Psychiatric Institutions and the Emerging Institutional Scene in Nigeria   (Pp 132-147)

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Abstract
 This study is a review of literature pertaining to inadequate impact of orthodox psychiatric institutions and services in Nigeria. It was aimed at (i) profiling factors impeding growth and use of orthodox psychiatric institutions, and (ii) to report the emerging institutions providing psychiatric services in Nigeria. The method employed was the ex-post facto research which enabled content analysis technique through a critical review of documents and materials related to Nigerian orthodox psychiatric institutions and services. The findings shows that (i) cultural conditions (traditional beliefs and myths, lifestyle, perception and discrimination, stigma, movements) and (ii) systemic factors (lack of funding, dearth of orthodox mental health practitioners, law and policies) are militating factors against robust orthodox psychiatric institutions and services. It was also found that unorthodox psychiatric institutions and services are built and rendered everywhere in emerging religious Pentecostal organizations and government approved but privately owned traditional psychiatric homes. Finally, it was concluded that orthodox psychiatric institutions and services are faced with difficulties due to systemic factors and deeply rooted traditional beliefs in the efficacy, lower cost and omnipresence of unorthodox psychiatric institutions and its practitioners .Therefore, it was recommended, among others, that government should pass into law, the mental health bill, taking into cognizance the potency and acceptability of these emerging institutional scenes.

Introduction

Generally, Psychiatric disorder has been characterized as a clinically significant behavioural or psychological pattern that occurs in an individual and is usually associated with distress, disability or increased risk of suffering. There is often a criterion that a condition should not be expected to occur as part of a person's usual culture or religion.

At the start of the 20th century there were only a dozen officially recognized mental health conditions. By 1952 there were 192 and the Diagnostic and Statistical Manual Fourth Edition (DSM-IV) today list 374. However, psychiatric services may be based in hospitals or in the community. Psychiatric illness is now common globally and it causes immense suffering. To combat it the World Health Organization (WHO) launched an orthodox psychiatric action programme, which it said was meant to scale up services for mental neurological and substance use disorders for countries around the world, especially in low and middle income ones. The programme, which was launched at the world body's headquarters in Geneva Switzerland, is known as the Mental Health Gap Action Programme, (mhGAP). According to the programme, with proper care, psycho-social assistance and medication, tens of millions could be treated for depression, schizophrenia and epilepsy, even in a depressed economy. The world body expressed dissatisfaction with the way people with these disorders are often subjected to abuses, such as social isolation poor quality of life due to economic poverty and increased mortality.

The objectives of this paper are:

i)   to profile factors impeding growth and use of orthodox psychiatric institutions in Nigeria.

ii)   to report the emerging institutions providing psychiatric services in Nigeria.

Organization of Psychiatric Services in Nigeria

Psychiatrists are charged with the professional responsibility of deciding whether a person is mentally ill or not. The Psychiatrist however has to work in a multidisciplinary setting with other members of the mental health profession namely; psychologists, psychiatric nurse, occupational therapists, and social welfare officers.

The identification and care of psychiatric patients in Nigeria pre-date written records. Orthodox psychiatric services were begun around the 20th century with an asylum in 1904 at Calaber in the present day Cross River State. Shortly afterwards, the Yaba Asylum in the present Lagos State was established in 1907. In 1954, the Aro mental hospital was established in Abeokuta in Ogun State. The Aro mental hospital, however was a clear departure from the Calaber and Yaba Asylum, in the sense that, it was to be the juncture in the development of psychiatry with community and world health initiatives managed by an indigineous though western trained psychiatrist, Dr. T.A. Lambo

The World Health Organization recommends a minimum of 10 beds per 100,000 populations. As at 1993, only a total of 3000 beds were available for mental health care in Nigeria. Also in 1993, one psychiatrist was available for 2 million of the population when the minimum desirable ratio is 1 for every 250,000 persons in Nigeria. Also, one trained psychiatric nurse was available for every 30,000 persons and one clinical psychologist for 4 million persons (WHO, 2002). The mental health professional to psychiatric patient ratio has not improved over the year with the issue of "brain drain" having a negative impact on the available manpower. In Nigeria the bulk of orthodox psychiatric service is provided by eight regional psychiatric hospitals and the department of psychiatry in 12 medical schools. Some general hospitals also provide psychiatric services (Ayorinde, et .al, 2004). In 1993, the Federal Ministry of Health and social services reported 20% of the country's population suffered from one type or another of mental disorders (WHO, 2002).

As at 2005, the WHO's statistics of psychiatric beds and professionals in Nigeria are contained in table one. A mental health bill was prepared and submitted by the Association of psychiatrists in Nigeria (APN). The bill is yet to be given its desired attention by the National Assembly.

Statement of the Problem
This study is aimed at profiling cultural and systemic factors that impede growth and use of orthodox psychiatric institutions and services for people suffering mental illness in Nigeria. Psychiatric services may be based in hospitals, clinics or the community. Often an individual may engage in different treatment modalities. They may be under case management, use impatient or day treatment, utilize a psychological rehabilitation programme or take part in an assertive community treatment programme. Individuals

may be treated against their will in some cases, especially if assessed to be at high risk to themselves or others. Services in some countries are increasingly based on a recovery model that supports an individual's journey to regain a meaningful life. In Nigeria, like most developing economies, psychiatric services is amorphous with few, heavily overburdened bureaucratic institutions due to some cultural practices and systemic crisis in these societies. For instance, in Nigeria, psychiatric staff strike paradoxically attracted the sympathy of inmates as described below;

> There was pandemonium at Yaba, Lagos. Traders abandoned their wares and joined panicky drivers to watch from a distance an uncommon procession of a crowd of people they had always regarded as neighbours. The protesters were not in any way violent. There were about 500 of them, and it was not their number that scared the people. The problem was that those who took to their heels assumed that, even in serenity, the protesters must not be taken for granted (Oyegbile, 2009:47).

Those in the procession were psychiatric inmates of the Federal Neuro-psychiatric Hospital, at Yaba in Lagos state, one of the only eight orthodox psychiatric institutions in Nigeria. What was the cause of this pandemonium? The inmates were showing sympathy for the nurses who had given them care, because the medical staff was protesting neglect of the hospital and their welfare. Paradoxically, as psychiatric cases increase in Nigeria, for instance, medical records at the Yaba psychiatric hospital show that 136, 124 and 137, 702 patients were attended to in 2007 and 2008 respectively, the country records a decline in the number of psychiatric experts and quality of facilities (Oyegbile, 2009). Recent studies in Nigeria (Eaton and Tilley-Gyado, 2009) found prevalence rates of 20-28% for diagnosable psychiatric condition in the general population. In Nigeria less than 3% of Gross Domestic Product (GDP) is spent on health and of this less than 1% is allocated to mental health institutions and services. The figure recommended by the WHO for mental health is 5%, and in many countries it is about 15%. The very low level of expenditure on psychiatry in Nigeria means that even if services were well organized, the majority of cases could not receive the orthodox psychiatric care they need.

Lip service is paid to the issue of improving the mental health care structures and service. Mental health care service for now appears to be non-existent at the primary health care level (which ought to cater for about 70% of Nigerian population living in rural areas) and near non-existent at the secondary level

of health care (Lawani, 2008a). Thus mental health professionals at the tertiary level of health care are overwhelmed with the volume of cases that seek their attention. It is pertinent to state that no psychiatric hospital in Nigeria benefited from the upgrading of facilities and infrastructure of tertiary health institutions to centre of excellence. This study is aimed at profiling factors negatively affecting orthodox psychiatric institutions and services resulting to its changing scene in Nigeria.

Method

The type of study design used is the ex-post facto research design. This design enabled content analysis technique for reviewing case studies, national dailies, and reports of national organizations on the subject matter of psychiatric institutions past and present state in Nigeria.

The Federal Republic of Nigeria extends over about 900,000 square kilometers land space. It has over 350 ethnic groups with about 200 spoken languages of which, Yoruba, Hausa and Ibo are spoken by about 60% of the population. Nigeria's 2007 estimated population total is 140,003,542 (Federal Government Gazette, 2007). The political system is democracy, characterized economically with a mixed economy which allows for government licensing of free enterprises such private medical institutions. The official language of government and educational instruction is English. The main income yielding commodity is crude oil. It is estimated that approximately 70 million Nigerians earn below US$1/day, the majority live in rural areas. The Human Development Report ranked Nigeria among the 20 poorest countries in the world (Human Development Report, 2000).

In Nigeria, there are only eight neuro-psychiatric hospitals across the 36 states and the Federal Capital territory of Abuja. These are owned and administered by the federal government. They are situated in Sokoto, Enugu, Maiduguri, Kaduna, Calabar, Abeokuta, Benin and Yaba. Some state governments also have psychiatric units in their central hospitals, while some teaching hospitals attend to patients in Universities with college of Health sciences. For instance in Delta State, there are 44 hospitals; only five have miniature psychiatric presence (Inside Delta State, 2000). There are five traditional psychiatric centres designated by the state government, to accommodate loafing sufferers of schizophrenia. The nearest hospital with full psychiatric service is the Uselu psychiatric hospital and the University of Benin Teaching Hospital psychiatric unit located in the neighbouring Edo State. Medical records are scanty because most people suffering from mental diseases are not formally reported to western type medical institutions.

Findings

i   Cultural and Systemic factors have been identified as conditions impeding the use of orthodox psychiatric institutions in Nigeria.

ii Therefore unorthodox psychiatric institutions are preferred to orthodox psychiatric institutions by consumers of psychiatric services in Nigeria.

Factors Affecting Growth of Orthodox Psychiatric Institutions And Services in Nigeria

Discussing the above mentioned findings in this study will inevitably enable highlighting the factors negatively affecting growth of orthodox psychiatric institutions and service in Nigeria. These are cultural factors of traditional beliefs, myths, lifestyles, perception and discrimination, stigma, and philanthropic associations (movements). The other is systemic factors of inadequate funding, dearth of orthodox psychiatric institutions and staff, and lack of laws and policies.

Nigerian Traditional Beliefs and Myths

The structure of African communal-individualism is the extended family system where kins help each other in every human endeavour. The kinship system acts the economic, social and medical units where strong members lend support to the weak (Onwuejeogwu, 1986). However, in the management of mental illness in Nigeria, the African philosophy of communal-individualism is put in 'reverse gear' resulting to the abandonment of people living with mental illness particularly schizophrenia. Most disturbing is the traditional beliefs amongst indigenes of Nigeria, that schizophrenia is a consequence of voodoo curses from aggrieved or envious relatives and acquaintances (Igun, 1988; Ewhrudjakpor, 2009b). Thus, are abandoned by family members, and government resulting to stigmatization and in society's negative attitude towards people living with schizophrenia (Jegede, 1981; Fabrega, 1991; Oshisada, 2006 and Ewhrudjakpor, 2008a). Natives of most ethnic groups in Nigeria, believe that psychoses are regulated by the climatic conditions Wet season and Dry season which occur between the months of May and September (Wet season) and October to April (Dry season), that psychosis exacerbates during the wet months of the year (Ohaeri, Adeyemi, Sunmola, and Ewhrudjakpor, 1992). The Urhobo people of Delta State of Nigeria, believe that a sufferer of schizophrenia who enters the market place to feed from the market ground, can no longer be treated and be well (Mume, 1976; Igun, 1988; Ewhrudjakpor, 2009b). These

are deeply held beliefs and myths blocking the support of sufferers of schizophrenia. Nigerians, hold deeply rooted traditional beliefs that witchcraft, voodoo and ancestors are each capable of causing schizophrenia. They also believe that only people who are witches or wizards, voodoo priests or ancestors, can heal the disease of schizophrenia (Kiev, 1972; Mume, 1976, Owumi, 1994).

Nigerians even the educated, believe that mental illness is caused by witchcraft. This is still contentious as orthodox medicine practitioners dismiss this claim. Oyegbile (2009) quoting a pastor of the Foursquare Gospel Church. In the pastor's words:

> As an African, if I say I don't believe in witchcraft as causing mental illness, I am telling lies, but I believe the power of God supercedes all other powers. If a man's way is right, God will make even his enemies to be at peace with him, p.49.

The above quotation epitomizes the deeply rooted traditional beliefs, even among the religious, about the mentally ill. Mental illness, particularly schizophrenia is still poorly understood by most Nigerians even the educated and high socio-economic status people.

Lifestyle
In contemporary society the reason why people are mentally ill is understood within a narrative of risk from contradictions in living versus cultural norms, and mores in emerging urbanization and globalization. We live in a risk-filled world in which our health is constantly under threat, and it is everyone's duty to avoid becoming ill. Thus 'irresponsible' acts like excessive marijuana are seen as the moral failings of the person living with schizophrenia. Therefore the cause of their illness is their own 'wrong' lifestyle. Most mental illnesses, particularly schizophrenia is a physical problem, a result of the biomedical model over traditional medicine in the understanding of mental diseases, although traditional views on links between schizophrenia and moral failings still seem to exist.

Perception and discrimination
Media coverage of mental illness comprises predominantly negative depictions of the mentally ill and mental health institutions for example, of incompetence on the part of the mentally ill. These have far less coverage of positive issues such as accomplishments or human rights issues (Diefenbach,

1998; Coverdate, Naim, and Classen, 2001; Edney, 2004; Ewhudjakpor, 2009d). such negative depictions, including in children's cartoons, in judging politicians or public officers misdeeds, are thought to contribute to stigma and negative attitudes in the public and in those with mental health problems themselves, although more sensitive or serious cinematic portrayals have increased in prevalence (Seff, 2003; Wahl, 2003).

Also, the general public have been found to have negative stereo-type of dangerousness and desire for social distance from institutions and individuals described as mental hospitals and mentally ill respectively. This gives credence to stigmatization.

Stigma

"Mental health problems remain a huge stigma in Nigeria with most people, even families of victims, choosing to ignore them in the hope that the problems will simply go away" Eaton and Tilley – Gyado (2009). According to these authors, a man whose wife suffers from schizophrenia says mental illness still attract shame to many families in Nigeria, hear him;

> My wife's mental illness started after the birth of our fourth child in 1993, at first I thought it was high fever but when it degenerated to the point of her making trouble with everybody in the neighbourhood and going nude at times. It has been hard for us, especially me, the husband, because of the costs, work and shame that I have to bear"

> (Eaton and Tilly-Gyado 2009)

A 'Sister' complains that treatment is expensive for her brother, Leonard, because the drugs are still so scarce. The 'Sister' like so many other relatives living with mental health, exhibits little faith in Nigeria's mental health institutions and sees little point in taking her brother to a psychiatric ward. "We refused admitting him in a psychiatric hospital because we believe he will be better with us than keeping him in the midst of other mentally derailed persons" Society can play significant role in eliminating or reducing the frequency of psychotic and mental illness labels (Scheff, 1964). Aspects of labeling include sufferers' social relationship, economic, political and psychological well-being. These negative labels are common in the 350 ethnic groups constituting the population of Nigeria. They are deliberately avoided in social gatherings even in mosques and churches, of course, avoiding them spreads to not employing them in any form of work even after treatment. They hardly marry (Ewhrudjakpor, 2009c) because other family

members are scared of the fact that mental illness do run in families. These labels which constitutes stigma are inevitably huge blockades to reintegration into society.

Philanthropic Organizations (Movement)

The consumer or patients' movement is made up of individuals who consider themselves "survivor" or "friends" of mental health services. The movement campaigns for improved mental health services and more involvement and empowerment within mental health services, policies and infrastructures (Everett, 1994, Rissmiller and Rissmiller, 2006; Oaks, 2006). In Nigeria, these movements are almost non existent, except the 'Association of friends of the psychiatric hospital' found in Yaba, Lagos, and Uselu in Benin City. The association is a philanthropic organization whose members expend their personal resources to help improve the physical and mental needs of psychiatric patients, and infrastructures Patients' advocacy organizations have expanded with increasing deinstitutionalization in developed countries, working to challenge the stereotypes, stigma, government neglect and exclusion associated with psychiatric conditions. An antipsychiatry movement fundamentally challenges mainstream psychiatric theory and practice including the reality or utility of psychiatric diagnoses of mental illnesses.

Lack of Funding

In Nigeria, less than 3% of Gross Domestic product (GDP) is spent on health and of this less than 1% is allocated to mental health-The figure recommended by the WHO for mental health is 5% and in many countries it is about 15%. The low level of expenditure means that even if services were well organized, the majority of cases could not receive the care they need.

The most severe mental illnesses require long-term treatment. Although this treatment when given in the community is not expensive, the system of paying out-of-pocket means that many families find it hard to afford the care their loved ones need month after month. There is a proposed National Health Insurance Scheme (NHS) but it is not clear whether it will adequately cover mental ill health, for most patients and families first point of call is the traditional healer or prayer house (Abiodun, 1995; Owumi; 1994).

The primary, secondary and tertiary health care systems have either collapsed or are in a moribund state. Medical attention in most of our health institutions at present is focused more on curative health than preventive. It is lack of adequate investment in the health sector by the various tiers of government

that has given rise to the present popularity that alternative medicine enjoys in the country (Akinbo, 2009).

Dearth of Orthodox Mental Health Practitioners

Apart from the stigma that patients suffer, psychiatrists are few and at times looked down on in the society. Oyegbile (2009) told a story of a teacher in Maiduguri that said, she would never allow any of her offspring to specialize in psychiatry nor marry one because of the age-long cultural belief among the Kanuri people that anyone treating mentally retarded persons would likely have one of his offspring suffering from mental ailment. Table 1 shows clearly the inadequacy of mental health professionals in Nigeria, particularly Psychiatrists. Coupled with this is the few orthodox mental health institutions that are riddled and disrupted by persistent strike actions inadvertently encouraging 'brain drain', that is movement of specialist professionals like psychiatrists to seek for job oversees depleting the very few psychiatrists in Nigeria. In fact, there are more Nigerian psychiatrists in Britain alone than in Nigeria (Eaton and Tilley-Gyado, 2009).

Laws and Policies

Three quarters of countries (Nigeria not included) around the world have mental health legislation (http://encyclopediathefreedictionary.Com/mental=illness) to guarantee compulsory admission to mental health facilities (also known as involuntary commitment or sectioning). From some points of view it can impinge on personal liberty and the right to choose, and carry the risk of abuse for political, social and other reasons. From other points of view, it can potentially prevent harm to self and others, and assist some people in attaining their right to healthcare when unable to decide in their own interest (WHO, 2005). The mental health bill is with the National Assembly and has not been passed into law, disenabling public and mental health professional knowledge of the provisions contained therein for implementation. Meanwhile, the existing legislation dates back to British colonial laws of 1916, adopted as the Lunacy Act in 1958.

Emerging Psychiatric Institutional Scene in Nigeria

There are huge blockade factors to growth of orthodox psychiatric institutions and services in Nigeria. Most importantly, the lack of adequate investment in the health sector by various tiers of government in Nigeria, has given rise to the present popularity that unorthodox psychiatric institutions enjoys among Nigerians irrespective of age, education, socio-economic

class, religion or region. Approximately 70% of mental health service provision is delivered through non-orthodox means such as religious organizations and traditional healers (Ayorinde et al, 2004). A number of centres have assessed the role of traditional therapists in mental health interventions (Adelakan, et. al. 2001). The emergent unorthodox institutional scene in Nigeria can be categorized into two types, namely (ii) syncretic religious organizations and (ii) traditional witch doctors.

Syncretic Religious Organizations

These are Christian and Islamic faith healers who also render psychiatric services to the mentally ill. They are referred to as syncretic because they combine indigenous (native medicine practices) and religious tenets from the holy bible or the Quran (Erinosho,. 1998; Adelakan, et. al, 2001). These Syncretic religious organizations mode of treatment is through the bible or Quranic recitations combines divination, exorcism and traditional incense with drinking of concoctions made from herbs or water used to wash the ink from a state on which Quaranic verses have been written (Oyegbile, 2009) Although the details of these unorthodox psychiatrists is shrouded in secrecy, they are founded in every nook and cranny and are widely patronized in Nigeria. The number of Pentecostal churches rendering psychiatric services in Nigeria is difficult to estimate because their activities are not monitored by government.

Traditional Witch Doctors

The traditional witch-doctors are variously known as Babalawo, Onisequn and Adahunse among the Yoruba people of western Nigeria, Dibia among the Igbo people of the Eastern region of Nigeria, Alfa/Boka among the Hausa/Fulani peoples of northern Nigeria, Obo among the Ora tribe of Edo State, Edjele among the Urhobo people of Niger-Delta region of Nigeria.They tend to specialize in the management of mental illness. This is done through witch craft practices (Jilek, 1971, Lawani, 2008b) such as confinement, exorcism, flogging, chaining and administration of concoctions to sedate violent patients.

The governments particularly state governments have resolve to recognize some of these traditional psychiatric healers, by evacuating the mentally ill from public view to some designated traditional psychiatric homes (Ewhrudjakor, 2008a, 2009c). For instance like in about 26 states, there are five Delta State government approved traditional psychiatric homes,

paradoxically, there is no private or government owned orthodox psychiatric institution in these states (Adelakan, et. al. 2001, Ewhrudjakpor, 2008a).

Although, patients are not treated with dignity, the healers treat in order to reintegrate patients into the society through their occupational therapies. The treatment here is familial and therefore holistic.

Conclusion

Orthodox psychiatric institutions and services dates back to the 20th century with asylums at Calaber and Yaba (both cities in the south of Nigeria). Aro Neuro-psychiatric Hospital established in 1954 also in a southern town of Abeokuta popularizes psychiatric services both nationally and internationally. Since then, the establishment of orthodox psychiatric institutions manpower and services has not matched the geometric growth of psychiatric ailments and patients in the country.

This study was aimed at, firstly profiling the cultural and systemic factors militating against growth of orthodox psychiatric institutions, manpower and services in Nigeria. Secondly, the identification of the emerging psychiatric institutions and manpower filling the vacuum left by orthodox psychiatric system. The research method was a review of earlier studies national medical statistical records, case studies, national dailies, magazines, and international and non-governmental organizations records on psychiatric institutions and services in Nigeria.

The findings show that (i) deeply held cultural beliefs, practices, and systemic factors like government unwillingness, dearth of manpower and the media were identified as anti-growth factors (ii) that, availability and accessibility of orthodox psychiatric institutions and manpower are negatively skewed in favour of north-south, rural-urban, and rich-poor in Nigeria (iii) filling this gap is the unorthodox psychiatric institutions and manpower in terms of faith healing, traditional medicine and other forms of complementary treatment methods in religious institutions and communities everywhere in Nigeria. This emergence of unorthodox psychiatric scene in Nigeria supports (Ayorinde, Gureje, and Lawal, 2004) of the supportive underpinnings of lay views about mental illness as deeply rooted in super-natural belief systems and traditional illness models as orthodox psychiatric care faces the challenge of proving its efficacy in the Nigerian society.

Recommendations

The federal government of Nigeria should consider the approximately 70% of mental health services provision delivered through non-orthodox institutions and pass into law the mental health bill, taking into cognisance the potency of unorthodox treatment methods. In addition, government should willingly through legislation build and equip more orthodox psychiatric institutions in all 36 states of the federation.

This is because majority of psychiatric presentations seen by clinicians emanates from primary care; therefore primary health centres (PHC) should have robust psychiatric facilities with the training of more psychiatric staff. And lastly encourage the media to embark on mass campaign to destigmatize psychiatric institutions and its service consumers.

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Table 1: Psychiatric beds and professionals in Nigeria

Total psychiatric beds	per	10,000 population	0.4	
Psychiatric beds in mental hospitals per		10,000 population	0.3	
Psychiatric beds in general hospitals per		10,000 population		0.04
Psychiatric beds in other settings	per	10,000 population	0.01	
Number of Psychiatrists	per	10,000 population	0.09	
Number of neurosurgeons	per	10,000 population	0.009	
Number of psychiatric nurses	per	10,000 population	4	
Number of neurologists	per	10,000 population		0.02
Number of psychologists	per	10,000 population	0.02	
Number of social workers	per	10,000 population	0.02	

Source: WHO Mental Health Atlas 2005

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