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Use of Mental Health Services in Primary Health Care Delivery Systems in a Developing Country: A Survey of Selected General Hospitals in Delta State Nigeria

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Abstract

Studies on the use of mental health services in Nigeria are scarce. Most of the existing studies have focused on psychiatric illnesses. However the context for the assessment and treatment of many mental health disorders in developing countries including Nigeria is moving from mental hospitals to primary health care providers (PHC). This present study was conducted in Delta State Nigeria to assess the use and provision of mental health services in PHCs (General Hospitals). Two sets of questionnaires were used for the study; one set was given to health practitioners (15), while the other was given to 50 community respondents who were patients in these facilities. The results show that there is low utilization of mental health services in PHCs. In addition, patients do not have a positive attitude towards the use of formal mental health services and also lack an awareness of the availability of these services in PHC settings.

Keywords: Mental health, Primary health care settings, General hospitals, Niger Delta, Nigeria, Developing countries.

Contents

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1. Introduction

Globally, mental health disorders constitute a major source of disability and persons with mental health disorders have high mortality rates in middle and low income countries (Wang *et al.*, 2007; Eaton *et al.*, 2011; Whiteford *et al.*, 2013). Mental health disorders also increase the likelihood of living in poverty (Ngui *et al.*, 2010) and creates significant cost to patients and their families in terms of burden of care (JackIde *et al.*, 2013). Uwakwe and Otakpor (2014) pointed out that middle and low income countries have significantly low levels of resources and qualified personnel for the provision of mental health services. In Nigeria, mental health services are in a parlous state (Eaton and Agomoh, 2008) and there is a significant treatment gap as a result of the unavailability of a coordinated treatment system, qualified mental health personnel and funding (Eaton *et al.*, 2011). According to the Central Intelligence Agency (CIA), less than 5.8 of Nigeria's GDP is spent on spent health expenditures (CIA, 2009). The World Health Organization reported that less than 2% of health funds are spent on mental health treatment in Nigeria (World Health Organization, 2006). The existing mental health policy document was formulated in 1991 and there are only eight psychiatric hospitals, eight psychiatric nursing programs and twelve medical schools that cater to the mental health needs of over 158 million people (JackIde *et al.*, 2013; World Bank, 2016). Thus, formal orthodox mental health establishments cater mostly to the need of severe mental health issues such as psychiatric illnesses (Adewuya and Makanjuola, 2005; Adewuya and Makanjuola, 2008; Eaton and Agomoh, 2008) while the bulk (approximately 70%) of mental health services are provided by religious organizations and traditional healers (Gureje *et al.*, 2006).

Results of previous studies conducted in high income countries showed that health practitioners in general health settings are often the pathway to early diagnosis of mental disorders. As a result, a simplified diagnosis and treatment guideline was developed and launched by the WHO (2008). In 2010, Nigeria was one of the countries selected for the adoption of this new simplified diagnosis and treatment guideline referred to as the Mental Health Gap Action program (mhGAP). The initiative focused on early detection and management of common mental health disorders such as depression, alcohol and other substance use disorders and epilepsy in the primary health-care settings. The program extends competence in diagnosis and management to non-mental health specialists including doctors, nurses and other health providers (WHO, 2008). The aim was for individuals to receive treatment through the more accessible general health practitioner without going to a specialist. The program allowed physicians in PHCs to prescribe psychotropic medications without restrictions. Also, non-physicians working in these settings were also permitted through this initiative to prescribe medications in situations of emergency (WHO, 2006). However, it remains to be seen how effective this policy has been in the provision of mental health services in primary health care (PHC).

The Niger Delta region comprises nine states in the country: Akwa Ibom, Cross River, Rivers, Edo, Delta, Bayelsa, Imo, Abia and Ondo. The region has over 40 ethnic groups and has a population of approximately 31 million people speaking over 250 dialects (Erhabor *et al.*, 2010). Delta and Rivers states are the dominant oil producers, producing approximately 75 per cent of Nigeria's oil reserves (World Bank, 2016). The region has also been plagued by conflicts, human rights violations and traumatic events that engender the development of mental disorders (Beiser *et al.*, 2010). Beiser et al. further noted that individuals that experience or survive such human-initiated disasters are at high risk for mental health disorders.

The context for this study is general hospitals in Delta State. General hospital settings were targeted as primary health care centers for the study because they were accessible, cost effective and offered mental health services alongside general medical practice. There are 62 state-government owned hospitals spread across the 25 local government areas of the state under the management of the Delta State Hospitals Management Board (DSHMB). These hospitals are structured into 11 medical zones with the headquarters located in Asaba (the state capital). The headquarters is responsible for coordinating and managing the activities of the hospitals through the respective zonal management committees. Each zone is headed by a medical consultant who serves as the director. These hospitals provide the bulk of general health services to individuals in the state.

2. Statement of the Problem

Delta State with a population of 4,098,291 (males: 2,674,306; females: 2,024,085), has a total land area of 16,842 square kilometers (6,503 sq. mi). The state has witnessed an increase in population due to influx of people attracted by oil exploration, and have also been the center of militancy and armed conflicts. Even with the billions of petro-dollars, there exist a host of environmental and social problems: environmental degradation and pollution, poverty, unemployment, collapsing basic infrastructure, insecurity, low life expectancy and high infant mortality rate. These significant environmental and social factors create stress or trauma which further prompts depression and other forms of mental disorders including substance abuse. However, there have been no known study that have examined both the public awareness and use of mental health services in PHC settings. According to WHO (2008) efforts to address mental health problems are significantly hampered by the absence of reliable data within and across countries. The current study therefore attempts to address the gap by examining the use of mental health services in PHC settings. In addition, the study also focuses on identifying the types of mental health services provided in PHC setting, practitioners' assessment of the adequacy of such services as well as the barriers or factors that impact access or the delivery of mhGAP in PHC settings

3. Methods

3.1. Participants and Sampling Technique

The participants for the study are medical professionals (General medical Practitioners, Consultant Psychiatrists, Social Workers and Nurses), as well as patients that receive services in one of the 11 medical zones in Delta state. Due to the fact that some of the patients were not able to read the questionnaires or were not fluent in English language, they were assisted by the primary researcher to complete the questionnaires. A multistage probability

sampling technique was used to select the participants (Galway *et al.*, 2012). In the first stage of the sampling, an ordered list was made of all the general hospitals in Delta States according the zones (11 zones). Each zone was considered a cluster and one cluster was chosen for the study. In the second stage, one cluster/zone consisting of two hospitals (Warri Zone) was chosen for the study.

3.2. Instruments

Two sets of Questionnaire were developed for the study; one for health professionals and the other for respondents receiving medical treatment at these centers. A total of 130 questionnaires were distributed in the ratio of 30 for health professionals and 100 for patients. The questionnaires completed by respondents included questions on demographics, awareness and use of mental health services, factors and situations constraining access to mental health services in primary health care settings, efforts made to extend competence in diagnosis and management of mental health, and how current services have met or have not met the mental health needs. A total of 65 participants completed responses to the questionnaires.

3.3. Procedures

Procedures for obtaining informed consent and protecting participants were approved and monitored by the management boards of each hospitals participating in the surveys. Written informed consent was attached to every instrument that was given to be completed by respondents. The questionnaires for the staff were dropped off at their offices and collected after two to three days, whereas questionnaires for patients were completed at the hospitals. The questionnaires were given to respondents by hand and later collected at an agreed time period. Participants unable to complete the questionnaires were assisted by the researcher verbally asking the questions and selecting the right responses.

3.4. Data Analysis

The Statistical Package for the Social Sciences (SPSS 23.0) was used to analyze the data. Descriptive statistics such as simple percentages (%), averages and standard deviations (SD) were calculated to achieve the purpose for the study.

3.4. Results

3.4.1. Description of Subjects

The demographic characteristics of the study participants are presented in Tables 1 and 2. Overall for professionals, 2.6% (n = 4) were general medical practitioners, 2% (n =3) were consultant psychiatrists, 2% (n=3) were social workers and 3.3% (n =5) were nurses. In addition, 12(7.9%) of the participants who were patients were public servants, 15(9.9%) were traders, 5(3.3%) were unemployed, 18 (11.8%) were unemployed. In terms of patients gender, there were more female participants (n = 35 or 77%) than male patient participants (n = 15 or 33%). With regard to the employment, a greater proportion (11.8%) of participants were self-employed, whereas only (3.3%) were unemployed. The largest participants age group was between 20 to 29 years (n = 24 or 27.8%).

Table-1. Demographic Characteristics of Professionals

Variable	n	%
Occupation		
General Medical Practitioner	4	26.6
Consultant Psychiatric	3	20
Social workers	3	20
Nurses	5	33.3

Source: Author's Computation from Survey Data, 2016

Table-2. Demographic Characteristics of Patients

	Variable	n	%
Occupation			
	Public Servants	12	24
	Traders	15	30
	Unemployed	5	10
	Self-employed	18	36
Age			
	< 20		
	20 – 29	24	42
	30 – 39	24	42
	40 – 49	13	26
	50 or >	4	8
Marital Status			
	Single	32	64
	Married	18	36
Gender			
	Male	35	70
	Female	15	30

Source: Author's Computation from Survey Data, 2016

3.4.2. Service Utilization

Tables 3 the service utilization information. As shown in Table 3, the most common mental health condition for

which patient received treatment in general hospital settings was mood disorders (n = 7, or 4.6%), whereas, the least was comorbid disorder (n = 5 or 3.3%). Patients who present for routine checkup and treatment (n = 7, 4.6%), and were diagnosed or recommended for mental health services were twice the number for those referred by family and other health institutions (n = 4 or 2.6%). 10 (66.6%) of health professionals responded that patients do not have a positive attitude towards the mental health services provided for their diagnosis, and many do not show up for follow up treatment. In terms of barriers to the use of services, 10 (66.6%) was attributed to beliefs about causation, 5(3.3%) was attributed to problems with access to treatment and services, 7(4.6%) to cost of medication and services. Others include stigma 5(3.3%), and mistrust of health professionals and treatment methods 10(6.6%). Specific services provided to the patients included diagnosis and medication, 11(7.2%), counseling 4 (2.6%) and referral to psychiatric hospitals 10 (6.6%). With regard to use of mental health services 35 (%) of patients reported that they have seen some type of professional for emotional distress/depression. 15(%) of patients reported that they have been taken to the hospital by family members for problems related to substance use and emotional disorder.

Table-3. Service Utilization

Variable		n	%
a.	Common Mental health conditions treated		
	Mood disorders	7	46.6
	Substance Abuse disorder	3	20
	Comorbid disorders	5	33.3
b.	Referral Source		
	Routine patient check-up/treatments	7	46.6
	Family/friends	4	26.6
	Other health institutions	4	26.6
c.	Barriers to use of Services	10	66.6
	Beliefs about causation	5	33.3
	Problems with access to treatment and services	5	33.3
	Cost of medication and services		
	Stigma	5	33.3
	Mistrust of health professionals and treatment methods/No follow-up	10	66.6
	Limited knowledge about mental health services	8	53.3
d.	Specific services provided		
	Diagnosis and medication	11	73.3
	Counseling	4	26.6
	Referral for psychiatric services	10	66.6
e.	Mental health conditions for which Services were received		
	Emotional distress	35	70
	Substance abuse and emotional distress	15	30

Source: Author's Computation from Survey Data, 2016

4. Discussion

The purpose of the present study was to assess the use of mental health services in primary health settings. Consistent with previous studies, only a small number of respondents patronize primary health care (general hospitals) for the treatment of emotional distress or co-occurring substance abuse and emotional disorder. Gureje *et al.* (2015) reported that only a small numbers of clients were seen for mental, neurological and substance use disorders in primary health centers despite the availability of services and a limited number of trained personnel. This finding likely reflects the lack of awareness among the general population of the existence or availability of such services. Government agencies charged with public health responsibilities or for social enlightenment may need to draw up programs to engage communities and ensure the acceptance and increase use of formal mental health services.

In addition, health professionals also reported that patients do not have a positive attitude towards the mental health services provided for their diagnosis, and many do not show up for follow up treatment. This finding is similar to McMurray and Smith (2001) observation that patients in many developing countries often fear or distrust western medicine. In addition, patients may use their experiences in accessing general health services to make sweeping assumptions about the quality and efficacy of mental health services that are available in these government owned hospitals.

5. Conclusion

This study has two limitations; the first involve sampling issues. Participants in this study consisted of a fairly small number of patients. Therefore, the results of this study may not be representative of the entire population. A larger sample may have allowed for more variation among participants level of prior contact with the mentally ill. Second, the design of the study which was cross sectional in general presents its own limitations. A longitudinal study that is carried out over two to three years may provide better information on mental health service utilization in PHC settings.

However, the results does provide great insight to service utilization patterns in general hospital settings. As can be observed and consistent with previous studies, there is generally a low utilization of mental health services in general hospitals and this is largely connected with the general attitudes towards to formal mental services and a lack of awareness of such services. However, it is pertinent to point out that utilization of services can be affected by other interacting factors such as the cultural and religious beliefs about causation as well as individuals' help-seeking behavior.

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