves to inform the action undertaken in the context, resources and provision domains. Language, concepts and terminology used in the template are as consistent as possible with mainstream health sector reform and that of World Health Organization generic terminology, which may provide a common language for effective communication across regions or countries (International Consortium for Mental Health Policy and Services, 2001).

1.9 OPERATIONAL DEFINITION

SERVICE USER: Any person receiving treatment or support for a mental health disorder from mental health services including clients and caregivers.

CLIENT: A person with a mental health problem being cared for and treated in a public mental health service.

FAMILY CAREGIVER: A person in the family who generally provides the most care and support to the person with serious mental health problems

MENTAL HEALTH PROFESSIONALS: Is a health care practitioner who by education and experience is professionally qualified to provide counseling interventions designed to facilitate the improvement of an individual's mental health or treatment of mental disorders.

SERIOUS MENTAL HEALTH PROBLEMS: The presence of any *DSM IV* mental disorder (bipolar disorders, schizophrenia, anxiety disorders, major depression and dementia), substance use disorder, or developmental disorder that leads to "substantial interference" with one or more major life activities.

1.10 CONCLUSION

Lack of mental health facilities in the communities creates barriers that pose significant challenges to persons with serious mental illness, not only in terms of clinical management of the disease but also in its psychological consequences (Kung, 2004; Awad & Voruganti, 2008). It imposes a significant cost on the patient in terms of personal sufferings, impaired ability to search for and sustain productive employment (Kohn et al., 2004; Patel, 2007) and initial treatment is frequently delayed for many years leading to chronicity, which may be due to lack of relevant and correct information about mental health service (Uys et al., 2004). The family also experience practical barriers, including cost of treatment, transportation, long waiting time, issues of accessibility, as well as limited availability or lack of availability of services, loss of job and cultural barriers consisting of credibility of treatment, recognition of need, and lack of knowledge about mental illness and fear of stigma (Kung, 2004; Chung et al., 2009).

The impact of poor facilities on society in terms of significant direct and indirect costs, such as the cost of frequent hospitalizations, need for psychosocial and economic support (Awad & Voruganti, 2008) and lost of productivity, which further impoverish society thus, the relationship between poverty and mental disorders has been liken to a vicious cycle (Patel, 2007; WONCA, 2008). Strengthening care and services for people with mental disorders should be a priority, to reduce treatment gap experienced by families living with persons with serious mental health problems (Wang et al., 2002; Patel et al., 2007; Tomlinson et al., 2009). These barriers experienced by patients and families can be overcome by generation of sufficient political will to improve availability of and access to

humane mental health services in the community (Saraceno et al., 2007; Alem et al., 2008). Furthermore, findings of research studies conducted in a well resourced context may be difficult to apply in a less resourced environment like Nigeria, in an attempt to understand policy implications on caregiving experiences of families. The paucity of research studies about the Nigerian policy context and the researcher's questioning about policy implication on caregivers experiences was a strong impetus for this study.

The study will provide baseline data for policy makers to have a broader understanding of the plight of families and persons living with serious mental health problems and plan services and programs in Nigeria. It will add to the body of knowledge and contribute to the existing literature on caregiving. It will also be useful for the Neuro-psychiatric Hospital Rumuigbo, Port- Harcourt where the research will be carried out, in seeking for funding and help to identify problems encountered by patients and families and be able to address identified needs. Other stakeholders such as, Ministry of Health and Hospitals Management Board will find the results of the study particularly useful, as it will provide explanation of issues that need to be considered in designing primary mental health care and family centered programs in the communities.

SECTION TWO: ARTICLES AND POLICY BRIEF

This section contains five articles that were written and submitted to various journals for publications as well as the policy brief for mental health policy reforms in Nigeria. Each article is written according to the relevant Journals' referencing style.

2. LAYOUT OF ARTICLES

The five articles comprises of 1). A description of current health care systems, 2). Family caregivers experiences of mental health services in the current policy environment, 3). Clients experiences as mental health service recipients, 4). Experiences of health care professionals of providing mental health care services, 5). Policy analysis and recommendation. All the articles have been revised and gone through a peer review processes of the various academic journals and have been resubmitted for publication, while three has being accepted for publication by: International Journal of Nursing and Midwifery (IJNM), International Journal of Mental Health Nursing (IJMHN) and West African Journal of Nursing (WAJN).

Table 2: OUTLINE OF ARTICLES

S/N	Title of Article	Method
1.	A comparative study of mental health services in two African countries: South Africa and Nigeria	**Theoretical review:** Accepted International Journal of Nursing and Midwifery
2.	Caregiving experiences of families of persons with serious mental health problems in the Niger Delta Region of Nigeria.	**Qualitative study:** Accepted International Journal of Mental Health Nursing.
3.	Clients with serious mental health problem experiencing care within the current policy context in the Niger Delta region of Nigeria	**Qualitative study:** Accepted West African Journal of Nursing.
4.	The experiences of mental health care professionals providing mental health care services in a neuropsychiatric hospital Port Harcourt, Rivers State, Nigeria.	**Qualitative study:** Reviewed and re-submitted to Journal of Mental Illness
5.	Policy Brief: Increasing access to mental health service through PHC in Nigeria	Reviewed and resubmitted to Journal of National Institute for Policy and Strategic Studies

2.1 FLOW CHART

The study was conducted in four phases and below is a summary of the various phases of the study.

Phase 1: Preparation

1a. Instrument development
Adapted from Townsend et al. 2004 Policy template
Questionnaires: In-depth interviews guide

1b. Approval from UKZN Ethics Committee, Rivers State Ministry of Health and Neuropsychiatric Hospital Rumuigbo, PH, Rivers State, Nigeria.

1c.Theoretical Review: Article 1 A comparative study of mental health services in two African countries: South Africa and Nigeria

1d. Participants recruitment meetings
Group 1: Family Caregivers- 22
Group 2: Clients coming for follow-up care- 30
Group 3: Mental Health Professionals-20 (Total=72)

Phase 2: Implementation

2a. Data collection Phase: (Five Months Period)

2b.Group 1. Familiy caregivers. 2c. Group 2. Clients coming for follow-up appointments. Group 3. Mental Health Professionals

Phase 3: Analysis/ Articles writing

3a. Data Analysis

3b. Caregivers interview

3c. Clients interview

3d. Professionals interview

3e. Results analyzed

3f. Data Verification: Focus Group Discussion
Group 1; Group 2 & Group 3.

3g. Article 2. Caregivers experiences

3h. Article 3. Clients experiencing care

3i. Article 4. Professionals' experiences

Phase 4: Intervention Study

4a. Policy Brief (article 5)
"Increasing access to mental health services through PHC in Nigeria"
Prepared from outcomes of the four articles:
Article1: Comparative study of mental health services
Article 2: Caregivers experiences
Article 3: Clients experiencing care
Article 4: Professionals experiences of providing care

FIGURE 2.1: Outline of study phases

32

2.2 ARTICLE ONE

A COMPARATIVE STUDY OF MENTAL HEALTH SERVICES IN TWO AFRICAN COUNTRIES: SOUTH AFRICA AND NIGERIA

Authors:

(1) Jack-Ide, I.O. Doctoral Research Student. School of Nursing, University of KwaZulu-Natal, Durban, South Africa. Phone: +01-404-789-0415; +27-788550525. Email: izibelokojackide@ymail.com

(2) Uys L. R. D Soc Sc. School of Nursing, University of KwaZulu-Natal, Durban, South Africa. Phone: +27 (12) 333-1415 Email: uys@ukzn.ac.za

(3) Middleton L.E. PhD. School of Nursing, University of KwaZulu-Natal, Durban, South Africa. Phone: +27- 714751016. Email: Middletonl@ukzn.ac.za

Abstract

Mental health services in South Africa and Nigeria were compared using the reports of World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) of both countries. WHO-AIMS assessment reveals the extent of implementation and provision of mental health care services. South Africa has made considerable progress with restructuring its mental health care system that provides mental health care at the community level. Nigeria, in spite of adopting mental health care as part of its primary health care services and having a strong academic history in psychiatry, does not provide services in rural communities. It is important for Nigeria that mental health care nurses become advocates for mental health policy reforms to improve access, and that countries with similar challenges learn from each other about providing care for people who cannot care for themselves, namely, the mentally challenged.

Keywords: Advocacy, integrated care, mental health policy, mental health services, primary health care.

Introduction

The World Health Organization (WHO) endorsed mental health as a universal human right and a fundamental goal for health care systems of all countries (WHO, 2005). The principles of primary health care at the Alma-Ata Declaration were about social justice and the right to better health for all, reaffirming the WHO's holistic approach to attaining good health and the importance of primary care. WHO World Health Report 2008 argues that a renewal and reinvigoration of primary care is important now, more than ever, as mental

health problems constitute 14% of the global burden of disease being one of the leading causes of disability world-wide (WHO, 2008). Integrating mental health services into primary care is the most viable way of closing the treatment gap for people with mental health problems and ensuring that they get the mental health care they need (World Organization and Association of Family Doctors [WONCA], 2008). It will also reduce discrimination of the mentally ill and increase their right to access treatment and care within their own community in the least restrictive environment, with the least restrictive treatment (WHO, 2009).

Equitable access to mental health care and the protection of rights is a central objective of many health care systems in developed and developing countries (Jacob et al., 2007). Mental health systems are generally a subsystem of the health care system, and how these services are organized, delivered and financed is significantly influenced by the way in which the overall health services system are run (Olson, 2006). The primary objective of a mental health system is to ensure that its organizations, institutions, and resources improve service provision and, thus, the mental health of the population. The WHO conceptualizes optimal actions for improved service provision as establishing national policies, programs, and legislation on mental health, providing services for mental disorders in primary care, ensuring accessibility to essential psychotropic medication, developing human resources, promoting public education and involving other sectors and promoting and supporting relevant research (WHO-AIMS, 2005).

However, mental health systems in low- and middle-income sub-Saharan African countries face challenges in ensuring optimal mental health care services (Saraceno et al., 2007). Most low-income countries do not have mental health legislation or policies to direct relevant programs, lack appropriately trained mental health personnel, and are constrained by the prevailing public-health priority agenda and its effect on funding. Other challenges includes the complexity of and resistance to decentralization of mental health services; scarce mental health resources and a mental health budget of less than 1% of the total health budget, stigma and discrimination (Patel, 2007), and the frequent scarcity of public-health perspectives in mental health leadership. It is possible that these challenges have contributed to the treatment gap of mental disorders in these countries (Demyttenaere et al, 2004). The importance of scaling up mental health services is essential for community well-being, this being essential to increase the impact of mental health-service interventions on a larger population (WHO, 2008).

Comparative studies show the varying health care philosophies and the differences in service provision among countries (Olson, 2006). The costs of providing health service are often cited as a reason for its poor provision. The mental health services in South Africa and Nigeria were chosen for comparison as South Africa is a middle income (MI) and Nigeria is a low middle income (LMI) country; both being rated as developing countries which have adopted primary health care as the model of care. Therefore, the aim of the study was to compare the status of mental health service provision of South Africa and Nigeria.

Method

A comparative analysis was done of the reports of the World Health Organization Assessment Instrument for Mental Health Systems conducted in South Africa (*WHO-AIMS Report on Mental Health System in South Africa, WHO and Department of Psychiatry and Mental Health, 2007)* and Nigeria (*WHO-AIMS Report on Mental Health System in Nigeria, WHO and Ministry of Health, 2006).* WHO-AIMS is a comprehensive assessment tool for mental health systems designed for middle- and low-income countries and consists of six domains: policy and legislative framework; mental health services; mental health in primary care; human resources; public information and links with other sectors; monitoring and research. All six domains were analyzed in both reports and provided essential information for a comparison of mental health policy and service delivery between the two countries. Other sources of South Africa information utilized for the comparison include Mental Health Policy Development and Implementation in South Africa: A Situation Analysis, Phase 1 Country Report (Lund et al., 2008); KwaZulu-Natal (KZN) Treatment Protocols for Mental Disorders; the Department of Health's Standard Treatment Guidelines and Essential Drug List; Mental Health Care Act (MHCA) No. 17 of 2002. Additional sources for Nigeria were the Essential Drug List, National Health Insurance Scheme (NHIS), Human Resources for Health Country Profile and Primary Health Care Policy documents of both countries.

Discussion

The six domains of the WHO-AIMS are discussed with respect to how they are provided for in Nigeria and South Africa: policy and legislative framework; mental health services;

mental health in primary care; human resources; public information and links with other sectors; monitoring and research.

Policy and legislative framework

This domain describes the type of mental health policies, programs and legislation in both countries.

While South Africa has no official mental health policy, its MHCA 2002, drives its mental health services and programs. The legislation made mental health a major public health issue and identified steps needed to address relevant services and improved quality of care. The Act is grounded in the principles of respect for human rights, and the promotion and protection of those rights (WHO, 2010). Nigeria currently has a draft Mental Health Bill at the National Assembly, which has yet to be passed into law. Mental health was adopted into the nation's Primary Health Care (PHC) in 1991, which in effect became its mental health policy (Federal Ministry of Health [FMOH], 1991). Since its adoption the policy has not been fully implemented and unrevised (WHO-AIMS, 2006). The draft Mental Health Legislation Bill, when passed, is expected to protect the rights of persons with mental disorders, ensure access to treatment and care, discourage stigma and discrimination and set standards for psychiatric practice in Nigeria.

The South African MHCA 2002 underpins a stronger human rights approach to mental health care service than previous legislation. The Act ensures that hospitalizing persons involuntarily due to harm of self and others does not take away their right. It requires certifying such persons within a 72-hour assessment period, allowing a period where they

38

can potentially be stabilized and be cared for in the community. Certification was usually done by psychiatrists and doctors, but the new Act recognizes that there are few psychiatrists, particularly in rural areas, and it enables mental health care practitioners to make such decisions (MHCA 2002: pp xvii, 34). A mental health care practitioner includes psychiatrists, psychologists, doctors, nurses, or social workers who trained in mental health. Once certified, patients are admitted to a hospital to be seen by qualified personnel. The intentions of the South African MHCA 2002 were to protect and destigmatise the mentally ill e.g. persons with mental disorders are regarded as 'mental health services users', since anyone could be predisposed as a user of mental health care services. The review and appeal process protects the rights of service users, giving them a right to representation, and the right to appeal against decisions made by mental health care practitioners concerning their care.

In Nigeria however, certification of the mentally ill is done only by psychiatrists thereby limiting the possibility of those needing care receiving it due to the shortage of people in this profession. There are no monitoring activities for mental health services; these facilities do not have reviews or inspection of human rights protection of patients (WHO-AIMS, 2006). Most admissions are involuntary, so human rights abuse may be present as legal provisions for patients' protection from unjust discrimination are not explicit (Gureje and Alem, 2000).

Mental health services

This domain deals with how mental health services are organized and delivered at various levels of care either for promotion, prevention or treatment of mental disorders, as well as for the rehabilitation of persons with mental illnesses.

Mental health service implementation in South Africa takes place through national, provincial and district structures. A national mental health authority- the National Directorate, Mental Health and Substance Abuse- provides advice to government on mental health policies and legislation (WHO-AIMS, 2007). The Directorate comprises a director, three deputy directors, assistant directors and administrative staff. The Directorate provides policy direction to the provincial mental health authorities, who are involved in service planning, management, coordination and monitoring, and quality assessment of mental health care (Lund et al., 2008). In Nigeria however, no posts have been created in the Ministries of Health at state or national levels for mental health, and these services are often supervised by officials with other primary duties (WHO-AIMS, 2006).

Nigeria's mental health facilities consist of eight federally funded psychiatric hospitals and six state-owned mental hospitals financed and managed by various state governments, for a population of over 150 million people. Given the limited number of these hospitals, their catchment's areas often go beyond their immediate location in terms of city or even state. None of the facilities have beds for children and adolescents. There is only one private community residential facility available with 10 beds in Lagos State and it is administered

by a religious organization for rehabilitation of persons with drug problems (WHO-AIMS, 2006).

South Africa has 3,460 outpatient mental health facilities; 1.4% of those are for children and adolescents. These facilities serve 1,660 persons per 100,000 of the general population in a year. There are 80 day treatment facilities and 41 psychiatric inpatient units in general hospitals with a total of 2.8 beds per 100,000 population; 3.8% of these beds are reserved for children and adolescents. Sixty-three community residential facilities provide a total of 3.6 beds per 100,000 population; 23 mental hospitals provide a total of 18 beds per 100,000 population. Children and adolescents have 1% of beds reserved for their care in mental institutions across South Africa (WHO-AIMS, 2007; Lund et al., 2008).

The lack of appropriate legislation in Nigeria has resulted in their mental health services remaining inequitable, which violates the principles of the primary health care system and essentially provides a vertical rather than an integrated service. Information about the level of mental health service in Nigeria is limited and it is therefore difficult to identify areas of need, to make informed decisions about policy direction, and to monitor progress. A consequence of this information gap is the continued neglect of mental health issues and the many unmet need for service that exists for mental health problems in the community (WHO-AIMS, 2006). In South Africa, the need to integrate mental health care into general health care has received particularly strong support. However, the extent to which this model has been implemented and its impact has not been assessed, but there are examples of good practice such as in the Moorreesburg and Ehlanzeni Districts (WONCA, 2008).

The use of general health workers, usually with substantial support from mental health specialists in supportive roles at community clinics, has reduced the gap in mental health service access from which important lessons can be derived for Nigeria.

Mental health in primary care

This domain describes the organization of mental health care services at primary care levels within communities.

After the first democratic elections of 1994, South Africa embarked on a major initiative to align the country's mental health services with international trends, such as integrating mental health into primary care centers and deinstitutionalizing care (WONCA, 2008). Promulgation of the Mental Health Care Act No.17 of 2002 made primary mental health care accessible at district hospital levels and primary health care centers in the community, thereby enhancing the accessibility of mental health services (WHO-AIMS, 2007; Burns, 2008). In South Africa, general physicians (GPs) play active roles in offering primary mental health care services such as outpatient care, screening, follow-up and referral. Secondary levels of mental health care are located in regional hospitals, and tertiary level institutions provide specialized services at designated psychiatric hospitals (Burns, 2008; Mkize et al., 2004).

At the 1978 Alma-Ata conference, provision of essential medicines was identified as one of eight key components of primary health care. Among the first new health strategies in South Africa was the 1996 national drug policy, which was committed to the use of an

essential medicines list including supply, distribution, education, training, information, informed decision-making and appropriate human resource development. The National Department of Health prepared and developed the Standard Treatment Guidelines and Essential Drug List which ensures that every citizen has access to good-quality, affordable health care, including access to medicines that are safe, efficacious and an acceptable quality in the most cost-effective manner. Similarly, the Nigerian mental health policy of 1991 formulated strategies for the promotion, prevention, management, treatment and rehabilitation of mental and neurological disorders through the provision of an essential drug list (WHO-AIMS, 2006). Nigeria also uses the essential drug list and views it as a strategy to support local governments to strengthen the provision of primary health care, but the drugs are usually not available due to an absence of primary mental health care (Revised National Health Policy, 2004; WHO-AIMS, 2006).

To ensure that treatment provision is standardized, South Africa currently uses treatment protocols for mental disorders in response to the need to promote mental health of persons with mental disorders, as well as a practical guide for primary care providers to be able to manage common psychiatric disorders across district and community levels (Burn et al., 2007; WHO-AIMS, 2007). The treatment protocols are in line with the Standard Treatment Guidelines and Essential Drug List. These medicines include antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs, and are all made available in mental hospitals at district- and community-level health facilities. Provincial governments ensure the availability of these psychotropic medicines, as sufficient funds are allocated to

purchase basic essential psychotropic drugs and are distributed amongst the different levels of care.

The South African treatment protocols assist non-psychiatrist clinicians such as medical officers and psychiatric nurses who are involved with day-to-day care and management of mental health care users in outreach clinics and health centers in the community (Burns et al., 2007). The use of treatment protocols is in line with the WHO recommendation that where there is a policy of community mental health care and its integration into general health services, essential drugs must be made available at these levels of care and mental health workers are authorized to administer the drugs (WHO, 2009). In South Africa, nurses in primary health care centers are allowed to use these protocols and although they are not allowed to make the initial prescription, they can prescribe during emergencies and for continue prescription (WHO-AIMS, 2007; Lund et al., 2008). In-spite of the integration of mental health services in PHC and standardized treatment procedures, South Africa faces the challenges of limited mental health human resources, low ranking of mental health as a public health priority, the biomedical orientation of health care, poverty, lack of infrastructure, and poor information systems to monitor mental health service delivery, amongst other factors, which poses difficulties in realizing an improved mental health care access (Lund et al, 2007; Mkhize and Kometsi, 2008).

Nigeria has no treatment protocols and there is no uniform standard of care and management of patients across big hospitals. Uniform treatment protocols are an important guideline for proper management of care even in tertiary hospitals. Protocols act as

guidelines for mental health practitioners, as these resources can be used to monitor and improve the quality of care given across these facilities. As care is institutional-based, mental health nurses work only in secondary and tertiary institutions with the psychiatrists who provide the prescriptions. Nurses are only allowed to prescribe in emergency situations (WHO-AIMS, 2006), compared to South Africa, where certain categories of nurses are designated as 'authorized prescribers' in terms of the Medicines and Related Substances Act. In addition, the need for psychiatric nurses to prescribe Schedule 5 medicines has been enabled in law (Nursing Act, 2005).

Many reasons have been advanced for failure of the primary mental health care program in Nigeria, including the fact that psychiatric care is only provided at a few large mental hospitals in big cities (Alem et al., 2008). Furthermore there is a lack of human resources and difficulty in retaining staff, particularly in rural areas as well as poor federal or state funding of mental health service (WHO-AIMS, 2006). Historically, Nigerian mental health care service dates back to 1904, when the first asylum was opened in the southern city of Calabar. In 1907, Yaba Asylum in Lagos opened, and another facility followed in 1914 at Lantoro, Abeokuta (Ayonrinde et al., 2004). The first Nigerian psychiatrist, Dr. Thomas Adeoye Lambo, spearhead service delivery on his return from the United Kingdom in 1952, when the Neuropsychiatric Hospital in Aro, Abeokuta, was still under construction. Lambo had just completed his training in psychiatry at the Maudsley Hospital, London, which played a central part in the development of psychiatry in Nigeria, with community practice been developed in collaboration with WHO initiatives (Boroffka, 2006). In spite of

a strong academic history in psychiatry, mental health care is still institutionalized and inadequate.

The historical legacy of South African shows that mental health services provision under the Mental Health Act (MHA) No. 18 of 1973 was concerned with the welfare and safety of the community, as 'protection of society' was given priority over the rights of the individual. A reasonable degree of suspicion of mental disorder was sufficient to have anyone 'certified' to a psychiatric institution. Certification was widely open to abuse, as certified patients had virtually no recourse to assistance from the law, and could languish in hospital, against their will, for weeks or months. Patients had no meaningful right of appeal or representation. Against this backdrop of human rights infringements, psychiatrists were forced to be doctor and gaoler (Burns, 2008). Mental health services were centralised in urban cities, far from the homes and communities of most patients, which meant transporting people over great distances before service can be accessed. The enactment of the MHCA 2002 protects the rights of people with mental disorders and rid the country of its public health legacy of the colonial and apartheid eras (WHO-AIMS, 2007).

While both countries operate primary health care systems, South Africa has integrated mental health care services in primary centers in the communities, while Nigeria operates an institutional care model, making mental health services accessible only in big institutions located in a few urban centers. Mental health care is provided in a few tertiary facilities that provide both primary and specialist care, none of which have beds for children and adolescents, as well as in a few secondary facilities that have psychiatric units

with general physician support, which may not always be functional (WHO-AIMS, 2006). South African legislation made provisions for a free mental health care, whereas in Nigeria, services are paid for on an out-of-pocket basis, the goals of NHIS to provide Free Medical Care is focused on how to reduce child and maternal mortality in order to achieve the Millennium Development Goals, MDGs, (NHIS, 1999), as such mental health care service coverage in its program is low priority. Mental health service reaches only a minority of the population; it's estimated that fewer than 20% of people with mental disorders receive any services, and those who do may not receive adequate treatment (Gureje and Lasebikan, 2006).

Human resources

This domain deals with staffing, which is the key to effective mental health care services. The number of professionals providing mental health care and issues of human resource training for mental health is highlighted in both countries.

South Africa is relatively well resourced compared to other sub-Saharan countries in regard to mental health personnel, as most middle- and low-income countries have grossly inadequate manpower to deal with mental disorders (WHO-AIMS, 2006; WHO-AIMS, 2007). To assess the manpower of both countries, the median number of health and mental health professionals (per 100,000 people) are outlined in Table 1:

Table 1: Median estimate of mental health professionals working in mental health facilities per 100,000 population.

Mental Health Professionals	South Africa	Nigeria
Psychiatric nurses	10.08	2.41
Psychiatrists	0.28	0.15
Other medical doctors (not specialized in psychiatry)	0.45	0.49
Psychologists	0.32	0.07
Social workers	0.4	0.12
Occupational therapists	0.13	0.05
Other health or mental health workers	0.28	8.03

In South Africa, mental health professionals work in the private and public sectors (WHO-AIMS, 2007, Lund et al., 2008). The availability of nurses with training in psychiatric nursing has been greatly enhanced by the comprehensive nurse training initiated in 1986. The four-year diploma or degree programs which provide access to the nursing profession include training as a registered psychiatric nurse. Furthermore, advanced or specialist mental health care courses which for at least one academic year of 44 weeks, are being offered for registered general/psychiatric nurses or midwives (South African Nursing Council [SANC]: Regulation 212). Although most comprehensively trained nurses do not end up working in exclusively psychiatric services, their training is used in PHC settings and district and regional hospitals.

In Nigeria, 95% of professionals who are psychiatrically trained work in tertiary institutions and the other 5% work in non-mental health care facilities (WHO-AIMS, 2006). Primary health care services are provided in rural communities but exclude mental health services, making early identification and treatment of mental health problems and the promotion of comprehensive health difficult to achieve. The provision of primary mental health care at tertiary and secondary institutions, create barriers for families and persons with mental disorders in rural communities during psychiatric emergencies. In Nigeria, psychiatric nurses are usually trained at a post-basic level for 18 months to obtain a diploma. Such persons must be a registered nurse (RN), and there are also a few generic diploma programs that provide training which run for three years, as well as a Bachelor of Nursing Science program for five years for people with a senior school certificate. Most of the trainees from the generic program work in general hospital setting due to the few psychiatric and mental health institutions in the country.

The scarcity of specialist mental health professionals in both countries is a hindrance for the development of primary mental health care (Human Resources for Health Country Profile– Nigeria, 2008; Saxena et al, 2007). To develop a coherent plan for the provision of human resources to meet the health care needs of its population, both countries should address the mal-distribution of health personnel, the disparities of mental health services provisions between urban and rural communities, and the lack of mental health specialists and primary health care workers. They also need to address the insufficient numbers of specialist mental health workers who can provide effective training and supervision of primary care workers, reorient the education and training curriculum for health sciences,

and deal with the crisis of an aging nursing profession and the limited number of new nurses to keep pace with attrition and retirement (Lehmann, 2008; Alem et al., 2008).

Public information and links with other sectors

This domain involves the provision of information for public education on mental health and disorders, and the level of public sectors participation in mental health promotional activities and programs.

Many mental disorders require psychosocial solutions, with the most appropriate entry point for mental health promotion depending on needs, as well as the social and cultural context of each community. Government and nongovernmental organizations, individuals and community health workers and volunteers play a critical role in primary mental health care by facilitating access to education, employment and rehabilitation of people with mental illness and in identifying and referring people with the disorders for early treatment, care and support. The scope and level of these activities vary among countries and while there is no single organizational approach for good service delivery there are common factors that underlie successful models (WHO, 2009). Thus, South Africa has well established links between mental health services and various community agencies at the local level for appropriate support, such as housing, welfare or disability benefits, employment, and other social service for persons with mental disorders for prevention and rehabilitation strategies (WHO-AIMS, 2007; Lund et al., 2008). These strategies have contributed to the reduction of other social problems such as youth delinquency, child abuse, school dropouts and work days lost to illness.

The South African MHCA 2002 provides an impetus to develop projects such as early detection of mental illnesses, alcohol and drug abuse prevention and violence against women and children. It also provides for partnerships with non-profit organizations and the formation of Mental Health Review Boards to oversee regular inspections of mental health facilities and act as external watchdogs to protect the rights of service users and their families (Lund et al., 2008). South Africa has a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders (WHO-AIMS, 2007). Advocacy and public awareness programs are carried out by the National Department of Health (Lund et al., 2008). The Department is assisted by various NGOs, the South African Federation for Mental Health, South African Depression and Anxiety Group (SADAG) and other professional, consumer and advocacy bodies. There are public education and awareness campaigns targeting the general population children, adolescents, women, trauma survivors, and ethnic groups (Lund et al., 2008).

In Nigeria, there is no coordinating body to oversee public education and awareness programs and there are no NGOs for mental health activities. There are very few public education and awareness campaigns; government agencies and professional organization involvement in mental health awareness and promotion campaigns of the public are poor, and the national human rights review commission established in 1995 is non-functional (WHO-AIMS, 2006).

South Africa has relatively good inter-sectoral collaboration in mental health care services with other organizations to promote the mental health of its people, such as the South

African Police Service (SAPS), Department of Justice, Department of Correctional Services and Department of Education. In terms of financial support for mental health service users, 1% to 20% of mental health facilities have access to programs outside mental health facilities that provide employment for users with severe mental disorders (Lund et al., 2008). Persons with mental disabilities receive a social grant known as the "Disability Grant." In contrast, Nigeria has no social support system and no legislative or financial provisions to protect and provide support for service users and their families; inter-sectoral collaboration is poor; there is no support for child and adolescent mental health; and there are no part-time or full-time mental health professional positions in primary or secondary schools (WHO-AIMS, 2006). Primary mental health care promotion activities are directed to combat stigma but with the heavy workload and manpower shortages, psychiatric nurses in Nigeria frequently focus on illness needs of individuals and families rather than mental health promotion activities.

Monitoring and research

The research domain is important in informing the development of evidence-based interventions for mental health care delivery. This item identifies the type of research conducted and how each country promotes and support relevant mental health research.

Neither country has formerly defined minimum data set of items to be collected by mental health facilities, and processes for collecting patients and clinical service data also vary. Mental health research is considered essential to prevent, promote, treat and rehabilitate sufferers; hence provisions are made to encourage researchers and funds are made available for research in South Africa (White Paper on Health). Two percent of all health

publications in South Africa were on mental health (WHO-AIMS, 2007, Lund et al., 2008). Areas of research include epidemiological studies in community and clinical samples; non-epidemiological clinical/questionnaire assessments of mental disorders; services research; biology and genetics; policy, programs, financing/economics, pharmacological interventions, psychosocial psychotherapeutic interventions.

Generally, the proportion of health systems research focusing on PHC issues in South Africa has increased significantly since 1994. However, this research has focused primarily on quality of care and human resources for health, while aspects of PHC, such as accessibility to, and equity of care have been relatively neglected compared to publications in the area of HIV and AIDS since 1994 (Lutge et al., 2008). Similarly, Nigeria reported 3% of health publications in research being on mental health, the current scope of research in Nigeria ranges from descriptive and social science and neurobiology studies to large and multicentre epidemiological research projects. Despite the dearth of resources, a number of significant contributions have been made to both international and local psychiatric research literature (Ayonrinde et al., 2004; WHO-AIMS, 2006).

Research institutions, oversight bodies and researchers, should give more attention to mental health research as information derived are used to monitor health services and is a powerful evaluation tool. An orderly collection of key information about mental health needs and service provision can transform services delivery and help focus resources on the most effective activities, and therefore offer guidance to managers and providers, as well as provide clear evidence of impact (Engelbrecht, 2000).

Conclusion

The comparison with South Africa highlights considerable gaps in mental health service provision in Nigeria in particular, with the non-implementation of integrating mental health care into the nation's primary health care services over 20 years after the adoption of this policy. As the intention of the policy were to bridge inequalities of access to mental health service, its lack of implementation raises questions about equitable access to mental health care for its citizens. A mental health policy articulated in the South African Mental Health Act protects the human rights of persons with mental disorders and ensures that these individuals have access to treatment and care, discourages stigma and discrimination, and sets standards for practice of psychiatry in every country. The lack of such legislation speaks to the low priority of mental health care in Nigeria.

There are several strengths in the South African mental health system. It has relatively well resourced mental health services including human resources, facilities and available psychotropic medications, in addition to its outreach clinics. Furthermore, it has provided for the integration of mental health service in primary care centers and the use of protocols to maintain a standard of treatment across various levels of care. The promulgation of the MHCA 2002 in South Africa has protected the human dignity of persons and families with mental health problems. Many mental health care reforms have been implemented in South Africa compared to the current situation in Nigeria. An institutional model of care is strongly upheld in Nigeria and there is a dearth of mental health human resources and a lack of incentives for the few trained mental health professionals, which has led to an exodus of mental health care professionals into other fields of practice. Stigma plays a

considerable role in accessing and providing services including health care professionals and policymakers. It is important for Nigeria that psychiatric nurses become advocates for mental health policy reform in order to improve access to quality care. Advocacy is an important nursing role, not only in terms of individual patients, but also with regard to policy and service provision.

The aim of the study was to compare the status of mental health service provision of South Africa and Nigeria. While the South African Department of Health is not without its challenges, it has managed to provide mental health services as part of its primary health care infrastructure in line with its national Acts and policies. Nigeria, however, has not reformed its provision of mental health services, has retained it centralized institutional care model, and has yet to prioritize the health of such persons in line with the Alma Ala Declaration. Stigma and a lack of resources are no longer justifiable excuses for this lack of service provision, as there are numerous examples in sub-Sahara which provide examples of ensuring that all aspects of its citizens' health are provided for.

REFERENCES

Alem A, Jacobsson L, Hanlon C (2008). Community-Based Mental Health Care in Africa: Mental health workers' views. World Psychiatry. 7: 54-57.

Ayonrinde O, Gureje O, Lawal R (2004). Psychiatric Research in Nigeria: Bridging Tradition and Modernization. Br J Psychiatry. 184: 536-538.

Boroffka A (2006). Psychiatry in Nigeria a partly annotated Bibliography. Enugu: Chuka. Available at http://psychiatrie.de/data/pdf/7a/03/00/boroffka_nigeria.pdf (Accessed 28 October 2010).

Burns J, King H, Saloojee S (2007). KZN Treatment Protocol for Mental Disorders. KwaZulu-Natal Provincial Directorate for Health.

Burns JK (2008). Implementation of the Mental Health Care Act (2002) at district hospitals in South Africa: Translating principles into practice. S Afr Med J. 98: 46-49.

Demyttenaere K, Bruffaerts R, Posada-Villa J, Gasquet I, Kovess V, Lepine JP, Angermeyer MC, Bernert S, de Girolamo G, Morosini P, Polidori G, Kikkawa T, Kawakami N, Ono Y, Takeshima T, Uda H, Karam EG, Fayyad JA, Karam AN, Mneimneh ZN, Medina-Mora ME, Borges G, Lara C, Graaf R, Ormel J, Gureje O, Shen Y, Huang Y, Zhang M, Alonso J, Haro JM, Vilagut G, Bromet EJ, Gluzman S, Webb C, Kessler RC, Merikangas KR, Anthony JC, Von Korff MR, Wang PS, Brugha TS, Aguilar-Gaxiola S, Lee S, Heeringa S, Pennell BE, Zaslavsky AM, Ustun TB, Chatterji S: WHO World Mental Health Survey Consortium. (2004). World Mental Health Survey Consortium Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys. JAMA. 291(21): 2581-2590.

Department of Health (1997). White Paper for the Transformation of the Health System in South Africa. Pretoria: Government Gazette. Available at http://www.info.gov.za/whitepapers/1997/health.htm (Accessed 19 March, 2010).

Engelbrecht B (2000). Health Expenditure Review Task Team. Guidelines for District Health Expenditure Reviews in South Africa: A guide for managers in the health sector. Durban: Health Systems Trust. Available at http://www.hst.org.za/uploads/files/dher.pdf (Accessed 19 March, 2010).

Federal Ministry of Health (FMOH), (1991). The Federal Ministry of Health National Mental Health Programme and Action Plan. Lagos.

Gureje O and Alem A (2000). Mental Health Policy in Africa. Bull World Health Organization. 78(4): 475-482.

Gureje O and Lasebikan V (2006). Use of Mental Health Services in a Developing Country. Results from the Nigerian survey of mental health and well-being. Soc Psychiatry Psychiatr Epidemio. 41: 44-46.

Human Resources for Health Country Profile – Nigeria (2008). African Health Workforce Observatory (AHWO). Global health workforce alliance and World Health Organization. Available at http://www.unfpa.org/sowmy/resources/docs/library/R050_AHWO_2008_Nigeria_HRHProfile.pdf (Accessed 19 March 2012).

Jacob KS, Sharan P, Mirza I, Garrido-Cumbrera M, Seedat S, Mari JJ, Sreenivas V, Saxena S (2007). Mental health systems in countries: Where are we now? Lancet. 370**:** 1061-10677.

Lehmann U (2008). Chapter 11: Strengthening Human Resource for Mental Health Care. In 2008 South African Health Review Edited by Barren, P. (Ed): Health Systems trust.

Lund C, Stein DJ, Flisher AJ, Mehtar S (2007). Challenges faced by South African health services in implementing the Mental Health Care Act. S Afr Med J. 97(5): 352-353

Lund C, Kleintjes S, Campbell-Hall V, Mjadu S, Petersen I, Bhana A, Kakuma R, Mlanjeni B, Bird P, Drew N, Faydi E, Funk M, Green A, Omar M, Flisher AJ (2008). Mental health policy development and implementation in South Africa: A situation analysis. Phase 1 Country Report. Cape Town: Mental Health and Poverty Project. Phase 1 Country Report.

Lutge E, Friedman I, Mbatha T (2008). Chapter 14: A Review of Health Research in South Africa from 1994 to 2007. In 2008 South African Health Review Edited by Barren, P. (Ed): Health Systems trust.

Mental Health Care Act (1973). No. 18 of 1973: Republic of South Africa, Government Gazette.

Mental Health Care Act, (2002). No. 17 of 2002: Health Care Act. No. 24024. Republic of South Africa, Government Gazette.

Mkhize N and Kometsi MJ (2008). Chapter 7: Community Access to Mental Health Services: Lessons and Recommendations. In 2008 South African Health Review Edited by Barren, P. (Ed): Health Systems trust.

Mkize DL, Green-Thompson RW, Ramdass R, Mhlaluka G, Dlamini N, Walker J (2004). Mental health services in KwaZulu-Natal. SAJP. 10**:** 8-13.

National Health Insurance Scheme (NHIS) (1999). National Health Insurance Scheme Decree No. 35 of 1999. Laws of the Federal Republic of Nigeria.

Nursing Act (Act 33 of 2005). Republic of South Africa. Available at http://www.info.gov.za/view/DownloadFileAction?id=67887 (Accessed 19 March 2012)

Olson PR (2006). Mental Health Systems Compared: Great Britain, Norway, Canada, and United States. Illinois: Charles Thomas.

Patel V, Araya R, Chatterjee S, Chisholm D, Cohen A, De Silva M, Hosman C, McGuire H, Rojas G, van Ommeren M (2007). Treatment and Prevention of Mental Disorders in Low-income and Middle-income Countries. Lancet. 370(9591): 991-1005.

Revised National Health Policy (2004). Federal Ministry of Health Abuja. Federal Republic of Nigeria.

Saraceno B, van Ommeren M, Batniji R, Cohen A, Gureje O, Mahoney J, Sridhar D, Underhill C (2007). Barriers to Improvement of Mental Health Services in Low-income and Middle-income Countries. Lancet. 370: 1164-74.

Saxena S, Thornicroft G, Knapp M, Whiteford H (2007). Resources for mental health: scarcity, inequity, and inefficiency. Lancet. 370(9590): 878-889.

South African Nursing Council (1993). (SANC Regulation 212). Regulations Relating to the Course in Clinical Nursing Science Leading to Registration of an Additional Qualification.

World Health Organization (2005). WHO Resource Book for Mental Health, Human Rights and Legislation. Stop Exclusion Dare to Care. Geneva. Available at http://www.who.int/mental_health/policy/resource_ book_ MHLeg.pdf (Accessed 10 April 2010).

World Health Organization (2008). Mental Health Gap Action Programme: Scaling up care for mental, neurological, and substance use disorders. Geneva. Available at

http://whqlibdoc.who.int/publications/2008/9789241596206_eng.pdf (Accessed 18 June 2010).

World Health Organization and World Organization of Family Doctors (WONCA) (2008). Integrating Mental Health into Primary Care: A Global Perspective. Geneva. Available at http://www.who.int/mental_health/policy/Integratingmhintoprimarycare2008_lastversion.pdf (Accessed 26 May 2010).

World Health Organization (2009). Improving Health Systems and Services for Mental Health (Mental Health Policy and Service Guidance Package). Geneva.

World Health Organization (2010). Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group. Geneva. Available at http://whqlibdoc.who.int/publications/2010/9789241563949_eng.pdf (Accessed 24 April 2011).

World Health Organization-Assessment Instrument for Mental Health Service (WHO-AIMS) Version 2:2, (2005). World Health Organization, Geneva. Available at http://www.who.int/mental_health/evidence/AIMS_WHO_2_2.pdf (Accessed 5 May 2010).

World Health Organization-Assessment Instrument for Mental Health Service (2006). WHO-AIMS Report on Mental Health in Nigeria. World Health Organization and Ministry of Health Ibadan, Nigeria. Available at http://www.who.int/mental_health/evidence/nigeria_who_aims_report.pdf (Accessed 5 May 2010).

World Health Organization-Assessment Instrument for Mental Health Service (2007). WHO-AIMS Report on Mental Health System in South Africa. WHO and Department of

Psychiatry and Mental Health, University of Cape Town, Cape Town, South Africa.

Available at:

http://www.who.int/mental_health/evidence/south_africa_who_aims_report.pdf (Accessed

5 May 2010).

2.3 ARTICLE TWO

CAREGIVING EXPERIENCES OF FAMILIES OF PERSONS WITH SERIOUS MENTAL HEALTH PROBLEMS IN THE NIGER DELTA REGION OF NIGERIA.

Authors:

(1) Jack-Ide, I.O. Doctoral Research Student. School of Nursing, University of KwaZulu-Natal, Durban, South Africa. Phone: +01-770-982-1302; +27-789312538. Email: izibelokojackide@ymail.com

(2) Uys L. R. D Soc Sc. School of Nursing, University of KwaZulu-Natal, Durban, South Africa. Phone: +27 (12) 333-1415 Email: uys@ukzn.ac.za

(3) Middleton L.E. PhD. School of Nursing, University of KwaZulu-Natal, Durban, South Africa. Phone: +27- 714751016. Email: Middletonl@ukzn.ac.za

Abstract

Mental health services are provided at Rumuigbo Hospital, a single facility that renders psychiatric services in Rivers State and surrounding states in the Niger Delta region of Nigeria. Psychiatric services are not provided at primary health care clinic or district hospitals, and access to this service can be problematic for many caregivers due to the time and costs involved. Therefore this study explored the family caregiving experiences of persons with serious mental health problems in terms of the mental health care policy and health systems environment. A qualitative study using a purposive sampling technique was conducted among 20 caregivers attending a neuropsychiatric clinic in Port Harcourt, Rivers State, Nigeria. The results show that seventy-two percent of caregivers lived outside Port Harcourt and 65% had no regular monthly income. Stigma, poor knowledge in managing symptoms of ill relatives, financial implications, lack of support network, and absence of community outreach clinics were found to affect family care giving experiences. Policies need to be developed and implemented that provide mental health care through primary health care services to ameliorate family's financial burden, enable early diagnosis and treatment, reduce the need to travel and improve the quality of life of family caregivers.

Keywords: Burden, Experiences, Family caregivers, Mental Health Care Services, Mental health problems.

Introduction

Persons with serious mental health problems experience difficulties in performing the activities of daily living and depend largely on family members for assistance with simple tasks ranging from dressing and personal hygiene to more complex responsibilities, such as managing psychiatric symptoms, medication administration and social relationships (Shibre *et al.* 2003; Seloilwe 2006; Dangdomyouth *et al.* 2008). The disabilities associated with serious mental illnesses result in substantial social, emotional, physical and economic burdens which have been described in the literature from developed or middle-to high-income countries such as the United States of America, Canada, Sweden and the United Kingdom (Gallagher & Mechanic 1996; Magliano *et al.* 2000; Veltman *et al.* 2002; Foldemo *et al.* 2005). The families of mentally ill persons face numerous challenges, including the daily stressors of the unpredictable and bizarre behaviors of their relatives, the cost of treatment (McDonell *et al.* 2003; Saunders 2003) and the stigma that leads to social withdrawal (Crisp *et al.* 2000; Corrigan 2004). Mental illness is regarded in this region as self inflicted, particularly in conditions of substance/drug use, or that the mentally ill person is reaping the wrath of the gods for their wicked acts.

Caregivers, particularly family members, spend a substantial amount of time providing care to ill relatives with little knowledge of how to deal with their condition (Health Canada 2004; Dangdomyouth *et al.* 2008). Their lack of knowledge, support and guidance from mental health services to manage ill relatives at home results in them being unable to provide the required care (McDonell *et al.* 2003; Seloilwe 2006). Research shows that caregivers who receive educational support from mental health professionals were able to

manage the needs of ill relatives, and as a result were less burdened by their condition (Health Canada 2004). Evidence has also shown that many caregivers who used religion as a social support network experience fewer burdens, are able to manage stressors and have a more positive attitude toward life (Rammohan *et al.* 2002; Shibre *et al.* 2003). The experience of caring for relatives or friends with mental health problems affects the physical, psychological and socio-economic well-being of the caregiver, as well as their capacity to cope with and adjust to those circumstances, often compromising their own health and well-being (Veltman *et al.* 2002; Magliano *et al.* 2006). A lack of professional mental health services to support families may also place a financial burden on them (Magliano *et al.* 2000; Knudson & Coyle 2002; Foldemo *et al.* 2005). While there is a growing understanding of the needs of families of persons with serious mental health problems and the caregiving experiences in developed countries (McDonell *et al.* 2003; Kung 2004; Awad & Voruganti 2008), very little is known about the nature and extent of caregiving experiences or the needs and outcomes of policies on caregivers in Nigeria (Ohaeri 2001; Alem *et al.* 2008). This necessitates an understanding of these implications to be able to develop appropriate programmes and interventions to address their needs.

The study was undertaken in Port Harcourt, the capital city of Rivers State, situated in the Niger Delta region of Nigeria. Rivers State is an oil-rich region and generates 84% of the country's income. The state has a high population density (284 persons per square kilometer compared with the national average of 96 per square kilometer) with a population of 3,187,864 people who are concentrated in a few towns and the capital city Port Harcourt. Despite its rich resources, the state lacks ability to harness these resources to lift its

inhabitants out of poverty, the majority of people live below the poverty line and Nigeria is classified by the World Bank as a lower middle income country. The neuropsychiatric Rumuigbo Hospital was built in Port Harcourt and commissioned in 1977 and has not been renovated since. It is the only hospital that provides all in- and out-patient psychiatric services for the state, as well as for the neighbouring states. Most service users' that access the facility come directly without a referral consultation, while only a few are referred from secondary or tertiary facilities which do not provide any basic psychiatric services, resulting in high patient volumes at the hospital. The social stigma attached to mental illnesses is mirrored in the health services which results in them being poorly funded and a low priority. It also serves as a primary, secondary and tertiary facility to training nursing and medical students during clinical posting.

 Given the challenges faced by families and caregivers of mentally ill persons in this region, this study aim to explore their experiences of living with and caring for persons with serious mental health problems within the context of the mental health policy environment in Port Harcourt, Rivers State, Nigeria.

Method

Ethical clearance for this study was obtained from the Social Sciences and Humanities Research Ethics Committee of University of KwaZulu-Natal Durban, South Africa, Rivers State Ministry of Health, Port Harcourt, and the Research Ethics Committee of the Neuro-Psychiatric Hospital Rumuigbo, Port Harcourt, Rivers State, Nigeria.

66

A qualitative approach was adopted to explore family caregiving experiences with an in-depth semi-structured interview method using the policy template of Townsend *et al.* (2004) as a basis for obtaining information. This consists of four domains which each address different aspects of health care access/delivery namely Context, Resources, Provision and Outcomes, which are detailed further below. The interview guide was piloted with six caregivers attending the clinic and modified for the study. The caregivers' previous experiences in accessing service were explored with respect to perceptions of ideal care, current issues and challenges in receiving care for their ill relatives. Critical incidents (Bradley, 1992) in the caregivers' journeys through the facility were explored, from specific aspects of the policy template that reflect users mental health needs, to their perspectives on the roles and responsibilities of policy and mental health professionals in providing care and their ideas for improving services. The interview questions were open-ended resulting in emerging issues being clarified with follow-up questions, and were recorded to enable the answers to be reviewed. For example, for the personal mental health element of the provision domain, the open-ended question was posed, "Where and how do you get support?" Depending on the reply, a follow-up question was posed, such as, "What kind of assistance do you receive from the health service and, or NGOs/community?"

Participants

Twenty two family caregivers who accompanied their relative to the Rumuigbo Hospital psychiatric out-patients clinic, were living in the same household and providing care were invited by word of mouth to participate in the study, and were conveniently recruited with the assistance of the clinic sister during one of their routine visits. Their informed consent

to participate in an audio-recorded interview was obtained during which they were asked to respond to a standard set of questions. Inclusion criteria consisted of; caregivers who were 18 years and older, who have at least a basic primary education to enable them to comprehend and respond to questions asked. They must have been involved in a care-giving role for not less than a year in order to have had a thorough experience of the mental health care system. The sample was a theoretical sample, allowing data collection to continue until data saturation occurred. Of these 22 participants, only 20 were included, as two audio-recordings were excluded for inaudibility. Mental health services are not provided in primary health clinics and referral systems across secondary and tertiary facilities are weak, with only 20% being referred by a general physician, others accessing the service due to advice from friends, relatives or religious leaders. Of the 20, 12 were female and 8 were male, and their mean age was 43.4. In terms of the relationship to the mentally ill person, caregivers were all members of clients' nuclear family. The majority (70%) were low-income earners, live outside Port Harcourt and 80% has secondary or tertiary education. (See Table I)

Table I: Demographic Information about caregivers

S/N	Relation-ship to sick person	Employment	Age	Educational Level	How they got to know about the hospital
Caregiver 1	Wife	Trader	52	Secondary	A friend
Caregiver 2	Son	Applicant	30	Tertiary	A friend
Caregiver 3	Mother	Trader	42	Primary	Pastor
Caregiver 4	Mother	Trader	56	Secondary	Neighbour
Caregiver 5	Mother	Trader	62	Secondary	General Physician
Caregiver 6	Daughter	Civil Servant	25	Secondary	Relative
Caregiver 7	Mother	Civil Servant	43	Tertiary	Spiritualist
Caregiver 8	Brother	Timber work	32	Secondary	Relative
Caregiver 9	Father	Retired (Shell)	70	Tertiary	General Physician
Caregiver 10	Father	Retried (Agip Oil)	68	Tertiary	A friend
Caregiver 11	Mother	Trader	62	Primary	Relative
Caregiver 12	Mother	Trader	35	Secondary	Relative
Caregiver 13	Father	Trader	55	Tertiary	A friend
Caregiver 14	Mother	Civil Servant	46	Tertiary	Pastor
Caregiver 15	Mother	Civil Servant	45	Tertiary	General Physician
Caregiver 16	Sister	Civil Servant	34	Secondary	A friend
Caregiver 17	Brother	Self Employed	35	Secondary	Relative
Caregiver 18	Brother	Civil Servant	53	Tertiary	General Physician
Caregiver 19	Brother	Pastor	46	Tertiary	Relative
Caregiver 20	Sister	Civil Servant	32	Tertiary	Relative

The interviews were guided by a series of open-ended questions adapted from the Townsend *et al.'s* survey (2004). The duration of the interviews varied from 45 minutes to an hour, and was conducted over five-months. The 20 interviews were transcribed and analysed using Crabtree and Miller's (1999) template analysis which involved describing, organising, connecting corroborating/legitimating and representing the account and in the process, bringing together related pieces of text which enabled connections to be made (Crabtree & Miller 1999). To increase the validity of the coding and interpretation of results, the principal investigator assumed primary responsibility for creating, modifying and making connections. The texts were repeatedly read for words, phrases and meanings associated with the policy domain and coded accordingly, using NVivo 8 software. The second and third researcher then reviewed the coding done on the first group of respondents. Subsequently, the results of this coding process were discussed amongst co-researchers and the principal investigator, modifications, deletions were carried out and emerging meanings were distilled and thematically refined and linked to the most appropriate domain. A final meeting to review coding was held, at which point researchers were satisfied with the consistency of coding. Two focus group discussions were subsequently held with twelve of the 20 family caregivers who had participated in the study to confirm the findings.

Conceptual framework

The paucity of research studies on the current mental health policy context in Rivers State and the researcher's questioning about policy implications on service users' were a strong impetus for this study. Mental health policy analysis is a mechanism to assess progress in

the processes of service delivery, and to determine how well mental health programmes and activities have been implemented. It provides baseline data for policy makers to have a broader understanding of the successes or failures of programmes and services. The conceptual framework for this study is based on the framework for Mental Health Policy developed by Townsend *et al.* (2004). This Mental Health Policy Template identifies four domains for service evaluation: Context, Resources, Provision, and Outcomes. Each domain considers a number of elements that may be applied or considered in refining or reviewing mental health policy and programmes. In this study, the domains were used to elicit caregivers' experiences of accessing mental health care service within which psychiatric care occurs to identify key issues that may impact on raising mental health service onto the policy agenda and result in policy in action from the perspectives of family caregivers.

Although use of this template was not found in other caregiving studies, it was however used by Niemi *et al.* (2010) to assess mental health policy in Vietnam. This template design was chosen and adapted to undertake an in-depth and comprehensive study of family caregivers' perspectives of how they are experiencing mental health care service, benefits and challenges. The intention is to inform policy and drive policy reforms in mental health care delivery in Rivers State, Nigeria as to ameliorate suffering of persons in need of mental health care.

Table II: Mental health policy template, adapted from Townsend *et al.* (2004)

Domains	Elements
Context	Societal organization and culture
	Public policy
	Governance
	Population need and demand
Resources	Financing
	Human resources
	Physical capital
	Consumables
	Social capital
Provision	Personal mental health services
	Population-based mental health services
	Intersectoral linkages
Outcomes	Health outcomes
	Service outcomes
	Economic outcomes
	Social outcomes

The four domains are outlined separately, namely Context, Resources, Provision and Outcomes, each having a number of elements that allow the caregivers' experiences of the policy environment within which psychiatric care occurs to be explored.

Context domain:

This describes how the caregivers experience the prevailing social, economic, cultural and political factors that impact on mental health service delivery.

Resources domain:

This describes how the caregivers experience the resources available to address their needs and its elements consist of the mental health services, such as beds, facilities, staff (human resources), medications and transport.

Provision domain:

This describes how the caregivers experience the provisions for delivering of mental health services that are directed toward preventing, treating mental illness and promoting mental health and well-being.

Outcomes domain:

This describes how the caregivers experience change with respect to the wellbeing and functioning of their ill relatives that are attributable to mental health services intervention.

Results

The elements of each of the four Domains were reviewed and ten themes were identified and categorised according to their fit with the Townsend *et al.* Policy Template Domains as are presented below (Table III).

Table III: Themes arising from the Policy template

Domains	Themes
Context	I. Not a matter to discuss II. Hospital is the last resort
Resources	III. Borrowing and begging to pay for service IV. Nurses and doctors advice V. A long journey to access service
Provision PHC	VI. Free Medical Care Programme VII. Maintain hospital and provide service in VIII. Only God provides support
Outcomes	IX. Poor health status of caregivers X. Positive treatment outcomes of ill relatives

Context Domain

This first domain refers to the social, economic and cultural factors that impact on family caregiving and is illustrated in the two themes of not discussing the matter and only seeking help at the hospital as a last resort.

I. Not a matter to discuss

Stigma and discrimination of those suffering mental illness is pervasive in Nigeria, prevailing attitudes towards mental illness influence the way families regard and access helping resources. Caregivers are concerned about how others perceive them and are not convinced of the value of speaking out. Secrecy is therefore necessary to maintain family dignity in the absence of limited to non-existent helping resources.

No…No in fact it's not a matter to discuss with people, instead of discussing it I think you make things worse so we don't… I'm old enough to know that if you carry out your problems to certain places you rather receive more trouble or problems, than the help you suppose to have received, I'm 70 years and I think I should know what is obtainable in the society. (Interview 9)

II. Hospital is the last resort

Superstitious beliefs and poor knowledge of positive treatment outcomes from orthodox care result in many families preferring traditional and spiritual healers. Family health care pathways reveal that mental health service is the last resort, with most families often seek psychiatric services only when these religious and traditional remedies fail.

We were not aware of this place and you know we felt the illness was a spiritual attack, so we took her to church, the church prayed to no avail and so I was advised to bring her here by a friend. (Interview 14)

Resources Domain

The second domain concerns resources and those elements that are injected into mental health service that aim to promote individual, family and societal well-being. There are three themes arising from this domain: borrowing and begging to pay for health services, the quality of advice provided by nurses and doctors and the journey to access help.

III. Borrowing and begging to pay for service

Payment for services is on out-of-pocket basis, where clients are required to pay for all service costs. The facility is also the only mental health service available in the state for follow-up appointments and prescriptions refills. As many people live outside of Port Harcourt, they also have to pay for transport and sometimes accommodation to access service. When service users are unable to come back to the hospital due to financial difficulties, they are severed from all forms of support from mental health service. For payees of the service, this quote illustrates the determination of respondents to access the resources (medication) they need to maintain ill relatives' mental health well-being.

My husband was paying but now it's me…nobody… there are times I pay, this last one I borrowed to come and sometimes I beg from people to pay. In a month I use to spend at times over ₦16,000 (110 Dollars), the medicine are very expensive. (Interview 5)

IV. Nurses and doctors advice

Caregivers expressed satisfaction with the illness management and advice provided by the few available mental health care professionals as it assisted in their understanding the psychiatric symptoms of ill relations which help them in their caregiving roles. Caregivers observed that for families who are able to afford the cost of service and sustain treatment reported that, their ill relatives' shows positive mental health outcomes and were able to return to their work and other family responsibilities.

When he was admitted we were counseled and advised on what to do to support him, after we were discharged they also advises us to watch out for certain behaviors, the drugs are very important we should ensure he takes them and keep the appointments, they are trying it just that you know there are few hands. (Interview 20)

They are helping with the advise yes...whenever we come to the clinic the nurses and doctors advise us on what to do to support my child, how to take the medicine and to come always for our appointments. (Interview 12)

V. A long journey to access service

The psychiatric facility is located in the State's capital, resulting in people living outside the city having to travel long distances to access service, often on public transport. This can take caregivers away from their family responsibilities and jobs for a number of days, and

this can pose great financial and emotional difficulty for families, particularly during times of illness crisis that need prompt interventions.

I know today is clinic...what we do is to come to Port Harcourt yesterday to enable us to come on time. If we are to come...by boat we will not meet up, even if we did we will be the last to leave and we will not be able to go back, so we normally come the previous evening, sleep overnight to be able to keep this appointment. We slept in the hotel, most of the time we sleep in the hotel. (Interview 17)

Provision Domain

The third domain refers to mental health activities and programmes that are aimed at the individual and population level either through government or non-government organisation. Three themes emerged in this domain, Free Medical Care Programme, maintain the hospital and provide service in PHC, and only God provides support.

VI. Free Medical Care Programme

The State use to provide free psychiatric treatment for all clients at the inception of the hospital, but this was abolished in 1998 due to an economic recession. Recently, the State Free Medical Care Programme that was intended to reduce the health burden of families as a means of alleviating poverty was extended to psychiatric treatments but only for children of six years and below and retirees above 60 years. Caregivers believe that if government supports treatment and extends the free medical care programme to every client, or at least subsidize it for the poor their relatives' treatment can be sustained.

Government should give free medication, not only for me because many people will benefit…many people you see on the street don't have anybody to care for them…But if government give free medication, I think these people will be off the street. Like my brother for example if we didn't have the money, we will not be able to provide the medications and he will roam about, this is my brother I don't want him to roam the street so I'm taking care of him and doing my best but it is very difficult. (Interview 17)

VII. *Maintain hospital and provide service in PHC*

Caregivers observed that poor maintenance of the hospital has led to the difficulties they experience accessing care and during clinic appointments. There are no mental health services in the communities for early identification and treatment of individuals with mental illness or to promote mental health wellbeing outside of the psychiatric hospital. Caregivers believed that if the hospital was maintained and these services made available within the communities, their burdens would be reduced.

Government should maintain this hospital because most of us have our joy back as we came here and for me what will life be if I see my mother roam the street, this hospital is helping me and so many others but you know…they should do something, like the staff, employ more staff especially the drug section, it takes so much time to get the prescription, government can do a lot for us the common man. (Interview 6)

My appeal to government is to increase the allocation for health sector, so that they can create awareness in the community. Government should renovate and build more facilities, new buildings. Employ and train people, this is a specialist area and society needs it for

proper functioning because with this economic hardship…people are going through a lot of mental stress…(Interview 13)

VIII. Only God provides support

The absence of social welfare and support nets limits many families' access to appropriate treatment, this being further exaggerated by poverty and reduced opportunities to earn a livelihood. Caregivers perceive themselves as having no form of support within the current policy environment and rely solely on God for material and spiritual sustenance to cope with ill relatives.

No, there is none, it is God that cares if not so it would have been very difficult…If you love me and want to help, give me something to do to support my family. I want to work, a little work even if as a cleaner because the burden is big. (Interview 1)

Support? Nowhere, nobody is helping…it is only God that is helping us, now that she can do something, we pull resources together so that we can keep coming, it is God. (Interview 16)

Outcomes Domain

Two themes arise from this fourth domain about family caregivers. They are the poor health status of caregivers as well as the positive treatment outcomes of their ill relatives that are attributed to the use of the mental health services.

IX. Poor health status of caregivers

Caregivers are concerned about the time spent caregiving and its economic, physical and psychological consequences on them and their family. They experienced poor health which affects their ability to function optimally and further impoverishes the family, as time devoted to caregiving could otherwise have been directed to economically viable activities, which resulted in lost opportunities to improve their education, trade, work and quality of life.

I have sleepless nights when she is awake I can't sleep and her illness has affected my health, it gives me ill health and all these has worsen my high blood pressure, I had hypertension before her illness started but it was not this bad, it's getting worse I'm taking treatment too. (Interview 5)

How can I be well with this type of sickness? I cannot sleep, look at me I have emaciated so much because of this my daughters illness, it makes me think all the time. I was not like this... My daughter's illness is really worrying me I've left my trade and everything, financially it has ruined my life. (Interview 11)

X. Positive treatment outcomes of ill relatives

The main concern of caregivers and families was the health and improved mental state of their ill relatives. It was reported that improvement in ill relative's mental state is a relief for the family and reduces the stress of caregiving, as clients become more stable with the medication, and are able to take care of and often support themselves.

I still thank God that I am free now because I go to work. Before now I can't leave him alone. These drugs are helping him and that is why I don't mind to borrow money to buy the drugs, even my neighbours testify that he has improved. (Interview 7)

Discussion

The results are discussed with special reference to the provision of mental health care services in Nigeria, mainly in light of international recommendations and findings. From the interview transcripts, 10 main themes were identified as important from the Context, Resources, Provision and Outcome Domains in addressing the burdens faced by caregivers and families. Table III provides an overview of the main themes.

Context Domain

In this first domain, the evidence of the pervasive effect of stigma and discrimination against persons and families living with mental illness (Crisp *et al.* 2000; Corrigan 2004; Dinos *et al.* 2004; Kabir *et al.* 2004) is re-inforced in this study. There is wide-spread ignorance about the causes of mental illness as well as how to care for persons with a mental illness among caregivers. A study in southwestern Nigeria by Adewuya and Makanjuola (2009) indicated that ignorance of psychiatric services made a spiritual model of care the preferred treatment for mental illness. There is a need for public information programs, using the mass media to educate the public on mental illness signs, symptoms, treatment and where such help can be accessed.

Resources Domain

The results in this 2nd domain reveal that inability to meet financial requirement to sustain positive treatment outcomes. The distance traveled to access service was of great concern for caregivers, as a result, many families could not continue treatment due to the associated costs. It is important to understand that in a low income community, the cost of taking the patient to another city for a consultation might consume about 50% of a family's monthly income of less than US $320. This was also found by other studies in Nigeria (Martyns-Yellow 1992; Nuhu *et al.* 2010). However, caregivers are aware of the importance of mental health service and advice of medical staff. Understanding the benefit of psychiatric consultations and not being able to maintain such treatment, greatly adds to the feelings of guilt, anger and helplessness in caregivers. This conflict can also be expected to add complexity to the relationship between health professionals and caregivers.

The caregivers wanted community outreach clinics or services to be provided locally to reduce transportation costs and allow affected people to continue to stay in treatment. This has important implications for families continuing to seek care, as it will reduce the associated costs and reduce stigma as more people become aware of and use the services. While mental health professionals should support families to care for their ill relatives at home by educating them and establishing support groups to enable caregivers cope in their caregiving roles, this cannot easily happen in a centralized care system.

Provision Domain

In this third domain caregivers are concerned with managing the symptoms of their ill relatives which involves mainly medication supported by minimal psychotherapy and family education. They felt that hospital facilities were extremely limited, thereby placing responsibility of care on family members with little opportunity of receiving support from the system and society and, as a result, felt very alone in their caregiving role.

The provision of support networks and safety nets for persons and families living with mental illness has clinical and economic ramification. Those who are treated early, continue to receive treatment and care, and have an informed support network to call upon are often able to remain stable and have productive lives (WHO 2001; Patel *et al.* 2007). Studies have shown that the absence of social net and the financial disabling aspect of mental illness over the years increase the vulnerability to neglect, discrimination, loss of dignity, and poverty (Jacob 2001; Oheari 2001). To address the absence of social welfare net, the age limit for beneficiaries of free state medical care for psychiatric patients should be reviewed to allow for the inclusion of more patients into the programme. Churches and other social network organizations need to be encouraged to learn more about mental illness to enable them to provide support for the families who seek religious support. Evidence has shown that these support networks would assist with the well-being of persons with mental illness and their families (Rammohan *et al.* 2002; Shibre *et al.* 2003), and reduce stigma and discrimination in their communities.

Poor funding of mental health service is reflected in poorly maintained hospital infrastructure and reduced human resource for mental health services delivery, resulting in the staff of the hospital being over stretched to provide efficient and good service. This finding confirms previous evidence of barriers in mental health service provision in low income countries (Saraceno *et al.* 2007; Alem *et al.* 2008). Being the only facility that provides psychiatric services for the state and the lack of expansion over the years, the capacity of the hospital is also stretched beyond its catchment areas of providing the care and support needed by the population. Therefore, health policy makers should place common mental disorders alongside other physical ailments, such as HIV/AIDS, and maternal and child health. Implement effective strategies that would address the rising demands for mental illness care services.

Outcomes Domain

The result in this fourth domain showed that caregivers' and families' main concern was the health and improved mental state of their ill relatives. They felt that the improved mental state of their relatives was as a result of the medications and support from mental health service. This, they believed, could be maintained if costs of services were made affordable and services were accessible within their communities. Consistent with previous studies, caregivers in this study also experienced burdens in caring for ill relatives (Seloilwe 2006; Dangdomyouth *et al.* 2008), such as adverse mental and physical health, financial and social consequences. The increased ill health of caregivers is of serious concern, since there is no alternative care system for patients. In the Nigerian system, almost the total care burden falls to the family, with the support from other sources being

so limited as to be non-existent. No social grants, no free medication, no easily accessible care makes the services extremely economical for the state, but very expensive for the caregivers. The implication is that there is little incentive for the state to change the system, and only social pressure locally, nationally and internationally can be expected to achieve results.

Study limitation

A limitation of this study is the small sample of caregivers and that the study was conducted at one location, the mental health facility in Port Harcourt. The generalization of findings may therefore only apply to families in the Niger Delta region. The strength of this study was the use of in-depth interviewing which allowed for themes to emerge and provide a comprehensive understanding of families' experiences of care provision under the current policy environment.

The Townsend *et al.* (2004) conceptual framework met the study objective of exploring families' care giving experiences, as the tool facilitated in highlighting difficulties and challenges of mental health care services recipients within the current mental health policy environment. The use of the temple is recommended for further studies to evaluate service user perspectives of mental health services in larger population.

Recommendations and Implication for policy

The following health policy recommendations are based on the responses of the caregivers:

- Mental health services need to be integrated into general health care to reduce stigma and discrimination and to improve access to care which will decrease the financial burden on families.

- To support the decentralization and integration of psychiatric care in to primary health care, health professionals should receive appropriate and effective mental health training at all levels. Training should focus on strengthening the ability of primary care services to provide effective screening, early diagnosis, treatment and a proper referral system, as well as offering support for caregivers who have to deal with stigma and the associated social problems.

- The Government should provide free psychiatric treatment, specifically medication to assist families, and reduce many of the difficulties experienced in sustaining treatment of ill relatives.

- Programmes need to be implemented to address stigma and discrimination at all levels of the health system, government and society.

- Further research is recommended that incorporates a larger and more diverse sample of caregivers across Nigeria.

Conclusion

Stigma and discrimination remain a considerable challenge to families with mentally ill relatives, and a concerted effort is needed by government to educate health care workers, society and the families themselves about its causes and where to find appropriate

treatment. This needs to be supported by affordable and accessible treatment at all levels of health care with appropriately trained staff and adequately resourced institutions. Mental illness has multiple determinants, requiring networks of social, economical and psychological care for them and their families.

Family involvement in the health care process related to sick relatives is essential to reduce morbidity and improve the quality of their lives, as most mental illnesses can be self-managed with an informal network of support. The experiences of the Nigerian families in the Niger Delta with serious mentally ill members are likely to be similar to those in the rest of the country, and urgent attention needs to be given to provide services to what are often treatable conditions. The Ministry of Health needs to take note of international trends and recommendations to meet the needs of its citizens and ensure that it meets its mandate of "reducing the health/economic burdens of indigenes of the state by providing adequate and efficient health care services including mental health" (Rivers State Free Medical Care Programme 2000).

References

Adewuya, A. O. & Makanjuola, R. (2009). Preferred Treatment for Mental Illness Among Southwestern Nigeria. *Psychiatric Services, 60* (1), 121-124.

Alem, A., Jacobsson, L. & Hanlon, C. (2008). Community-based Mental Health Care in Africa: Mental Health Workers' views. *World Psychiatry, 7,* 54-57. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2327237/pdf/wpa010054.pdf Accessed: 23 March 2011.

Awad, G. D. & Voruganti, L. N. P. (2008). The Burden of Schizophrenia on Caregivers. *Pharmacoeconomics, 26* (2), 149-162.

Bradley, C. P. (1992). Turning anecdotes in to data: the critical incident technique. Family Practice, *9,* 98-103.

Corrigan, P. (2004). How Stigma Interferes With Mental Health Care. *American Psychologist*, *59* (7), 614-625.

Crabtree, B. & Miller, W. (1999). *Doing Qualitative Research*, 2nd Ed., Sage, London.

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I. & Rowland, O. J. (2000). Stigmatization of People with Mental Illness. *The British Journal of Psychiatry, 177,* 4-7.

Dangdomyouth, P., Stern, P. N., Oumtanee, A. & Yunibhand, J. (2008). Tactful Monitoring: How Thai Caregivers Manage their Relatives with Schizophrenia at Home. *Issues in Mental Health Nursing, 29,* 37-50.

Dinos, S., Stevens, S., Serfaty, M., Weich, S. & King, M. (2004). Stigma: The feelings and
experiences of 46 people with mental illness. Qualitative study. *British Journal of
Psychiatry, 184,* 176-181.

Foldemo, A., Gullberg, M., Ek, A. C. & Bogren, L. (2005). Quality of life and burden in parents of
outpatients with schizophrenia. *Social Psychiatry and Psychiatric Epidemiology 40,* 133-
138.

Gallagher, S. K. & Mechanic, D. (1996). Living with the mentally ill: Effects on the health and
functioning of other household members. *Social Science & Medicine, 42* (12), 1691-1701.

Health Canada. (2004). Informal/Family Caregivers in Canada Caring for Someone with a Mental
Illness. Final Report. Decimal Research Inc. http://www.hc-sc.gc.ca/hcs-
sss/alt_formats/hpb-dgps/pdf/pubs/2004-mental-care-soins/2004-mental-care-soins-eng.pdf
Accessed: 23 March 2011.

Jacob, K.S. (2001). Community Care for People with Mental Disorders in Developing Countries.
British Journal of Psychiatry, 178, 296-298.

Kabir, M., Iliyasu, Z., Abubakar, I. S. & Aliyu, M. H. (2004). Perception and beliefs about mental
illness among adults in Karfi village, northern Nigeria. *BMC International Health and
Human Rights, 4,* 3. http://www.biomedcentral.com/content/pdf/1472-698X-4-3.pdf
Accessed: 26 January 2011.

Knudson, B. & Coyle, A. (2002). Parents' experiences of caring for sons and daughters with
schizophrenia: a qualitative analysis of coping. *European Journal of Psychotherapy,*

Counselling & Health, *5* (2), 169-183. http://epubs.surrey.ac.uk/1718/1/fulltext.pdf Accessed: 12 June 2011.

Kung, W. W. (2004). Cultural and Practical Barriers to Seeking Mental Health Treatment for Chinese Americans. *Journal of Community Psychology*, *32* (1), 27–43.

Magliano, L., Fadden, G., Economou, M. *et al.* (2000). Family Burden and Coping Strategies in Schizophrenia: 1-Year Follow-up Data from the BIOMED I Study**.** *Social Psychiatry and Psychiatric Epidemiology, 35,* 109-115.

Magliano, L., Fiorillo, A., De Rosa, C., Maj, M. & the National Mental Health Project Working Group. (2006). Family burden and social network in schizophrenia vs. physical diseases: preliminary results from an Italian national study. *Acta Psychiatrica Scandinavica*, *116* (Suppl. 429), 60-63.

Martyns-Yellow, I. S. (1992). The Burden of Schizophrenia on the Family: A Study from Nigeria. *British Journal of Psychiatry, 161,* 779-782.

McDonell, M. G., Short, R. A., Berry, C. M. & Dyck, D. G. (2003). Burden of Schizophrenia Caregivers: Impact of Family Psychoeducation and Awareness of Patient Suicidality. *Family Press, 42* (1), 91-103.
http://spokane.wsu.edu/researchoutreach/wimhrt/documents/McDonell_et_al_20031.pdf Accessed: 24 May 2010.

Niemi, M., Thanh, H. T., Tuan, T. & Falkenberg, T. (2010). Mental health priorities in Vietnam: a mixed-methods analysis. *BMC Health Services Research, 10,* 257.
http://www.biomedcentral.com/1472-6963/10/257 Accessed: 26 February 2011.

Nuhu, F. T., Yusuf, A. J., Akinbiyi, A., Fawole, J. O., Babalola, O. J, Sulaiman, Z. T. & Ayilara, O. O. (2010). The burden experienced by family caregivers of patients with epilepsy attending the government psychiatric hospital, Kaduna, Nigeria. *Pan African Medical Journal, 5,* 16. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3032618/pdf/pamj-05-16.pdf Accessed: 23 March 2011.

Ohaeri, J. U. (2001). Caregiver Burden and Psychotic Patient's Perception of Social Support in a Nigerian Setting. *Social Psychiatry and Psychiatric Epidemiology, 36,* 86-93.

Patel, V., Araya, R., Chatterjee, S. *et al.* (2007). Treatment and Prevention of Mental Disorders in Low-income and Middle-income Countries. *Lancet, 370* (9591), 991-1005.

Rammohan, A., Rao, K. & Subbakrishna, D. (2002). Religious Coping and Psychological Wellbeing in Carers of Relatives with Schizophrenia. *Acta Psychiatrica Scandinavica, 105,* 356-362.

Rivers State Free Medical Care Programme (2000). Ministry of Health, Port Harcourt Rivers State, Nigeria.

Saraceno B., Van Ommeren M., Batniji, R. *et al.* (2007). Barriers to Improvement of Mental Health Services in Low-income and Middle-income Countries. *Lancet, 370,* 1164-74.

Saunders, J. C. (2003). Families Living with Severe Mental Illness: A Literature Review. *Mental Health Nursing, 24,* 175-195.

Seloilwe, E. S. (2006). Experiences and Demands of Families With Mentally Ill People at Home in Botswana. *Journal of Nursing Scholarship, 38* (3), 262-268.

Shibre, T., Kebede, D., Alem, A. *et al.* (2003). Schizophrenia: Illness impact on family members in a traditional Society – rural Ethiopia. *Social Psychiatry and Psychiatric Epidemiology, 38,* 27-34.

Townsend, C., Whiteford, H., Baingana, F. *et al.* (2004). The Mental Health Policy Template: Domains and Elements for Mental Health Policy Formulation. *International Review of Psychiatry, 15* (1-20), 18-23.

Veltman, A., Cameron, J. I. & Stewart, D. E. (2002). The Experience of Providing Care to Relatives with Chronic Mental Illness. *The Journal of Nervous and Mental Disease, 190* (2), 1902-108.

World Health Organisation (2001). Mental Health: New Understanding, New Hope. The World Health Report, Geneva. http://www.who.int/whr/2001/en/whr01_en.pdf Accessed: 12 June 2011.

2.4 ARTICLE THREE:

CLIENTS WITH SERIOUS MENTAL HEALTH PROBLEMS EXPERIENCING CARE WITHIN THE CURRENT MENTAL HEALTH POLICY IN THE NIGER DELTA REGION OF NIGERIA

Authors:

(1) Jack-Ide, I.O. Doctoral Research Student. School of Nursing and Public Health, University of KwaZulu-Natal, Durban, South Africa. Phone: +91-404-789-0415; +27-788550525. Email: izibelokojackide@ymail.com

(2) Uys L. R. D Soc Sc. School of Nursing and Public Health, University of KwaZulu-Natal, Durban, South Africa. Phone: +27 (12) 333-1415 Email: uys@ukzn.ac.za

(3) Middleton L.E. PhD. School of Nursing and Public Health, University of KwaZulu-Natal, Durban, South Africa. Phone: +27- 714751016. Email: Middletonl@ukzn.ac.za

Abstract

Persons with serious mental health problems experience fluctuating course of illness that interacts both with the environment and the individuals' effort to sustain healthy living. The burdens associated with mental illness may increase further, given the policy and implementation challenges facing mental health services in Nigeria. This study explored the experiences of clients with serious mental health problems receiving care within the current health care environment. METHODS: A qualitative study was conducted among 30 clients attending the neuropsychiatric outpatient clinic in Port Harcourt, Rivers State, Nigeria. Socio-demographic characteristics of clients were recorded. RESULTS: The mean age of clients is 36.43 years; duration of illness is seven years; 46.6% are males, 13.3% have a regular monthly income, 3.3% use the free medical care programme, and 66.6% have used spiritual or traditional models of care. A high burden associated with mental illness presented with symptoms of illness, family members' negative attitude, cost of medication, long-distance travels and high service charges among unemployed and low-income clients. CONCLUSION: Clients experience significant burden of the disease, mainly associated with cost of service utilisation, long waiting times, discrimination and stigma. In spite of difficulties caused by mental illness, clients with serious mental health problems can be treated and live productive lives if provided with adequate social support.

Introduction

Mental health is an integral and essential component of health.[1] Mental health problems constitute 14% of the global burden of disease and are one of the leading causes of disability worldwide.[2] It is argued [1] that this burden of mental illness is likely to have been underestimated because of the inadequate appreciation of the connectedness between mental illness and other health conditions for example, depression, anxiety, and adjustment disorders are seen in patients with cancer.[3] Furthermore, many individuals with mental health problems remain untreated although effective treatments exist.[4, 5, 6] It is therefore anticipated that by 2020, mental health problems will constitute 15% of the global burden of disease and account for 37% of all healthy life years lost through disease.[4,5]

Community-based epidemiological studies have estimated that the worldwide lifetime prevalence rates for mental disorders in adults range from 12.2% to 48.6%, with a 12-month prevalence rate of between 8.4% and 29.1%.[2] The extent of the burden and prevalence of mental disorders is of serious concern for national health systems, and particularly for mental health service delivery in developing countries.[7, 8] A WHO report shows that developing countries has a higher proportion of persons with serious mental health problems than developed countries due to poor resource environment and that between 76–85% of persons with mental health problems in developing countries received no treatment in the previous 12 months compared to 35-50% in developed countries.[2] A review of world literature on mental health found treatment gaps to be 32% for schizophrenia, 56% for depression, 50% for bipolar disorder, 56% for panic disorders and as much as 78% for alcohol use disorders.[2]

Reports of mental health service utilization over a period of 12 months illustrate the seriousness of the situation for both developing and developed countries. For example, only 2% of persons with mental health problems in Nigeria used a mental health service in the preceding year as compared to 18% of persons in the United States, while only 11% of persons in China received care on first service contact as compared to 61% in Belgium. Follow-up treatment seems higher than service utilization in developed countries – the follow-up rate is 70% in Germany as compared with 10% in Nigeria.[4]

Currently, primary and community-based mental health care is the global approach to providing mental health services.[6, 9, 10, 11, 12] The main purpose of this approach is to reduce stigma and provide affordable, effective mental health and physical care in tandem with people at the community level, closer to where they live, with minimal disruption to family.[13, 14, 15] The aim of the study is therefore to explore the experiences of clients with serious mental health problems receiving care within the current policy environment in a state funded mental health service in the Niger Delta region of Nigeria.

Statement of problem

The 1991 National Mental Health Policy in Nigeria states that individuals with mental, neurological and psychosocial disorders shall have the same rights to treatment and support as those with physical illness and shall be treated in health facilities as close as possible to their own community. No person shall suffer discrimination because of mental illness. At all levels of health care, mental health services shall as far as possible be integrated with general health service. In this way the preventive, therapeutic, rehabilitative and social

reintegration aspects of mental health care shall be available to all Nigerians.[16] However, lack of these facilities in communities creates barriers that pose significant challenges to persons with serious mental illness, not only in terms of clinical management of the disease, but also in its psychological consequences.[17, 18] It imposes a significant cost to the client in terms of personal suffering and impairs their ability to search for and sustain productive employment.[4, 19] Often, initial treatment is delayed for many years, leading to chronicity and isolation due to lack of relevant information about mental health care service.[20] The financial cost of making long-distance travels to procure treatment in big cities is more distressing to clients and families living in rural areas than the effects of illness on their daily routine.[21] Clients also experience practical barriers, which include cost of treatment, long waiting times, issues of accessibility, and limited availability of services. [18, 22]

Cultural barriers consist of the belief that hospital treatment is not credible and that persons with mental illnesses are reaping the wrath of the gods for their evil acts.[23 24, 25] Poor access, high cost of treatment, and lack of psychosocial and economic support for mental disorders worsen the economic condition of clients and families, setting up a vicious cycle of poverty and mental disorder which further impoverishes society from loss of productivity.[19, 26, 27] Furthermore, the pervasive effects of negative stereotypes of mental illness on society's attitudes and behaviour toward persons with serious mental health problems delay help-seeking.[28, 29, 30] Therefore, strengthening care and services for people with mental disorders should be given priority to reduce difficulties experienced by clients with serious mental health problems. These barriers can be overcome by generating

sufficient political will to integrate mental health services into general health care to improve access to mental health care services in the community.

Setting

The study took place in Port Harcourt, Rivers State, which is the heart of the Niger Delta region of Nigeria, is in the south of the country. Rivers State is an oil-rich region which generates 84% of the country's wealth. The state has a high population density (284 persons per square meter as compared with the national average of 96 per square meter) with a population of 3,187,864 people, 51.9 % of whom are males and 48.1% of whom are females. The state's population accounts for 3.58% of the total Nigerian population. A significant proportion of this population is concentrated in a few towns and the state capital, Port Harcourt. Mental health services in this state are delivered through a single mental health hospital, the neuropsychiatric Rumuigbo Hospital, which provides outpatient and in-patient services not only for the state, but also other neighboring states. Ethical clearance to perform the study was obtained from the Ethics Committee of Neuro-Psychiatric Hospital Rumuigbo, Port Harcourt, Rivers State, Nigeria and the Biomedical Research Ethics Committee of the University of KwaZulu-Natal, South Africa.

Methods

A qualitative method was used to obtain information about clients' experiences of receiving care within the current mental health policy environment. A semi-structured interview schedule was designed using Townsend's mental health policy template.[31] The population for this study was client with serious mental health problems attending the

99

outpatient clinic of neuropsychiatric Rumuigbo Hospital. Inclusion criteria were that participants had to be 18 years and older and not overtly psychotic so that they could comprehend and answer questions. Newly diagnosed patients and all those currently in the hospital were excluded from the study. A purposive sampling technique was used to recruit 50 clients who were informed of the study by nurses working at the outpatient clinic. Response rate of clients invited to participate was 80%. Twenty percent declined due to long waiting times at the clinic and the long journey required to get to their homes. Of the 50 clients recruited, 30 participated. The mean age was 36.43 years, the average illness duration was seven years, 3.3% were under the free medical care programme, 46.6% were males, 13.3% had a regular monthly income, and 66.6% used a spiritual or native model of care before coming to the psychiatric hospital. (See Table 1: Demographic information about clients).

Table 1: Demographic Information about clients

S/N	Gender	Age	Employment	Illness duration in years	Care pathway	Means of payment
Client 1	Male	22	Student	3	Private hospital	Out of pocket
Client 2	Female	32	Petty trader	4	Spiritualist	Out of pocket
Client 3	Female	34	Student	10	Church	Out of pocket
Client 4	Female	32	Unemployed	6	Church	Out of pocket
Client 5	Female	49	Unemployed	13	Church	Out of pocket
Client 6	Female	28	Unemployed	5	Herbalist	Out of pocket
Client 7	Male	26	Student	2	Private hospital	Out of pocket
Client 8	Male	43	Petty trader	11	Herbalist	Out of pocket

Client 9	Male	50	Self employed	8	General hospital	Out of pocket
Client 10	Male	34	Missionary	5	Herbalist/ Church	Out of pocket
Client 11	Female	27	Unemployed	4	Spiritualist	Out of pocket
Client 12	Female	25	Public servant	5	Spiritualist	Out of pocket
Client 13	Male	32	Unemployed	8	Herbalist	Out of pocket
Client 14	Female	30	Unemployed	5	General hospital	Out of pocket
Client 15	Female	45	Farmer	6	Church	Out of pocket
Client 16	Male	42	Missionary	3	Psychiatric hospital	Out of pocket
Client 17	Female	55	Unemployed	24	Church	Out of pocket
Client 18	Female	53	Public servant	10	Psychiatric hospital	Out of pocket
Client 19	Female	34	Unemployed	4	Spiritualist	Out of pocket
Client 20	Female	24	Unemployed	3	Church	Out of pocket
Client 21	Female	44	Public servant	19	Church	Out of pocket
Client 22	Male	63	Public servant	2	Psychiatric hospital	Free medical care
Client 23	Female	30	Unemployed	8	Private hospital	Out of pocket
Client 24	Male	28	Unemployed	8	Psychiatric hospital	Out of pocket
Client 25	Male	58	Petty trader	10	Church	Out of pocket
Client 26	Male	24	Unemployed	6	Native/ Spiritualist	Out of pocket
Client 27	Female	36	Unemployed	5	Herbalist	Out of pocket
Client 28	Male	48	Petty trader	8	Spiritualist	Out of pocket
Client 29	Male	21	Unemployed	2	Church	Out of pocket
Client 30	Male	24	Student	3	Psychiatric hospital	Out of pocket

Procedure

The researchers and nurses at the outpatient clinic approached potential participants, solicited their interest, informed them of the study and distributed a copy of the information sheet to those potential participants who demonstrated an interest in participating in this project. Those who agreed to participate were requested to complete the consent form, and arrangements for an interview with each potential participant were made. All participants were advised that they could withdraw from the study at any time. A semi-structured interview schedule was designed using Townsend policy template.[31]

Interview questions were structured along the policy template domains and elements and were designed to promote open-ended responses i.e. of such questions asked in the outcome domain on health outcome; *"How has the illness impacted on you and your family?"* To further clarify emerging issues a follow-up question could be posed i.e. *"What was your life like before this illness?"*

Interviews lasted between 45 minutes and an hour. Thirty interviews were recorded with the permission of participants and transcribed verbatim. Transcripts were analyzed using NVivo 8 qualitative data analysis software. A framework analysis approach was adopted for main themes and then coded according to those themes using the template editing style of Crabtree and Miller[32] making it possible for the researcher to focus on a particular aspect of the text. The template process reduces the amount of data being considered at any one time and brings together related pieces of text in the process, which facilitates making connections. The primary researcher performed an initial scan of the data, highlighting words or phrases used by the participants and locating initial themes. Core themes were

identified through a process of collaborative analysis and the themes were linked to the domains and elements of the mental health policy template. Finally, the primary researcher reread the data and assigned excerpts that illustrate the final themes. All coding was checked by co-authors to ensure accuracy.

Theoretical framework

The conceptual framework for this study is based on the assumptions of health policy analysis and, specifically, on the framework for mental health policy implementation.[31] Mental health policy analysis provides insight into ongoing processes of service delivery and difficulties of providing mental health services and programmes. Mental health policy template outlines the domains and associated elements that may be considered in reviewing mental health policy.[31] In this study, the domain and elements were used to explore how persons with mental illness experience care within the current psychiatric care delivery system. The template consists of four domains: context, resources, provision, and outcomes. Each domain considers a number of elements that can be used in service assessment as well as programme implementation. (See Table 2: Mental health policy template)

Table 2: Mental health policy template, adapted from Townsend et al.[32]

Domains	Elements
Context	Societal organization and culture
	Public policy
	Governance
	Population need and demand
Resources	Financing
	Human resources
	Physical capital
	Consumables
	Social capital
Provision	Personal mental health services
	Population-based mental health services
	Intersectoral linkages
Outcomes	Health outcomes
	Service outcomes
	Economic outcomes
	Social outcomes

Results

The analysis of interviews revealed 16 themes arising from the four domains and elements of the policy template. (See Table 3: Themes arising from interview transcripts)

Table 3: Themes arising from interview transcript

Domain	Themes
Context	Mental illness attributed to witchcraft or punishment from gods Managing the illness Verbal and physical abuse Absence of welfare support net
Resources	Cost of service utilization Ability to access service Effects of disclosing illness
Provision	State Free Medical Care Programme (FMCP) Long waiting time Distant travels Inability to sustain treatment Poor infrastructure
Outcomes	Positive impact of service on clients' health Provision of service in rural communities Impact of illness on clients Self check

Context domain

Here we describe prevailing social structures and systems (organization), including the role of religion, family, cultural perspectives, beliefs and values that impact clients' health and the kind of resources they can draw upon for support.

Mental illness attributed to witchcraft or punishment from gods

Care pathways in this study show 55% of clients receiving mental health services sought help from churches/traditional healers first and came to the hospital when these remedies fail. Lack of knowledge about mental health care service and the attribution of mental

illness to witchcraft or punishment from the gods for evil deeds of individual or family may have influenced care pathways.

We used native way before we got here. My father said this type of sickness is not a hospital thing that we should go to church or herbalist, so...they didn't take me to hospital. (Interview 3)

Managing the illness

The management of symptoms of mental illness and daily medication administration is the greatest challenge clients' face in maintaining their self care and staying healthy.

It is this sickness that is my most difficult times…how this illness will leave me and I can be myself again at least without taking medicine every day. (Interview 6)

Verbal and physical abuse

The ways in which the family manages the illness and perceive the ill relative negatively affects self-esteem, this has potentially serious physical consequences for the client and impedes their coping ability. Clients face challenges within the family some are flogged, mechanically restrained and verbally abused. Furthermore, an undertone of alienation permeates clients' descriptions of the family system, which to some extent illustrates the broader social context.

You people should advise them – my parents, my family and my relatives. Anything pertaining to flogging, caning, fighting or tying of robe or even taking me to a place where they will chain me…I don't like that. They should stop flogging me and tying me with rope. (Interview 20)

My greatest problem has been from my family you understand...so to me it was an irony of a thing... when you are well and okay you know...may be you have been stable for some months, they will start all over again... treating you anyhow...People who call you mad or something like that, you are better than them, much better than them because the things they tell me I cannot say it to them, not to a relative. When a family member calls you mad, you are this or that, just like yesterday my mum and my younger sister were saying such things to me, you are mad...(Interview 21)

Absence of welfare support net

Clients expressed dissatisfaction with lack of support. There are no rehabilitative or social welfare support from anywhere for a sustainable wellness activities and programmes to support clients' recovery processes, that have a direct or indirect effect on their families' well-being.

Nobody...no community, no church, no brother, no friend. Just myself... Nobody. (Interview 8)

No...body...nobody since this my illness nobody...all the people I have helped no body except my husband brother nobody even in my own family too, nobody is helping. (Interview 5)

<u>**Resources Domain**</u>

These are elements that are injected into mental health services to promote clients' well-being and positive family outcomes such as medications, transport, mental health facilities and beds.

Cost of service utilization

The study shows that 13.3% of clients have a regular monthly income; others are students or are unemployed. Payment for mental health service is out-of-pocket and most clients complained of inconsistency of cost of medication and service charges at follow-up appointments. These high costs and unbudgeted expenses increased clients' financial burden and were most often responsible for non-follow-up of care.

It was like a disaster...financially, it ran me down completely. It's only by God's intervention that I'm able to come. That was one of the things that depressed me that time. (Interview 28)

A lot...a lot, so much that I don't have the right words to explain to you but it is very heavy on my family. It's affecting me because the little money I get, I also add to buy the drugs and also to pay for transport to come to hospital. (Interview 3)

Ability to access service

Clients report getting support from health care service only when they are able to come to the hospital, there is no link with any health service for support outside the facility. Once clients are unable to keep follow-up appointments due transport difficulties, lack of money to purchase medication or a relapse, they are cut off from professional support and left to the goodwill of concerned family members, who may provide the necessary resource to come back to hospital.

The help I get is my drugs and they also give me advice, how to avoid this and that...their advice is helping me and as I take the drugs my condition has improved... (Interview 1)

Effects of disclosing illness

Clients suffer discrimination and stigma at work that leads to losing employment and being turned down for jobs for which they are competent and skilled. Some believed they lost their jobs due to rumors about their illness.

It's tough...where I was working, I told them the truth that I was coming for my drugs at psychiatric hospital...they just terminated my appointment. Yes...there was another one I lost; they...saw me when I was at home, when I was really sick, jumping fence, running around with my brother's wife on the street. So now, seeing me teaching their children is like, "Ha...this is the sick person." That was it.... (Interview 14)

Provision Domain

This pertains to what health service does to promote and improve the mental health of clients and their families, and which services are provided and organized within the health sector and other government departments.

State Free Medical Care Programme (FMCP)

The mission of the Free Medical Care Programme is to reduce the health/economic burdens of indigenes of the state by providing adequate and efficient health care services including mental health care for children below six years and retirees 60 years and above who had worked in the state public service. In this study, only 3.3% are covered by the free medical care programme. The others are excluded as they were not within the age bracket, clients want this policy reviewed to enable every indigene of the state to benefit and live a more rewarding life.

The age limit at 60 before you get free medical care is not proper; at least it should be reduced to 30 or less years. I think so…because mental illness now affects a lot of communities; for people to get to 60 is very difficult. If you see somebody 60-plus in Rivers State where life is very hard, then that man has gone through a lot of storms. Actually, they should bring the age down to 30 so that the assistance can go to a larger population, because those above 60 are very, very few indeed. (Interview 22)

Long waiting time

There were complaints of spending long waiting times to consult the doctor and get their prescriptions. However, clients expressed satisfaction with health care professionals' support, such as health education on the importance of medication, keeping follow-up appointments, avoiding stress, and spiritual and emotional counseling.

At times when you come to buy your drugs you stand there… first of all, they will collect it, cost it and bring it back to you. You now give them money. Before you're finished it will take the whole day; you waste a lot of time there. People will crowd up there waiting for their drugs; this is a very serious problem for us. (Interview 27)

Distant travels

Mental health care service is located in the state capital Port Harcourt, and most clients using the facility live outside Port Harcourt. Clients embark on long-distance journeys, traversing creeks and rivers to access the mental health service. Furthermore, due to long waiting times for consultation, many clients may not get back to their homes and villages,

thereby incurring extra financial cost for sleepover in hotels, making these journeys expensive and follow-up appointments difficult, if not impossible.

Sometimes when you don't come, it's because of no money. When you think of transport, the medicine, how can you come? You can't come, or are you coming to just look at the people here? You come because maybe your drug is finished so that you can buy, but if the money is not there what do you do? Then when you manage to come, they say you default, pay this, pay that…. (Interview 23)

Inability to sustain treatment

Clients reported that the cost of procuring treatment is one of the greatest challenges. The medications aid steady improvement in their mental state and allow them to function better, but without the medications, clients believe they may not have control over their lives. Therefore, there is need for continuous medication to stay healthy, and finance is the main factor impeding staying healthy.

My greatest problem is how to get money to come here for treatment. I'm getting old and my bones are getting weak. I will not be able to hawk things around to raise money…then what will happen to me? (Interview 17)

Poor infrastructure

Clients appeal to government to support and maintain the facility to improve service for users. They seek provision of toilet facilities, chairs, additional staff to assist with workload, and general maintenance of the infrastructure with basic amenities such as electricity and water.

Since I have been coming here I have never seen toilets...no toilets. Because if one is pressed, you go outside and find somewhere to ease yourself. If I am pressed, I go out to some corner and ease myself. (Interview 25)

Outcomes Domain

Outcomes are the impact of mental health services and programmes at the client and population levels. They include changes in the mental health functioning of clients that are attributable to care and treatment received from the facility.

Positive impact of service on clients' health

There is positive impact of the usage of the facility by clients and their families. Most clients say they are able to carry out activities of daily living and go about their work and business due to treatment they receive from the service.

Yes, I am satisfied with treatment they give me. Without this hospital or without these drugs, I don't think I will get well.... It's here that I come that I have my peace. (Interview 8)

Provision of service in rural communities

Clients believe that continuous positive outcomes in their mental state can be maintained if necessary support is provided by government. There should be outreach clinics at health centres in local government areas to provide mental health care service where clients can receive their prescriptions rather than making long-distance journeys to access service, and medications should be subsidized to an affordable level.

112

They should build this hospital in other places because sometimes one may not have money for transport to come here. If government is able, they should bring this service nearer to us, like a unit... so that I don't travel all the way to Port Harcourt. (Interview 4)

Impact of illness on clients

Clients expressed the negative impact of illness on their lives – their actions are always misinterpreted by others, they are not trusted and are always relegated to the background. They experience difficulty in expressing their opinions at work, family members and among peers, whatever clients do or say is usually perceived through the "lens of mental illness."

It's very insulting, very humiliating...the way people look at you.... Like last time...I relapsed, and in such a place where I went for a workshop...Such a thing happen and everybody seeing and saying all sorts... It's not easy being identified with this type of ill health. (Interview 18)

Self check

Mental illness brings changes in the lives of clients as they struggle to stay healthy and function in society. Clients expressed regrets for these negative portrayals; to avoid stigma and discrimination they often avoid activities and programmes that may compound their mental state in the family, workplace school and social activities.

Because of my condition...you know I watch myself, I know myself.... I'm not forward...at school because I try to avoid anything that may bring or give me stress. (Interview 30)

Discussion

Lack of knowledge about available mental health services is prevalent, giving rise to use of spiritual models of care. Evidence shows that this pathway to care is underpinned by the attribution of mental illness as punishment from the gods.[25] Pathway to care plays a significant role in mental illness treatment outcomes. Confirming the finding, Gureje & Lasebikan [28] argue that delays in treatment of mental illness may be driven by stigma and the public's poor knowledge. Also, poor knowledge of where and how to access scarce mental health service influences the use of unorthodox models of care, as mental health service is often located in big cities. [10, 12] The perception that mental illness is a consequence of an individual's wicked acts may also explain the general neglect, discrimination and low-priority status given to mental health by policymakers. These problems could be overcome with the help of the media as evidence shows it can play an important role in reducing negative portrayals and be a powerful vehicle for changing society's perception about mental illness.[2, 33]

Lack of social support hinders clients' recovery process. Persons with mental illness are simply left with whatever support the extended family system can provide. This finding is consistent with other studies.[21, 22, 26] Research has also shown that social support helps to address multiple social needs of clients/families, which promotes the activities of daily living and re-integration into society.[14] The lack of social support and the financial disabling aspect of mental illness over the years may increase the vulnerability of clients abandoned by families. This would be addressed if the mental health policy were to be

implemented as it stipulates that the state provide support for clients/family and reintegration within the community.[16]

Mental health services are bought by clients through out-of-pocket payments. As a result, only a few are able to sustain treatment and maintain follow-up care. Evidence has shown that out-of-pocket payments for service may contribute to poverty and jeopardize clients' and their families' well-being.[19, 26] It is argued that the low-priority status of mental health is responsible for poor funding of service.[27] The strategic status of the state as the "cradle of the nation's wealth" gives the state the mandate to provide needed support and affordable mental health service for the poor and unemployed.

Clients with mental illness report a wide range of discriminatory experiences in both occupational and social settings, including being turned down for jobs for which they are competent and qualified, and loss of employment, clients are verbally and physically abused and sometimes becomes destitute. Evidence has shown that persons with mental illness suffer discrimination in workplaces and social relationships due to misconceptions.[2, 14, 23] To protect the human rights of persons with mental illness, WHO made a clarion call on all countries to implement mental health legislation and policy.[33] Legislation will help protect persons and families from indiscriminate human rights abuses.

Mental health human resources are crucial. As the only psychiatric facility serving the state, Rumuigbo Hospital need to be given the required human resources to fulfill its objective of care provision and improve the current level of service. The WHO has stressed

the importance of human resources development, most mental illnesses that result in high morbidity and mortality do not require sophisticated and expensive technologies and highly specialized professionals to render service.[2, 12] It is argued that human resources are the most valuable asset of mental health delivery as services rely on competent and motivated personnel that are supported and supervised to provide care for persons with mental illness and prevent mental disorders.[10, 27] According to WHO[2] "restoration of mental health is not only essential for individuals' well-being, but is also necessary for economic growth and reduction of poverty in societies."

The free medical care programme of the state only provides medical care for children below six years and state government retirees 60 years and above, and only clients within these age brackets are allowed to benefit with regard to mental health care service. However, taking the life expectancy[34] in Nigeria of 46.76 years for males and 48.41 years for females, there is need to review the free medical care programme, as it affects persons with mental illness, because the burden of mental illness is maximal in young adults, the most productive section of the population.[20] Evidence has shown that without proper mental health financing, the treatment gap will increase, with untold difficulties on clients and families.[4, 13, 19] It is argued that direct and indirect costs of mental ill-health worsens the economic plight of clients and families, setting up a vicious cycle of poverty.[26]

The greatest challenge faced by clients with mental illness in sustaining treatment and maintaining an improved mental state is having the fund to procure medication and to keep follow-up appointments. Similarly, research shows that the shift of financial responsibility

to the client/family will worsen their economic situation, giving rise to poverty. [26] This, in turn, creates poor access and reduced involvement of persons with mental illness with service, causing difficulties not only for such individuals, but society in general. The key area of concern in this study is the perceived failure of policy to move to effective implementation of integrated care. The primary mental health policy was to ensure mental health service is integrated at all levels of care, and that clients be treated in health facilities as close as possible to their community in line with the current global approach.[6, 12, 16] The non-integration of mental health service into primary health care has increased suffering and burden on clients and families.[14, 15, 8]

The majority of clients expressed satisfaction with changes in functioning attributable to treatment and care received at the facility. Previous studies revealed that new discoveries in psychotropic medications have positive treatment outcomes for mental illness for those engaged with service.[7, 23] Furthermore, to confirm findings, Prince et al[1] and Kohn et al[4] argue that persons with mental health problems can live productive lives if given necessary care and treatment.

Evidence of the pervasive effects of negative stereotypes of mental illness on society's attitudes and behaviours toward people with serious mental illness is also reinforced in this study. There is consistent opinion across all participants that stigma is highly problematic to their recovery process, which most often leads to rejection and isolation by family, peers and social engagements.[23] Issues fueling this negative public image are the traditional beliefs about causes of mental illness.[25] Clients with mental illness are viewed by the public

as responsible for their illness and reaping the wrath of the gods for their wicked acts, as shown in most Nigerian movies and particularly when it is related to drug or substance use. As such, they do not get the required sympathy that is usually extended to sick persons. Similarly, evidence reveals that these beliefs and misconceptions are responsible for poor service utilization and also underpin the low-priority status of mental health care financing by policy.[2, 23, 24]

Recommendations for policy and practice

In line with the philosophy of the primary health care approach, integrate mental health care into general health care service and establish outreach clinics at every local government headquarters to increase access to treatment and care. To sustain clients' positive treatment outcomes, the free medical care programme of the state should be extended to all with mental illness, or subsidized at an affordable level for the poor and unemployed in line with WHO recommendations for a wider coverage.[11] Medications should be decentralize from the psychiatric hospital to other health care facilities where there are trained nurses and general practitioners to reduce the financial burden on clients' transportation costs for follow-up visits or to refill prescriptions, thereby preventing indirect cost associated with sustaining positive treatment outcomes.[6]

There is need for family education and support. As such, mental health professionals should continue efforts to engage families in a partnership for the benefit of their ill relatives.

Limitation of the study

This is a purposive study carried out in only one centre in the country. The data was based on self-reporting and clients' experiences were not corroborated in any way. Clients were excluded who have used the facility for less than a year to ensure the inclusion of clients who had sufficient experience of service utilization that are regularly receiving treatment at the facility.

Conclusion

Although the findings may not be transferable to other institutions in Nigeria, they have contributed to the evidence that clients with serious mental health problems experience financial burden in procuring medications, paying service charges and funding the cost of long-distance travels to access service. This burden can be alleviated by integrating mental health care in PHC to increase access to service.

References

1.   Prince M, Vikram A., Saxena, S. et al. No Health without Mental Health. The Lancet 2007; 370 (9590): 859-877.

2. World Health Organisation. Mental Health Gap Action Programme: Scaling Up Care for Mental, Neurological and Substance Use Disorders. Geneva: World Health Organisation 2008.

3.   Mitchell AJ, Chan M, Bhatti H. et al. Prevalence of Depression, Anxiety, and Adjustment Disorder in Oncological, Haematological, and Palliative-Care Settings: A Meta-Analysis of 94 Interview-Based Studies. Lancet Oncol 2011; 12: 160–74.

4. Kohn R, Saxena S, Levav I. et al. The Treatment Gap in Mental Health Care. Bull World Health Organ, 2004; 82: 858-866.

5.   Wang PS, Aguilar-Gaxiola S, Alonso J. et al. Use of Mental Health Services for Anxiety, Mood, and Substance Disorders in 17 Countries in the WHO World Mental Health Surveys. Lancet 2007; 370 (841-850): 841-850.

6. World Health Organization and World Organization of Family Doctors (WONCA). Integrating Mental Health into Primary Care: A Global Perspective. Geneva: World Health Organisation 2008.

7. Jacob KS, Sharan P, Mirza I. et al. Mental Health Systems in Countries: Where Are We Now? Lancet 2007; 370: 1061–1077.

8. Chisholm D, Flisher A J, Lund C. et al. Scale up Services for Mental Disorders: A Call for Action. Lancet 2007; 370: 1241-125.

9. World Health Organisation. Optimal-mix of service for mental health. Geneva: World Health   organization,   2009.   Retrieved   from

http://www.who.int/mental_health/policy/services/2_Optimal%20Mix%20of%20Services_Info sheet.pdf Accessed 20 March, 2011.

10.   World Health Organisation. Human resources and training in mental health. Mental Health Policy and Service Guidance Package. World Health Organization, 2005.

11.   World Health Organisation. The World Health Report: Health System Financing: The Path to Global Coverage. Geneva: World Health Organisation. 2010.

12.   World Health Organisation. The World Health Report: Primary Health Care Now More Than Ever. Geneva: World Health Organisation, 2008.

13.   Saxena S, Thornicroft G, Knapp M. et al. Resources for Mental Health: Scarcity, Inequity, and Inefficiency. Lancet 2007; 370 (9590): 878–89.

14. Browne G and Courtney MC. Housing, Social Support and People with Schizophrenia: A Grounded Theory Study. Issues Ment Health Nurs 2005; 26: 311-326.

15.   Gavois H, Paulsson G and Fridlund B. Mental Health Professional Support in Families with a Member Suffering from Severe Mental Illness: A Grounded Theory Model. Scand J Caring Sci 2006; 20: 102-109.

16.Federal Ministry of Health. The National Mental Health Policy in Nigeria. Lagos, Nigeria, 1991.

17. Awad GD and Voruganti LNP. The Burden of Schizophrenia on Caregivers. Pharmacoeconomics 2008; 26 (2): 149-162.

18. Kung WW. Cultural and Practical Barriers to Seeking Mental Health Treatment for Chinese Americans. J Community Psychol 2004; 32 (1): 27–43.

19. Patel V. (2007) Mental Health in Low- and Middle-income Countries. Br Med Bull 2007; 81and 82: 81–96.

20. World Health Organisation. Improving health systems and services for mental health. (Mental health policy and service guidance package). Geneva: World Health Organisation, 2009.

21. Martyns-Yellow IS. The Burden of Schizophrenia on the Family: A Study from Nigeria. Br J Psychiatry 1992; 161: 782–799.

22. World Health Organisation –Assessment Instrument for Mental health Service (WHO-AIMS). Report on Mental Health in Nigeria. World Health Organisation and Ministry of Health. Ibadan, Nigeria, 2006.

23. World Health Organisation. Mental health and development: Targeting people with mental health conditions as a vulnerable group. Geneva: World Health Organisation, 2010. Retrieved from http://www.who.int/mental_health/policy/development/en/index.html and http://www.psychiatry.uct.ac.za/mhapp/ Accessed 20 March, 2011.

24. Sartorius N. Stigma and Mental Health, Lancet, 2007; 370: 810-811. Retrieved from www.thelancet.com Accessed 10 January, 2011.

25. Gureje O, Lasebikan VO, Ephraim-Oluwanuga O. et al. Community Study of Knowledge of and Attitude to Mental Illness in Nigeria. Br J Psychiatry 2005; 186: 436-441.

26. Patel V and Kleinman A. Poverty and Common Mental Disorders in Developing Countries. Bull World Health Organ 2003; 81:609-615.

27. Saraceno B, van Ommeren M, Batniji R. et al. Barriers to Improvement of Mental Health Services in Low-income and Middle-income Countries. Lancet 2007; 370: 1164-74.

28. Gureje O and Lasebikan VO. Use of Mental Health Services in a Developing Country Results from the Nigerian Survey of Mental Health and Well-being. Soc Psychiatry Psychiatr Epidemio 2006; 41: 44–49.

29. Dinos S, Stevens S, Serfaty M. et al. Stigma: The Feelings and Experiences of 46 People with Mental Illness. Qualitative study. Br J Psychiatry 2004; 184: 176-181.

30. Corrigan PW, River PL, Lundin RK. et al. Three Strategies for Changing Attributions about Severe Mental illness. Schizophr Bull 2001; 27 (2):187-195.

31. Townsend C, Whiteford H, Baingana F. et al. The Mental Health Policy Template: Domains and Elements for Mental Health Policy Formulation. Int Rev Psychiatr 2004; 15 (1-20): 18-23.

32. Crabtree B and Miller W. Doing Qualitative Research, 2nd Ed, Sage, London, 1999; 164-194.

33. World Health Organisation Resource Book on Mental Health, Human Rights and Legislation. Geneva: World Health Organization, 2005.

34. United Nations International Children Emergency Fund (UNICEF). At a Glance: Nigeria. Life Expectancy at Birth. 2009. Retrieved from http://www.unicef.org/infobycountry/nigeria_statistics.html Accessed 04 January, 2011.

2.5 ARTICLE FOUR

THE EXPERIENCES OF MENTAL HEALTH CARE PROFISSIONALS PROVIDING MENTAL HEALTH CARE SERVICES IN A NEUROPSYCHIATRIC HOSPITAL PORT HARCOURT, RIVERS STATE, NIGERIA.

Authors:

(1) Jack-Ide, I.O. Doctoral Research Student. School of Nursing and Public Health, University of KwaZulu-Natal, Durban, South Africa. Phone: +01-404-789-0415; +27-788550525. Email: izibelokojackide@ymail.com

(2) Uys L. R. D Soc Sc. School of Nursing and Public Health, University of KwaZulu-Natal, Durban, South Africa. Phone: +27 (12) 333-1415 Email: uys@ukzn.ac.za

(3) Middleton L.E. PhD. School of Nursing and Public Health, University of KwaZulu-Natal, Durban, South Africa. Phone: +27- 714751016. Email: Middletonl@ukzn.ac.za

Abstract

Mental health services for Rivers State and surrounding States in the Niger Delta region of Nigeria are only provided at neuropsychiatric Rumuigbo Hospital in Port Harcourt City. The study explored mental health care professionals' experiences in service delivery as to provide insight and identify the challenges of mental health care provision in Rivers state, Nigeria. A qualitative study using in-depth interview was conducted among 20 mental health care professionals working at a neuropsychiatric hospital in the capital city, Port Harcourt, Rivers State. This was reviewed within the Townsend mental health policy template of context and resources domains. There is a low-priority status of mental health services, institutional model of care is strongly upheld, out-of-pocket payment is a challenge for service users, a lack of incentives and professional stigma that has led to a lack of interest for mental health practice and lack of public information on causes of mental illnesses. The need to provide education and training of mental health professionals should be given priority to remedy human resource shortage, provide incentives to motivate health professionals for psychiatric practice and move toward decentralization of care into general health care services. Provide information at all levels to overcome the myths surrounding the causes of mental illnesses, to reduce stigma and discrimination of the affected and their families.

Keywords: Mental health policy; Mental illness; Primary mental health care; Professional experiences

Background

Mental disorders account for a significant and growing proportion of the global burden of disease, yet remain a low priority in many low- and middle-income countries.[1] It is anticipated that by 2030, mental health problems will constitute 15% of the global burden of disease.[2] In spite of the growing burden of mental disorders and the resultant level of suffering for individuals and society, efforts to address it remain unsatisfactory.[3,4,5]

Currently, policies on the provision of mental health care have undergone a paradigm shift from institutional care to decentralized community-based mental health care service provision.[6,7] The World Health Organization (WHO) proposes the integration of mental health services into primary health care that is supported by other levels of care.[8] It is anticipated that this model has the potential to reduce stigma, address health worker shortages, and improve access to services by removing barriers to early treatment and support.[7] Failure to addresses the problems associated with caring for people with mental health problems can increase poverty in families, and contribute to the poor attitude of policy makers to issues of mental health.[9,10]

A nation's health policy affects the mental health of its citizenry countries should establish mental health systems that are equitable, efficient and financially supportive to their needs and expectations.[11,12,13] In 1981, Nigeria implemented Primary Health Care (PHC) as its national health policy, and adopted mental health as its ninth component in an attempt to provide care and improve the quality of life of persons with mental illness.[14,15] The policy made provision to establish mental health services in rural communities however, several years after its adoption this has not happened, and the service is still institutionalized. In Rivers State, Nigeria,

treatment for mental illness was free until 1996, when the government realized that patients from neighboring states were benefiting from the program, after which patients were required to pay out-of-pocket with a level of subsidy. The impact of this policy change on the River State inhabitants has not been established nor the implications for the lack of mental health services at PHC level.

This study took place in Port Harcourt, capital city of Rivers State, which is an oil producing region with a population of approximately three million people, with a large proportion of this population being concentrated in a few towns and the state capital. Mental health services in this state are delivered through a single mental health hospital, the neuropsychiatric Rumuigbo Hospital, which provides treatment for all types of mental disorders – neurosis or psychosis, acute or chronic, outpatient and inpatient care for Rivers State and surrounding states. Majority of users access the facility directly due to advice they received from friends and relatives without referral consultations, while only a few are referred from secondary or tertiary facilities. The hospital has no working relationship with other health facilities, providing health care service in the Rivers States 23 local government areas (LGAs), none of which provide mental health services. This has resulted in an increased workload for the few mental health professionals at the hospital.

This facility is located in the State capital making access to mental health services difficult for people living in rural areas, particularly those living far away. Due to the provision of this service in only one facility in the state, it is important to know the health professionals' experiences of providing care in the current mental health policy environment in Rivers State,

Nigeria. The study aim to explore mental health care professionals experiences of providing mental health services for persons/families with mental health problems and to identify difficulties/challenges of providing these services as to suggest for policy reforms. Ethical approval for the study was obtained from the Social Sciences and Humanities Research Ethics Committee of University of KwaZulu-Natal, Durban, South Africa, the Ministry of Health, Port Harcourt and from the Ethics Committee of Neuro-Psychiatric Rumuigbo Hospital, Port Harcourt, Rivers State, Nigeria.

Methods

The study used a qualitative survey with in-depth semi-structured interviews schedule developed from Townsend's mental health policy template[16] to obtain information about professionals' experiences of providing mental health care service. The model provides a framework for systematic policy evaluation and consists of four domains: context, resources, provision, and outcomes, each of which considers a number of elements that can be used in mental health service assessment and programs implementation. In this study, the experiences of mental health professionals were explored within the first two domains of context and resources. The interview schedule was piloted with four service providers and modified for the study. The remaining domains of Provision and Outcomes will not be addressed in this article (Table 1).

Table 1: Mental health policy template, adapted from Townsend.[16]

Domains	Elements
Context	Societal organization and culture
	Public policy
	Governance
	Population need and demand
Resources	Financing
	Human resources
	Physical capital
	Consumables
	Social capital

Context Domain:

This domain consists of four elements, namely Societal organization and culture, Public policy, Governance and Population need and demand. It describes how mental health professionals experienced the prevailing social, economic, cultural and political factors that impact on mental health service delivery as well as programs necessary for mental illness prevention and treatment.

Resources Domain:

The Resources Domain consists of five elements; Financing, Human resource, Physical capital, Consumables and Social capital. It describes the resources available to address the needs of patients/families with mental health problems and the inputs that are injected into mental health services to provide mental health care from the perspectives of mental health care professionals.

The study population was the mental health care professionals providing care for persons with all forms of mental disorders at the neuropsychiatric Rumuigbo Hospital, who were employed full-time with at least one year experience working at the facility. A purposive sampling technique was used to recruit 20 service providers that were invited by word of mouth to participant in the study. The sample was divided equally between men and women, 75% were nurses, almost half were above 46 years old, and 70% had worked for 11 to over 31 years (Table 2).

Table 2: Demographic details reported by participants		
Items	Frequency (N)	Percentage (%)
Participants:		
Nurses	15	75
Physician	2	10
Pharmacist	1	5
Social worker	1	5
Psychologist	1	5
Gender:		
Male	10	50
Female	10	50
Age range:		
18-25	1	5

26-35	2	10
36-45	8	40
46-55	9	45
Years of experience:		
1-5	4	20
6-10	2	10
11-20	4	20
21-30	8	40
31 and above	2	10
Educational level:		
Secondary	1	5
Diploma	2	20
Tertiary	17	75

On completion of a consent form, an audio taped interview was conducted that lasted up to one hour, using open-ended questions that allowed emerging issues to be clarified with follow-up questions. The transcripts were transcribed, analyzed and organized according to the elements of the mental health policy, and were coded according to those themes using the template editing style described by Crabtree and Miller.[17] This process reduced the amount of data being considered at any one time and brought together related pieces of text. QRS NVivo 8 software for analyzing qualitative data was used to facilitate this process. An initial scan of the data highlighted words or phrases used by the participants, and matched them against the domains and elements of the policy template to ensure internal consistency. This was followed by

finding connection between themes, while emerging meanings were distilled and thematically refined in consultation with co-researchers. The data was then reread and assigned excerpts that illustrated each element of the policy template. Two focus group discussions were held with 14 professionals who had participated in the study to confirm findings.

Results

The results are presented according to the Context and Resources Domains and their respective elements.

Context domain This domain and its elements describes public policies and governance that define government's actions and roles towards implementing mental health services and programs, as well as addressing specific factors necessary for mental illness prevention.

Societal organization and culture: Reports of stigma and negative attitudes among health professionals is reflected in a general lack of interest in following a career in mental health practice. Professionals observed that stigma contributes to the low status of mental health in policy agenda and also responsible for the reduced manpower for service delivery. *Stigma is one of the major challenges in the profession; most people don't want to practice in this area because psychiatry is not regarded as important couple with lack of incentives. (Interview 7)*

Public policy: There is policy failure, mental health units in PHC would have resolve most of the difficulties of service users, especially those coming from rural areas. According to the participants, policy makers feels psychiatric hospital is not a specialty area as such, mental

health is not seen as a health need, currently renovations of state hospitals is ongoing excluding the psychiatric hospital.

Psychiatry is always kept at the background, nobody wants to mention psychiatry, nobody wants to associate with psychiatry so that is the problem, until those at the helm of affairs begin to recognize the need of psychiatry. (Interview 9)

Governance: The Ministry of Health (MOH) is responsible for all health care systems, for implementing the primary mental health policy and carrying out regulatory and supervisory roles in mental health activities and programs. There are no mental health professionals in PHC clinics, or in schools for mental health assessment and promotion. The lack of a Director position in the MOH responsible for mental health programs was considered an obstacle to service delivery by the staff interviewed.

I think its management problem, who is there at the head in MOH? There are lots of politics over there, this hospital was open in 1977since then till now mental health has not taken a proper position. (Interview 10)

Population need and demand: The respondents identified the need for information about identifying mental illness and mental health services to be made available. Currently, apart from the health education sessions for clients and families during clinic appointments, no information is provided for the public. The participants identified the need for facilities that can treat and accommodate all types of mental disorders: neurosis or psychosis, acute or chronic, due to increase in mental illnesses resulting in a greater demand for their services.

Mental illness is on the increase due to economic hardship, the kind of patients we have now…we were not having acutely ill cases but now we have more acute cases and more prevalence is Indian-hemp and occasionally cases of cocaine addiction… (Interview 11)

Resources domain

This domain and its elements describe resources that are injected into mental health services to provide care and how these resources impact on service delivery.

Financing: All State hospitals are required to generate funds for their running cost including the psychiatric hospital. The facility is able to procure the medications through revolving loans given by the government to prevent them from becoming out-of-stock, while patients pay through out-of-pocket for the service.

The hospital is not having any external support, the facility is maintained from fees patients pay, all state hospitals for now are autonomous, autonomous in the sense that you run your affairs and maintain yourself apart from staff salaries. (Interview 5)

Human resources: Previously, people were recruited and trained in various aspects of mental health practice and posted to work in psychiatric hospital after their training. Government no longer sponsored or train people to work in the hospital. Due to lack of recognition of mental health professionals, many people prefer to train in other fields of health care. Participants observed that while other specialists working in general hospital setting receives more incentives such as call duty (extra pay), hazard allowances and even in-service trainings, they

do not receive any special benefits. Professionals face challenges that are specific to working in a psychiatric environment and indicated that they needed some form of compensation.

There are no incentives to encourage people to work here, nobody want to train in psychiatry because there is no incentives, why should they come and endanger their lives, these are the challenges...let me put it this way, people are not interested to do psychiatry because there are no incentives. (Interview 9)

Physical capital: Physical capital includes hospital beds, equipment, outpatient care, rehabilitation facilities, community outreach clinics, and other non-health infrastructures that are provided to promote mental health of the population. There are absences of these resources and no mental health services in PHC, as such all forms of care or support can only be access in this single psychiatric hospital. The respondents indicated that the mental health facility is too small to cope with the number of patients, and overcrowding is hampering their ability to work. This also places additional burden on staff that are stressed with the high patient loads and lack of resources to provide adequate levels of care.

Government can do a lot of course the health centers are there, train staff and organize service with a good referral system. The suffering of these people will be minimized, some of them travel as far as....to this place just to get their prescription, whereas such persons could have gone to a nearby health center to get his or her medication. (Interview 6)

Consumables: The supply and pricing of psychiatric medications is regulated by the state government. All follow-up appointments are carried out in this facility, including doctors' appointments and prescription repeats, with enough psychotropic medications resulting in all

categories of mental illness being relatively well managed. However, as patients are required to pay for the medications, it lacks of affordability makes it difficult for most of the patients to pay and continue to stay in treatment.

Clients buy their medications, the drugs are not all of the same price, depending on the prescription…some will pay as low as N500 while others may pay as much as N10,000 for just one month. The inpatients actually spend a lot…it's very difficult for most of them to meet up with the cost. (Interview 11)

Social capital: These are social and religious organizations in which people participate and derive support that helps them cope with the activities of daily need. The participants indicated that these organizations are absent except for a few local church and women organizations that comes occasional to pray and donate clothes and food items for in-patients. There is no welfare net nor do any official consumers or family associations exist to promote mental health or provide support.

There are no supports for clients, in terms of government or NGOs, local or international. I have not seen any except some religious organizations who comes in to donate food and cloths. (Interview 17)

Discussion

The Townsend policy template enabled themes within each domain and elements to be identified and specific recommendations to be made. In general, the health professionals surveyed in Rumuigbo Hospital had a negative experience with regard to the Context and Resource Domains, both of which will be explored in more detail.

Context Domain

Mental health care professionals suffered stigma and discrimination from within the Ministry of Health at both a policy and professional level, as well as from the public, as has been reported in other studies.[10,18,19] Health professionals are reluctant to take up psychiatric practice due to stigma and a lack of institutional support, this being similar to a study of medical students' attitude in Nigeria by Aghukwa[20] where only 2% showed a preference for psychiatric practice due to its low prestige and status as a profession despite the fact that more than 75% had positive views on the efficacy of psychiatry. Professionals reported that many people in need of mental health care avoid coming to psychiatric hospital for fear of being labeled. The finding supports another study in Nigeria, where 53% of the general health workers in a teaching hospital with a psychiatric facility hospital did not want their office near it.[18] Stigmatization of health professionals working in mental health care needs to be addressed through education at all levels and a concerted effort should be made to inform people about the medical causes of mental illness to address the beliefs that they are caused by gods for a person's wicked acts.

The findings concerning public policy indicate the lack of implementation of mental health policy by the government, which is reflected in the absence of mental health services in PHC and the difficulties families face in accessing services. There are primary health care centers in rural communities at which mental health service should be provided to assist those who cannot reach the hospital. The capacity of the facility is overstretched beyond its catchment area of Rivers State, affecting the social-economic well-being of the population it serves. Evidence has shown that developing formal community and hospital-based mental health services is crucial for the clients' quality of life.[2, 7] Policies should therefore implement primary mental health

care in rural communities to improve access to care, uptake of treatment and, thereby reduce the burdens associated with mental illness.

The absence of a Mental Health Coordinators and Directors in the Ministry of Health to overseer mental health activities and programs may explain poor governance, the lack of primary mental health care services, and the low priority status of service delivery. There are no supervisory functions for mental health services as there are no staffs to manage outside the hospital. However, other African countries i.e. South Africa have national mental health authorities that provide policy directions and are involved in mental health service planning, management and coordination, as well as the monitoring and quality assessment of mental health service delivery.[11] To ensure good governance of the mental health care system, policy should established mental health director and coordinator positions to facilitate mental health activities and programs in the Ministry of Health.

Information dissemination could greatly assist families to give priority to their own health needs as well as their ill relative, as been shown in previous studies which indicate that health service can assist people by providing information in pamphlets, electronically and in the print media to promote mental health and to prevent or reduce the risk of mental illness.[3,7] With appropriate education about self care, most persons with serious mental illnesses can significantly reduce the impact of their illness and find a satisfying measure of achievement and independence. The staff felt that there was poor knowledge and understanding of mental disorders and positive treatment outcomes in the general population, this is consistent with previous study in Nigeria which shows that 96.5% of people had poor knowledge of causation

of mental illness.[21] Without access to information, community attitudes and beliefs will continue to play a role in determining their help-seeking behavior and treatment of patients with mental illness.

Resources Domain

Mental health services are structurally disadvantaged in Rivers State, with inadequate financing which hinders mental health delivery in the state. This finding is supported in a study in Nigeria where resources allocated to mental health service delivery were inadequate at the federal level, with mental health being allocated less than 1% of the total health budget.[22] Consistent with previous studies out-of-pocket payment for mental health service was considered detrimental and unsatisfactory because severe mental disorders can lead to heavy financial expenditure, create inequitable access to treatment, and cause family poverty and suffering for people with mental disorders.[23,24]

Participants observed that the poor funding of services is due to policy–makers holding people with mental illnesses in low regards, this being partly due to the common belief that mental illness are afflictions from supernatural forces for an individual's or family's wrong doings, or that drugs, and alcohol are responsible for their illness. These findings are supported in a study by Kapungwe[19] in Zambia where mental illness was seen as self inflicted, resulting in discrimination at the level of government and policy. The provisions of quality mental health service is driven by proper financing of service, without which families and persons with mental illness may not receive the treatment, they require in order to live normal and productive lives. Policies need to consider the patients/families difficulties, and the government

should establish community outreach clinics or provide services at existing clinics to reduce costs of accessing services and allow affected people to continue to stay in treatment.

The human resources at the hospital are inadequate to provide the required mental health care delivery service. Human resources shortages and lack of incentives for professionals was seen as a barrier in mental health service, this being supported by other studies.[2,25] Research has shown that human resources are the most valuable asset of any mental health service, and that efficient service provision relies on competent and motivated mental health personnel to provide the required services and increase the access of underserved population.[12,26] The hospital lacks all categories of mental health professionals, the dearth of human resource for mental health contribute to the absence of community mental health services. There is therefore a need to make psychiatric practice attractive to other health professionals and this will only be possible if there are similar financial rewards to other specialized areas of care.

Physical capital for psychiatric services are poor, as no mental health services are rendered at local government areas (LGAs) levels in the state, all categories of mental illness are treated in this single mental health facility. There is lack of amenities necessary for care provision and to promote efficient service delivery. Since the establishment of the hospital in 1977, no renovations have been carried out in other to address the increased use of the facility. Evidence shows that providing efficient mental health service requires developing and maintaining infrastructure, and providing basic amenities to deliver service.[5,6,12] Mental health should be given priority status on the public health agenda to address needs of the mentally ill.

All consumable are supplied and priced in the hospital, and the facility generally holds enough psychotropic medicines for all categories of mental illness. However, the cost of purchasing these medications from the hospital is a challenge to most patients and their families. The finding support a study of cost-effectiveness of an essential mental health intervention package in Nigeria[22] which shows cost-effective interventions using older antipsychotic drugs combined with psychosocial treatment produced one extra year of healthy life at a cost of less than US $320, which is the average per capita income in Nigeria. Many services users do not have any monthly income, some are unemployed, or have lost their employment due to mental illness. Policy changes need to be carefully costed to make mental health services affordable to those seeking care.

Social capital is the resources that are provided to manage mental health between individuals and formal or non formal organizations. The extent of collaboration among individuals, communities and formal institutions for mutual benefits are currently absent in the State. However, when clients do receive care and maintain follow-up care it has positive outcomes, with improvements in their mental state. Research has shown that social support networks can improve the quality of life with better mental health outcomes and also influence policy changes.[27,28,29] Policy should therefore build, support and strengthen social organizations to facilitate the wellbeing of persons and families with mental illness.

Limitations

The main limitation was the small sample size which was recruited exclusively from the neuropsychiatric Rumuigbo Hospital. However, as the intention was to assess the experiences

141

of mental health care professionals in River State, it was not possible to include anyone else due to the lack of additional mental health services. The results may therefore not reflect other regions of the country where there are more federal funded psychiatric services.

Recommendations

The following recommendations are made as a result of this study to improve health care services for seriously mentally ill persons in River State in Nigeria:

▪ Stigmatization of health professionals working in mental health care needs to be addressed through education at all levels, and a concerted effort made to inform people about the medical causes of mental illness to address negative perceptions.

▪ Public health services should include community-based care and not be centered only in psychiatric hospitals.

▪ Health professionals should be encourage to enter mental health services by providing education and training to overcome the current human resources shortage and make provision for future growth in this sector.

▪ Monetary incentives for health professionals providing mental health care need to be made available to attract staff into the discipline.

▪ The provision of psychotropic medications should be decentralized from psychiatric hospitals to other health care facilities where there are trained nurses and general practitioners to enable clients to refill prescriptions locally.

▪ Social welfare net for persons with mental illness should be provided.

Conclusion

The current model of institutionalized mental health care in River State not only results in insufficient care to the communities it serves, it also impacts negatively on the experiences of the health professionals who provide the care. The lack of resources for community based services and information at all levels perpetuates the myths around the causes of mental illnesses, resulting in professional stigma and discrimination of affected persons and families. The lack of policy support has resulted in health professionals not wanting to specialize in this area, and services to those in need are therefore limited, expensive and often inaccessible.

In executing its mandate, the Federal Ministry of Health needs to implement the policies it has developed, appoint appropriate directors, train the necessary staff and provide the resources to enable these services to be put in place. Failure to address the needs of the staff will result in their continued low morale, depleting mental health human resources and the marginalization and stigmatization of people affected by the disease.

References

1.   World Health Organization. Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group. Geneva. World Health Organization 2010.

2.   World Health Organization. Improving Health Systems and Services for Mental Health. (Mental health policy and service guidance package). Geneva. World Health Organization 2009.

3.   Gavois H, Paulsson G, Fridlund B. Mental Health Professional Support in Families with a Member Suffering from Severe Mental Illness: A Grounded Theory Model. Scand J Caring Sci 2006; 20: 102-109.

4.   Prince M, Patel V, Saxena S, et al. No Health Without Mental Health. Lancet 2007; 370(9590): 859-877.

5.   Patel V, Araya R, Chatterjee S, et al. Treatment and Prevention of Mental Disorders in Low-income and Middle-income Countries. Lancet 2007; 370(9591): 991-1005.

6.   World Health Organization WHO. The World Health Report: Primary Health Care Now More Than Ever. Geneva. World Health Organization 2008.

7.   World Health Organization and World Organization of Family Doctors (WONCA). Integrating Mental Health into Primary Care: A Global Perspective 2008.

8.   World Health Organization Mental Health Gap Action Programme: Scaling Up Care for Mental, Neurological and Substance Use Disorders. Geneva. World Health Organization 2008.

9.   Crisp AH, Gelder MG, Rix S, et al. Stigmatisation of People with Mental Illnesses. Br J Psychiatry 2000; 177: 4-7.

10.   Ssebunnya J, Kigozi F, Lund C, et al. Stakeholder Perceptions of Mental Health Stigma and Poverty in Uganda. BMC Int Health Hum Rights 2009; 9-5.

11. Lund C, Kleintjes S, Campbell-Hall V, et al. Mental Health Policy Development and Implementation in South Africa: A Situation Analysis Phase 1. Country Report Cape Town: Mental Health and Poverty Project 2008.

12. Funk M, Drew N, Saraceno B, et al. Framework for Mental Health Policy, Legislation and Service Development: Addressing Needs and Improving Services. Harvard Health Policy Review 2005; 6(2): 57-69.

13. World Health Organization. World Health Report 2001: Mental Health: New Understanding, New Hope. Geneva. World Health Organization 2001.

14. Federal Ministry of Health (FMOH). The National Mental Health Policy in Nigeria. Lagos 1991.

15. Federal Ministry of Health (FMOH). Revised Draft National Health Policy. Federal Ministry of Health, Abuja 2004; 1(1): 12.

16. Townsend C, Whiteford H, Baingana F, et al. The Mental Health Policy Template: Domains and Elements for Mental Health Policy Formulation. Int Rev Psychiatr 2004; 15(1-20): 18-23.

17. Crabtree BF and Miller WL. Doing Qualitative Research 2nd Edition: Sage, London 1999; 164-194.

18. Aghukwa CN. Attitude of health workers to the care of psychiatric patients. Annals of General Psychiatry 2009; 8: 19.

19. Kapungwe A, Cooper S, Mwanza J, et al. Mental illness- stigma and discrimination in Zambia. Afr J Psychiatry 2010; 13: 192-203.

20. Aghukwa CN. Attitudes towards psychiatry of undergraduate medical students at the Bayero University. SAJP. 2010; 16(4): 147-152.

2.6 ARTICLE FIVE (POLICY BRIEF)

Authors:

(1) Jack-Ide, I.O. PhD Candidate. School of Nursing and Public Health, University of KwaZulu-Natal, Durban, South Africa. Phone: +01-404-789-0415; +27-78-855-0525. Email: izibelokojackide@ymail.com

(2) Uys L. R. D Soc Sc. School of Nursing, University of KwaZulu-Natal, Durban, South Africa.

Phone: +27 (12) 333-1415 Email: uys@ukzn.ac.za

(3) Middleton L.E. PhD. School of Nursing and Public Health, University of KwaZulu-Natal, Durban, South Africa. Phone: +27- 714751016. Email: Middletonl@ukzn.ac.za

Revised and re-submitted to Journal of National Institute for Policy and Strategic Studies

Increasing Access to Mental Health Service through Primary Health Care in Nigeria

Introduction

An institutional model of psychiatric service delivery was inherited in Nigeria from the British colonial health care system. This model was introduced in the early 20th century with the establishment of the first psychiatric asylum in Calabar in 1904. Although Britain and the rest of Europe have made the transition from hospital to community-based care over the last 40 years, institutional care remains the dominant form of care in Nigeria. This approach of sequestering people with mental illness from public life and public view reinforces commonly held lay beliefs that psychiatric patients are social outcasts and should be quarantined until judged to have returned to normal. These views continue to fuel stigma and discrimination and in so doing, prevent people from seeking help, and policy makers from ensuring that those in need receive the necessary services.

The Background

For the past 29 years, Nigeria's primary health care approach has been used successfully to deliver general and midwifery services. A comprehensive health service is one that provides for at least the basic physical, mental and social needs of the population across their life span near to where they live. Mental health care needs and services have been systematically excluded from Nigeria's primary health care approach. Mental health professionals, particularly psychiatric nurses, continue to provide curative care in large psychiatric hospitals rather than community-based, preventive and promotive facilities. Mental healthcare services are not provided at primary care centers, nor are health professionals with psychiatric training stationed at these sites.

The Argument

Mental illness is prevalent in Nigerian society but data on incidence of mental illness is scarce due to the absence of large-scale psychiatric epidemiological surveys. However, in a large-scale community study on the prevalence of mental disorders in Yoruba-speaking areas of Nigeria (Lagos, Ogun, Osun, Oyo, Ondo, Ekiti, Kogi and Kwara), Gureje et al., (2006), 12.1% of the respondents had a lifetime rate of at least one DSM IV disorder (Diagnostic and Statistical Manual 4th edition), 23% had seriously disabling disorder, and only 8% had received treatment in the preceding 12 months.

Findings from another study conducted in Southern Nigeria by Martyns-Yellow, (1992) showed that distance traveled and associated transport costs were major barriers for treatment seeking by family members for persons with mental illness. Similar finding was reported in the study by Nuhu et al., (2010) in Northern Nigeria in which many caregivers complained of long travel days, and high transportation expenses as limiting access to receiving mental health service for ill relatives, thus increasing the family burden of care giving.

Health Systems research in Nigeria has further shown that:

1. Politically, mental health is of low-priority as reflected in the inadequate resource allocation to its service components. Approximately 3.3% of the health budget is allocated to mental health, 90% of which is used for structural maintenance of the large hospitals, and payment of staff salaries including the specialists. There are currently only 2.41 psychiatric nurses and 0.15

psychiatrists per 100,000 people in Nigeria (Table 1). The underlying causes of this human resource shortage include stigma, an aging and retiring workforce; health professionals lack of interest in psychiatric practice; inadequate in-country training opportunities; failure to recognize psychiatry as a health and service need; and inadequate pay and reimbursement for mental health professionals.

Table 1: Median estimate of mental health professionals working in mental health facilities in Nigeria per 100,000 populations.

Psychiatric nurses	2.41
Psychiatrists	0.15
Other medical doctors (not specialized in psychiatry)	0.49
Psychologists	0.07
Social workers	0.12
Occupational therapists	0.05
Other health or mental health workers	8.03

Source: WHO-AIMS, (2006)

2.   The non-decentralization of mental health services to Primary Health Care level overstretches the capacity of centralized and hospital-based mental health facilities beyond their capacity to provide quality service.

3.   Primary Health Care services provided in rural communities exclude mental health services thereby making early identification and treatment of mental health problems and the promotion of comprehensive health difficult to achieve.

Interview Quote from a Mental Health Care Professional

Right now, there are no forms of community outreach activities, no community care because that unit was not seen as a need by management. All we do now is advice patients and relations on discharge on how to take the drugs and come for follow up treatment. Before now, we had a community psychiatric unit that goes into the community but right now it is not there, couple with shortage of staff, so we just work with the patients and their relations when they come to hospital...the type of health service we are providing now is just rendering care, nothing more than that...rendering care to in-patients and out-patients (Interview 8).

Source: Jack-Ide PhD Thesis, (2012)

Overall, the current lack of mental health care services at primary health care level within community reach has the following consequences:

1.   Many mental health conditions that could be prevented and treated remain undiagnosed, denying people the opportunity for improved mental health.

2.   Increase human rights violation, stigma and discrimination of persons with mental illness, which could hasten their expulsion from the community and becoming homeless or destitute.

3.   People with mental illnesses face greater challenges   such as from wasted expenditures arising from difficult access to centralized hospital-based facilities and the high cost of services to poor family members. This reduces the opportunity for timely recovery. Recent studies have suggested that   early treatment can lead to better clinical outcomes (Gureje et al., 2007; Patel et al., 2007). It also impacts on family members' ability to earn a livelihood.

Interview Quote from a Family Caregiver

Many people roam the street because they don't have people to take care of them...My plea is for extension of this hospital in other places to reduce our expenses especially on transport and the cost of the drugs. For me, I know how much I am spending, there are people out there that do not have the money and that is why they are not coming... like my brother's case for example, if we don't have the money we will not be able to provide the drugs and he will be roaming about...this is my brother, I don't want him to be on the street, so I'm taking care of him and doing my best, but it is very difficult, transport to come here and the cost of drugs... a lot of people do not have the money that is why they are there on the street. Government should subsidize the drugs and provide the service around us, so that we don't travel far to look for care, the hospital is very far from us, if there is one like this near us... we will be happy...(Interview 17).

Source: Jack-Ide PhD Thesis, (2012)

A comparison of mental health services in Nigeria and South Africa shows that:

1. Nigeria has no separate department in either the federal or state Ministries of Health responsible for coordinating mental health. In South Africa, mental health programs are coordinated through national, provincial and district structures (A national mental health authority, The National Directorate, Mental Health and Substance Abuse), which provide advice to the government on mental health policies, legislation and policy direction to the provincial mental health authorities.

2. In Nigeria, mental health care is mostly provided in some tertiary and secondary facilities unlike South Africa where integrated mental health services exist dovetailing from national to primary care centers and the communities.

3. Mental health services are paid for on an out-of-pocket basis in Nigeria, which prevents about 80% of people with mental disorders from receiving care because of difficulty in sustaining treatment and associated costs. The South African Mental Health Care Act 17 of 2002 made provisions for free mental health care services and has a wider coverage, thus reducing the treatment gap for psychiatric care.

4. In Nigeria, Psychiatrists alone provide medication prescriptions at the tertiary institutions, with nurses having no prescriptive rights. In South Africa, nurses in primary health care centers use treatment protocols and, while they are not allowed to make the initial prescription, can prescribe during emergencies and continue prescriptions.

5. Nigeria has no special coordinating body that oversees public mental health promotion and educational activities directed at promoting awareness and reducing stigma, which is not the case in South Africa.

Required Policy action to increase access

The lack of access to appropriate, affordable and timely treatment through primary care services has consequences on affected persons, their families and the communities they live in. Untreated mental illness affects people's capacity to effectively engage in the activities of daily living, including their economic productivity, and creates social and economic burdens for society.

Therefore, to make mental health care more accessible and affordable to clients and their families, the government needs to develop and implement the following strategies as a matter of urgency for improving the quality of life of those affected by the condition in the following ways.

1. Decentralize mental health services into the mainstream of health care system in line with global trends of care and best practices.

2. Institute the provision of affordable, effective mental health and physical care to people at the community level, closet to where they live and with minimal disruption to their work and family life. (World Health Organization, 2003, 2008; World Health Organization and World Organization of Family Doctors [WONCA], 2008).

3. Establish psychiatric units at general hospitals in state capitals and at existing comprehensive primary health care centers in each local government headquarter to increase access to care.

4. With the limited number of psychiatrists in Nigeria, psychiatric units should be staffed and managed by at least two psychiatric nurses (requiring 1878 in 939 mental health units in a total of 939 LGAs), with a psychiatrist visiting the unit once every 2-3 months.

5. Meet the dual challenges of relevant mental health training by increasing the production of mental health professionals and other health staff to work at primary care level. Training should include community-based care and not centered only in psychiatric hospitals.

6. Ensure the use of standard treatment protocols and an essential drug list to assist non-psychiatrist clinicians and psychiatric nurses involved with day-to-day care and management of mental health service users at the health centers in the community. The availability of essential psychotropic

medications in these mental health units to maintain positive treatment outcomes should be ensured.

7. Make provision for prompt and an efficient referral system to secondary and specialist levels of mental health care services and ongoing training, supervision and support for primary mental health care staff.

8. Provide monetary incentives for mental health professional to work in the community to motivate others to be trained in mental health.

Implementing these recommendations will significantly increase access to mental health services, reduce the burden of families and persons with mental illnesses, and ensure that everyone in need has access to mental health care.

References:

Gureje, O. Lasebikan, V. O., Kola, K., & Makanjuola, V. A. (2006). Lifetime and 12-month prevalence of mental disorders in the Nigerian Survey of Mental Health and Well-Being. *British Journal of Psychiatry,* 188: 465-471. Doi: 10.1192/bjp.188.5.465

Gureje O, Chisholm D, Kola L, Lasebikan V, Saxena S. (2007). Cost-effectiveness of an essential mental health intervention package in Nigeria. *World Psychiatry,* 6:42-48.

Jack-Ide, I.O. (2012). Doctoral Thesis. School of Nursing, Howard College, University of KwaZulu-Natal, Durban 4041, South Africa.

Martyns-Yellow, I. S. (1992). The Burden of Schizophrenia on the Family: A Study from Nigeria. *British Journal of Psychiatry,* 161: 779-782. Doi:10.1192/bjp.161.6.779

Nuhu, I. T., Yusuf, A. J., Akinbiyi, A., Fawole, J. O., Babalola, O. J, Suleiman, Z. T., Ayilara, O. O. (2010). The burden experienced by family caregivers of patients with epilepsy attending the government psychiatric hospital, Kaduna, Nigeria. *Pan African Medical Journal,* 5:16. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3032618/pdf/pamj-05-16.pdf Accessed: 23 March 2011.

Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M., Hosman, C., McGuire, H., Rojas, G. & van Ommeren, M. (2007). Treatment and Prevention of Mental Disorders in Low-income and Middle-income Countries. *Lancet,* 370(9591): 991-1005.

World Health Organization-Assessment Instrument for Mental Health Service [WHO-AIMS], (2006). Report on Mental Health in Nigeria. World Health Organization and Ministry of Health Ibadan, Nigeria. Available at http://www.who.int/mental_health/evidence/nigeria_who_aims_report.pdf (Accessed 5 May 2010).

World Health Organization, (2003). Organization of Service for Mental Health (Mental health policy and service guidance package). Geneva. Available at http://www.who.int/mental_health/policy/resourcebookMHLeg.pdf (Accessed 10 April 2010).

World Health Organization, (2008). Mental Health Gap Action Programme: Scaling up care for mental, neurological, and substance use disorders. Geneva. Available at http://whqlibdoc.who.int/publications/2008/9789241596206_eng.pdf (Accessed 18 June 2010).

World Health Organization & World Organization of Family Doctors [WONCA], (2008). Integrating Mental Health into Primary Care: A Global Perspective. Geneva. Available at http://www.who.int/mentalhealth/policy/Integratingmhintoprimarycare2008lastversion.pdf (Accessed 26 May 2010)

SECTION THREE: CONCLUSION

3. DISCUSSION

This section presents the discussion and conclusion of the findings using the six research questions presented in section one and Townsend et al conceptual framework. However, the findings of caregivers/clients (service users) and mental health professionals will be combined in the discussion.

3.1 HOW IS THE MENTAL HEALTH SERVICE IN NIGERIA ORGANISED AND HOW ARE SERVICES DELIVERED COMPARED TO THAT OF SOUTH AFRICA?

The mental health care system in Nigeria is organized around the institutional model of care, with mental health services being accessed only in large psychiatric hospitals located in big cities. This has created a treatment gap for the majority of persons and families with mental illness, as they are unable to get to these specialist facilities (Alem et al., 2008). This gap in access to treatment has made the spiritual model of care the most preferred within rural and even urban communities (Adewuya & Makanjuola, 2009). Mental health services are not found in primary care centers resulting in clients and their families not having any form of support outside the psychiatric hospital environment. In comparison, the South African mental health system has several strengths. It has relatively well resourced mental health services including human resources, facilities and available psychotropic medications. They are integrated into general health care service, primary care centers and outreach clinics (Lund et al., 2008), thereby creating wider coverage and

access within communities without incurring financial cost from embarking on long distance travels.

Mental health services are paid for on an out-of-pocket basis in Nigeria. It's estimated that fewer than 20% of people with mental disorders receive any services, and those who do have difficulty sustaining treatment due to cost of service (Gureje & Lasebikan, 2006). In South African however, the Mental Health Care Act 17 of 2002 made provisions for free mental health care services resulting a wider coverage, reducing the treatment gap for psychiatric care and protecting the human dignity of persons and families with mental health problems.

Nigeria has no treatment protocols and there are no uniform standard of care and management of patients across big hospitals. As care is institutional-based, 95% of professionals who are psychiatrically trained worked in secondary and tertiary institutions while the other 5% worked in non-mental health care facilities (WHO-AIMS, 2006). Medication prescriptions are only provided by psychiatrists in these tertiary institutions and nurses have no prescriptive rights at all. In South Africa, nurses in primary health care centers use treatment protocols and, although they are not allowed to make the initial prescription, they can prescribe during emergencies and for continue prescription (Lund et al., 2008; World Health Organization-Assessment Instrument for Mental Health Services Report on Mental Health System in South Africa (WHO-AIMS, 2007).

Nigeria has no department in the federal and states Ministries of Health responsible for mental health. Mental health activities and programs are often supervised by officials with other duties. South Africa, mental health programs are coordinated through a national, provincial and district structures. A national mental health authority- the National Directorate, Mental Health and Substance Abuse- provides advice to government on mental health policies and legislation, as well as on policy direction to the provincial mental health authorities (WHO-AIMS, 2007). Provincial authorities are involved in service planning, management and coordination, as well as monitoring and quality assessment of mental health care. The Directorate comprises a director, three deputy directors, assistant directors and administrative staff.

Nigeria is a lower income country and the life expectancy at birth is 46.76 years for males and 48.41 years for female. The proportion of the GDP sent on health is 3.4%, in regard to government expenditure as a percentage of total expenditure on health is US $31, while per capital expenditure on health is $7, lagging behind many other lower income countries (WHO-AIMS, 2006). In comparison, South African proportion of health budget to GDP is 8.6%, with the per capita total expenditure on health being US $626 of which the government per capita expenditure on health is $270. Life expectancy at birth is estimated at 49 years for males and 52 years for females (WHO-AIMS, 2007).

The provisions of mental health human resources are scarce in Nigeria, with a ratio of 4 psychiatric nurses per 100 000 people, equating to 0.9 psychiatrists, with that of psychologists and social workers being 0.02 per 100 000, the mental health bed ratio is 0.4

per 100 000. South Africa has the highest mental health resource in the sub-Saharan Africa of 7.5 psychiatric nurses per 100 000 people, 1.2 psychiatrists per 100 000 people and 4.5 mental health beds (Jacob et al., 2007). Nigeria has no coordinating body to overseer public education and awareness campaigns on mental health and mental disorders, while South African has a coordinating body that overseer's mental health promotional activities and treatment of mental disorders (WHO-AIMS, 2007; Lund et al., 2008).

3.2 WHAT ARE THE CAREGIVERS, CLIENTS (SERVICE USERS) AND MENTAL HEALTH PROFESSIONALS' EXPERIENCES WITHIN THIS POLICY AND THE MENTAL HEALTH SYSTEM ENVIRONMENT?

The common and devised issues raised from the in-depth interview by caregivers/clients (service users) and professionals are discussed below. Table 3 shows the themes arising from the Townsend et al conceptual framework.

Table 3: Themes arising from use of conceptual framework

Caregivers	Clients	Professionals
Context Domain		
Not a matter to discuss Hospital is the last resort	Mental illness attributed to witchcraft or punishment from gods Managing the illness Verbal and physical abuse Absence of welfare support net	Societal organization and culture Public policy Governance Population need and demand
Resources Domain		
Borrowing and begging to pay for service Nurses and doctors advice Long journey to access service	Cost of service utilization Ability to access service Effects of disclosing illness	Financing Human resource Physical capital Consumables Social capital
Provisions Domain		
Free Medical Care Program Maintain hospital and provide service in PHC Only God provides support.	State Free Medical Care Programme (FMCP) Long waiting time Distant travels Inability to sustain treatment Poor infrastructure	Personal mental health services Population based mental health services Intersectoral collaboration
Outcomes Domain		
Poor health status of caregivers Positive treatment outcomes of ill relatives	Positive impact of service on clients' health Provision of service in rural communities Impact of illness on clients Self check	Individual health outcomes Population health outcomes Service outcomes Economical outcomes Social outcomes

3.2.1 Context Domain

Stigma plays prominent role in the lives of clients with mental illness and their families.

The family experience negative perceptions regarding their ill relatives, they become social

outcast and are alienated from society. Aware of society's prevailing negative perception, affected individuals and families conceal their illness status, preferring denial to bearing the burden of been stigmatized with resultant delays in seeking health care service and early treatment. This finding is similar to other studies in Nigeria which shows that stigma is a stressor for families and persons with mental illness (Gureje et al., 2000; Kabir et al., 2004; Adewuya & Makanjuola, 2009).

Family caregivers and clients were concerned about the poor public knowledge of mental illness, with many people being unaware that people suffering from mental illness can be treated effectively with pharmacological and/or psychosocial interventions (Wang et al., 2002; Patel et al., 2003). The belief that people with mental disorders cannot recover or return to a normal life after the onset of an illness was widespread. It is not surprising, therefore, that the negative portrayal that people with mental illness should be locked away and confined in psychiatric institutions rather than in the community. This was supported in a study of community knowledge and attitude to mental illness in Nigeria by Gureje et al. (2005) which showed that 96.5% of people had poor knowledge of the causation of mental illness. Health service needs to provide information that will help individuals to sustain improved mental well-being, as without access to information, community attitudes and beliefs will continue to play a role in determining the help-seeking behavior and successful treatment of patients with mental illness.

The institutional stigma also contribute to access problems, with many persons needing help may not want to be seen in a psychiatric facility, as they represent an important

instrument of social isolation of persons with mental illness (Schulze, 2007). Stigma also defines the family care pathway in the community, as most of the care pathways to mental health service by families reflect the use of traditional and spiritual model of care. This is influenced by beliefs that mental illness is caused by super natural forces, and with easy access to these healers and spiritualists within the communities, most families consult them to seek explanations from the gods for remedies and to proffer solutions to their ill relatives' mental health problems. These finding supports a study in southwestern Nigeria by Adewuya and Makanjuola, (2009) that poor knowledge of positive mental illness treatment outcomes makes a spiritual model of care the preferred treatment, causing suffering in families of persons with mental illness.

In this context domain, clients were concerned about the difficulties in dealing with mental illness symptoms and also, the poor knowledge of family members about mental disorders. They were often misunderstood and their actions were usually perceived through the "lens of mental illness." Poor knowledge within families about mental illness creates un-conducive home environment for harmonious interaction. Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning. Mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life. Therefore, persons with mental illness need family understanding and support to cope with the illness.

Evidence has shown that, individuals with family support seem to cope better with their illness, having greater opportunities to make and maintain supportive social relationships

that contribute to a general wellbeing (Magliano et al., 2000; Browne & Courtney, 2005; Langeland & Wahl, 2009). Research shows that caregivers who receive educational support from mental health professionals were able to manage the needs of ill relatives, and as a result, were less burdened by their condition and able to seek specialist support during illness crisis (Knudson & Coyle, 2002; Health Canada, 2006; Chung et al., 2009). Currently, there are no programs or documents directed to educate the public and family on mental illness, causes, treatment and mode of management. There is a need for family and public education, by providing information as to improve public knowledge and better understanding of mental illness.

Mental health professionals in this context domain reported experiencing stigma, which is observed to be responsible for the low human resource for mental health service delivery. Many health professionals prefer to practice in other areas of health care rather than take-up psychiatric practice due to stigma and lack of incentives. A good working environment is one that motivates workers and benefits the employers in terms of productivity, staff morale and the external perceptions of a conducive working environment, as motivated staffs are more productive and tend to stay on the job. The low priority status of mental health funding is also attributed to the negative perceptions of policy makers appears to be an important factor negatively affecting mental health policy processes (Sartorius, 2007; Kapungwe et al., 2010).

This negative public view of mental illness and psychiatric treatment is described as further adding to the stigma experienced by families and persons with mental illness. Although

psychiatric treatment has changed dramatically with new discoveries in psychotropic medications and psychosocial therapy, the public image of mental illness is dominated by the view that people suffering from mental illness are violent and dangerous and incurable and are responsible for their illness (Mayeye et al., 2004; Adewuya & Makanjuola, 2005; Kakuma et al., 2011), taking away the sympathy that are usually shown to a sick person in the community i.e. someone with cancer, stroke, or malaria replacing compassion with disdain and affected individuals are ostracized. Findings in this context domain from family caregivers, clients and mental health professionals show that stigma and discrimination is ingrained in the fabric of the Nigerian society.

3.2.2 Resource Domain

Mental health resources for service delivery are very limited, the facility is poorly financed, and running cost are partly obtained from fees and service charges paid by service users. The infrastructure requires maintenance, no form of renovation has taken place since it was built and commissioned in 1977, basic amenities such as toilets facilities, electricity and water are absence. However, the drug revolving load from the government assists in the procurement of all consumables and prevent psychotropic medications become out-of-stock. Evidence shows that the poor facilities for mental health care delivery are reflections of stigma and discrimination of mental illnesses on public health policy agenda (Sartorius, 2007; Thornicroft, 2008).

In this Resource domain, family caregivers and clients experience financial burden in procuring medications and transport cost associated with accessing mental health services.

Most of the service users live outside Port Harcourt and travel long distances to keep follow-up appointments, incurring financial burdens. The high cost of services makes many families and clients unable to procure medications and sustain treatment. The continuous use of prescribed medications is necessary to maintain an improved mental state. However, finances are the determining factor for maintaining clients' wellbeing, except for a few who are able to afford the cost of treatment and provide for themselves. Evidence has shown that the absent of a social welfare net for persons and families with mental illness increase the burden of mental illness, with poor mental outcomes, and poverty (Wang et al., 2002; Magliano et al., 2006; Thornicroft, 2007). A study of caregiver's burden and psychotic patients perception of social support in Nigeria by Oheari, (2001) shows that caregivers without any a social welfare net had higher burden, experienced more family disharmony and had greater social stigma. The provision of social welfare net as a support mechanism will reduce financial burden of many families and persons with mental illness and allow them to sustain treatment.

Employment is fundamental to the quality of life and wellbeing, the main source of income for most people, is a major influence on social networks and a defining feature for social status (WHO, 2002). In this Resource domain, clients suffer stigma and discrimination from employers once there is illness disclosure. Some suffer immediate termination while others are demoted, or given lesser responsibility, the assumption being that they are incapable of performing task, or making decisions. Evidence has shown that discrimination and exclusion in community life is common and occurs in employment as well as other social relationships (WHO, 2010). Studies shows that mental health is determined by

socioeconomic and environmental factors and that employment and job security give a sense of wellbeing. Stable employment, secure incomes and social capital are predictors of good mental health, can prevent mental health problems and make it possible for the afflicted to remain at work (WHO, 2002; Browne & Courtney, 2005).

Mental health professionals in this domain observed that, the absence of social capital to support families and persons with mental illness makes them vulnerable to poverty and make recovery difficult. Social capital is the quality of social relationships within societies or communities, including community networks, civic engagement, sense of belonging and norms of cooperation and trust that services users could engage with for mutual benefit (Rammohan et al., 2002; Seloilwe, 2006;), but resources are not directed towards providing people with the support and care needed.

3.2.3 Provision Domain

Service users observed that policies for social welfare benefits and services for disability resulting from mental illness are absent in Nigeria. The only existing welfare support currently is the Free Medical Care Programs (FMCP) for mental health service users by the Rivers State government for the people of the state. There are three categories of beneficiaries of the FMCP, under-6 children, retirees above 60 years who must have worked for the state government and vagrants. The under-6 children and retirees 60 years and above are not frequently seen using the mental health service, vagrants are usually picked from the streets especially when very important personalities (VIPs) are visiting the state and taken to a rehabilitation camp of the Ministry of Social Welfare, where the

government accommodate, feed and provide all necessary medical treatment until they become stable and are discharged, leaving a vast majority of servicer users in the prime of their lives without any form of support.

Government should take cognizant of the fact that serious mental illness such as schizophrenia often develops in adolescence or early adulthood, the longer it is untreated the more impact it can have on quality of life and increase costs associated with health, social care, and criminal justice and lost employment. Early detection of the symptoms of mental illness, reduce the risk of transition to full psychosis and shorten the duration of untreated mental illness for those who do develop it. According to mental health professionals early intervention soon after a diagnosis of psychosis has been recognized to prevent some of the more adverse consequences of the disorder and high cost of treatment. Costs avoided through earlier intervention outweigh the costs of late treatment, therefore, free medical care for mental illness should be inclusive of these adolescents and young adults as they constitute the majority of service users.

Evidence has shown that persons with mental illness who are treated early and adequately, and who continue to receive the necessary care, usually remain stable and have productive lives (Patel et al., 2003; Thornicroft & Tansella, 2004; Dixon et al., 2006). However, a small number may become a danger to themselves or others, and may require involuntary hospitalization and intensive outpatient care. Investing in measures for the early detection and treatment of mental illnesses should be on the agenda of public health policy. Research confirms that mental illnesses have impoverished many families, who end up living below

the poverty line and then need support to maintain their wellbeing (Jacob et al., 2007; Patel, 2007).

Poor mental health has a significant economic impact on both the health system and the wider economy of any society. The economic consequences of mental health problems are mainly in the form of lost productivity, as severe mental disorders often start in adolescence or young adulthood, and the loss of productivity can be long-lasting. The Provision domain also reveals that meeting the challenges of delivering quality mental health services for individuals and population requires not only proper financing but also restructuring services to meet the needs of the population. The primary mental health care approach would have increased access to mental health care and shifted the focus to preventing mental health problems and detecting them early.

The current psychiatric hospital-dominated health care delivery reduces access and inequity in mental health service. Thus, most people with treatable mental disorders do not have access to medical treatment, even when people with mental disorders are able to find their way into the mental health facility they often opt out due to the direct and indirect costs of sustaining treatment. Studies have shown that integrated care has wider coverage for the population in need than institutional care (Funk et al., 2005; Saraceno et al., 2007; WONCA, 2008). Therefore, to reduce the burden and sufferings of families and persons with mental illness, decentralization of mental health service and treatment should be given priority status as mental health is a critical indicator of human development and a basis for social stability of any society (WHO-UNDESA, 2010).

A well established intersectoral collaboration can achieve the goal of positive mental health outcomes for clients and families, as well as achieving more efficient resource utilization. However, there has been no intersectoral collaboration between the various relevant departments with mental health services, i.e. Department of Education, Justices system and the Police. There is weak collaboration with the Ministry of Social Welfare only in the area of drug prescriptions for vagrants in the ministry's rehabilitation camp.

3.2.4 Outcomes Domain

Families and clients with mental illness in this domain expressed satisfaction for positive treatment outcomes from mental health service intervention. The changes in their improved mental health functioning are attributed to treatment and care received at the mental health facility. Research shows that recent discoveries in mental illness etiology and different treatment modalities has led to the availability of more effective interventions for the outcome of persons with mental illness in contact with service (Mohit, 2001; Funk et al., 2005; Wang et al., 2007; WONCA, 2008). When it is believed that recovery from mental health conditions is not possible, resources are not directed towards providing people with support and care. Instead, people with mental health conditions are most often abandoned and do not receive the necessary care. Rather they are exposed to abuse and violations of their basic human right, which further exacerbate their conditions. Confirming this finding Prince et al. (2007) and Kohn et al. (2004) reported that persons with mental health problems can live productive lives if given necessary care and treatment.

Mental health professionals in this Outcomes domain confirmed positive mental illness treatment outcomes for those who are able to sustain the treatment and keep to follow-up appointments. However, there are concerns about poor resources at the facility which pose a challenge for quality mental health service delivery to the wider population. Therefore, a policy is needed to address the consequences of untreated or undertreated mental illness it does not only affects individuals and families with mental illness, but also the general society (WHO, 2002). Severe mental illness affects all aspects of a person's life and the lives of their loved ones. Productivity in individuals and society depends on mental activity, as cognitive impairment hinders the ability to perform simple and complex tasks. Evidence suggest that insufficient treatment system often sets in motion and perpetuates a cascade of increasing mental instability and concurrent impairments in performance (Dixon et al., 2006; WHO, 2010).

Mental illness, when left untreated, disrupts daily living and creates social and economic loss, it decreases life expectancy and increases the load on health care systems. Despite the enormity of its negative effects and the sizable number of people directly and indirectly influenced by mental illness in Nigeria (Gureje et al., 2006), this remains largely unaddressed and the problem may be greater than estimated in many rural communities of the country. The WHO (2009) reported that persons with mental illness need basic services, which at a minimum include diagnosis and treatment planning, medication, crisis services, inpatient care, and case management for better mental health treatment outcomes. Rehabilitation and other social supports are also necessary, without these basic services, the

mental state of persons with mental illness worsens and their future treatment becomes even more costly.

3.3 WHAT IS THE PATHWAY TO BE FOLLOWED IN ENGAGING POLICY MAKERS IN NIGERIA ON MENTAL HEALTH POLICY IMPROVEMENTS?

There is increasing recognition that research is required to inform evidence-based policy and health service development. Promoting good practice in policy making is fundamental to the delivery of quality outcomes for citizens and to the realization of public sector reform (Start & Hovlan, 2004). Policy makers should have the widest and latest information on research and best practice available to ensure that all decisions are demonstrably rooted in this knowledge. As the need for social change and the rising expectations of government on the part of the citizen call for more responsive, informed policy-making and more effective service delivery, research will help policy makers to reform and modernize the country's vital health care delivery systems and redesign them around the service user.

Public policy is defined by WHO as: "a public statement by government which clearly articulates an organized set of values, principles and objectives which are underpinned by the vision, intention and commitment of government" (WHO, 2003, p.17). While policy making is: "the process by which governments translates their political vision into programs and actions to deliver 'outcomes' - desired changes in the real world" (Modernizing Government White Paper, 1999). This concern with achieving real changes in people's lives is reflected in government's overall strategy for improving public services.

Research is likely to have an indirect influence through collaboration of networks, organizations, institutions and individuals. Civil society organizations all over the world are increasingly recognizing the need to influence policy and decision making processes more effectively, whether to represent the needs of their interest groups, or of a wider society. Unfortunately in Nigeria, nongovernmental organizations (NGOs) seem not to be active participants in public policy design and governance, the nonperformance of NGOs is largely responsible for the gradual retreat of the government from provision of public service delivery (Oshewolo, 2011). There are also no NGOs for mental health programs and advocacy to let the voices of persons and families living with mental illness heard.

The policy brief developed based on the results of this study were used to raise awareness of the challenges of providing mental health services to clients and families in need and indicated possible policy improvement. The policy brief has been sent to the following:

Professional Organizations:

• Nursing: Association of Psychiatric Nurses of Nigeria, National Association of Nigerian Nurses and Midwives and Nursing and Midwifery Council of Nigeria

• Medical: Association of Psychiatrists of Nigeria

Political leaders:

• Parliamentarians (Constituency Representatives in National and States House of Assemblies).

• State Governors

• Local Government Areas Chairmen

- Local Government Counselors

- Religious leaders

- Community Leaders

- Civil Organizations

Managers of Health:

- Minister of Health

- State Health Commissioners

- Permanent Secretaries

- Directors Nursing Services

- Directors Primary Health Services

Mass Media:

- Radio and Television

- Print (News papers)

Policy improvement is usually driven by public demand, and not only by science. Such demand can be stimulated by releasing relevant information, making such information widely available, and by creating lobby groups. In this case the articles will be published, but the Policy Brief should have a greatest impact, since it speaks directly to the stakeholder groups.

The summary of current mental health care service environment is important for policy. Evidence shows that mental health human resource in Nigeria is inadequate to provide for a population of over 140 million (WHO-AIMS, 2006). Unfortunately, mental health services are mainly located in urban areas, and most of the rural areas, where majority of the populace (approximately 70%) resides, are void of any mental health care service. The emphasis of the primary health care has been geared mostly towards maternal and child care and treatment of minor physical ailments. Mental health professional are not found in primary health care centers and primary care workers as per their training has limited knowledge of mental disorders and virtually the absence of mental health services in PHC (Alem et al., 2008; Erinosho, 2010). Mental health services are provided in psychiatric institutions and a few private own general hospitals seem to be the only hope for the minority of the populace.

Stigma and discrimination of mental illness is pervasive in the Nigeria public, the superstitious beliefs about causation of mental disorders and the poor knowledge of positive treatment outcomes from orthodox care result in many preferring traditional healers and churches, as these traditional and religious healers are easily accessible to the people (Gureje et al., 2000; Gureje & Lasebikan, 2006; Adewuya & Makanjuola, 2009). The deep rooted belief in the supernatural causes of mental illness defers educational status of individuals and most families and persons only seek orthodox treatment when the efforts of these healers seem to have failed (Jegede, 2005; Kapungwe et al., 2010). To combat these challenges of mental health service delivery, negative beliefs and portrayals in the Nigerian public, there is need to get policy makers convinced and committed to the

importance of adequate mental health care provision at the primary care level. A mental health policy brief on the importance of increasing access to mental health service through PHC in Nigeria has been developed and presented to policy makers in order to meet the challenges of service provision.

To engage stakeholders in discussions about the need for a policy for mental health reform began with identifying stakeholders or interest groups. This was followed by creating awareness on the plights of person and families with mental illness as to solicit for support, in order to ensure that the needs and concerns of mental health service users are adequately represented. Stakeholders with high power and interests that aligned with the project, were fully engaged and brought on board, these people are the targets of the campaign for change. Stakeholders with high interest but low power were kept informed and use to form the basis of an interest group and coalition which lobby for change, while those with high power but low interest were used as patrons or supporters for the proposed policy change. Table 4: shows categories of stake- holders or interested groups for advocacy to engage policy.

Table 4: Categories of stakeholders

Private sector stakeholders	Public sector stakeholders	Civil society stakeholders
Oil companies Financial Institutions Professional bodies Corporation and businesses Individual business leaders	Parliamentarians Ministers and advisors State Health Commissioners Civil servants Local government/councils International organizations	Media Advocacy groups Churches/religious leaders Schools/Universities Trade unions Service users/ families National and International NGOs

The concept of advocacy in mental health is to join forces with families and persons with mental illness to make their voices heard by policy for improved services (WHO, 2003). In general advocacy directed purely at political structures is called lobbying, this process of lobbying was used to mobilize government officials at the highest levels of the rationale of improving access to mental health care service in PHC, and this however involves careful and thoughtful planning to fit in with the overall mission and goals of supporting families with mental disorders. Outlined is the strategy and outcome of engaging policy

3.3.1 Goal:

Improving access to mental health services through PHC in Nigeria

3.3.2 Objective:

To engage stakeholders to develop a policy for improved access to mental health services, and to enable families and clients to access care closest to where they live with minimum cost on transportation and less disruption to their work or vocation.

3.3.3. Strategy to lobby policy

- Alert government of their commitments to mental health promotion

- Establish contacts with the Ministry of Health and hold meetings to remind government of their responsible of implementing the primary mental health care policy.

- Work in partnership with interested organizations (academicians, social and public health experts, civil society members, community and religious leaders) to arrange meetings with member of national and state Parliamentarians.

- Provide evidence based information on the situation, and present a policy brief on the need to improve access to mental health services

- Promote the need for a national dialogue to address poor access to service if there are bottle-necks in engaging policy by using multi-stakeholders, this being beneficial for a more holistic and inter-connected approach.

3.3.3 Expected outcomes

- A policy brief to create a basis of engagement with stakeholders and policy makers for mental health service reform

- A broadened understanding and support base for improving access to improved mental health care service through discussion.

- Training of mental health human resource for improve service delivery

- Increased resource allocation for mental health activities and programs

- Improvement of personal and population mental health wellbeing

This open debate and democratic participation assist to arrive at consensus and concerted action for policy reform. Figure 1 below shows the pathway to engage policy makers to address necessary change.
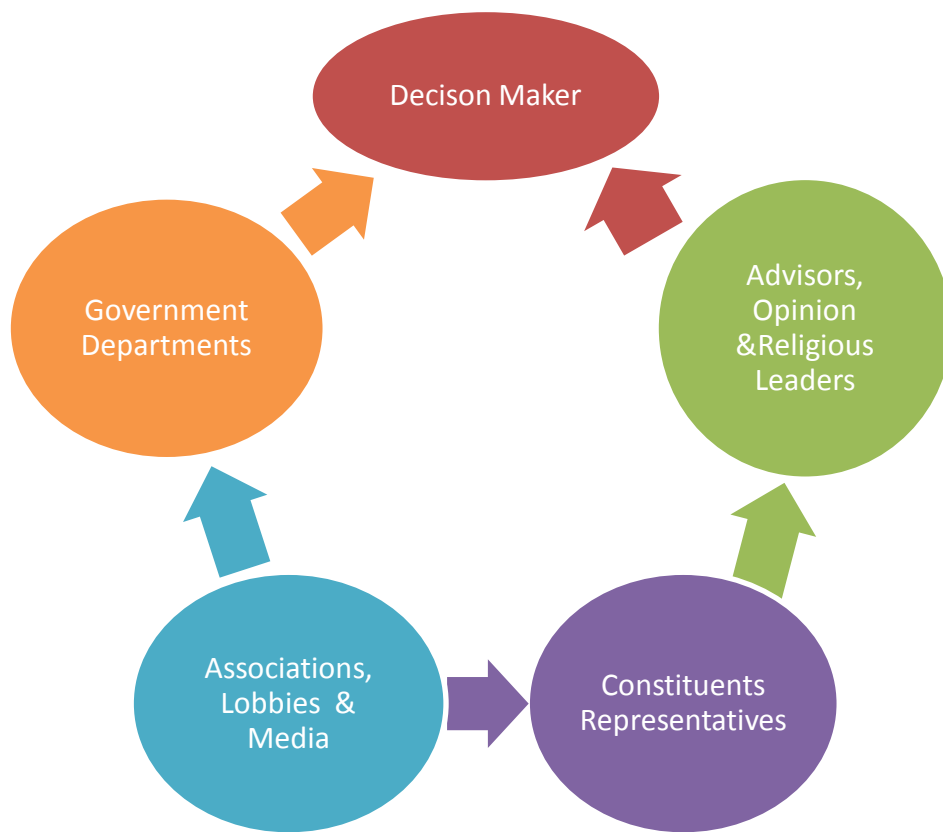
FIGURE 2: Pathway to engage policy for mental health service reform

3.4 WHAT POLICY IMPROVEMENTS WILL AMELIORATE THE BURDEN ON CLIENTS AND FAMILIES OF THOSE EXPERIENCING SERIOUS MENTAL HEALTH PROBLEMS?

There are several barriers for families and clients to access appropriate mental health care service i.e. stigma and discrimination, low human resource, lack of skills at the primary health care level, low priority status of mental health care on government agenda, and lack of rational and comprehensive policies and legislation (Saraceno et al., 2007; Kakuma et al., 2011). The WHO global mental health gap action program identified four core strategies for countries to improve mental health of its population, each of which has been outlined below with respect to its relevance to this study.

- Increase and improve information for better decision-making and technology transfer to increase capacity.

- Raise awareness about mental disorders through education and advocacy for more respect of human rights and less stigma and discrimination.

- Design policies and develop comprehensive and effective mental health services to reduce disease burden.

- Build local capacity for public mental health research to enhance mental health of the population (WHO, 2002).

1.) Increase and improve information for better decision-making and technology transfer to increase capacity.

The generation and strategic use of information, intelligence and research on health and health systems is an integral part of the leadership and governance function. A well

functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely health information by decision-makers at different levels of the health system, both on a regular basis and in emergencies. It involves three domains of health information: health determinants; health systems performance; and health status.

2.) Raise awareness about mental disorders through education and advocacy for more respect of human rights and less stigma and discrimination.

The emergence of mental health advocacy movements in several countries has helped to change society's perceptions of persons with mental disorders. Mental health advocacy involves various actions aimed at changing the major structural and attitudinal barriers to achieving positive mental health outcomes in populations. Advocacy is beneficial for creating awareness for stigma reduction and promotes the rights of people with mental disorders. It is also an important tool for improved mental health policy development (WHO, 2003).

3.) Design policies and develop comprehensive and effective mental health services to reduce disease burden.

An available and skilled workforce is essential to respond to the substantial burden of mental disorders, there can be no mental health care without the necessary human resources (Kakuma et al., 2011). The mental health workforce is all the people who are engaged in actions whose primary intent is to protect and improve mental health of the population. They consist broadly of health service providers as well as health management and support

staff. This includes private as well as public sector health workers, unpaid and paid workers; lay and professional cadres. A well-performing mental health workforce is one which is available, competent, responsive and productive. To achieve this, actions are needed to address issues of motivation and retention of mental health workforce, and improve the distribution and performance of existing health workers.

4.) Build local capacity for public mental health research to enhance mental health of the population

A common research policy on mental health is needed for the effective management of resources and to support informed evidence-based policy decisions (WHO, 2008a). Research should be closely linked to the information needs of policy-makers and practice. Research-generated information is essential in determining needs, proposing new cost-effective interventions, monitoring their implementation and evaluating their effectiveness. Such information also enables better utilization of limited mental health resources, the consequence of the lack of relevant research being a lack of an effective policy.

The Nigeria government needs to show strong political will and be committed to delivering effective and affordable mental health care at primary care level. To make mental health care more accessible and affordable to clients and their families, mental health services should be decentralized (WHO, 2009; WONCA, 2008) into the mainstream of health care by attaching psychiatric units to general hospitals in state capitals and at existing comprehensive primary health care centers in each local government headquarter. This can be done in the following ways:

- Meet the challenges of providing relevant mental health training and increasing the number of mental health professionals and staff to work at the primary care level. Training should include community-based care and not be centered only in psychiatric hospitals.

- With the limited number of psychiatrists in the country, psychiatric units should be managed by psychiatric nurses, each unit having at least two in service, with the psychiatrist visiting the unit once monthly.

- Providing two psychiatric nurses at every mental health unit in Nigeria will require 1878 psychiatric nurses to be trained and deployed to comprehensive health centers in every local government area headquarters to provide appropriate and effective mental health care services.

- Ensure the availability of essential psychotropic medications in these mental health units, which will require standard treatment protocols and an essential drug list.

- Make provision for appropriate primary mental health care services at clinic level, with an efficient referral system to secondary and specialist levels of care as well as ongoing training, supervision and support for primary mental health care staff.

- Provide monetary incentives for psychiatric nurses to work in the community so as to motivate others to take up community-based mental health care practice.

- Payment of salaries and allowances should be under each state ministry of health and not local government authorities because psychiatric out-patients are attached to and operate under state hospitals.

3.5 APPLICATION OF THE TOWNSEND'S CONCEPTUAL FRAMEWORK

The Townsend model was effective in achieving the purpose of highlighting the challenges and difficulties of receiving and providing mental health care services within the current mental health policy environment. Below are summary of key findings derived from the conceptual framework of service users' experiences as care recipients and mental health professionals' experiences of providing care.

3.5.1 Service users' perspectives of mental health services:

The Context, Resources, Provisions and Outcomes domain of the framework reveals that social, political and cultural factors influence mental health care service provision. Fear of stigma and discrimination cause delays in seeking early treatment. Non integration of mental health services in PHC also reduces treatment for population in need of mental health care services. The absence of mental health care service in the community gives rise to the use of traditional and spiritual model of care, while poor knowledge fuel beliefs in supernatural forces as causes of mental illness. Service users experience financial burden in accessing service, many families embark on distance traveled with huge financial cost, as a result many families cannot continue to seek treatment.

There is absence of welfare support net from the government, NGOs or community. Services are procured by out-of-pocket and service users' experience long waiting time due to the few staff. Facility is overcrowded, no toileting facilities for service users, with poor electricity and water supply. However, servicer users who are able to maintain the treatment believed their health and improved mental health state were enhanced with their

continuous medication administration and their main concern was the improved mental state during service engagement. This, they believe, can be maintained if service is made affordable and accessible. Figure 3 below shows how service users experience mental health care services.

FIGURE 3: Service user's perspectives of experiencing mental health care service

3.5.2 Mental health professionals' experiences of providing care:

This reveals how mental health professionals' are experiencing mental health service delivery at the Rumuigbo Hospital.

The Context, Resources, Provisions and Outcomes domain show all types of resources for the provision of mental health care in the state are inadequate- the societal values, the policy and governance in particular. Professionals suffers stigma and discrimination from other health care providers, and their low-priority status in the policy agenda and negative beliefs on causation of mental illness is observed to be responsible for the low-priority status of mental health financing by policymakers. Mental health policy document of 1981 has never been reviewed and the 2004 national plan of action to implement integrated care in PHC was never followed through. Underlying causes of mental health human resources shortage include stigma, an aging and retiring -workforce; lack of interest in psychiatric practice by general health professionals; inadequate in-country training opportunities; non-existent recruitment initiatives; failure to recognize psychiatry as a health and service need; and inadequate pay and reimbursement of mental health professionals.

There are primary health care centers in rural communities for PHC but no mental health service provision in these facilities. There are absences of non-governmental organizations, international, national or state level for mental health programs and activities. Institutional model of care remains the dominant model of care. The medical management of mental illness in the facility involves mainly medication administration, with minimal psychotherapy and family education. On information dissemination, although the Ministry of Health is unable to provide mental health promotion and prevention programs for self-

care to the wider population through radio and pamphlets, clients using the facility are instructed on principles of self-care and how to maintain an improved mental well being. Intersectoral collaboration with other government agencies is lacking while there is a weak collaboration with the Ministry of Social Welfare for drug prescriptions at its rehabilitation camp. All forms of mental illness are being relatively well managed in the facility due to availability of the drugs. However, this single mental health facility in the state has not created access for many individuals and families that need care and support. The high cost of mental health service and cost of long-distant travel to access the services is a challenge for most individuals and families with mental illness.

The Townsend conceptual framework for this study has helped to highlight the challenges of mental health care recipients and care provision within the current mental health policy. In spite of the enormity of the negative effects of mental illness and the sizable number of people directly and indirectly influenced by mental illness, access to mental health service remains largely unaddressed by the current policy.

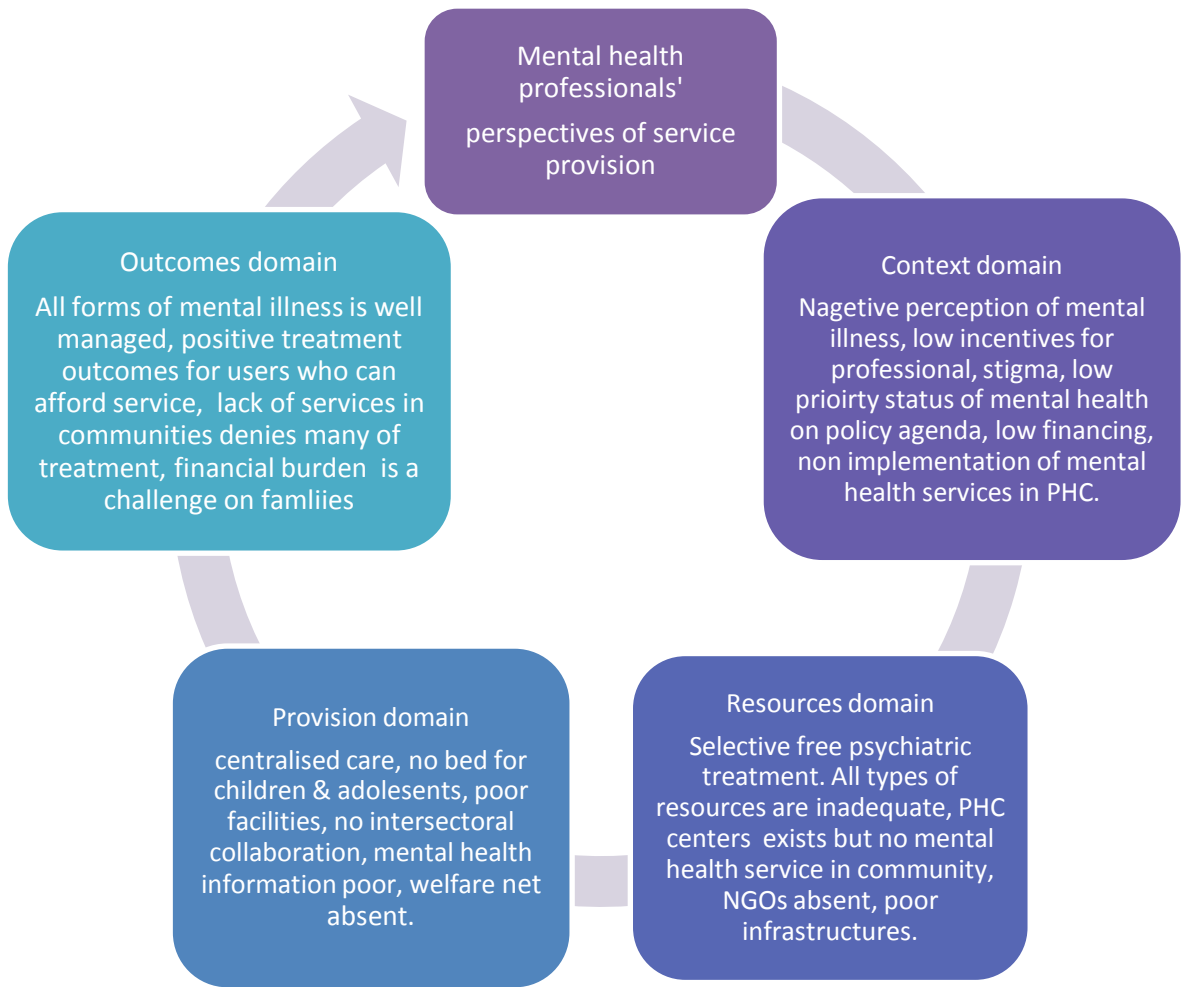Figure 3.4 shows how mental health professionals experienced provision of mental health services.

FIGURE 4: Mental health professionals' experiences of providing care.

3.6 RELEVANCE OF STUDY TO NURSING KNOWLEDGE, SCHOLARSHIP AND PRACTICE

The principle of human rights and equity is an integral part of nursing ethics. This is affirmed within the preamble to the International Council of Nursing (ICN) *Code of Ethics for Nurses* (2006) which states that "Inherent in nursing is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status" (ICN, 2006 p. 1). Nurses play an important role in policy development through advocacy and research, particularly within the domains of health service delivery and restructuring. However, as Reutter and Duncan argue, the need to address the social determinants of health means that there is also a need for strong advocacy in the realm of broader public policy which "extend beyond traditional health agencies and government health departments to bring together sectors such as finance, agriculture, education, transportation, energy and housing" (Reutter & Duncan, 2002, p. 295).

The ability to access mental health services is key to improving the health, well-being and life expectancy of people with mental illnesses. Yet, achieving this fundamental requirement remains limited by societal negative portrayals of mental illness, service cost, proximity, policies and practices, as well as many other factors. As the principal group of mental health professionals providing care in these large psychiatric institutions, nurses has responsibility towards improving access to mental health care and adding quality to the outcome of care provision. Lobbying and advocacy thus are an essential part of nursing's

role in addressing needs of families/clients as to develop a clear understanding of how the public health policy can act to reduce mental health inequities thereby giving voice to the voiceless. Therefore, it is important for Nigeria that psychiatric nurses become advocates for mental health policy reform in order to improve access to quality care. Advocacy is an important nursing role, not only in terms of individual patients, but also with regard to policy and service provision.

This study adds to the body of knowledge and has made contribution to the field of mental health nursing. It also shed light on the mental health human resource challenges and the dearth of caregiving literature, the inequity in mental health care delivery systems, how families/clients with serious mental health problems experience service provisions in a resource lacking environment, and the public negative portrayals and myths surrounding mental illness in the Niger Delta region of Nigeria. This study highlights the barriers that exist in accessing mental health services in Nigeria, and outlines how nurses can become advocates in addressing these needs and in so doing improve access for people with mental illness and their families.

3.7. LIMITATION OF THE STUDY

A limitation of this study is that the sample is mainly drawn from clinical practice areas and thus excludes service users who do not utilize hospital service, and small sample size of caregivers, clients and mental health professionals. The study was conducted at one location, the State government funded mental health facility in Port Harcourt. The transferability of findings may therefore only apply to families' caregivers, clients and

mental health professionals in the six states of the Niger Delta region. However, given that the model of care is the same throughout Nigeria, it may well apply elsewhere in the country. The strength of this study is the use of in-depth interviewing which allowed for themes to emerge and provide a comprehensive understanding of families' caregivers' experiences, clients' perspectives of care recipients and mental health professionals' experiences of care provision under the current policy environment in Rivers State, Nigeria.

3.8 IMPLICATION FOR FURTHER STUDIES

The Townsend et al. (2004) conceptual framework provided a useful outline to meet the study objectives of exploring families' caregiving experiences, clients receiving care and mental health professionals' experiences of providing mental health care services. The tool facilitated highlighting difficulties and challenges of mental health care services recipients and providers within the current mental health policy environment. The use of the temple is recommended for further studies to evaluate services users' perspectives of mental health services and mental health professionals' experiences of providing care in a federally funded mental health facilities and covering a larger population. Similar studies should be done using this template at all other psychiatric hospitals to determine whether they are experiencing similar issues, as this will provide greater impetus to motivate for reform.

3.9. CONCLUSION

In Nigeria mental health services is organized around institutional model of care. Of concern is Nigerians poor - integration of mental health care into its primary health care service more than 20 years after the adoption of this policy. As this policy is intended to enable access to mental health service in PHC, lack of implementation questions whether the population has equitable access to mental health care. Furthermore, the development of a mental health policy, as articulated in a Mental Health Act, is intended to protect the human rights of persons with mental disorders and ensure that these individuals have access to treatment and care, discourage stigma and discrimination, and set standards for practice of psychiatry in the country. The lack of a policy despite the legislation requiring its development speaks to the low priority mental health care has in Nigeria.

There are several strengths in the South African mental health system compared to Nigeria, it is relatively well resourced including human resources to deliver services in PHC, there are specialized mental health facilities for children and adolescents, and psychotropic medications are available in outreach clinics. Mental health care services are integrated into primary care services and there are treatment protocols to maintain standards of care across various levels of health care. The promulgation of the Mental Health Care Act (2002) in South Africa has protected the human dignity of persons and families with mental health problems.

The daily experiences of caregiving of families and persons with serious mental health problems uncovered in this study show that, family caregivers and persons with serious

mental illness experience burden accessing mental health service and managing symptoms of mental illness of ill relatives. Many of the difficulties experienced were generated from fixed cultures and traditions which will not be easily changed such as, persons with mental illness are viewed by the public as being responsible for their illness and deserving the wrath of the gods for their wicked acts. Poor knowledge about mental disorders, and positive treatment outcomes have fueled the belief in supernatural factors as causing mental illness, resulting in the continual use of spiritual models of care and the unfortunate disregard of proven scientific treatment approaches. The lack of social support as well as the financially disabling aspect of mental illness over the years increases the vulnerability of persons with mental illness for human right abuse, neglect, stigma, loss of dignity and discrimination. It also reduces their opportunity to earn a livelihood and support themselves and their families. The greatest challenges faced by persons with mental illness and families in sustaining treatment is the cost of long-distant travel to access these centralized hospital-based services as well as the high cost of these services.

The experiences of mental health professionals' shows gross lack of mental health human resources and a lack of incentives for the few trained professionals which has led to mass exodus of mental health care professionals into other fields of practice. The move toward decentralization of care into general health care, the detection of mental illness, and the active involvement of other government departments and NGOs are absent in the Nigerian mental health policy environment. As mental health services are not decentralized and offered at primary health care level, the capacity of centralized and hospital-based mental health facilities are stretched beyond their ability to provide a good service. Mental health

care is characterized by unclear policy, low priority and stigma continues to affect services provision, even among health care professionals and policymakers. Mental health professionals (nurses and psychiatrists) need to identify and change the misconceptions and myths surrounding mental illness that adversely affects the health and well-being of the mentally ill person, there are potential for mental health care professionals to empower clients and their families within their limited capacity. There is also a need to recognize the expertise of the different mental health professionals and what each group can offer in meeting the challenges of service provision.

The aim of exploring families' caregivers experiences of caring for persons with serious mental health problems, the clients' experiences of receiving care within the current mental health policy environment, the mental health care professionals experiences of providing mental health care services for families/clients with mental health problems, and identifying difficulties/challenges of providing these services so as to engage policy makers and suggest policy reforms was achieved. The significance and major implications of this study is to ameliorate the burden on families and clients experiencing serious mental health problems. Policies should meet the challenges of training and increasing mental health human resource, and establish psychiatric units at general hospitals in state capitals and at existing comprehensive primary health care centers in each local government headquarter to make mental health care more accessible and affordable to clients and their families.

REFERENCE

ADEWUYA, A.O., & MAKANJUOLA, R.O.A. 2005. Social Distance Towards People with Mental Illness Amongst Nigerian University Students. *Soc Psychiatry Psychiatr Epidemiol,* 40: 865–868.

ADEWUYA, A.O., OLA, B.A., MOSAKU, S.K., FATOYE, F.O., EEGUNRANTI, A.B. 2006. Attitude towards Antipsychotics among Out-patients with Schizophrenia in Nigeria. *Acta Psychiatr Scand,* 113: 207-211.

ADEWUYA, A.O., & MAKANJUOLA, R. 2009. Preferred Treatment for Mental illness Among Southwestern Nigeria. *Psychiatric Services*, 60 (1): 121-124.

ALEM, A., JACOBSSON, L. & HANLON, C. 2008. Community-based Mental Health Care in Africa: Mental Health Workers' views. *World Psychiatry, 7*, 54-57. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2327237/pdf/wpa010054.pdf (Accessed 11/03/2010).

AMORIM, A. K. & DIMENSTEIN, M. 2009. De-institutionalization of mental health and care practices in the context of home-based care. *Cien Saude Colet,* 14(1): 195-204.

AWAD, G.D., & VORUGANTI, L.N.P. 2008. The Burden of Schizophrenia on Caregivers. *Pharmacoeconomics,* 26(2): 149-162.

BROWNE, G., & COURTNEY, M.C. 2005. Housing, Social Support and People with Schizophrenia: A Grounded Theory Study. *Issues in Mental Health Nursing,* 26: 311-326.

CHANG, K.H., & HORROCKS, S. 2006. Lived Experiences of Family Caregivers of Mentally ill relatives. *Journal of Advanced Nursing,* 53(4): 435-443.

CHEN, S & RAVALLION, M. 2008. The developing world is poorer than we thought but not less successful in the fight against poverty. Development Research Group, *World Bank,* 1818 H Street, NW, Washington DC, 20433, USA.

CHISHOLM, D., FLISHER, A. J., LUND, C., PATEL, V., SAXENA, S., THORNICROFT, G., TOMLINSON, M. 2007. Scale up Services for Mental Disorders: A Call for Action. *Lancet,* 370, 1241-125.

CHUNG, K., ESSEX, E. L & SAMSON, L. 2009. Does Caregiver Knowledge Matter for Hospice Enrollment and Beyond? Pilot Study of Minority Hospice Patients. *Am J Hosp Palliative Care,* 26(3): 165-171. DOI: 10.1177/1049909109331883

CORRIGAN, P. W., RIVER, P .L, LUNDIN, R. K., PENN, D. L., UPHOFF-WASOWSKI, K., CAMPION, J., MATHISEN, J., GACNON, C., BERGMAN, M., GOLDSTEIN, H., KUBIAK, M. A. 2001. Three Strategies for Changing Attributions about Severe Mental illness. *Schizophrenia Bulletin,* 27(2):187-195.

CRABTREE, B., & MILLER, W. 1999. *Doing Qualitative Research* 2nd Ed, Sage, London.

CUIJPERS, P., & STAM, H. 2003. Burnout Among Relatives of Psychiatric Patients Attending Psychoeducational Support Groups. *Psychiatric Services,* 51(3): 375-379.

DANGDOMYOUTH, P., STERN, P.N., OUMTANEE, A., YUNIBHAND, J. 2008. Tactful Monitoring: How Thai Caregivers Manage their Relative with Schizophrenia at Home. *Issues in Mental Health Nursing*, 29:37–50.

DIXON, A., MCDAID, D., KNAPP, M., CURRAN, C. 2006. Financing Mental Health Services in Low- and Middle-income Countries. *Health Policy and Planning*, 21(3): 171-182.

EPPING-JORDAN, J. E., PRUITT, S.D., BENGOA, R., WAGNER, E.H. 2004. Improving the Quality of Health Care for Chronic Condition. *Quality and Safety in Health Care*, 13, 299-305.

ERINOSHO, L. 2010. Community Psychiatry in Nigeria: Retrospection, Challenges, and Future Prospects. *Keynote address the Annual Conference of Association of Psychiatrists in Nigeria*, Enugu, December 13.

FEDERAL MINISTRY OF HEALTH (FMOH). 1991. *The National Mental Health Policy in Nigeria*. Lagos: Federal Ministry of Health.

FEDERAL MINISTRY OF HEALTH (FMOH). 2004. *Revised Draft National Health Policy*. Federal Ministry of Health, Abuja, 1(1): 12.

FOLDEMO, A., GULLBERG, M, EK, A.C., BOGREN, L. 2005. Quality of life and burden in parents of outpatients with schizophrenia. *Soc Psychiatry Psychiatr Epidemiol,* 40: 133–138.

FUNK, M., DREW, N., SARACENO, B., DE ALMEIDA, J. M. C., AGOSSOU, T., WANG, X., & TAYLOR, J. 2005. Framework for Mental Health Policy, Legislation and Service Development: Addressing Needs and Improving Services. *Harvard Health Policy Review*, 6(2): 57-69. Available at http://www.hcs.harvard.edu/~hhpr/currentissue/funk.pdf (Accessed 06/06/2010).

FUNK, M., LUND, C., FREEMAN, M., & DREW, N. 2009. Improving the Quality of Mental Health Care. *International Journal for Quality in Health Care, 21*(6): 415-420. Available at http://intqhc.oxfordjournals.org/content/21/6/415.full.pdf+html (Accessed 06/06/2010).

GALLAGHER, S.K., MECHANIC, D. 1996. Living with the mentally ill: Effects on the health and functioning of other household members. *Social Science & Medicine,* 42(12): 1691-1701.

GAVOIS, H., PAULSSON, G., & FRIDLUND, B. 2006. Mental Health Professional Support in Families with a Member Suffering from Severe Mental Illness: A Grounded Theory Model. *Scand J Caring Sciences,* 20: 102-109.

GUREJE, O., ACHA, R.A., & ADEJIDE, O.A. 2000. Pathways to Psychiatric Care in Ibadan, Nigeria. *International Journal of Social Psychiatry,* 46(4): 281-289.

GUREJE, O. & ALEM, A. 2000. Mental Health Policy Development in Africa. *Bulletin of the World Health Organization,* 78(4): 475-482.

GUREJE, O. 2003. Psychiatry in Nigeria *International Psychiatry,* 2: 10–12.

GUREJE, O., LASEBIKAN, V.O., EPHRAIM-OLUWANUGA O., OLLEY B.O., KOLA, L. 2005. Community Study of Knowledge of and Attitude to Mental Illness in Nigeria. *British Journal of Psychiatry,* 186: 436-441.

GUREJE, O., LASEBIKAN, V.O., KOLA, L., MAKANJUOLA, V.A. 2006. Lifetime and 12-Month Prevalence of Mental Disorders in the Nigerian Survey of Mental Health and Well-Being. *British Journal of Psychiatry,* 18(8): 465-471.

GUREJE, O., & LASEBIKAN, V.O. 2006. Use of Mental Health Services in a Developing Country: Results from the Nigerian Survey of Mental Health and Well-being. Soc Psychiatry *Psychiatr Epidemio,* 41: 44-49.

HEALTH CANADA, 2004. *Informal/Family Caregivers in Canada Caring for Someone with a Mental Illness. Final Report.* Decimal Research Inc. Montreal, Canada.

INTERNATIONAL CONSORTIUM FOR MENTAL HEALTH POLICY AND SERVICES. 2001. *Mental Health Template Domains and Elements for Mental Health Policy Formulation.* Supported by the Global Forum for Health Research, and the governments of Australia, United Kingdom and United States of America.

INTERNATIONAL COUNCIL OF NURSES. 2006. *The ICN Code of Ethics for Nurses.* Geneva: International Council of Nurses.

JACOB, K. S. 2001. Community Care for People with Mental Disorders in Developing Countries. *British Journal of Psychiatry,* 178: 296-298.

JACOB, K.S., SHARAN, P., MIRZA, I., GARRIDO-CUMBRERA, M., SEEDAT, S., MARI, J.J., SREENIVAS, V., SAXENA, S. 2007 Mental Health Systems in Countries: Where are we Now? *Lancet,* 370: 1061–1077.

JEGEDE, A. S. 2005. The Notion of 'Were' in Yoruba Conception of Mental Illness**.** Nordic *Journal of African Studies, 14*(1): 117–126.

KABIR, M., ILIYASU, Z., ABUBAKAR, I.S., ALIYU, M.H. 2004. Perception and beliefs about mental illness among adults in Karfi village, northern Nigeria. *BMC International Health and Human Rights,* 4(3): 1-5.

KAKUME, R., MINAS, H., GINNEKEN, N. VAN., DALPOZ., M.R., DESIRAJU, K., MORRIS, J.E., SAXENA, S., SCHEFFLER, M. 2011. Human resources for mental health care: current situation and strategies for action. *Lancet,* 378: 1654-1663. DOI:10.1016/S0140-6736(11)61093-3

KAPUNGWE, A., COOPER, S., MWANZA, J., MWAPE, L., SIKWESE, A., KAKUMA, R., LUND, C., FLISHER, A.J., & MENTAL HEALTH & POVERTY PROJECT. 2010. Mental illness- Stigma and Discrimination in Zambia. African Journal of Psychiatry, 13: 192-203.

KNUDSON, B., & COYLE, A. 2002. Parents' experiences of caring for sons and daughters with schizophrenia: a qualitative analysis of coping. *European Journal of Psychotherapy, Counseling & Health,* 5(2): 169-183. Retrieved from http://epubs.surrey.ac.uk/1718/1/fulltext.pdf (Accessed 16/02/2009).

KOHN, R., SAXENA, S., LEVAV, I., SARACENO, B. 2004. The Treatment Gap in Mental Health Care. *Bulletin of the World Health Organization*, 82: 858-866.

KUNG, W.W. 2004. Cultural and Practical Barriers to Seeking Mental Health Treatment for Chinese Americans. *Journal of Community Psychology*, 32(1): 27–43.

LANGELAND, E., & WAHL, A.K. 2009. The Impact of Social Support on Mental Health Service Users. Sense of Coherence: A longitudinal Panel Survey. *International Journal of Nursing Studies,* 46(6): 830-837.

LUND, C., & FLISHER, A. J. 2006. Norms for Mental Health Services in South Africa. *Soc Psychiatry Psychiatric Epidemiology,* 41:587–594.

LUND, C., KLEINTJES S, CAMPBELL-HALL V, MJADU S, PETERSEN I, BHANA A, KAKUMA R, MLANJENI B, BIRD P, DREW N, FAYDI E, FUNK M, GREEN A, OMAR M & FLISHER, A.J. 2008. Mental Health Policy Development and Implementation in South Africa: A Situation Analysis Phase 1. Country Report Cape Town: *Mental Health and Poverty Project*.

MAGLIANO, L., FADDEN, G., ECONOMOU, M., HELD, T., XAVIER, M., GUARNERI, C., MALANGONE, C., MARASCO, C., MAJ, M. 2000. Family Burden and Coping Strategies in Schizophrenia: 1-Year Follow-up Data from the BIOMED I Study. *Soc Psychiatry Psychiatr Epidemiol,* 35: 109-115.

MAGLIANO, L., FIORILLO, A., MALANGONE, C., DE ROSA, C., MAJ, M. 2006. Social Network in Long-term Diseases: A Comparative Study in Relatives of Persons with Schizophrenia and Physical illnesses Versus a Sample from the General Population**.** Social Science and Medicine, 62: 1392-1402.

MARTIN, K., FUNK, M., CURRAN, C., PRINCE, M., GRIGG, M., MCDAID, D. 2006. Economic Barriers to Better Mental Health Practice and Policy. *Health Policy and Planning,* 21(3): 157-170.

MAYEYA, J., CHAZULWA, R., MAYEYA, P.N., MBEWE, E., MAGOLO, L.M., KASISI, F., BOWA, A.C. 2004. Zambia Mental Health Country Profile. *Inter Rev Psychiatry,* 1-2(16): 63-72.

MCDONELL, M.G., SHORT, R.A., BERRY, C.M., DYCK, D.G. 2003. Burden of Schizophrenia Caregivers: Impact of Family Psychoeducation and Awareness of Patient Suicidality. *Family Press,* 42(1): 91-103.

MENTAL HEALTH CARE ACT. 2002. *No. 17 of 2002: Health Care Act. No. 24024.* Republic of South Africa, Government Gazette.

MODERNISING GOVERNMENT WHITE PAPER. 1999. *Modernizing Government.* Presented to Parliament. By the Prime Minister and Minister of the Cabinet Office by Command of Her Majesty March 1999. Retrieved from http://www.nationalschool.gov.uk/policyhub/docs/modgov.pdf (Accessed 16/10/2011).

MOHIT, A. 2001. Psychiatry and Mental Health for Developing Countries, Challenges for the 21st Century. *13th Congress of Pakistan Psychiatric Society, Islamabad, Pakistan,* January 25-28. Available at http://www.emro.who.int/mnh/whd/TechPres-Pakistan.pdf (Accessed 06/04/2009).

NATIONAL POPULATION COMMISSION. 2006. *Population and Housing Census Facts and Figures.* National Population Commission, Abuja.

OHAERI, J. U. 2001. Caregiver Burden and Psychotic Patient's Perception of Social Support in a Nigerian Setting. *Social Psychiatry Psychiatric Epidemology*, 36: 86-93.

OHAERI, J. U. 2002. The Burden of Caregiving in Families with a Mental Illness: A Review of Literature. *Current Opinion in Psychiatry,* 16: 457-465.

OSHEWOLO, S. 2011. Limited policy engagement of non-governmental organizations: A guilt trip on the Nigerian State. *Journal of Sustainable Development in Africa*, 13(1): 142-152.

PATEL, V., CHISHOLM D., RABE-HESKETH S., DIAS-SAXENA F., ANDREW, G., MANN, A. 2003. Efficacy and Cost-effectiveness of Drug and Psychological Treatments

for Common Mental Disorders in General Health Care in Goa, India: A Randomised, Controlled Trial *Lancet* 361: 33-39.

PATEL, V. 2007. Mental Health in Low- and Middle-income Countries. *British Medical Bulletin,* 81and 82: 81–96.

PATEL, V., ARAYA, R., CHATTERJEE, S., CHISHOLM, D., COHEN, A., DE SILVA, M., HOSMAN, C., MCGUIRE, H., Rojas, G., VAN OMMEREN, M. 2007. Treatment and Prevention of Mental Disorders in Low-income and Middle-income Countries. *Lancet,* 370(9591): 991-1005.

PETERSEN, I., BHANA, A., CAMPBELL-HALL, V., MJADU, S., LUND, C., KLEINTJES, S., HOSEGOOD, V., FLISHER, A.J. 2009. Planning for District Mental Health Services in South Africa: A Situational Analysis of a Rural District Site. *Health Policy and Planning,* 1–11.

PRINCE, M., PATEL, V., SAXENA, S., MAJ, M., MASELKO, J., PHILLIPS, M.R., RAHMAN, A. 2007. No Health without Mental Health. *Lancet*, 370(9590): 859-877.

RAMMOHAN, A., RAO, K., SUBBAKRISNA, D.K. 2002. Religious Coping and Psychological Wellbeing in Carers of Relatives with Schizophrenia. *Acta Psychiatrica Scandinavica,* 105: 356-362.

REUTTER, L., & DUNCAN, S. 2002. Preparing Nurses to Promote Health-Enhancing Public Policies. *Policy, Politics & Nursing Practice*, November Vol.3 No.4, pp. 294-305

ROSSLER, W., SALIZE, H.J., VAN OS, J., RIECHER-ROSSLER, A. 2005. Size and Burden of Schizophrenia and Psychotic Disorders. *European Neuropsychopharmacology,* 15(4): 399-409.

SARACENO, B., VAN OMMEREN, M., BATNIJI, R., COHEN, A., GUREJE, O., MAHONEY, J., SRIDHAR, D., UNDERHILL, C. 2007. Barriers to Improvement of Mental Health Services in Low-income and Middle-income Countries. *Lancet,* 370: 1164-74.

SAUNDERS, J. C. 2003. Families Living with Severe Mental Illness: A Literature Review. *Mental Health Nursing,* 24: 175-195.

SARTORIUS, N. 2007. Stigma and Mental Health, *Lancet,* 370, 810-811. DOI: 10.1016/S0140-6736(07)61245-8. Available at www.thelancet.com (Accessed 26/02/2009).

SAXENA, S., THORNICROFT, G., KNAPP, M., WHITEFORD, H. 2007. Resources for Mental Health: Scarcity, Inequity, and Inefficiency. *Lancet*, 370 (9590): 878–89.

SCHULZE, B. 2007. Stigma and Mental Health Professionals: A Review of the Evidence on an Intricate Relationship. *Int Rev Psychiatr,* 19 (2): 137-155.

SCHULZ, R & MARTIRE, L.M. 2004. Family Caregiving of Persons with Dementia Prevalence, Health Effects, and Support Strategies. *Am J Geriatr Psychiatry,* 12 (3):

SELOILWE, E. S. 2006. Experiences and Demands of Families With Mentally Ill People at Home in Botswana**.** *Journal of Nursing Scholarship,* 38(3): 262-268.

SELOILWE, E., & THUPAYAGALE-TSHWENEAGAE, G. 2007. Community mental health care in Botswana: Approaches and opportunities. *International Nursing Review,* 54: 173–178.

SHIBRE, T.K.D., ALEM A., NEGASH, A., DEYASSA, N., FEKADU, A., FEKADU, D., JACOBSSON, L., KULLGREN, G. 2003. Schizophrenia: Illness Impact on Family Members in a Traditional Society Rural Ethiopia. *Soc Psychiatry Psychiatr Epidemiol*, 38: 27-34.

SOUTH AFRICA: EHLANZENI DISTRICT, MPUMALANGA PROVINCE, & MOORREESBURG DISTRICT. 2008. Western Cape Province Integrated Primary Care Services and a Partnership for Mental Health Primary Care. Available at http://www.who.int/mental_health/policy/services/SouthAfrica.pdf (Accessed 21/07/09).

START, D., & HOVLAN, I. 2004. *Tools for policy impact.* A handbook for researchers. Research and Policy in Development Programme, London. Available at http://www.odi.org.uk/resources/download/156.pdf   (Accessed 06/09/2011).

THORNICROFT, G. 2007. Most people with mental illness are not treated. *Lancet*, 370: 807-808.

THORNICROFT, G. 2008. Stigma and discrimination limit access to mental health care. *Epidemiologia Psichiatria Sociale*, 17(1): 14-19.

THORNICROFT, G., & TANSELLA, M. 2004. Components of a Modern Mental Health Service: A Pragmatic Balance of Community and Hospital Care: Overview of Systematic Evidence. *British Journal of Psychiatry,* 185: 283–290.

TOMLINSON, M., RUDAN, I., SAXENA, S., SWARTZ, L., TSAI, A.C., PATEL, V. 2009. Setting Priorities for Global Mental Health Research. *Bulletin World Health Organization*, 87: 438-446.

TOWNSEND, C., WHITEFORD, H., BAINGANA, F., GULBINAT, W., JENKINS, R., BABA, A., MAK, L., MANDERSCHEID, R., MAYEYA, J., MINOLETTI, A., MUBBASHAR, M.H., KHANDELWAL, S., SCHILDER, K., TOMOV, T., DEVA, M.P. 2004. The Mental Health Policy Template: domains and elements for mental health policy formulation. *International Review of Psychiatry*, 15(1-20): 18-23.

UYS, L., MAJUMDAR, B., GWELE, N. S. 2004. The KwaZulu-Natal Health Promotion Model. *Journal of Nursing Scholarship*, 36(3): 192-196.

VELTMAN, A., CAMERON, J. I., STEWART, D. E. 2002. The Experience of Providing Care to Relatives with Chronic Mental Illness. *The Journal of Nervous and Mental Disease,* 190(2):1902-108.

WANG, P. S., DEMLER, O., KESSLER, R. C. 2002. Adequacy of Treatment for Serious Mental Illness in the United States. *American Journal of Public Health,* 92(1): 92-98.

WANG, P. S., AGUILAR-GAXIOLA, S., ALONSO, J., ANGERMEYER, M. C., BORGES, G., BROMET, E. J., BRUFFAERTS, R., GIROLAMO, G., GRAAF, R., GUREJE, O., HARO, J. M., KARAM, E. G., KESSLER, R. C., KOVESS, V., LANE, M.C., LEE, S., LEVINSON, D., ONO,Y., PETUKHOVA, M., POSADA-VILLA, J., SEEDAT, S., WELLS, E. 2007. Use of Mental Health Services for Anxiety, Mood, and Substance Disorders in 17 Countries in the WHO World Mental Health Surveys. *Lancet,* 370: 841-850.

WORLD HEALTH ORGANISATION. 2000. *Health Systems: Improving Performance*. The World Health Report, Geneva.

WORLD HEALTH ORGANISATION. 2001. *Mental Health: New Understanding, New Hope*. The World Health Report, Geneva.

WORLD HEALTH ORGANISATION. 2002. *Mental Health and Work: Impact, issues and good practice*. (Nations for Mental Health)   The World Health Report, Geneva Switzerland.

WORLD HEALTH ORGANISATION. 2003. *Mental health policy and service guidance package: mental health policy plans and programmes*. Geneva, World Health Organization.

WORLD HEALTH ORGANISATION. 2005a. *World Health Organization Assessment Instrument for Mental Health Systems* (WHO-AIMS). Geneva.

WORLD HEALTH ORGANISATION. 2005b. *Human Resources and Training in Mental Health*. Mental Health Policy and Service Guidance Package. World Health Organisation.

WORLD HEALTH ORGANISATION. 2008a. *Mental Health Gap Action Programme: Scaling Up Care for Mental, Neurological and Substance Use Disorders*. WHO, Geneva.

WORLD HEALTH ORGANISATION. 2008b. *World Mental Health Day: Making Mental Health a Global Priority*. WHO, Geneva.

WORLD HEALTH ORGANISATION. 2008c. *The World Health Report: Primary Health Care Now More Than Ever.* WHO, Geneva.

WORLD HEALTH ORGANISATION. 2009. *Improving health systems and services for mental health. Mental health policy and service guidance package*. World Health Organization, Geneva. Available at http://whqlibdoc.who.int/publications/2009/9789241598774_eng.pdf. (Accessed 10/12/09).

WORLD HEALTH ORGANISATION. 2010. *Mental health and development: Targeting people with mental health conditions as a vulnerable group*. WHO Press, Geneva. Available at http://www.who.int/mental_health/policy/development/en/index.html and http://www.psychiatry.uct.ac.za/mhapp/ (Accessed 19/07/2010).

WORLD HEALTH ORGANISATION-ASSESSMENT INSTRUCMENT FOR MENTAL HEALTH SERVICE. 2006. *WHO-AIMS Report on Mental Health in Nigeria*. WHO and Ministry of Health Ibadan, Nigeria.

WORLD HEALTH ORGANISATION-ASSESSMENT INSTRUCMENT FOR MENTAL HEALTH SERVICE. 2007. *WHO-AIMS Report on Mental Health System in South Africa, WHO and Department of Psychiatry and Mental Health, University of Cape Town, Cape Town, South Africa.*

WORLD HEALTH ORGANISATION & UNITED NATIONS DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS (WHO-UNDESA). 2010. Policy Analysis: Mental Health and Development: Integrating Mental Health into All Development Efforts including MDGs. Geneva. Available at http://intqhc.oxfordjournals.org/content/21/6/415.full.pdf+html (Accessed 02/04/2011).

WORLD HEALTH ORGANISATION & WORLD ORGANISATION OF FAMILY
DOCTORS. 2008. *World Health Organization and World Organization of Family Doctors Integrating Mental Health into Primary Care: A Global Perspective*. WHO Press, Geneva.

ANNEXURE 1:

INTERVIEW GUIDE FOR FAMILY CAREGIVERS

Title of study: Policy implementation: Implication on caregiving experiences of families and persons living with serious mental health problems in Nigeria

The policy template as a conceptual framework will be used to ask questions on each domain and elements however, these questions will be interwoven within the elements and domain to be able to solicit required data.

1. Pathway to care (items 1, 4 and 10)

Question: Tell me how the illness of your relation started and what you did?

(Probes)

When did you notice the illness?

Where did you go first for help?

And then what did you do?

How did you get to this hospital?

2. Provision domain (items 7, 8 and 9)

Question: Which health service are you using currently and what are they doing for him/her and your family?

(Probes)

Who pays for the Medicine?

Do you receive professional advice?

Do you have referral services for other ill health?

Do you have Social support network?(can be explain further where necessary)

3. Individual outcome (item 13)

Question: What is the client's health like now?

(Probes)

Who looks after the client in the house?

What do you about their care?

How is the condition of your relative since you start using this hospital?

Are there any changes in him/her?

4. Financing (item 2, 3 and 5)

Question: What medication is the client taking?

5. Economic outcomes (item 15)

Question: What is the impact of caring for the client on your household finances, how much do you spent?

(Probes)

Transport?

Medicine?

Food?

Other physical illness?

6. Health outcomes (item 13 and 4)

Question: How has the illness impacted on you and your family?

(Probes)

What was your life like before now?

How is your life now?

How is your health?

How well are your other family members doing?

7. Provision & Resources (item 8, 9 and 12)

Question: Where and how do you get support?

(Probes)

a.   What kind of assistance do you receive from the health service?

b.   What other kind of assistance do you receive in the community?

c.   What kind of assistance can the health service give you that would make the most difference to your life?

8. Provision (item 10)

Question: What does your family provide for you and what do you do for the client?

(Probes)

What motivates you about caring?

What have been your most challenging/difficult times?

What are the happy moments in your life?

9. Resources (item 6, 7 and 14)

Question: Are you getting the necessary professional help?

(Probes)

Are you satisfied with the health care professionals?

Are you satisfied with the treatment?

By what means did you get here?

How long did it take you to get here?

10. Outcome (item 16)

Question: What is your life like?

(Probes)

How is your family looked upon in the community?

Do the client and your family members take part in community activities?

What would you consider most useful to improve service?

ANNEXURE 2:

DEMOGRAPHIC DATA FOR FAMILY CAREGIVERS

Tribe:
Gender: (a) Male ☐   (b) Female ☐

Age: (a) 18-25 ☐   (b) 26-35 ☐   (c) 36-45 ☐ (d) 46-55 ☐

(e) 56-65 ☐   (f) 66-75 ☐   (g) 76 & Above ☐

Marital Status: (a) Single ☐ (b) Married ☐ (c) Divorced ☐ (d) Widow ☐

(e) Widower ☐

Educational Level: (a) Primary ☐ (b) Secondary ☐ (c) Tertiary ☐ (d) None ☐

Occupation: (a) Self employed ☐ (b) Trader ☐ (c) Farmer/fishing ☐

(d) Public Servant ☐ (e) Company Staff ☐ (f) House wife ☐

Religion: (a) Christian☐ (b) Muslim ☐ (c) Pagan ☐ (d) Traditional ☐

Relationship to the sick person:
Duration of care:
Family size:
Who makes decision about care:
Type of health care used before coming to hospital:
Any history of mental illness in the family:
History of illness in the family:

ANNEXURE 3:

INTERVIEW GUIDE FOR CLIENTS

Title of study: Policy Implementation: Implication on caregiving experiences of families and persons living with serious mental health problems in Nigeria

The policy template as a conceptual framework will be used to ask questions on each domain and elements however these questions will be interwoven within the elements and domain to be able to solicit required data.

1.   **Pathway to care (item 1,4 and 10)**

Question: Tell me how your illness started and what you did?

(Probes)

a. When did you notice the illness?

b. Where did you go first for help?

c. And then what did you do?

d. How did you get of this hospital?

2.   **Provision domain (item 7, 8 and 9)**

Question: Which health service are you using currently and what are they doing for you and your family?

   (Probes)

   a. Who pays for the Medicine?

   b. .Do you receive professional advice?

   c. Do you have referral services for other ill health?

   d. Do you have Social support network?

3. Individual outcome (item 13)

Question: How is your health like now?

   (Probes)

a.   Who looks after you in the house?

b.   What do you about your care?

c.   How is your health condition since you started using this hospital?

d.   Are there any changes?

4.   Financing (item 2, 3 and 5)

   Question: Who pays for the treatment and exactly what medication are you on currently?

5.   Economic outcomes (item 15)

Question: What is the impact of the illness on your household finances, how much do you spent?

(Probes)

a.   Transport?

b.   Medicine?

c.   Food?

d.   Other physical illness?

6.   Health outcomes (item 13 and 4)

Question: How has the illness impacted on you and your family?

(Probes)

a.   *What was your life like before now?*

b.   *How is your life now?*

c.   *How is your health?*

d.   *How well are your other family members doing?*

7.   **Provision & Resources (item 8, 9 and 12)**

Question: Where do you get support?

    (Probes)

a.   *What kind of assistance do you receive from the health service?*

b.   *What other kind of assistance do you receive in the community?*

c.   *What kinds of assistance can the health service gives you that would make the most difference to your life?*

8.   **Provision (item 10)**

Question: What does your family provide for you and what do you do yourself?

    (Probes)

a.   *How you in any employment/school?*

b.   *What have been your most challenging/difficult times?*

c.   *What are the happy moments in your life?*

9.   **Resources (item 6, 7 and 14)**

Question: Are you getting the necessary professional help?

(Probes)

a.   *Are you satisfied with health the care professionals?*

b.   *Are you satisfied with the treatment?*

c.   *By what means did you get here?*

d.   *How long did it take you to get here?*

10.   Outcome (item16)

Question: What is your life like?

(Probes)

a.   *How are you looked upon at work/school, community?*

b.   *Do you take part in community activities?*

c.   *What would you consider most useful to improve service?*

DEMOGRAPHIC DATA FOR CLIENTS

Tribe:
Gender: (a) Male ☐   (b) Female ☐

Age: (a) 18-25 ☐   (b) 26-35 ☐   (c) 36-45 ☐   (d) 46-55 ☐   (e) 56-65 ☐   (f) 66-75 (g) 76

and Above

Marital Status: (a) Single ☐   (b) Married ☐   (c) Divorced ☐   (d) Widow ☐

(e) Widower ☐

Educational Level: (a) Primary ☐   (b) Secondary ☐   (c) Tertiary ☐   (d) None ☐

Occupation: (a) Self employed ☐   (b) Trader ☐   (c) Farmer/fishing ☐   (d) Public Servant ☐

(e) Company Staff ☐ (f) House wife ☐

Religion: (a) Christian ☐   (b) Muslim ☐   (c) Pagan ☐ (d) Traditional ☐

Current Employment:
Previous Employment History:
Diagnosis:
Duration of Onset of Illness:
Admission Rate:
Any history of mental illness in the family:
Type of medication:
Compliance with treatment regimen:
Compliance with follow-up care:

ANNEXURE 5:

INTERVIEW GUIDE FOR SERVICE PROVIDERS

Title of study: Policy Implementation: Implication on caregiving experiences of families and persons living with serious mental health problems in Nigeria

The policy template as a conceptual framework will be used to ask questions on each domain and elements however these questions will be interwoven within the elements and domain to be able to solicit required data.

1. Pathway to care (items 1, 4 and 10)

Question: Tell me the type of patients that comes to this hospital?

2. Provision domain (items 7, 8 and 9)

Question: Which type of health service are you providing?

3. **Individual outcome (item 13)**

Question: How is the client's health when they start using this facility?

4. Financing (items 2, 3 and 5)

Question: Who pays for the treatment clients receive?

5. Economic outcomes (item 15)

Question: What is the impact of this health service on the client and his family?

6. Health outcomes (items 13 and 4)

Question: How does the facility maintain continuity of care to promote clients' and family wellbeing?

7. Provision & Resources (items 8, 9 and 12)

Question: How is the hospital supported?

(Probes)

What kind of assistance does the hospital receive from ministry/ NGOs?)

8. Provision (item 10)

Question: How is community psychiatric care rendered?

9. Resources (items 6, 7 and 14)

Question: What are the challenges in rendering psychiatric care in the community?

10. Outcome (item 16)

Question: How can mental health care service be integrated into primary health care?

What are the contributions of this service to clients?

ANNEXURE 6:

DEMOGRAPHIC DATA FOR SERVICE PROVIDERS

Tribe:
Gender: (a) Male   (b) Female

Age: (a) 18-25 ☐ (b) 26-35☐ (c) 36-45 ☐ (d) 46-55 ☐ (e) 56 & Above☐

Marital Status: (a) Single ☐ (b) Married ☐ (c) Divorced ☐ (d) Widow ☐

(e) Widower ☐

Educational Level: (a) Secondary ☐ (b) Diploma/Higher Certificate ☐ (c) Tertiary ☐

Professionals: (a) Nurses ☐ (b) Psychiatrist ☐ (c) General Physician ☐

(d) Psychologist ☐ (e) Pharmacist ☐ (f) Social worker ☐

Religion: (a) Christian ☐ (b) Muslim ☐ (c) Pagan☐ (d) Traditional☐

Years of experience on current position:

ANNEXURE 7:

INFORMATION SHEET

Study title: Policy implementation: implication on caregiving experiences of families and persons living with serious mental health problems in Nigeria

Introduction:

Good day and warmest greetings to you! I am Izibeloko Jack-Ide a PhD student from the University of KwaZulu-Natal, School of Nursing, Howard College Campus, Durban, South Africa, doing research on "Policy implementation: implications on caregiving experiences of families and persons living with serious mental health problems in Nigeria"

The research study is a process to assist in understanding how people with serious mental health problems and their families currently experience the health care they receive from the public health sector. I will develop policy proposals based on this study and I hope that this will lead to service improvement in Nigeria.

Invitation to participate: I am here by inviting you to participate in the study. Your role in this study will be to be interviewed by the researcher and asked to questions on the caregiving and also participate in a focus group discussion with other caregivers. This study will take about one to one and half hours of your time, depending on the type of information you will be willing to share for the study.

Risks of being involved in the study: This so far does not involve any risk or harm to you as a result of participating. You will be interviewed at a place that is most convenient to you. Privacy will be ensured at all times, if you do not wish to be interviewed or questioned in any

areas please indicate this to the researcher and your wish will be respected. Your name and identifying data will not be disclosed to anyone. However, if you take part in a focus group, your fellow participants will know you and the information you share.

Benefits of being in the study: You will be given pamphlets on issues of mental health and disorders. After the results of the study are available, the policy proposals will be shared with you.

Participation in the study: Your participation in this study is voluntary and you are free to decline to participate or choose to participate in the study. You are assured that refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue participation at any time without penalty of or loss of benefits if you wish to do so.

Reimbursements for "out of pocket" expenses: There are no funds available for this research, the researcher will not be financially responsible for any cost incurred during your visit to the health facility. The study will be conducted on the spot during participants visit to the facility or the researcher will go to participants home.

Confidentiality: You are assured that all information provided will be kept in the utmost secrecy and participants name will not be recorded on any of the documents provided for the study. Efforts will be made to maintain confidence with every personal information shared with

researcher. Any information collected during the study, will be accessed only by the researcher and used for the final reporting granting anonymity.

Contact details of researcher: If you have any question or further information on the study, please feel free to ask me and my supervisors.

Primary Supervisor: Prof Leana Uys   Researcher: Izibeloko O.Jack-Ide

                                            Tel. No: +0788550525

Email: UYS@ukzn.ac.za   Email: 209527704@ukzn.ac.za

Co- Supervisor: Dr Lyn Middleton   Email: middleton@ukzn.ac.za

ANNEXURE 8:

CONSENT DECLARATION FORM

Study title: Policy Implementation: Implication on caregiving experiences of families and persons living with serious mental health problems in Nigeria

The research study, including the above information, has been described to me orally. I understand what my involvement in the study means and I voluntarily agree to participate. I have been given an opportunity to ask any questions that I might have about participation in the study. I understand that I am at liberty to withdraw from the project at any time, should I so desire.

Signature of participant: _____   Date: _____

ANNEXURE 9:

CONTENT VALIDITY OF INSTRUMENT

S/N	Component of theoretical framework	Element Numbers	Question number
1	Societal and cultural organization, population needs /demand and personal health needs (prevailing social economic, cultural and political contexts that impact on mental health)	1, 4 and 10	1. Tell me how your illness started and what you did?
2	Physical facility, consumables and social capital (all mental health and related services that are or should be provided to the community in order to prevent and treat mental illness and promote mental health and well-being).	7, 8 and 9	2. Which health service are you using currently and what are they doing for you and your family?
3	Health population, community, family and individual health (Changes in functioning, morbidity or mortality that are attributable to the treatment and care received).	13	3. How is your/the client's health like now?
4	Public policy and financing (Financing of health and mental health services comes from a combination of sources within the public and private sectors).	2 and 5	4. Who pays for the treatment and exactly what medication is the client taking?

5	Economic outcomes (The economic consequences of mental health intervention, or lack of intervention, to the community as a whole as well as the individual, their family and other carers).	15	5. What is the impact of caring for the patient on your household finances, how much do you spent?
6	Health outcomes on individual (Direct and indirect costs, productive role, externalities poverty in the individual and population).	13 and 4	6. How has the illness impacted on you and your family?
7	Essential drugs, social networks and intersectoral collaboration (relationships between mental health services and those social services that influence individual mental health outcomes and general well-being. E.g. welfare, religious, educational, rehabilitation, vocational, employment, accommodation, correctional, police and other services required by people with mental illness and disability).	8, 9 and 12	7. Where do you get support?
8	Personal mental health services (services provided at the level of the individual— whether for prevention, treatment, rehabilitation or health promotion and well-being.	10	8. What does your family provide for you and what do you do for the client?

9	Human resources and physical capital (clinical and non-clinical staff; complementary and religious or traditional healers and NGOs as well as families and carers, health facilities beds and equipment, day treatment, rehabilitation facilities and community clinics, non-health infrastructure such as roads, schools and prisons).	6, 7 and 14	9. Are you satisfied with health care professionals?
10	Governance and social outcomes (Issues of governance, population need and demand, and the environmental/social factors that influence the health of the population).	3 and16	10. What is your social life like?

RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL: sshrec@ukzn.ac.za

UNIVERSITY OF
KWAZULU-NATAL

26 MARCH 2010

MRS. IO JACK-IDE (209527704)
SCHOOL OF NURING
HOWARD COLLEGE CAMPUS

Dear Mrs. Jack-Ide

PROTOCOL REFERENCE NUMBER: HSS/0773/09D
PROJECT TITLE: "Policy Implementation: Implication on caregiving experiences of families and persons living with Serious Mental Health Problems in Nigeria"

FULL APPROVAL NOTIFICAITON – COMMITTEE REVIEWED PROTOCOL

This letter serves to notify you that your response in connection with the above study has now been granted full approval by the Social Sciences & Humanities Research Ethics Committee:

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study.

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Best wishes for the successful completion of your research protocol

Yours faithfully

PROF. S COLLINGS (CHAIR)
SOCIAL SCIENCES & HUMANITIES RESEARCH ETHICS COMMITTEE

cc. Supervisor (Dr. L Middleton)
cc. Prof. L Uys
cc. Mr S Reddy

Founding Campuses: ▬ Edgewood   ▬ Howard College   ▬ Medical School   ▬ Pietermaritzburg   ▬ Westville

223

GOVERNMENT OF RIVERS STATE OF NIGERIA

Your Ref:

Our Ref:

MINISTRY OF HEALTH
MEDICAL SERVICES DEPARTMENT
STATE SECRETARIATE COMPLEX
BLOCK ,A
PORT HARCOURT
Tel:084741552
E-Mail: rivmedserv@yahoo.com
19th March, 2010.

Mrs Izibeloko O. Jack Ide
School of Nursing
College of Health Sciences,
Howard College,
University of Kwazulu –Natal,
Durban, South Africa.

Madam,

Approval to conduct data collection in Neauro-Psychiatric Hospital Rumuigbo: on study titled- Policy Implementation: Implication on care giving experiences of families and persons living with serious mental health problems in Nigeria.

With reference to your letter on the above subject dated 22nd October, 2009.

I am directed to forward to you the approval of the Rivers State Ministry of Health to carry out the study at the Neuro-psychiatric Hospital Rumuigbo, Port Harcourt.

I am further directed to inform you that the study must be carried out within the limits of international approved standard on study involving humans.

Wishing you the best.

Dr. Mandah Chijioke
For: Director, Medical Services.

RIVERS STATE HOSPITALS MANAGEMENT BOARD

NEURO-PSYCHIATRIC HOSPITAL,
RUMUIGBO,
P.M.B. 6244,
PORT HARCOURT.

Our Ref:..........................

13/01/2010

Your Ref:..........................
Telephone: (084) 238242

..........................200.......

Mrs. Izibeloko O. Jack-Ide
School of Nursing
College of Health Sciences,
Howard College,
University of KwaZulu-Natal,
Durban, South Africa.

Madam,

Approval to Conduct Data Collection in Neuro-Psychaitric Hospital Rumuigbo

With reference to your letter dated 2nd November, 2009, requesting for approval to conduct data collection on a study titled **"Policy implementation: Implications for caregiving experiences of families and persons living with serious mental health problems in Nigeria"** for your Doctoral thesis at the University of Kwazulu-Natal, Durban, South Africa.

The Ethics Committee of the Neuro-Psychiatric Hospital, Rumugbo, Port Harcourt hereby approve your application and grant you permission to conduct and collect data hoping that, you will adhered strictly to the rules governing the conduct of research in this hospital. We assure you the co-operation of staff and all those that may be involved during the data collection process. Wishing you the best in your academic pursuit.

Signed..........................
Date..13/01/2010..........................
Dr Elizabeth E. Wilcox
Chairman Ethics Committee

ANNEXURE 13: ACCEPTANCE OF MANUSCRIPT FOR PUBLICATION INTERNATIONAL JOURNAL OF NURSING AND MIDWIFERY

Subject:	IJNM-12-002 has been accepted/Payment Reminder
From:	International Journal Nursing and Midwifery (ijnm.manuscripts@gmail.com)
To:	izibelokojackide@ymail.com;
Date:	Monday, 2 April 2012, 10:03

Academic Journals
www.academicjournals.org

Dear Dr. Izibeloko Jack-Ide,

I am pleased to inform you that your manuscript **IJNM-12-002** has been accepted for publication in the **International Journal of Nursing and Midwifery (IJNM).** There are some corrections which we will make before the proof is sent to you.

Please note that your manuscript will be included for publication and the Official Acceptance Letter will be sent to you after you have effected payment for your article. Kindly make payment as soon as possible to enable us include your manuscript in the next publication.

Kindly make payment directly into any of our accounts below:

1	**Bank Name:** Citibank New York **Address:** 111 Wall Street 19th Floor New York 10043 **Swift Code:** Citius33xxx Or Aba 021000089 **Account Name:** Stanbic IBTC Bank (SWIFT CODE: SBICNGLX) **Account No:** 36127476 **For The Account Of:** Academic Journals Limited, Account No. 7300097461
2	**Bank Name:** Standard Chartered Bank **Address:** 1 Aldermanbury Square London **Swift Code:** Scbl Gb2l Sort Code 60-91-04 **Account Name:** Stanbic IBTC Bank (SWIFT CODE: SBICNGLX) **Account Number:** 01 01 2541432 50 USD **For The Account Of:** Academic Journals Ltd, Account No: 7300097461
3	**Bank Name:** Commerzbank Ag **Address:** Kaiserplatz 60261 Frankfurt Am Main **Swift Code:** Cobadeffxxx **Account Name:** Stanbic IBTC Bank (SWIFT CODE: SBICNGLX) **Account Number:** 400/8801037/01 USD **For The Account Of**: Academic Journals Ltd, Account No: 7300097461

Please do not send cheque or bank draft

Contact us if you prefer to use Western Union.

Kindly send a confirmation e-mail to accounts_acadjourn@yahoo.com

Kindly include your manuscript number. We appreciate your publishing with us.

 Best regards,

 Lucky Eni,

Edirorial Assistant.

International Journal of Nursing and Midwifery (IJNM)

E-mail: ijnm.acadjourn@gmail.com

ANNEXURE 14: ACCEPTANCE OF MANUSCRIPT FOR PUBLICATION INTERNATIONAL JOURNAL OF MENTAL HEALTH NURSING

Print - Close Window

Subject:	International Journal of Mental Health Nursing - Decision on Manuscript ID IJMNH-1279.R3
From:	b.happell@cqu.edu.au (b.happell@cqu.edu.au)
To:	izibelokojackide@ymail.com;
Date:	Friday, 18 May 2012, 7:32

18-May-2012

Dear Ms. Jack-Ide:

I am pleased to advise that your manuscript entitled "Caregiving experiences of families of persons with serious mental health problems in the Niger Delta Region of Nigeria." has been accepted for publication in a future edition of the International Journal of Mental Health Nursing.

Please forward your completed copyright form to Ms Jasmine Sng - INM@wiley.com. The copyright form can be found at: http://www.blackwellpublishing.com/pdf/inm_elf.pdf.

You will be provided with a PDF offprint of your article once it has been published. In order to retrieve it, you will be required to register with Wiley-Blackwell's Author Services facility (http://authorservices.wiley.com/bauthor/register.asp). Author Services is a resource offered to authors of papers published by Wiley-Blackwell which offers you the facility to track the production of your article. If you don't wish to track production, you can still enjoy many benefits of registering with Author Services, such as having free online access to your article in perpetuity, information on how you can claim a 25% discount on books published by Wiley, and, to increase readership and citations of your article, Author Services lets you and your co-authors nominate up to 10 colleagues each to receive a publication alert and gain free access to your published article. All article accesses via Author Services count towards the article's overall online usage. We plan to develop new features in the future that will apply to all previously registered articles. News of these upcoming features will appear on the website.

Sincerely,
Prof. Brenda Happell