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Help-seeking behaviour of individuals with mental illness before pursuing professional mental health care services in Lagos, Nigeria

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Abstract

Introduction: Due to the social stigma associated with mental illness, to avoid the stigma, individuals with mental illness opt to seek help from variety of sources before eventually accessing professional mental health care. This study investigated the help-seeking behaviours, delays to psychiatric care and the association between help-seeking pattern and sociodemographic characteristics of mentally-ill patients visiting a teaching hospital in Lagos.

Methods: A total number of 94 patients seen at the outpatient's clinic of the department of psychiatry of Lagos State University Teaching Hospital, Ikeja, Lagos, Nigeria for the first time were recruited for the study. They were interviewed with the ICD-10 and World Health Organization Pathway Encounter Form for psychiatric care.

Results: Three major help-seeking gateways to professional psychiatric care were identified. Majority of the participants 63% patronised the indirect routes while about one third 37.3% sought for direct professional psychiatric care. Depression and schizophrenia were the commonest diagnoses. The delays ranged from 3 weeks to 44 weeks for those that patronised the direct route and 2 weeks to 416 weeks for participants who utilised the indirect routes. Depression ($X^2=0.03$, $p=0.84$), schizophrenia ($X^2=0.39$, $p=0.53$), neurotic disorder ($X^2=0.46$, $p=0.49$), and mania ($X^2=1.29$; $p=0.25$) were more prevalent in females although the relationship between the sex distribution were not statistically significant.

Conclusion: The help-seeking behaviours of mentally-ill patients in Lagos Nigeria were predominantly the indirect routes. There is an urgent need for regular public education, advocacy and awareness mental health campaigns to provide knowledge about the aetiologies of mental illness to further to reduce the social stigma associated with mental illness. The local, state and federal governments of Nigeria should as a matter of urgency integrate mental healthcare into primary healthcare.

Keywords: Help-seeking behaviours, mentally-ill patients, Lagos, Nigeria

Introduction

Mental disorders have been reported to be global health concern [1]. About 500 million people were reported to be suffering from mental illness globally and only a small fraction of these patients receive professional psychiatric care especially in the low and middle-income countries [1-4]. Nigeria is a developing country located in the western part of Africa, with a massive population of 180 million people. The available mental health personnel are scanty [5-6]. There were 0.028 mental health outpatient facilities per 100,000 population and less than 300 specialist psychiatrists [5-6].

Although, specialist mental health hospitals were observed to be few and are mostly located in capital cities isolated from the rural communities making professional psychiatric services inaccessible and far from those living in rural areas [5-6]. For this reason, Nigerian mentally-ill patients patronise the local traditional and faith-based healers close to their communities and resort to modern orthodox psychiatric treatment after failing to get the desired healing from the traditional and faith-based healers [4-7]. However, erroneous beliefs in supernatural and spiritual aetiologies of mental disorders, social stigma, discrimination and social distance towards individuals with mental illness were also reported to influence the choice of help-seeking behaviours for mental disorders in developing countries including Nigeria [2, 4-7].

The help-seeking behaviours of the mentally-ill in low and middle-income countries were observed to be diverse and based on the sociocultural, economic factors, availability and accessibility of specialist mental health hospitals [2-4, 7-9].

Similarly, the reported diverse help-seeking behaviours observed among the Nigerian mentally-ill could also be due to these identified factors [4-7]. However, help-seeking behaviours of the mentally-ill and their close relations were also identified to be similar in many low and middle-income countries such as India, Bangladesh, Ethiopia and China [2-3, 8-10]. Studies also indicated that the mentally-ill from the high-income countries would rather prefer to be treated by the family physicians, general practitioners at the primary care level [11].

It is therefore important that policy makers should have an understanding of the help-seeking attitudes of the mentally-ill is necessary for effective planning of mental health services, training of mental health care personnel, the integration of mental health services into primary care and recognition of delays to professional care [8-11]. In the same vein, it is also desirable to find out the particular reasons why Nigerian families of the mentally-ill perceive mental disorders and their reasons for choosing nonorthodox help-seeking attitudes. This is important because the acquired knowledge could be helpful in providing public education, advocacy, outreach and awareness programmes with regards to the aetiologies of mental illness and the availability of professional mental health care services within the communities [1,5-7].

Scientific studies on help-seeking behaviours of the mentally-ill especially in Nigeria and the sub-Saharan Africa were scanty and mostly out-of-date [12-14]. It is therefore necessary to learn more about prior psychiatric help-seeking behaviours of Nigerians whether it has changed from findings of two decades ago or not. It is also believed that the findings of this study of Nigerians with mental illness will also create recent knowledge that will be useful for health policy makers in Nigeria.

The strength of help-seeking studies is that they determine various types of help-seeking behaviours of the mentally-ill, and studies on this topic can be carried out quickly with minimal resources [1, 11, 15]. It was in this light that this study was designed to investigate the help-seeking behaviours of the mentally-ill patients, delays to psychiatric care and the association between help-seeking and sociodemographic characteristics of patients visiting a teaching hospital in Lagos, South-western, Nigeria.

Materials and Methods

Study location

The study took place at the department of psychiatry of the Lagos State University Teaching Hospital, Ikeja, Lagos, Nigeria. The hospital is located at Ikeja, the capital city of Lagos State. It has 30 wards with 640 beds and also runs 25 outpatients' clinics. It runs in and outpatient services with 24-hour medical and surgical emergency services. It also offers undergraduate training for medical students and postgraduate training for resident doctors. The teaching hospital attends to patients largely from Lagos city, a metropolis with a population of more than 20 million people. The hospital provides primary, secondary and tertiary healthcare services to the citizens of Lagos State due to its open door, walk-in government policy. There are no conditions for appointments or referrals to the general outpatients' department or the medical or surgical emergency departments of the hospital. The department of psychiatry runs an outpatients' clinic twice weekly. It also runs a clinic once a week for newly-referred patients. The

department attends to about 60 to 80 patients per clinic day. The department has four consultant psychiatrists and 8 resident doctors.

Design and sampling

The study was a hospital-based, cross-sectional, descriptive study that took place between November and December 2017. The study also used convenience sampling method by recruiting all newly registered patients that agreed to participate in the research at the outpatients department of the department of psychiatry of the Lagos State University Teaching Hospital, Ikeja, Lagos, Nigeria.

Measures

The recruited individuals were asked to complete the World Health Organisation Pathways Encounter Form [11, 15]. The diagnoses were made according to the guidelines of the WHO International Classification of Diseases [16].

Participants

Patients who registered and attended outpatients' clinic of the department of psychiatry, Lagos State University Teaching Hospital, Ikeja, Lagos, Nigeria for the first time were recruited for the study. This study adopted the methods of the World Health Organisation (WHO) pathway multicentred study conducted in Eastern Europe which demonstrated that the sample size of 50 participants was modest and sufficient as representation for gateway to care [11-15]. However, 100 participants were recruited for this study and only 94 questionnaires were properly filled. All the recruited patients were interviewed with the semi-structured World Health Organisation Pathways Encounter Form [11-15]. The form took about 5-10 minutes to complete.

Definition of pathways and delays

Help-seeking routes refers to the sequence of contacts the mentally-ill person makes with medical services provided by individuals or organisations, prompted by the efforts of the distressed person or his close family members in the process of seeking treatment. These routes include the point when mental health symptoms were first recognised (onset point) and the point when the individual sought professional mental health care system (contact point). In between these two points the individual may have had contacts with other providers of medical care such as medical practitioner, faith-based or traditional healers that did not result in significant resolution of symptoms [17-18]. The delay in help-seeking is measured as the lag between onset and treatment point [17-18]. Previous contact points were settings where the individual with mental illness sought medical care for their mental disorders such as medical doctors, nurses, social workers, pharmacists, religious or traditional healers.

Ethics

Permission to carry out the study was sought from the Research and Ethics Committee of the hospital. Written informed consent was also obtained from every participant that took part in the study.

Data Analysis

Data collected were analysed with the Statistical Package for Sciences Solutions (SPSS Inc, version 23, NY, USA). Continuous and categorical data were described with means, standard deviations, numbers and percentages, respectively.

Chi-square (X^2) tests were used to explore associations between sets of categorical variables. Significance was put at $p < 0.05$. The routes to specialist psychiatric care were also compiled to produce a pathway diagram.

Results

There were more females 52 (55.9%) than males. They were within the 18 to 70 years; the age bracket 30 to 49 years were in the majority 42(44.6%) followed by the age bracket 18-29 years 31 (33.3%). Most of the participants 59 (62.8%) were married and living with their spouses; 44 (46%) were single. Of the participants, 61 (64%) were within the average socio-economical position, while 19 (20.7%) and 14 (15.2%) were within the above and below socio-economic positions respectively as shown in Table 1. Table 2 showed the ICD-10 diagnoses of the participants, past psychiatric history, who suggested referral for psychiatric care and whether participants lived in the survey area. The results also showed that depression 33 (33.5%) was the most common diagnosis followed by schizophrenia 22 (23.4%), neurotic disorders 9 (9.6%), mania 8 (8.8%) and bipolar affective disorders respectively. With regards to referral for psychiatric care, majority of the participants families 66 (70.2%) suggested that participants should receive psychiatric care, while 12 (12.8%) of the participants decided to seek for psychiatric care on their own, previous carer 8 (8.5%) and friends 6 (6.3%) also suggested that they seek for professional care. Similarly, majority of the participants 77 (87.5%) lived within the location where the study took place.

Table 3 shows the number of healers they visited before accessing specialist psychiatric care. From this study, there were three major routes to professional psychiatric care in Lagos, Nigeria. The first gateway was the direct route to professional psychiatric care, the second was the health workers route (hospital doctors, nurses, pharmacists), and third, the traditional or religious healers route. Of the number of participants, 35 (37.3%) used the direct professional psychiatric care route, followed by the health workers route 34 (36.2%) and 25 (26.5%) patronised the traditional and religious paths as reflected in Table 3.

With regards to delay in weeks from the onset of illness to professional psychiatric care, the duration of time from onset of illness to arrival at psychiatric care were shorter for participants that had direct contact with professional psychiatric care, compared with those that had indirect route to care. The long delays were experienced by participants with depression (416 weeks), schizophrenia (260 weeks), bipolar affective disorder (57 weeks), substance abuse and mania (18 weeks) respectively as shown in Table 4.

The univariate analysis did not show any statistical differences between the sociodemographic variables and the direct and indirect routes to care as shown in Table 6. However, Table 7 showed the relationship between the diagnoses and gender of the participants. Comparatively, depression ($X^2=0.039$, $p=0.84$), schizophrenia ($X^2=0.39$, $p=0.53$), neurotic disorder ($X^2=0.46$, $p=0.49$), and mania ($X^2=1.29$; $p=0.25$) were more prevalent in females than their male counterparts, although the relationship between the sex distribution were not statistically significant. Figure

1 shows the three major routes of the participants towards professional psychiatric care. About one third of the participants, 37(39.8%) accessed professional psychiatric care directly, 36.2% utilised the health workers routes while 26.5% patronised the traditional or religious healers routes.

Table 1: The sociodemographic characteristics of the participants

	Frequency (n)	Percent (%)
Sex		
Male	42	44.6
Female	52	55.9
Age (Years)		
18 – 29	31	33.3
30-39	21	22.3
40 – 49	21	22.3
50 – 59	9	10.1
50 – 69	8	8.0
Above 70	4	4.2
Marital Status		
Single	44	46.8
Married living together	42	44.6
Separated/divorced	8	8.51
Social Position		
Below average	14	15.2
Average	61	64.8
Above average	19	20.7

Table 2: ICD-10 Diagnoses of participants who sought for psychiatric care, their previous history, who suggested care and those who live in survey area

	Frequency (n)	Percent (%)
Diagnose		
Depression	33	33.5
Schizophrenia	22	23.4
Neurotic disorder	9	9.6
Mania	8	8.8
Bipolar affective disorder	8	8.8
Alcohol and substance abuse	7	7.4
Seizures	5	5.4
Alzheimer’s disease	2	2.1
Previous history		
Yes	35	37.2
No	59	62.7
Who suggested for care		
Family	66	70.2
Patient	12	12.8
Previous carer	8	8.6
Friends	6	6.3
Employer	2	2.1
Whether participant lives in Survey area		
Yes	70	74.4
No	24	25.6

Table 3: The major routes to medical care according to diagnoses of the participants

	Total Patients with new diagnoses (n) (%)	Religious/Traditional Care (n) (%)	Doctor/Nurse Pharmacist (n) (%)	Direct Psychiatric Services (n) (%)
Depression	33 (33.6)	10 (10.6)	14 (14.9)	9 (9.6)
Schizophrenia	22 (23.5)	8 (8.5)	7 (7.5)	7 (7.5)
Neurotic disorder	9 (9.6)	1 (1.06)	4 (4.3)	4 (4.3)
Mania	8 (8.9)	2 (2.1)	3 (3.2)	3 (3.2)
Bipolar affective disorder	8 (8.9)	-	3 (3.2)	5 (5.4)
Alcohol and substance abuse	7 (7.5)	4 (4.3)	-	3 (3.2)
Seizures	5 (5.5)	-	3 (3.2)	2 (2.1)
Alzheimer's disease	2 (2.5)	-	-	(2.1)
Total	94 (100)	25	34	35

Table 4: Delay in weeks on routes to care according to diagnoses of participants

	Total Patients with new diagnoses n (%)	Religious/Traditional care n (Duration)	Doctor/Nurse Pharmacist n (Duration)	Direct Psychiatric Services n (Duration)
Depression	33 (33.6)	10 (416)	14 (12)	9 (13)
Schizophrenia	22 (23.5)	8 (260)	7 (2)	7 (44)
Neurotic disorder	9 (9.6)	1 (2)	4 (2)	4 (4)
Mania	8 (8.9)	2 (18)	3 (2)	3 (8)
Bipolar affective disorder	8 (8.9)	3 (57)	3 (18)	2 (16)
Alcohol and substance abuse	7 (7.5)	4 (18)	-	3 (3)
Seizures	5 (5.5)	-	3 (3.2)	2 (2.1)
Alzheimer's disease	2 (2.5)	-	-	2 (3)
Total	94 (100)	25	34	35

Table 5: Relationship between routes to care and sociodemographic details

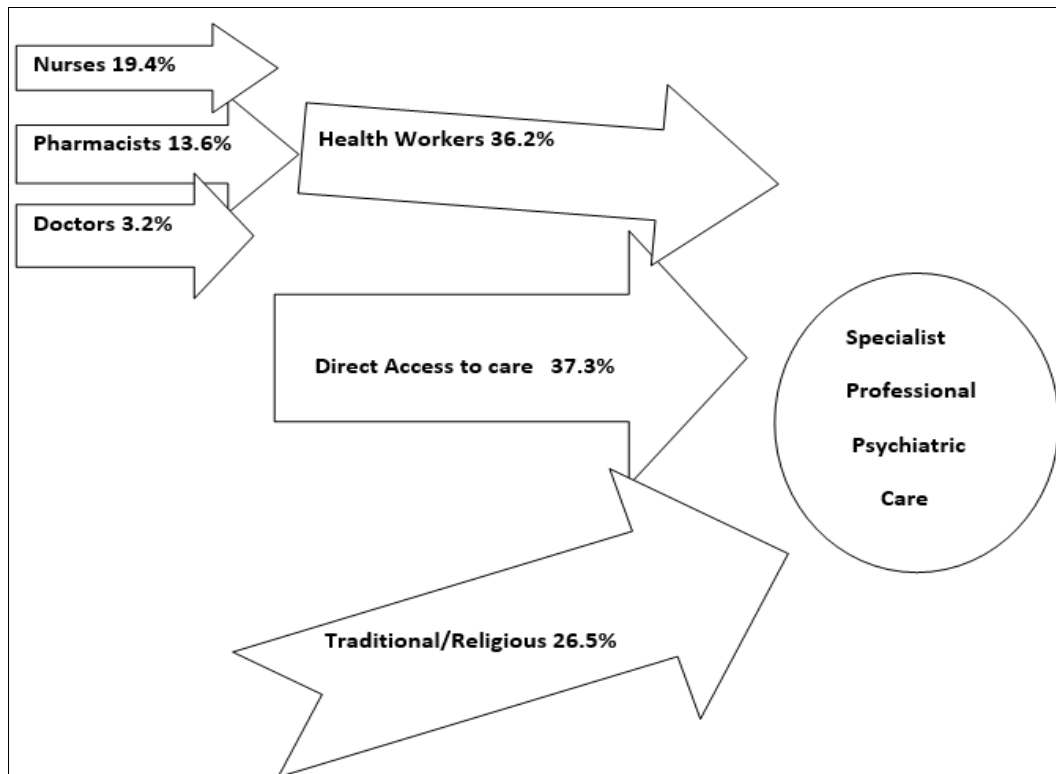
Variable	Direct Psychiatric Services n (%)	Indirect route of care n (%)	Statistics (X ²)	P
Sex				
Male	15 (15.9)	27 (28.7)	0.027	0.869
Female	18 (19.2)	34 (37)		
Marital status				
Single	14 (14.8)	30 (32.3)		
Married living together	10 (10.8)	20 (21.5)		
Separated/divorced	8	8.51		
Social position				
Below Average	4 (4.4)	13 (13.8)		
Average	18 (19.8)	40 (43.9)	0.938	0.626
Above Average	8 (8.8)	11 (12.1)		
Age in years (mean +SD)	30 (SD=32.6)	35 (SD=33.4)	48.109	0.274

Table 6: The relationships and distribution of diagnoses and gender

Variable	Male n (%)	Female n (%)	Statistics (X ²)	df	P
Depression	15 (16.3)	18 (16.3)	0.039	1	0.844
Schizophrenia	9 (9.5)	13 (14.1)	0.395	1	0.530
Neurotic Disorder	3 (3.3)	6 (6.5)	0.467	1	0.494
Mania	2 (2.2)	6 (6.5)	1.293	1	0.255
BAD	5 (5.3)	3 (3.4)	0.005	1	0.946
Alcohol and Substance abuse	5 (5.3)	2 (2.2)	1.327	1	0.249
Seizures	4 (4.3)	1 (1.1)	0.641	1	0.423
Alzheimer's disease	2 (2.1)	0	0.029	1	0.865
Total	45 (47.9)	49 (52.1)			

Table 7: The relationship between the diagnoses sex among the participants

Variable	Male	Female n (%)	X ² n (%)	P
Depression	0.039	0.844	15 (16.3)	18 (16.3)
Migraine	1.282	0.258	1(1.1)	0
Schizophrenia	0.395	0.530	8(12.9)	13(14.1)
Epilepsy	0.641	0.423	2(2.2)	1(1.1)
Drug Dependence Syndrome	1.327	0.249	4(4.3)	2(2.2)
Hypertension	0.797	0.372	0	1(1.1)
Manic Episode with Psychotic symptoms	1.293	0.255	2(2.2)	6(6.5)
Personality change due to organic disorder	1.282	0.258	1(1.1)	0
Neurotic Disorder	0.467	0.494	3(3.3)	6(6.5)
Alzheimer's disease	0.029	0.865	1(1.1)	1(1.1)
Bipolar	0.005	0.946	3(3.3)	4(4.3)



The diagram showing three major routes to professional psychiatric care in Lagos, Nigeria. Of all the participants 35 (37.3%) sought for direct care, while 62 (66.8%) sought for indirect care through hospital workers 34 (36.2%) and traditional/religious care 25 (26.5%)

Fig 1: The Pathway Diagram.

Discussion

This study investigated the help-seeking behaviours, delays to professional psychiatric care of and the association between help-seeking and sociodemographic characteristics of individuals with mental disorders in Lagos, Nigeria. The findings of this study revealed three major routes to professional psychiatric care in Lagos. From the findings of this study, about one third of the participants utilised the direct route to professional psychiatric care while majority accessed professional psychiatric care through the indirect routes. These results were also supported by other findings from the low and middle-income countries [2-4, 8-10, 17-18].

The frequent utilisation of indirect help-seeking behaviours in low and middle-income countries was observed to be mostly due to inadequate mental health personnel, limited mental health hospitals and the localisation of these hospitals in major cities [5-6, 19-20]. The observed indirect routes could also be due to lack of mental healthcare services at the primary and secondary care settings [5-6]. In the same vein, lack of reasonable knowledge, awareness and education about the aetiologies of mental illness probably also influenced the choice of help-seeking behaviours of the mentally-ill and their families [2-4, 8-10].

Nonetheless, previous published evidence indicated that patients and their family members from developing countries believed that mental illnesses were caused by various supernatural forces, witches, witchcraft and preternatural forces. Therefore, it was not uncommon for patients and their family members to patronise the traditional and spiritual based healers who most times prescribed, ceremonial rites, incantations, sorcery, exorcisms, prayers, fasting, night vigils and deliverances from evil spirits for various treatments for mental illnesses [18-22].

When our findings were compared with findings from high-income countries, our results were not in consonance with their findings. This was because majority of individuals with mental illness in Europe for instance accessed mental health care services through the primary or secondary health care facilities [11, 15, 22-23].

With regards to referral for professional psychiatric care, majority of the suggestions to seek for mental health care were mainly from the participants' families. The implication of this observation was that the family still remained the basis of social protection. The Nigerian nuclear and extended families were always quick to show concern when a member of the family is severely ill [5, 21]. The attitude of family members towards help-seeking with regards to mental illness also depended on how educated and enlightened the family members were. Therefore, the importance of the role of the family in treatment and rehabilitation of individuals with mental illness must be taken into consideration by clinicians and policy makers during awareness and advocacy programmes and while setting up a community mental health services [4, 5, 7, 21, 26].

In the same vein, our findings also showed that a large majority of the participants 87.5% lived within the study location. It could be deduced that since the teaching hospital was located in Lagos, the citizens of the state would have easier access to the facility compared to those living on the outskirts of the state. This observation may explain why participants had indirect access to health workers (doctors, nurses, pharmacists) as their first contact of care. Lagos State was the former capital city of Nigeria. It is a modern city where a large population of health workers live among the populace. Studies showed that when Nigerians were ill, they would rather seek medical consultations with a local nurse, chemist or pharmacist before thinking of seeking for

orthodox medical care [5-7].

The delays according to the findings of this study ranged from 3 weeks to 44 weeks for those that patronised the direct route while those that utilised the indirect routes had delays that ranged between 2 weeks to 416 weeks. Obviously, short delays to either direct or indirect route to care could be due to the acute and disturbing symptoms presented by the mentally-ill which would make close family members to urgently seek for treatment. However, The possible reasons why there were longer durations from onset of illness to specialist psychiatric care could be due to non-availability of psychiatric services at the primary and secondary health care facilities within the communities of the participants, negative stigmatising attitudes of Nigerians towards individuals suffering from mental illness, long distance and high cost of hospital treatment [1-2, 4, 6, 20, 26].

It is in this light that Zhang *et al.* [3] reported two types of delays in help-seeking behaviours for professional psychiatric care. First, the delay between onset of illness and contact with the first carer which could depend on how acute the illness was before reaching an agreement to seek for care and secondly, the delay caused by contacting a non-orthodox healer who may not urgently refer to the mental health specialist until the illness becomes severe. Nonetheless, previous empirical documents indicated that the average duration or delay between onset of illness and professional psychiatric care is between 1 and 2 years for positive symptoms and 5 to 8 years for those with negative symptoms [15-16, 23-26].

Nevertheless, the long delays to specialist psychiatric care observed in this study may continue for a while because there were no community psychiatric services in Lagos State and mental healthcare is yet to be fully integrated into primary care in Nigeria. Likewise, there were no psychiatric departments or units in all the 26 general hospitals in Lagos except for two. Similarly, medical officers who were available at the primary and secondary health care facilities were not fully trained on how to recognise and manage common psychiatric disorders which could also further enlarge the mental health treatment gap.

The implications of all these findings were that these long delays and utilisation of indirect routes to professional psychiatric care could have severe detrimental effects on the mentally-ill, worsen prognosis and continue to lead to chronicity. Therefore, it is essential that health policy makers must enact bills to make the treatment of psychiatric disorders affordable and available to all Nigerians. However, in order to bridge the mental health treatment gap and make mental healthcare available and accessible to majority of Nigerians who live in the rural areas, mental healthcare services must urgently be integrated into primary care medical services [5-6, 26].

This study has its limitations and they include the small sample size. However, a sample size of 50 participants was reported in previous studies to be sufficient enough to give representation to pathways to psychiatric care [11-15]. There might have been recall bias among the participants since data gathered were based on self-reports. Nonetheless, the strength of this study include the use of the standardised World Health Organisation Pathway Encounter Form to build an evidence-based scientific knowledge for further development of mental healthcare services with a view to reducing mental health treatment gap in Lagos and Nigeria as a whole. This study provided recent insights about the

help-seeking routes of Nigerians with mental illness. It is however, desirable that further multi-centred studies on help-seeking behaviours of Nigerians to specialist psychiatric care need to be carried out in other cities and states of Nigeria.

Conclusion

This study was able to demonstrate that help-seeking behaviours of the mentally-ill in Lagos were mostly through the indirect routes. This could be due to the availability of few mental health experts, high cost of medical care, non-availability of mental health care at the primary and secondary care hospitals, widespread of Pentecostal churches and traditional healers in the community. Therefore, there is an urgent need for regular public education, advocacy and awareness campaigns to provide knowledge about the aetiologies of mental illness to further reduce the social stigma associated with mental illness. The local, state and federal governments of Nigeria should as a matter of urgency integrate mental healthcare into primary healthcare.

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