BARRIERS TO UTILIZATION OF MENTAL HEALTH SERVICES IN NIGERIA.

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Abstract
Mental health is an integral component of health which includes different aspects of activities that are directly and indirectly related to promotion of wellbeing, prevention of mental disorders, and treatment as well as rehabilitation of people with mental illnesses. Despite the recent worldwide focus on mental health, the burden of mental disorders is still on the increase. It is estimated that about three quarters of those with mental disorders, mainly in low income countries, have no access to treatment due to poor /lack of standard health service delivery and/or how services are delivered. In this study, the amount of funding, distribution and allocation of mental health services, poor health education, the long duration of treatment, and fear of stigma among others were identified as barriers to the utilization of mental health services in Nigeria. It is recommended that mental health issue be encompassed in primary health care to ensure quality and a better service delivery.
Keywords: access to treatment, stigma, mental health, utilization, primary healthcare

Introduction

The World Health Organization WHO (2014) defines mental health as a state of wellbeing in which individuals realize their own abilities, can cope with normal stresses of life, can work productively, and are able to make contributions to their own community. Mental health is an integral component of health including different aspects of activities which are directly and indirectly related to promotion of wellbeing, prevention of mental disorders, and treatment as well as rehabilitation of people with mental illnesses (WHO, 2014). According to the WHO mental health atlas 2011–2012, only 36 % of the people in low-income countries have mental health legislations which suggests there is the need to improve mental health and reinforce mental health systems, especially in low-income countries (WHO, 2013). Despite the recent worldwide focus on mental health, the burden of mental disorders is still on the increase with a projection for depression alone to be the second cause of disability in 2020. Furthermore, about three quarters of those with mental disorders, mainly in low-income countries, have no access to treatment (WHO, 2013).

Mental health service delivery according to WHO is the means by which effective interventions for mental health are delivered (WHO, 2010). It is all that can be done to promote good mental health for all the people. Mental health service delivery also has much to do with the type of facility on ground for disordered patients. It is measured by the number of such treatment facilities available, how many health workers per patient care ratio etc, (Jack-Ide, 2012) views mental health service delivery as dealing 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.

The National Standard for Mental Health Services (2010) states that mental health service delivery must and should focus on; how services are delivered; whether they meet expected standards of communication and consent; whether also they comply with policy directions and whether they have procedures and practices in place to monitor and govern particular areas- especially those which may be associated with risk to the consumer, or which involve coercive interventions. WHO (2007) recommends that mental health issue be encompassed in primary health care to ensure quality and a better service delivery.

Health Care Delivery System in Nigeria

Nigeria has three main competing and distinct systems of care: the traditional/indigenous native, spiritual, and the cosmopolitan/orthodox. Cosmopolitan western-style medicine was first introduced to the country in order to meet the health needs of British settlers who came to the country in the wake of British colonialism, civil servants and missionaries (Erinosho, 2006). Health care facilities were initially located in urban communities where settlers resided and the orientation of health care delivery was largely curative. The cosmopolitan western-style sources of care can be subdivided into two: the private and the public. The former incorporate clinics and hospitals, which are owned and managed by private medical practitioners, trained midwives and non-governmental organizations like missions, while the latter are government owned.

The public sector health care facilities, which constitute about 80% of all facilities in Nigeria are owned and managed by the three tiers of government. This is so because health is on the concurrent list in the Nigerian constitution. The Federal Government formulates broad policy in collaboration with the states; mobilizes funds from external sources for health care programs; and tackles epidemics and other special programs. State governments manage and fund

secondary health care institutions (and tertiary in some cases) as well as assist in the implementation of the primary health programs in their respective areas of operation while the local government authorities are vested with the provision of primary health care.

The major sources of funding for public sector health care programs are domestic and external, with the bulk from the former sources in the form of annual budgetary allocations to health care programs by the federal, state and the local government authorities. Allocations are in the form of grants which are disbursed to cover capital and recurrent expenditures on health. Since very little is internally-generated by health care institutions in Nigeria, the three tiers of government account for executing their health programs. External support for health care programs is provided by international bilateral and multilateral agencies.

For many years, the orientation of health care delivery in Nigeria was attuned to curative care rather than prevention, resulting in a huge investment in high technology health care facilities such as specialist and university teaching hospitals which are urban-based and serve only a very small proportion in the population (Erinosho, 2006). Yet Nigeria's high technology health care facilities are inappropriate, in a state of disrepair or broken down, and under-utilized (Erinosho, 1991). However, the need to extend coverage to a broader segment of the population most especially the rural dwellers, led to a re-orientation and the restructuring of the health sector and programs.

Overall, health care delivery in Nigeria is a product of the socio-historical antecedents underlying colonialism. This model is still basically intact, and the practice of medicine in the public sector remains largely bureaucratic in nature, of which the practice of medicine has continued to undermine professional ethos, job satisfaction, and quality care (Erinosho, 1982). Furthermore, the burgeoning and cosmopolitan private sector remains un-integrated into the national health care delivery system. Several studies suggest the existence of barriers to access and the utilization of mental health services especially in low and middle income countries.

In a qualitative survey of international mental health experts and leaders to review barriers to mental health service development, it was reported that the prevailing public health priority agenda and its effect on funding; the complexity of and resistance to decentralization of mental health services; challenges to implementation of mental health care in primary-care settings; the low numbers and few types of workers who are trained and supervised in mental health

care; and the frequent scarcity of public-health perspectives in mental health leadership represented significant barriers that need to be addressed by national governments. The authors conclude that population-wide progress in access to humane mental health care will depend on substantially more attention to politics, leadership, planning, advocacy, and participation (Saraceno, van Ommeren, Batniji, Cohen, Gureje & Mahoney, 2007) On the bright side, a recent systematic review of literature and a survey of key national stakeholders in mental health identified a large number of programmes which suggest that successful strategies can be adopted to overcome barriers to scaling up mental health services nationally. These barriers include the low priority accorded to mental health, scarcity of human and financial resources, and difficulties in changing poorly organized services (Eaton, McCoy, Semrau, Chatterjee, Baingana & Seedat, 2011).

A study in the Niger delta of Nigeria examined the barriers to the utilization of mental health services from the service users' perspective. The study result revealed there are economic, physical, and cultural barriers to the utilization of mental health services including stigma, poor knowledge of mental health services, centralization of mental services, and waiting time. The research also assessed user's socio-demographics barriers which could hinder access to mental health services (Jack-Ide & Uys, 2013). In South Africa, structural and attitudinal barriers to mental health care were examined together with the predictors of treatment dropout using face to face interviews. Attitudinal barriers, including the lack of perceived need for treatment, stigma, and the perception of mental disorders as a personal weakness were more commonly reported by interviewees than structural barriers such as financial cost and lack of availability of services (Bruwet, Sorsdahi, Harrison, Stein, Williams & Seedat, 2011).

Furthermore, inadequate financial and human resources, lack of collaboration and consultation, and not being a priority by policy makers were recognized as barriers to mental health policy implementation in Ghana (Awenva, Read, Ofori-Attah, Doku, Akpalu & Osei, 2010). Data from Sudan is very limited, with only one study (Abdelgadir, 2012) exploring the barriers to the utilization of mental health services in the capital Khartoum from the perspectives of health care providers and policy makers. In this study, the amount of funding, distribution and allocation of mental health services, poor health education, the long duration of treatment, and fear of stigma were identified as barriers to the utilization of mental health services in Nigeria. To our knowledge, not much has been done particularly in South Eastern Nigeria to examine

the barriers to the utilization of mental health services from the perspectives of carers of mental patients and this study in part seeks to contribute to this gap in the literature. Given this background, the aim of this study is to identify barriers to mental health services utilization in South-Eastern Nigeria from the point of view of both carers of mentally ill patients and psychiatrists and to elicit solutions to address these barriers, thereby expanding mental health services utilization in Nigeria.

Theoretical framework

Health Belief Model (HBM) was used to inform the study. This model explains why people fail to engage in certain preventative health behaviours. Conceptualizing mental health care utilization using HBM as a framework has been previously described in an article which proposes that HBM could be used for research in mental health service utilization as well as to communicate to mental health policy makers the need to implement and evaluate effective programs that decrease barriers to treatments (Henshaw, Freedman-doan & Michigan, 2009). The HBM assumes that behavior change occurs with the existence of three ideas at the same time:

- An individual recognizes that there are enough reasons to make a health concern or concerns relevant (perceived susceptibility and severity).
- That individual understands he or she may be susceptible to a disease or negative health outcome (perceived threat).
- The individual recognizes that behaviour change can be beneficial and the benefits of that change will be greater than any costs of the behaviour change (perceived benefits and barriers).

For this study, the beliefs of carers of mental health patients rather than the beliefs of the patients themselves are examined. This is because it is more common in Africa for family members to have the burden of seeking mental health care for sick relatives rather than the patients seeking care themselves (Ambikile & Outwater, 2012; Olawale, Mosaku,Fatoye, Mapayi & Oginni, 2014). The model was also extended by examining the perceptions of psychiatrists about what they perceive to be barriers hindering health services utilization by patients and their carers

Barriers to the Treatment of Mental Illness

The under-representation in outpatient treatment of people suffering from mental illness appears to be the result of cultural differences as well as financial, organizational, and diagnostic factors. The service system has not been designed to respond to the cultural and linguistic needs presented by many patients or patient relations. What is unresolved are the relative contribution and significance of each factor for distinct patients.

I. Primary Care Providers

Depression and anxiety carry a major toll on individuals, families and society at large. This has led the World Health Organization to identify depression as the second leading cause of disability worldwide (WHO, 2011). Currently, about 10 % of primary care patients suffer from depression and as many as 7 % suffer from at least one type of anxiety disorder (Serrano-Blanco et al. 2010). Primary care providers serve as major gatekeepers in the treatment of depression and anxiety (Thombs et al. 2012). Despite the prominent role of primary care providers in the management of depression and anxiety and the various interventions employed to facilitate the treatment of mental illness in primary care (Katon et al. 2010; Vickers et al. 2013), there is a growing body of literature on barriers to adequate mental health care in primary care (Whitebird et al. 2013). The literature addresses three major types of barriers for the management of mental illness in primary care. These include barriers at the contextual level, the patient level and the provider level (Benzer et al. 2012; Schumann et al. 2012).

At the contextual level, reimbursement strategies, lack of resources and time, the stigma of mental illness (Schumann et al. 2012), inadequate care coordination and difficulties initiating referrals to mental health providers have shown to impact access to mental health treatment in primary care (Kessler 2012). In contrast, integrated care, in which mental health services are provided within the premises of the primary care clinic has resulted in improved access to services and clinical outcomes (Ayalon et al. 2007). High levels of patient burden and inadequate time allocated for meeting with patients have also been shown to hamper mental health treatment in primary care (Chong et al. 2013).

At the patient level, barriers include the stigma of mental illness, a general preference for psychotherapy, rather than medication (Bell et al. 2011), inadequate knowledge about mental illness, the belief that depression will go away on its own (Elwy et al. 2011), a lack of trust in the primary care provider (Kravitz et al. 2011), and a somatic presentation of symptoms and a

preference for a somatic diagnosis (Schumann et al. 2012). The conceptualization of mental illness in ways that diverge from the traditional bio-psychosocial model also hampers access to services (Bener & Ghuloum 2011).

Finally, at the provider level, physicians have shown to have difficulties to accurately detect and diagnose depression (Coyne et al. 1995) as well as to treat mental illness, given a tendency to normalize and trivialize mental illness in comparison to other chronic medical conditions (Coventry et al. 2011). Those physicians who reported negative attitudes towards mental illness and perceived depression as a stigmatizing condition were less likely to provide adequate care (Wallace 2012). Consistently, mental health training has yielded a more adequate approach to the management of mental illness (Smith et al. 2014).

II. Stigma

Mental illness-related stigma, including that which exists in the healthcare system and among healthcare providers, has been identified as a major barrier to access treatment and recovery, as well as poorer quality physical care for persons with mental illnesses (Abbey et al. 2012; Henderson et al. 2014) Stigma also impacts help-seeking behaviours of health providers themselves and negatively mediates their work environment (Wallace 2012) What follows is a consideration of the literature on the main sources of personal and interpersonal stigma in healthcare, impacts for both patients and providers, and evidence-based solutions that can be implemented to improve patient-provider interactions and quality of care.

Developed from Goffman’s pioneering work,(Goffman, 1963) stigma is conceptualized as a complex social process of labeling, othering, devaluation, and discrimination involving an interconnection of cognitive, emotional, and behavioural components (Corrigan, Druss, & Perlick 2014). Stigmatization occurs on multiple levels simultaneously—intrapersonal (eg, self-stigma), interpersonal (eg, relations with others), and structural (eg, discriminatory and/or exclusionary policies, laws, and systems) (Livingston 2013). It is also keenly recognized that only powerful social groups can stigmatize (Link & Phelan,2001) Such an understanding is helpful for appreciating how stigmatization occurs on multiple levels throughout the healthcare sector, including structural (eg, investment of resources, quality of care standards, organizational culture), interpersonal (eg, patient-provider interactions, discriminatory behaviours, negative attitudes), and intra-individual (eg self-stigma, patient reluctance to seek care, provider reluctance to disclose a mental illness and/or seek care) (Livingston, 2013). Research has identified a number of issues contributing to stigmatization in healthcare, which

have direct and indirect impacts on access and quality of care for persons living with mental illnesses. These have been described as ‘‘key learning needs’’ (Knaak & Patten 2016) acknowledging that they are specific concerns that can be changed through targeted initiatives.

III. Negative attitudes and behaviours

People with lived experience of a mental illness commonly report feeling devalued, dismissed, and dehumanized by many of the health professionals with whom they come into contact (Olawale, Mosaku, et al 2014; Topper,van Rooyen, Grobler,etal 2015). Key themes include feeling excluded from decisions, receiving subtle or overt threats of coercive treatment, being made to wait excessively long when seeking help, being given insufficient information about one’s condition or treatment options, being treated in a paternalistic or demeaning manner, being told they would never get well, and being spoken to or about using stigmatizing language (Teferra, Shibre,2012; Andersson, Schierenbeck, 2013). While research also highlights many positive patient experiences (eg, Clark et al.2007; Barney et al.2009, and Connor et al.2006), the pervasiveness with which negative interactions are reported suggests the problem is not isolated to a few insensitive providers but is more systemic in nature—that it is a problem with how healthcare culture prioritizes and perceives persons with mental illnesses (Abbey , Charbonneau , Tranulis , Moss , et al., 2012). Research with healthcare providers is consistent with this idea, finding that stigmatizing attitudes and behaviours towards persons with mental illnesses exist across the spectrum of healthcare (Henderson, Noblett , Parke , et al., 2014). Also, patients with certain disorders, such as personality disorders, tend to be particularly rejected by healthcare staff and are often felt to be difficult, manipulative, and less deserving of care.

IV. Lack of awareness

Another issue is a lack of awareness and unconscious biases, which acknowledge the power of hidden beliefs and attitudes that can underlie stigma-related behavior (Knaak & Patten, 2016; Sukhera & Chahine, 2016). Qualitative research has found that for many healthcare providers, it is only through the experience of receiving anti-stigma training that they become aware of the subtle and unintended ways certain beliefs and behaviours may have been contributing to stigmatizing experiences among their patients (Knaak & Patten, 2016; Sukhera & Chaline ,2016; and Horsfall et al, 2010)

V. Therapeutic pessimism

Research consistently demonstrates that healthcare providers tend to hold pessimistic views about the reality and likelihood of recovery, which is experienced as a source of stigma and a barrier to recovery for people seeking help for mental illnesses (Henderson, Noblett , Parke , et al.2014) Research also suggests that pessimism about recovery for some providers is associated with a sense of helplessness, leading them to believe that ''what they do doesn't matter.'' (Knaak & Patten, 2016)

VI. Lack of skills

Inadequate skills and training seem to be associated with stigmatization in two ways. First, it is believed to lead to feelings of anxiety or fear and a desire for avoidance and social/clinical distance among practitioners, which can negatively impact patient-provider interactions and quality of care. Second, it can lead to less effective treatment and poorer outcomes.

VII. Cost

Cost is yet another factor discouraging utilization of mental health services. Low income persons are less likely than wealthy persons to have private health insurance, but this factor alone may have little bearing on access. Public sources of insurance and publicity supported treatment programs fill some of the gap. Roth (1969) and Anderson et al (1963) in Erinosho (2006) have highlighted the role of economic factors in the utilization of health services. Family income is an important determinant of the pattern of use of health care institutions because family units take cost care into consideration before their members seek care among the available channels of care. Patients may also opt for costly services if they are sure and convinced that they will receive prompt attention and/or have access to services, which they cannot afford.

Some studies indicate that Nigerians prefer to use the more costly cosmopolitan private health care providers than those within the public sector because it is believed that quality care is provided by the former (World Bank, 1990). On the other hand, non-literate patients are more likely to use traditional healers partly because of the perceived cost of care of cosmopolitan services, which they believe they cannot afford. Yet, there is indication that the cost of care, which is rendered by traditional healers, is not necessarily lower in real terms than that provided by the cosmopolitan in view of the fact that patients expend large sums of money on a variety of items, which are used for rituals in the therapeutic regimen prescribed by the healers.

Even among working class and middle-class persons in America who have private health insurance, there is under-representation of patients in out patients' treatment (Snowden, 1998). Yet, studies focusing only on poor women, most of whom were mentally ill, have found cost and lack of insurance to be barrier to treatment (Miranda & Green, 1999). The discrepancies in findings suggest that much research remains to be performed on the relative importance of cost, cultural, and organizational barriers, and poverty and income limitations across the spectrum of people and ethnic groups.

VIII. Clinician Bias

Advocates and experts alike have asserted that bias in clinician judgment is one of the reasons for over-utilization of inpatient treatment by patients of mental illness. Bias in clinician judgment is thought to be reflected in over-diagnosis or misdiagnosis of mental disorder. Since diagnosis is heavily reliant on behavioural signs and patients' reporting of the symptoms, rather than on laboratory tests, clinician judgment plays an enormous role in the diagnosis of mental disorders. The strongest evidence of clinician bias is apparent for Nigerians with schizophrenia and depression (Oguamanam, 2004). Several studies found that African Americans were more likely than were whites to be diagnosed with schizophrenia, yet less likely to be diagnosed with depression (Hu et al., 1991; Lawson et al., 1994). In addition to problems of over-diagnosis or misdiagnosis, there may well be a problem of under-diagnosis among minority groups, such as Asian Americans, who are seen as "problem-free" (Takeuchi & Uehara, 1996). The extents of this type of clinician's bias are not known and need to be investigated.

Discussion

Our study reveals a number of barriers to the utilization of mental health services in Sudan from the perspectives of carers and psychiatrists, including physical barriers, attitudinal barriers in seeking alternative care to mental health, mental health system infrastructure, and a low priority for mental health in policy making. Most of these barriers are consistent with the HBM and explain why some mentally ill patients do not access treatments or utilize mental health services (Henshaw.,et al 2009). Our results suggest a large proportion of patients travel long distances to access mental healthcare which is located primarily in the national capital Khartoum and this may hinder many people from accessing mental health services. This finding is consistent with the results of previous studies in Nigeria which revealed that the long waiting time as well as the long travel distance to access mental health service act as barriers

to services utilization, especially for rural residents (Jack-Ide & Uys, 2013). Another study showed that depressed patients living 30 to 60 miles away from psychiatric health services were less likely to receive therapy compared to those who were living within shorter distances (Pfeiffer, Glass, Austin, Valenstein, McCarthy, & Zivin, 2011). The distance patients have to travel to access mental health care are important modifying environmental factors affecting health seeking behaviour in the HBM (Henshaw et.al 2009). The closer health facilities are to where patients reside, the more likely it is that they will seek health care and vice-versa. The only related study in Sudan did not identify distance as an important constrain to accessing mental health care, however the authors reported that policy makers and health care providers who were interviewed were all of the opinion that mental health services in Sudan are below the minimum acceptable international standards. The psychiatrists interviewed in our study agreed that the number of health personnel in Sudan is much below the number needed to provide adequate mental health care and the few psychiatrists working in Sudan lack the appropriate motivation and incentives and this creates barriers to the provision and utilization of mental health services. Lack of staff was also identified as a barrier to access and receive mental health care in a study conducted in Eastern Cape, South Africa (Schierenbeck, Johansson, Andersson & vanRooyen 2013). About three quarters of patients, regardless of the educational level of their carers, sought other types of treatments before coming to the psychiatric hospital and over half of all the carers thought the origin of psychiatric illness is spiritual in nature. In the HBM, the likelihood that a person will follow a preventive behavior is influenced by their subjective weighing of the costs and benefits of the action. The response to the perceived threat is influenced by information and the balance between the perceived efficacy and cost of alternative courses of action which creates pressure to act, but does not determine how the person will act (Henshaw,et.al, 2009).

Our study suggests that the beliefs and attitude of people in seeking alternatives to mental health care are important barrier to mental health services utilization, in particular, as consulting religious healers was found to be the main alternative to mental health care. Many people in Nigeria perceive that mental illnesses are caused by spiritual forces which may inform their decision to seek help from spiritual and traditional healers in the initial instance rather than seek conventional psychiatric care from mental health services, and this health seeking behaviour is consistent with the HBM. These attitudinal barriers to the utilizing mental health services from carer’s perspective were confirmed by the psychiatrists. These results are

consistent with the recent study in Southeast Nigeria in which all health care providers and administrator respondents agreed that psychiatric patients usually come to hospital in the late stages, after religious or traditional healers have failed to cure their sicknesses (Oguamanam, 2017). In addition, literature from some African countries supports our arguments. For example, not only were the beliefs around the origin of psychiatric disorders linked to curses and the effects of the devil's eye in studies in Sudan and Ethiopia; consulting religious healers was also found to be the preferred remedy by most of participants, leaving mental health care as a last option (Henshaw, et.al, 2009; Teferra & Shibre, 2012).

A range of barriers to seeking mental health care in low-and middle-income countries has been investigated. Little, however, is known of the barriers to care and help-seeking behaviour among people with posttraumatic stress disorder (PTSD) in low- and middle-income countries. In a population-based study including 977 people aged 18-40 years with posttraumatic stress disorder from the Eastern Cape Province in South Africa, it was reported that the most striking barriers to mental health services utilization were stigma and a lack of knowledge regarding the nature and treatment of mental illness (Topper, vanRooyen, Grobler, vanRooyen & Andersson, 2015). Similarly, of the variety of barriers identified for patients with depression in the same province to seeking mental health services, the most significant were related to stigma, lack of knowledge of their own illness and its treatability, as well as financial constraints (Andersson, Schierenbeck, Strumpher, Krantz, Topper & Backman,et al, 2013). Stigma is therefore a major barrier to mental health services utilisation and it is another important modifying environmental factor in the HBM. Accordingly, some psychiatrists suggests that carers of mentally ill patients prefer to send their sick relatives to religious healers to avoid labelling the patients; indicating the interaction of social cultural and belief systems in utilizing mental health services.

These observations are consistent with what was reported in the recent study in Southeast Nigeria (Oguamanam, 2017). Furthermore, in a qualitative study in Nepal, in addition to pragmatic barriers at the health facility level, mental health stigma and certain cultural norms were found to reduce access and demand for services. Respondents in this study perceived the lack of awareness about mental health problems to be a major problem underlying this, even among those with high levels of education or status. They proposed strategies to improve awareness, such as channeling education through trusted and respected community figures, and

responding to the need for openness or privacy in educational programmes, depending on the issue at hand (Brenman, Luitel, Mall & Jordan, 2014). Although more than half of the carers of mentally ill patients experienced a financial problem in accessing mental health care services, most carers felt obliged to treat their mentally ill patients. This suggests the existence of a huge financial burden on carers of psychiatric patients as the cost of the cheapest antipsychotic medication is high. Poverty and absence of social grants for mentally ill patient increase the burden of psychiatric disorders leading to poor mental health outcomes (Thornicraft, 2007). According to the HBM, someone living in poverty would be more threatened by a disease if they could not afford health care (Henshaw et.al, 2009). From health care provider's perspective, financial problems, especially the cost of psychiatric medications, is one of the major barriers to obtaining mental health care. This is particularly so because patients need to pay for their psychiatric medications which usually require long term use. Thus, although financial barriers related to medications were among the major themes which emerged from the study according to the psychiatrists, the cost of psychiatric medications were identified as hinders to access mental health services by a large proportion of carers. In line with carers' perspective regarding financial barriers in this study, carers and service users in Nigeria experienced financial difficulties in paying for their psychiatric medications and follow-up appointments (Jack-Ide &Uys, 2013). Our results also suggest that mental healthcare is not accorded sufficient priority by policy makers in Nigeria where health do not receive up to 4% of the annual budget as against 15% minimum of international standard best practices and the government does not allocate sufficient funding for mental healthcare which creates barriers to the provision and utilization of adequate mental health care services. Furthermore, the problem of poorly trained staff can be seen as a quality barrier to access mental health care in Nigeria.

Recommendations

Various suggestions have been proposed in this study to tackle the different challenges hindering mental health patients from utilizing mental health services in Nigeria. Although all the proposed suggestions require good policy coordination for effective implementation, our study suggests that policy makers themselves are a major part of the problem. Consequently, as a start, policy makers need to recognise and understand the different dynamics at play within mental health care delivery system. Psychiatrists, human rights advocates and all civil society organizations that are not for profits have roles to play in educating and lobbying policy makers

so that they prioritise mental healthcare. Political will serves as the major solution to improve the problem together with the advocacy for people with mental illness. Secondly, increasing people's awareness of mental health through educational programs and using different types of media platforms serves as a solution to overcoming stigma and improving mental health services utilization. In addition, improving public awareness through using pictures, posters, religious idioms, and simple language for communication will go a long way in improving mental health services utilization. Opening of more psychiatric health centres, opening of psychiatric departments in general hospitals and mobilization of mental health services to rural areas were recommended.

Policy makers should advocate for the integration of mental health services into primary care and other facilities. According to the WHO (2009), integration of mental health in general services together with creation and strengthening of community based facilities such as psychiatric outpatient facilities and community based inpatients units can strengthen the mental health system in Nigeria. Furthermore, as a solution, mental health staff should be motivated, through provision of attractive working environment, to provide the required level of mental health care. Health professionals need to be encouraged to work in rural areas as there are hospitals without psychiatrists. The WHO also proposed increasing the number of mental health staff as a way of strengthening the mental health system in Nigeria. According to Crotty, Henderson & Fuller (2012), community participation and working in relationships between different local services or collaboration were found to be effective in improving health services utilization. Task-shifting of responsibilities from psychiatrists to community health workers, social workers and community lay counsellors have also been reported to be effective in increasing the mental health workforce in poor countries like Nigeria. Nigeria can adopt this strategy to increase the skills mix of it mental health work force at the community level and thereby, expand on the mental health coverage for the population. This may also be an effective tool to mitigate the long distances people need to travel to access conventional mental health services. Offering free psychiatric medication to psychiatric patients and their inclusion in the health insurance was recommended as a way of increasing mental health services utilization in Nigeria. Health insurance coverage as a successful policy to improve patient's access to psychiatric medications was also suggested. Furthermore, increasing the availability of essential psychiatric medications was recommended by the WHO (2009) to strengthen mental health system in Nigeria. Finally, improvement in the process of identification, diagnosis, and treatment of mental health conditions has been recommended as a way to overcome barriers to

the availability, accessibility, efficiency and equity of mental health care in low and middle income countries like Nigeria.

Conclusion

The study has identified barriers to mental health services utilization in Nigeria. Overall, these are in consistent with the HBM and also in line with previous literatures which reports the presence of several barriers to the utilization of mental health services including: people's beliefs and understanding, cultural, attitudinal, financial and political barriers. These barriers seem to be interacting and leading to each other hindering proper mental health care in Nigeria. In addition to increased public education and awareness creation about mental health to reduce stigma, quality mental health services provided by well-trained and well-motivated staff need to be close to where people live to prevent the travel burden. Furthermore, psychiatric medication needs to be made free as a way of increasing the utilization of health services. Finally, an expansion in the mental health services delivery and utilization in Nigeria require the active support of policy makers who should consider mental health as a priority.

References

Abbey, S., Charbonneau, M., Tranulis, C., & Moss, P., et al. (2012). Stigma and discrimination. *Canadian Journal of Psychiatry, 56*(10), 1-9.

Abdelgadir, E. (2012). *Exploring barriers to utilization of mental health services at the policy and facility level in Khartoum Sudan.* thesis (master's)-university of washington . Accessed online on the 6th of October 2017 at: http://dlib.lib.washington.edu/dspace/handle/1773/20682.

Ambikile, J. S., & Outwater, A. (2012). Challenges of caring for children with mental disorders:Experiences and views of caregivers attending the outpatient clinic at Muhimbili National Hospital, Dar es Salaam - Tanzania. *Child Adolesc Psychiatry Ment Health*, *6*(1), 16.

Andersson, L. M., Schierenbeck, I., Strumpher, J., Krantz, G., Topper, K., & Backman, G, et al. (2013). Help-seeking behaviour, barriers to care and experiences of care among persons with depression in Eastern Cape, South Africa. *J Affect Disord. 151*(2), 439–48.

Awenva AD, Read UM, Ofori-Attah AL, Doku VCK, Akpalu B, Osei AO, et al. (2010). From mental health policy development in Ghana to implementation: what are the barriers? *Afr J Psychiatry. 13*(3), 184–91.

Barney. L., Griffiths, C. H., & Jorm A.(2009). Exploring the nature of stigmatizing beliefs about depression and help-seeking: implications for reducing stigma. BMC Public Health. 61. doi:10.1186/1471-2458-9-61.

Bruwer, B., Sorsdahl, K., Harrison, J., Stein, D.J., Williams, D., & Seedat, S. (2011). Barriers to mental health care and predictors of treatment dropout in the South African Stress and Health Study. *Psychiatr Serv (Washington, DC), 62*(7), 774–81.

Clark D, Dusome D, Hughes L. (2007). Emergency department from the mental health client's perspective. *Int J Ment Health Nurs, 16*(2), 126-131.

Connor SL, Wilson R. (2006). It's important they learn from us for mental health to progress. *Journal of Mental Health, 15*(4), 461-474.

Corrigan, P., Druss, B., & Perlick, D. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychol Sci Public Interest, 15*(2), 37-70.

Crotty, M. M., Henderson, J., & Fuller, J. D. (2012). Helping and hindering: perceptions of enablers and barriers to collaboration within a rural South Australian mental health network. *Aust J Rural Health, 20*(4), 213–8.

Eaton, J., McCay, L., Semrau, M., Chatterjee, S., Baingana, F., Araya R, et al. (2011). Scale up of services for mental health in low-income and middle-income countries. *Lancet. 378*(9802), 1592–603.
.

Erinosho, O. A. (1998). *Health Sociology*. Ibadan: Bookman Social Science Series.

Erinosho, O, A. (2006). *Health Sociology for Universities, Colleges & Health-related Institutions.* Abuja. Bulwark Consult.

Erinosho, O. A. (1991). Health care and the medical technology in Nigeria: An Appraisal. *International Journal of Technology Assessment in Health Care, 7*(4), 545-552.

Erinosho, O. A. (1982). Health planning in Nigeria: A Critique. *Nigerian Journal of Anthropology & Sociology, 8,* 49-54.

Goffman, E. (1963). Stigma: Notes on the Management of Spoiled Identity. Englewood Cliffs, NJ: Prentice Hall.

Henderson, C., Noblett, J., Parke, H., et al.(2014). Mental health-related stigma in healthcare and Mental health-care settings. *Lancet Psychiatry. 1*(6), 467-482.

Henshaw, E.J., Freedman-doan, C.R., & Michigan, E. (2009). Conceptualizing Mental Health Care Utilization Using the Health Belief Model. *Clin Psychol Sci Pract, 16*(4), 420–39.

.Horsfall, J., Cleary, M., & Hunt, G. (2010). Stigma in mental health: clients and professionals Issues. *Ment Health Nurs, 31*(7), 450-455
.

Hu, T. W., Snowden, L. R., Jerrell, J. M., & Nguyen, T. D. (1991). Ethnic populations in Public mental health: Services choice and level of use. *American Journal of Public Health, 81,* 1429-1434.

Jack-Ide, I.O., & Uys, L. (2013). Barriers to mental health services utilization in the Niger Delta Region of Nigeria: Service users' perspectives. *Pan Afr Med J. 14*:159. doi:10.11604/pamj.14.159.1970.

Knaak, S., & Patten, S. (2016). A grounded theory model for reducing stigma in health professionals in Canada. *Acta Psychiatr Scand. 134*(suppl 446):53-62,.doi:10.1111/acps.12612.

Lawson, W.B., Hepler, N., Holladay, J. & Cuffel, B. (1994). Race as a factor in inpatient and outpatient admissions and diagnosis. *Hospital and community Psychiatry, 45,* 72-74.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annu Rev Sociol, 27* (6), 363-385.

Livingston, J. D. (2013). Mental Illness-related Structural Stigma: The Downward Spiral of Systemic Exclusion. Calgary, Alberta: Mental Health Commission of Canada. Available at: http://www.mentalhealthcommission.ca. Accessed May 18, 2016.

Miranda, J., & Green, B. L. (1999). The need for mental health services research focusing on poor women. *Journal of Mental Health Policy and Econo mics, 2,* 73-89.

Oguamanam, G. O. (2004). Religion, Social Work and Mental Illness: Some rehabilitative perspectives. In M.I.Okwueze (eds) *Religion and Societal Development: Contemporary Nigerian Perspectives*.37-47, Nsukka.

Oguamanam, G.O. (2017). *Socio-cultural factors affecting health seeking behavior for mental illness in South Eastern Nigeria*. An unpublished Ph.D thesis, University of Nigeria Nsukka.

Olawale, K. O., Mosaku, K. S., Fatoye, O., Mapayi, B. M. & Oginni, O. A. (2014). Caregiver burden in families of patients with depression attending Obafemi Awolowo University teaching hospitals complex Ile-Ife Nigeria. *Gen Hosp Psychiatry. 36*(6), 743–7.

Pfeiffer, P. N., Glass, J., Austin, K., Valenstein, M., McCarthy, J. F. & Zivin, K. (2011). Impact of distance and facility of initial diagnosis on depression treatment. Health Serv Res. *46*(3), 768–86.

Roth, J. (1969). The Treatment of the Sick.. In J.Kosa et.al, (eds.). *Poverty andHealth,* (214-243). Massachusetts: Harvard University Press.

Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., & Mahoney, J., et al .(2007). Barriers to improvement of mental health services in low-income and middle-income countries. *Lancet. 370*(9593), 1164–74.

Schierenbeck, I., Johansson, P., Andersson, L. & Van Rooyen, D. (2013). Barriers to accessingand receiving mental health care in Eastern Cape, South Africa. *Health Human Rights. 15*(2), 110–23

Snowden, L.R. (1998). *Barriers to effective mental health services for African Americans*. Manuscript submitted for publication
.
Snowden, L. R., & Cheung, F. K. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist, 45,*347-355.

Takeuchi, D. T., & Uehara, E. S. (1996). Ethnic minority mental health services: Current research and future conceptual directions. In B. L. Levin & J. Petrila (Eds.), *Mental health services: A public health perspective* (63-80). New York: Oxford University Press

Teferra S, & Shibre, T. (2012). Perceived causes of severe mental disturbance and preferred interventions by the Borana semi-nomadic population in southern Ethiopia: a qualitative study. BMC Psychiatry. 12:79. doi:10.1186/1471-244X-12-79.

Topper, K., van Rooyen, K., Grobler, C., van Rooyen, D., & Andersson, L. M. (2015). Posttraumatic Stress Disorder and Barriers to Care in Eastern Cape Province, *South Africa. J Trauma Stress, 28*(4), 375–9.

Wallace, J. E. (2012). Mental health and stigma in the medical profession. Health (London). 16(1):3-8. doi:10.1177/1363459310371080

WHO (2014). Mental health: strengthening our response. Accessed online on the 1st of February 2015 at:http://www.who.int/mediacentre/factsheets/fs220/en/.

WHO (2014). Health topics, Mental disorders. Accessed online on the 1st of February 2015 at: http://www.who.int/topics/mental_disorders/en/.

WHO (2011). Mental health atlas 2011. Accessed online on the 1st of February 2015 at: http://apps.who.int/iris/bitstream/10665/44697/1/ 9799241564359_eng.pdf.

WHO (2013). Mental health action plan 2013-2020. 2013. Accessed online on the 1st of February 2015 at: http://apps.who.int/iris/bitstream/10665/89966/1/ 9789241506021_eng.pdf.