

# WHO-AIMS

**WHO-AIMS REPORT ON  
MENTAL HEALTH SYSTEM  
IN NIGERIA**



**World Health  
Organization**



**MINISTRY OF HEALTH  
NIGERIA**

**WHO-AIMS REPORT ON**  
**MENTAL HEALTH SYSTEM**  
**IN NIGERIA**

*A report of the assessment of the mental health system in Nigeria  
using the World Health Organization - Assessment Instrument for  
Mental Health Systems (WHO-AIMS).*

*Ibadan, Nigeria*

2006



**World Health  
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NIGERIA**

*WHO, Country office for Nigeria  
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Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website.

[http://www.who.int/mental\\_health/evidence/WHO-AIMS/en/index.html](http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html)

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The WHO-AIMS project is coordinated by Shekhar Saxena.

## **Executive Summary**

### **Background**

Information on the mental health service in Nigeria is lacking. In this report, we have used the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) to collect information on the mental health system in the country. The goal of collecting this information is to provide a comprehensive analysis of the system, focusing on resources in the context of the population they are meant to serve. Essentially, the information contained in this report can provide baseline data required in the identification of specific targets and goals for the development of mental health service in the country. It should also be useful for monitoring progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation. Even though the results presented here broadly reflect the national picture, their interpretation however requires caution as the survey was conducted in a few selected states of the country rather than on the entire country. The states, representing about 17% of the national population, were selected from the six geopolitical zones in the country. However, the states, on the whole, may be better resourced than most other states in regard to mental health facilities as within them are located six of the eight federally-funded psychiatric hospitals in the country.

### **Results**

There is considerable neglect of mental health issues in the country. The existing Mental Health Policy document in Nigeria was formulated in 1991. It was the first policy addressing mental health issues and its components include advocacy, promotion, prevention, treatment and rehabilitation. Since its formulation, no revision has taken place and no formal assessment of how much it has been implemented has been conducted. Though a list of essential medicines exists, they are not always available at the health centers. No desk exists in the ministries at any level for mental health issues

and only four per cent of government expenditures on health is earmarked for mental health.

All of the seven mental health facilities studied are owned by government. In all these facilities, no beds are set aside for children and adolescents. Many of the admissions to community-based inpatient psychiatric units and mental hospitals are involuntary but there are no extant laws to regulate admission policies and protect patients' rights. Presently ninety-five percent of psychiatrists in the surveyed areas work only for government administered mental health facilities and five percent work only for NGOs, for profit mental health facilities and private practice. Though physicians are coordinators of the primary care centers located within local government areas, such centers are run by non-physicians. Physicians in PHCs are allowed to prescribe psychotropic medications without restrictions. Non-physicians working at primary care levels can sometimes prescribe but only in situations of emergency.

Family and patient associations focusing on mental health issues do not exist in the surveyed areas (and possibly in the entire country). The non-governmental organizations in the surveyed areas are generally not involved in individual assistance activities such as counselling, housing, or support groups. There is no coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. There are no formal structures or provisions for interaction between mental health providers and primary healthcare staff. Also no systematic reporting of information exists for mental health.

In general terms, several countries in Africa are better resourced in regard to mental health personnel. Countries such as South Africa, Egypt, and Kenya have more psychiatrists per 100,000 persons and also higher proportions of psychiatric beds. Many countries in Africa also give better official attention to mental health issues. More recent mental health legislations exist in several and mental health issues are specifically addressed by designated senior bureaucrats.

# **WHO-AIMS COUNTRY REPORT FOR NIGERIA**

## **INTRODUCTION**

Nigeria is a country with an approximate area of 924 thousand square kilometers and a population of 127.117 million (WHO, 2005). The sex ratio (men per hundred women) is 102 (UNO, 2004). The proportion of the population under the age of 15 years is 44% and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 74.4% for men and 59.4% for women (UNESCA/MoH, 2004). The life expectancy at birth is 48 years for males and 49.6 years for females (WHO, 2004). The health life expectancy at birth is 41 years for males and 42 years for females. The main languages used in Nigeria are English, Hausa, Yoruba, Igbo, and Pidgin English. The largest ethnic groups are the Hausa and Fulani in the north, Yoruba in the southwest, and Igbo in the southeast. The largest religious groups are Christian and Muslim, and the other religious groups are indigenous groups. The country is a lower income group country based on World Bank 2004 criteria. The proportion of health budget to GDP is 3.4%. The per capita total expenditure on health is US\$31, of which US\$7 represented government expenditures (WHO, 2004).

Information about the level of mental health service in Nigeria is hard to come by. As will be shown in this report, systematic data gathering and collation are non-existent. It is therefore difficult to identify areas of need, to make informed decisions about policy direction, and to monitor progress. A consequence of this information gap is the continued neglect of mental health issues and the large unmet need for service that exists for mental health problems in the community. In this project, the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Nigeria. The goal of collecting this information is to provide data on the extent of mental health service situation in the country. This is seen as a necessary first step in any attempt to improve the mental health system and provide a set of basic statistics that could help in monitoring change. Data for this study was collected in 2005 and is based on the year 2004.

## **COVERAGE OF THIS REPORT**

This report is based on data collected from six states: Lagos (south-west), Calabar (south-south), Enugu (south-east), Kaduna (north-central), Maiduguri (north-east), and Sokoto (north-west). These states represent about 17% of the total Nigerian population. The choice of study sites was dictated by: 1) availability of funds for the surveys; 2) a desire to cover as many geo-political units as possible; and 3) the locations of the main mental health facilities in the country. Six of the seven “mental hospitals” (i.e. federally funded standalone psychiatric hospitals) in the country are located in these states. Given the limited number of these hospitals, their catchment areas often go beyond their immediate location in terms of city or even state. However, because the catchment areas are not strictly defined, it is impossible to determine the population for which the facilities cater.

In reading this report therefore, it is important to know that estimates of service per population are based on very rough conjectures. It is also necessary to know that the estimates of available personnel are based on those present in the facilities in the surveyed areas and not on total national profile. Thus, for example, the number of psychiatrists reported is the number working in the states covered. The selection of the states covered also excludes two states with large mental hospitals: Ogun and Edo states. The Aro Neuropsychiatric Hospital is located in Ogun while the Uselu Psychiatric Hospital is in Benin City, Edo. Both are large hospitals, with the Aro Hospital having over 500 beds.

The implication of the scope of this report is that some estimates may be better than the actual national profile especially given the nature of the distribution of mental health facilities and resources. On the other hand, some estimates may look poorer than they actually are in the country. For example, it is possible that patient support groups or non-governmental organizations are non-existent in the surveyed areas but exist in areas not surveyed. However, the overall picture herein presented is, if anything, likely to be more

positive since the selected states are in fact among the few with large government-funded mental hospitals in the country.

In this report, “mental hospitals” are standalone psychiatric hospitals while “community-based psychiatric facilities” are psychiatric units located in general hospital settings (i.e. psychiatric departments of teaching (or tertiary) hospitals and those of secondary health care facilities).

## **Domain 1: Policy and Legislative Framework**

### **Policy, plans, and legislation**

Nigeria's mental health policy was first formulated in 1991 and includes the following components: advocacy, promotion, prevention, treatment, and rehabilitation. These components are addressed in the following manner:

- Persons with mental, neurological and psychosocial disorders having the same rights to treatment as individuals with physical illnesses.
- Integration of mental health into general health care services at all levels of healthcare
- Ensuring comprehensive coverage through delivery of mental health services through primary health care.
- Appropriate training of mental healthcare personnel
- Intersectoral collaboration to be fostered with the aim of improvement quality of life
- Promotion of healthy attitudes and positive socio-cultural attributes particularly among youths
- Elimination of stigma through the promotion of positive attitudes towards the mentally ill in the general population
- Use of appropriate preventive therapeutic and rehabilitative measures to reduce the problems of alcohol and drug abuse
- Special care to be provided to different disadvantaged minority groups in the community
- Encouragement of NGOs in the promotion, preventive and rehabilitative aspects of mental health services
- Collaboration with appropriate international organizations with relevant objectives
- Periodic review of legislation governing the care of the mentally ill.
- Encouragement and funding of mental health related research

In addition, a list of essential medicines is present. These medicines include:

**Antipsychotics:** chlopromazine, Flupenthixol, Fluphenazine, Haloperidol ,

**Anxiolytics:** Diazepam, Lorazepam, Nitrazepam

**Antidepressants:** Amitriptyline, Imipramine

**Mood stabilizer:** No specific drugs are listed as mood stabilizers but Sodium valporate is listed as an anti epileptic

**Antiepileptic drugs:** Carbamazepine, clonazepam, Diazepam, Ethosuximide,

Magnesium sulphate, Paraldehyde, Phenobarbital, Phenytoin sodium, sodium valporate

The mental health plan, as contained in the 1991 policy, has the following components:

- Formulation of strategies for promotion, prevention, management, treatment and rehabilitation of mental and neurological disorders and their subsequent disability through the most appropriate approach
- Improvement of general healthcare services through facilitating the application of mental health principles, knowledge and skills of behavioural sciences
- Enhancing the use of mental health principles to promote social health
- Reduction of mental health harmful effects and consequences on individuals, families and communities

In addition, guiding principles of the strategies to the mental health plan are:

- Establishment of a national mental health advisory committee to advise the minister of health on all matters relating to mental health particularly primary mental healthcare programmes
- Appointment of a schedule officer at the federal level to coordinate implementation of mental healthcare policy and programmes
- Regular revision and implementation of the mental health laws
- Integration of primary mental health programmes into the National primary healthcare programme
- To provide adequate training and back up referral system in the secondary and tertiary health-care level for the primary mental health care

- Provision of training in the areas of mental health for all health-care personnel whether medical or non-medical for better management of mental health problems
- Identifying the needs of special groups within the community and provision of relevant and appropriate services to such

No disaster/emergency preparedness plans for mental health exist in the country. Emergency or disaster agencies have no specific mental health work. Other than indirect references to mental illness in some areas of the nation's criminal codes, no comprehensive mental health legislation currently exists in the country. A bill to that effect is currently under consideration in the National Assembly, the country's legislature.

The bill makes provisions for:

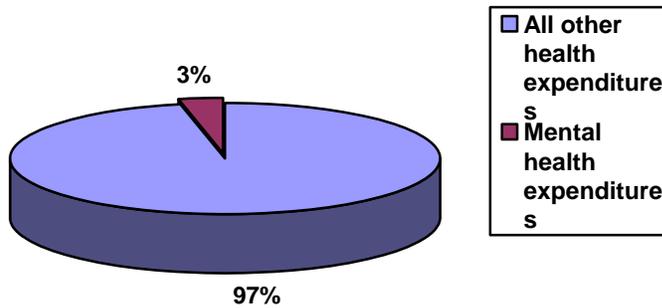
- Access to mental healthcare and services
- Voluntary and involuntary treatment
- Accreditation of professional and facilities
- Law enforcements and other judicial issues for people with mental illness.
- Mechanisms to oversee involuntary admission and mechanism to implement the provision of Mental health Legislations

However, what the final document will look like is not clear yet. There are other laws relevant to mental health: for example those relating to human rights and sales of alcohol.

### **Financing of mental health services**

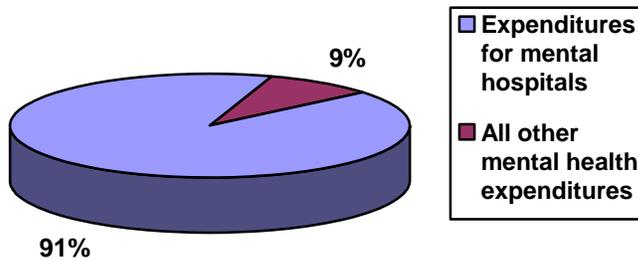
About 3.3% of the health budget of the central government goes to mental health, with over 90% of this going to mental hospitals.

**GRAPH 1.1 HEALTH EXPENDITURE TOWARDS MENTAL HEALTH**



Of all the expenditures spent on mental health, 91% is directed towards mental hospitals (Graph 1.2).

**GRAPH 1.2 MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS**



Thirty three percent of the population has free access (at least 80%) to essential psychotropic medicines. Although the new National health insurance scheme provides short-term coverage for “affective mental disorders”, currently payment for drugs is out of pocket. This provision through the health insurance scheme is presently for workers in the formal sectors. The cost of antipsychotic medication using old antipsychotics for a day is N18 (7% of the daily minimum wage) and antidepressant medication is N12 (5% of the daily minimum wage), the sum of N250 being one day minimum wage in the local currency. The duration of treatment in many cases is a maximum of 21 days.

### **Human rights policies**

A national human rights review commission established by an act in 1995 does exist in the country. However, it has no specific monitoring activities for mental health but does conduct visits to prisons. No mental hospitals, community-based inpatient psychiatric units or community residential facilities have review/inspection of human rights protection of patients at anytime. Fourteen percent of mental hospitals staff and twenty percent of inpatient psychiatric units and community residential facilities staff have had at least one day training, meeting, or other type of working session on human rights protection of patients in the year of assessment. A workshop on human rights was conducted in one of the mental hospitals with attendees from the other hospitals.

## **Domain 2: Mental Health Services**

### **Organization of mental health services**

No desk exists in the ministries at any level for mental health. Mental health issues are often supervised by officials with other primary duties. Health services in general are not provided on a defined catchment basis and this often leads to uncoordinated delivery of service. In view of their few numbers, mental health facilities tend to provide service to patients coming from very distant locations with the resultant negative effect on continuity of service.

### **Mental health outpatient facilities**

Six out of the seven mental health facilities studied are owned by the federal government and had outpatient clinics. The seventh is owned by the government of one of the states. None of these mental health facilities is specifically for children and adolescents only. These facilities treated 89,938 users (328 per 100,000 general population). Of all users treated in mental health outpatient facilities, 45% are female and 2% are children or adolescents. The users treated in outpatient facilities are primarily diagnosed with schizophrenia (52%) and mood (affective) disorders (31%). The average number of contacts per user is one. Other than clinic-based follow-up, no outpatient facilities provide follow-up care in the community, and there are also no mental health mobile teams. In terms of available interventions, less than 20% of the outpatient facilities offer specific psychosocial interventions. A hundred percent of the outpatient facilities available in the surveyed areas had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or a near-by pharmacy all year round.

### **Day treatment facilities**

There is only one day treatment facility in the surveyed areas (and possibly in the country), and it is available to all age groups. The current capacity of the facility is for 20 users (0.07 per 100,000 general population). Of all users treated in the day treatment facility, 30% are females. The proportion of children and adolescents treated is not known. On average, users spend two hundred and fifty days in the day treatment facility.

### **Community-based psychiatric inpatient units**

There are five community base psychiatric inpatient units available in the country for a total of 124 beds (0.45 per 100,000 population). There are no beds in community-based inpatient units specifically reserved for children and adolescents. Thirty-five percent of admissions to community-based psychiatric inpatient units are female and 6% are children/adolescents. The admission diagnoses of patients to the community-based psychiatric inpatient facilities were primarily schizophrenia and related disorders (43%) and mood (affective) disorders (25%). On the average, patients spend 21 days on admission. Between 21-50% of patients in community-based psychiatric inpatient units were estimated to have received one or more psychosocial interventions in the last year. All the community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

### **Community residential facilities**

There is only one community residential facility available in the surveyed areas with a total of ten beds. This facility is in Lagos and it is run by a religious mission for rehabilitation of patients with drug problems. No bed in this community residential facility is reserved for children and adolescents. Twenty percent of users treated in the community residential facility are female and the percentage of children being treated in the facility is unknown. The number of users in the community residential facility is ten and the average number of days spent in community residential facilities is two hundred and ninety days.

### **Mental hospitals**

There are seven mental hospitals available in the surveyed areas with a total of 1,092 beds (3.99 beds per 100,000 population). Eighty six percent of these facilities are organizationally integrated with mental health outpatient facilities. That is, these facilities have functional outpatients departments or units. While none of these beds in mental hospitals are reserved for children and adolescents, we believe that a substantial proportion of patients treated in the hospitals will be children even though there are no records to make a reliable estimate of this proportion. The number of beds has increased by 1% in the past five years. The patients admitted to mental hospitals have the following primary diagnoses; Schizophrenia, schizotypal and delusional disorders (51%) and mood (affective) disorders (24%). The number of patients in mental hospitals is 3,495. The average number of days spent in mental hospitals is about fifty two days (51.7). Ninety three percent of patients spend less than one year, 3% of patients spend 1-4 years, 2% of patients spend 5-10 years, and 1% of patients spend more than 10 years in mental hospitals. Twenty-one to fifty percent of patients in mental hospitals received one or more psychosocial interventions in the past year. All seven mental hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

### **Forensic and other residential facilities**

In addition to beds in mental health facilities, there are also twenty-two beds (0.08 per 100,000 population) for persons with mental disorders in forensic inpatient units and eighty-five in six other residential facilities such as homes for persons with mental retardation, detoxification inpatient facilities, homes for the destitute, etc. In forensic inpatient units no patient spent less than one year: 9% of patients spent 1-4 years, 23% of patients spent 5-10 years, and 68% of patients spent more than 10 years in mental hospitals.

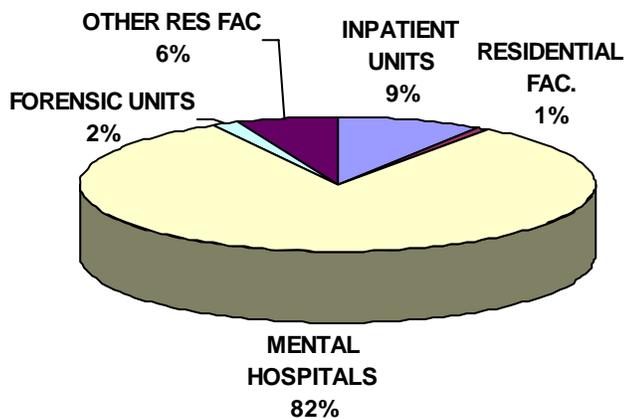
### **Human rights and equity**

Reflecting the profile of patients seen in the facilities and the nature of their contacts with service, 51% of all admissions to community-based inpatient psychiatric units and 64% of all admissions to the mental hospitals surveyed are involuntary, that is, initiated by the families and resisted by the patients. Though the practice varies across facilities, between 11-20% of patients on average were restrained or secluded at least once within the last year in community-based psychiatric inpatient units, and the same percentage range can be said of patients in mental hospitals.

The density of psychiatric beds in or around the largest city (Lagos) is 1.60 times the density of beds in the rest of the country. Such a distribution of beds prevents easy access for rural users. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is moderate in the country.

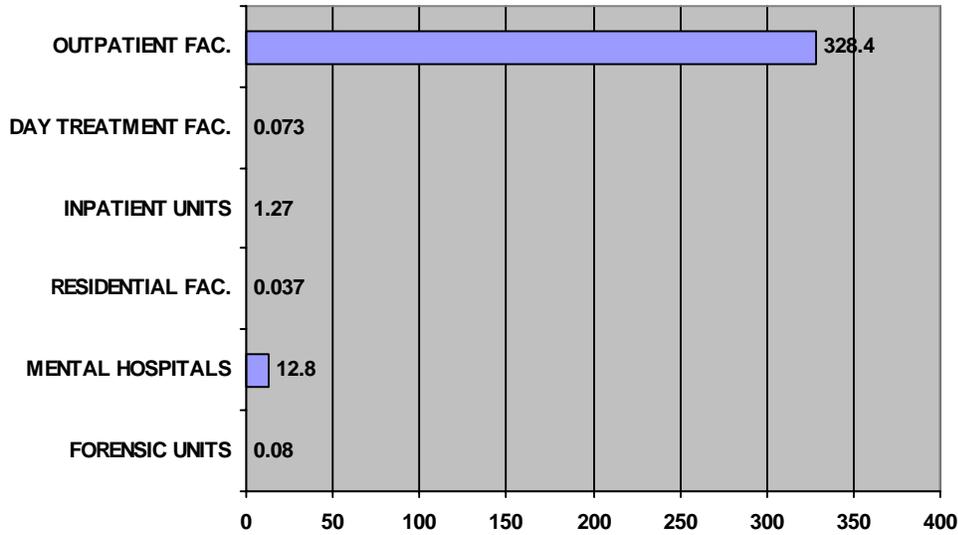
The majority of beds in the country are provided by mental hospitals, followed by inpatient units (Graph 2.1).

**GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES**



The majority of the consumers of mental health services are treated in outpatient facilities (328 patients per 100,000 population). See Graph 2.2.

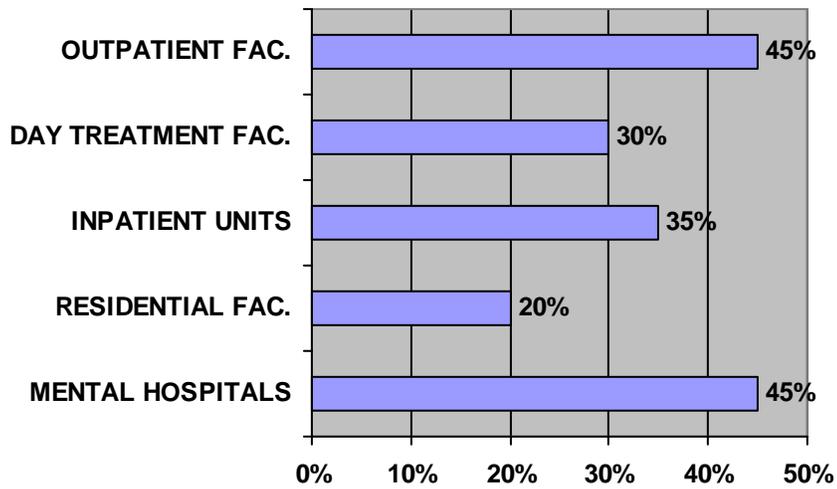
**GRAPH 2.2 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)**



Note: In this graph, the number of beds in Forensic Units is taken as proxy for number of patients treated.

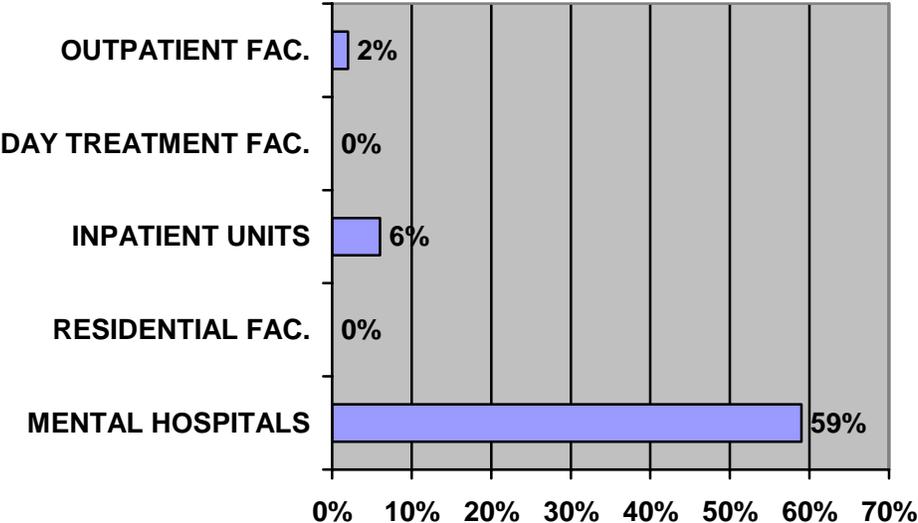
Female users make up over 45% of the population in all mental health facilities in the country. This equals the proportion of female users in outpatient units. Female users are lowest in residential facilities and day treatment facilities (Graph 2.3).

**GRAPH 2.3 - PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES**



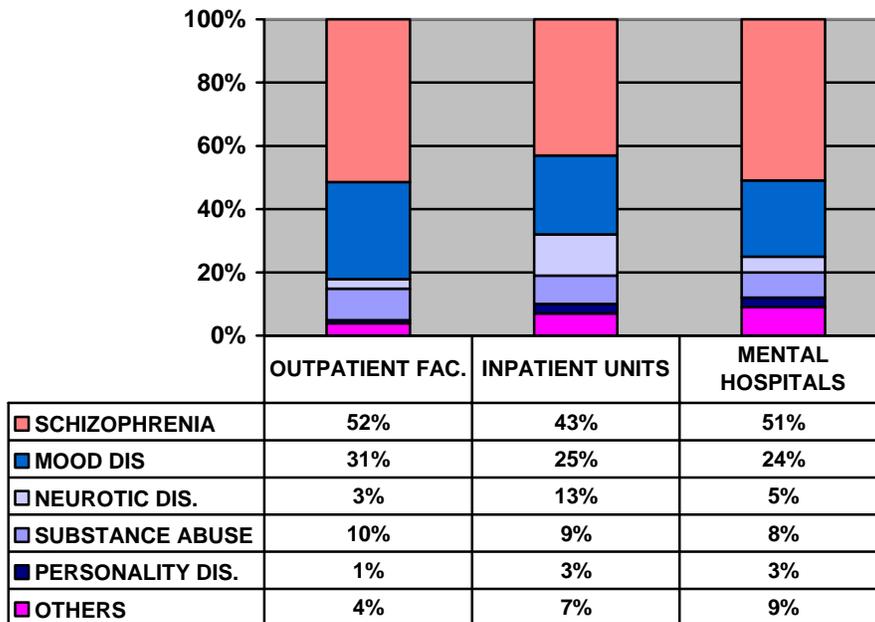
The percentage of users that are children and/or adolescents varies substantially from facility to facility. The proportion of children/adolescent users is highest in mental health hospitals. No child or adolescent patients are treated in residential and day treated facilities (Graph 2.4).

**GRAPH 2.4 - PERCENTAGES OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES**



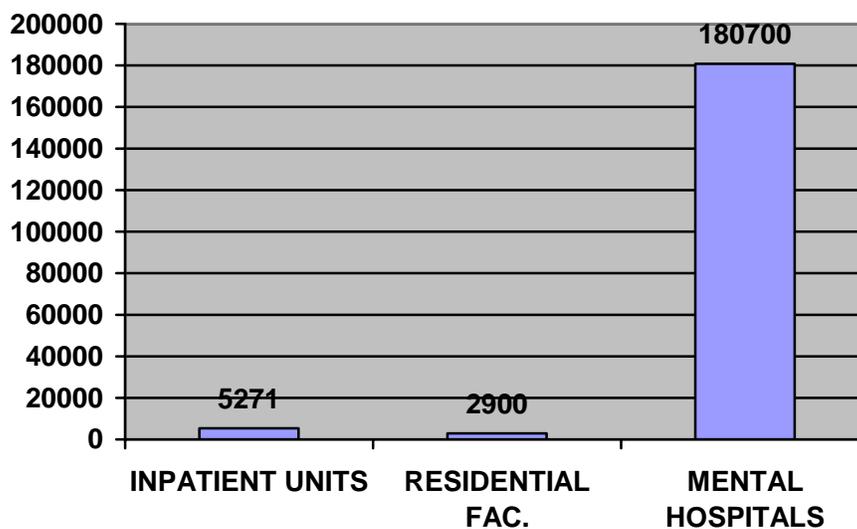
The distribution of diagnoses varies across facilities: in outpatients facilities mood disorders and schizophrenia are most prevalent. The distribution of diagnosis is not different in in-inpatient units and in mental hospitals (Graph 2.5).

**GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS**

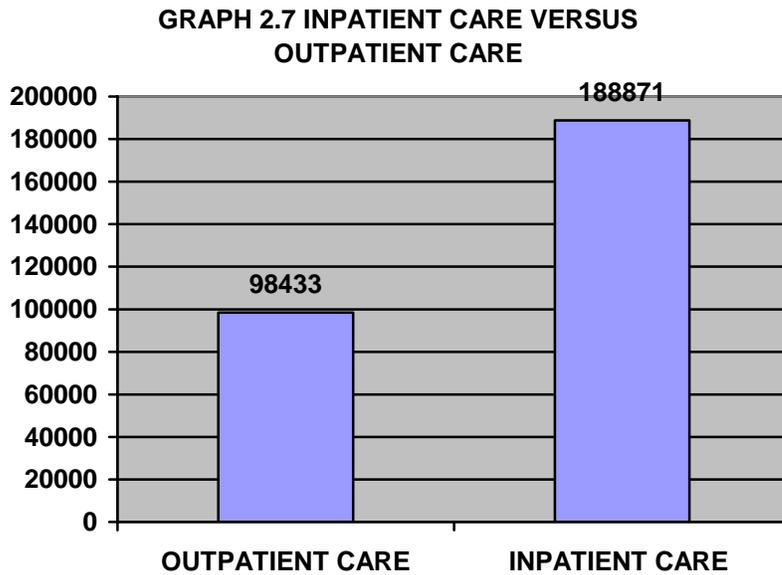


The longest length of stay for users is in mental hospitals (Graph 2.6).

**GRAPH 2.6 - LENGTH OF STAY IN INPATIENT FACILITIES (days per year)**



The ratio between outpatient/day care contacts and days spent in all the inpatient facilities (mental hospitals, residential facilities and general hospital units) is an indicator of extent of community care: in this country the ratio is about 1:2 (Graph 2.7).



Psychotropic drugs are available in all mental health facilities.

### **Domain 3: Mental Health in Primary Health Care**

#### **Training in mental health care for primary care staff**

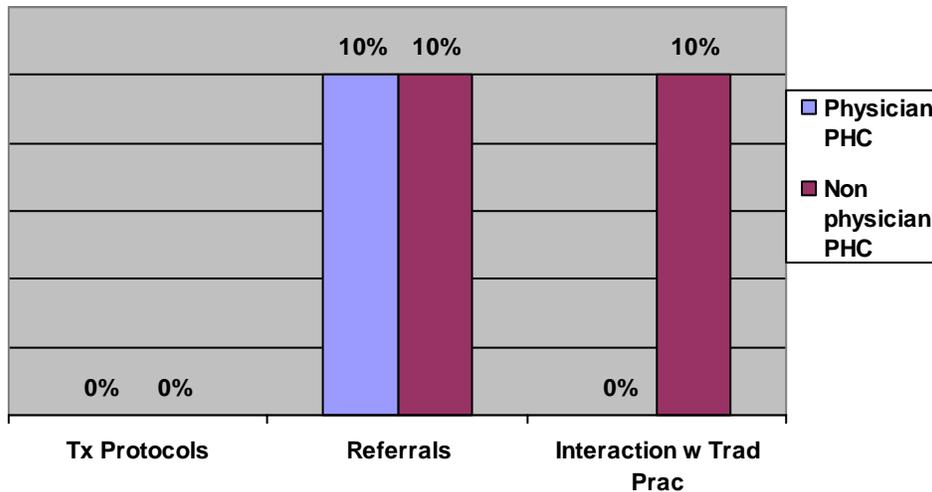
It is estimated that about three percent of the undergraduate training hours for medical doctors is devoted to mental health, in comparison to 13% of the training hours for nurses and 3% for non-doctor/non-nurse primary health care workers. In terms of refresher training, it is unknown how many primary health care doctors, nurses and non-doctor/non-nurse primary health care workers have received such training. The reason why these data could not be obtained is because the primary healthcare medical personnel are employed by the local government rather than the state. It would be expensive to visit all the local government involved in each state to get the information. The percentage of

primary care professionals with any kind of refresher training course in mental health within the last year is unknown.

**Mental health in primary health care**

Though physicians are coordinators of the Primary Healthcare Clinics (PHCs) at the local government level, no PHC has a full-time physician in the surveyed areas (or anywhere in the country). Less than 20% of PHCs make referrals to mental health professionals. There are no formal avenues for professional interaction between primary health care staff and other care providers. There are also no formal avenues for interaction between PHC staff with complimentary/alternative/traditional practitioners. The likelihood of informal interactions, which could occur in rural area, is estimated to be about 10% (Graph 3.1).

**GRAPH 3.1 - COMPARISON OF PHYSICIAN BASED PRIMARY HEALTH CARE WITH NON-PHYSICIAN BASED PRIMARY HEALTH CARE**



**Note:** Tx protocols = % of PHC clinics with treatment protocols available for key mental health conditions; Referrals = % of PHC who make at least one mental health referral per month; Interaction w Trad Prac = % of PHC interacting with complimentary/alternative/traditional practitioners per month. These figures represent the average of WHO-AIMS category ranges.

**Prescription in primary health care**

Physicians in PHCs are allowed to prescribe psychotropic medications without restrictions. Nurses, non-doctor/non-nurse primary health care workers are sometimes also allowed to prescribe psychotropic medications but only in emergency situations.

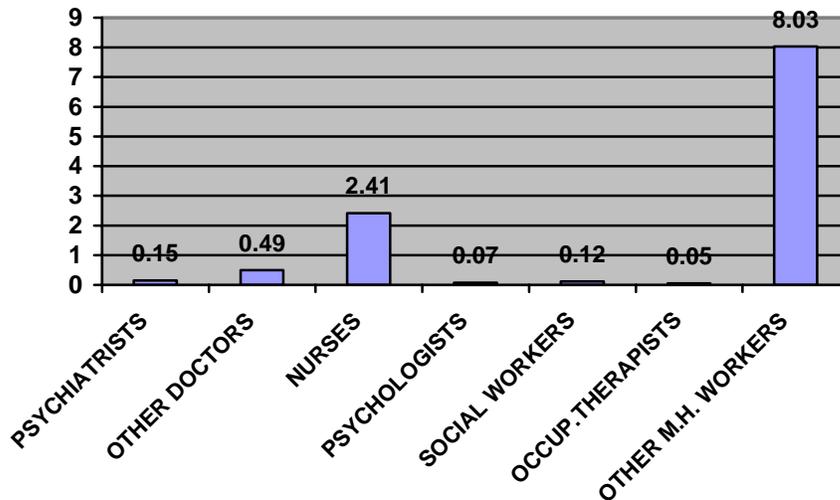
## **Domain 4: Human Resources**

### **Number of human resources in mental health care**

The total number of human resources working in mental health facilities or private practice in the surveyed states is 3,105 (11.37 per 100,000 population). The breakdown according to profession is as follows (also depicted in Graph 4.1):

Psychiatrists	42	(0.15 per 100,000)
Other medical doctors	135	(0.49 per 100,000)
Nurses	659	(2.41 per 100,000)
Psychologists	20	(0.07 per 100,000)
Social workers,	34	(0.12 per 100,000)
Occupational therapists	15	(0.05 per 100,000)
Other health or mental health workers	2200	(8.03 per 100,000)

**GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH**  
(rate per 100.000 population)

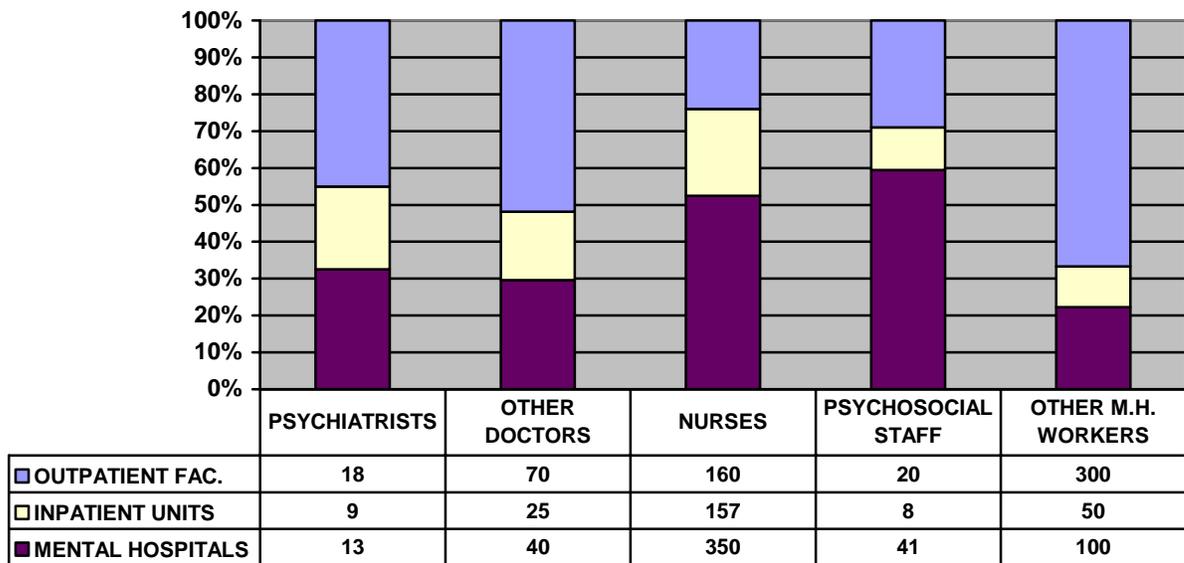


The category of other health workers includes auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, and professional and paraprofessional psychosocial counselors). Ninety five percent of psychiatrists work only for government administered mental health facilities and five percent for NGOs or for private mental health facilities. No psychiatrists were working for both government and private at the time of survey. Ninety eight percent of psychologists, social workers, nurses and occupational therapists work only for government administered mental health facilities, two percent work for NGOs or for private mental health facilities.

In regard to staffing of facilities in the surveyed areas, eighteen psychiatrists work in outpatient facilities, nine in community-based psychiatric inpatient units and thirteen in mental hospitals. Seventy medical doctors, not specialized in mental health, work in outpatient facilities, twenty-five in community-based psychiatric inpatient units and forty in mental hospitals. One-hundred and sixty nurses work in outpatient facilities, one hundred fifty seven in community-based psychiatric inpatient units and three hundred and fifty in mental hospitals. Psychologists, social workers and occupational therapists, all

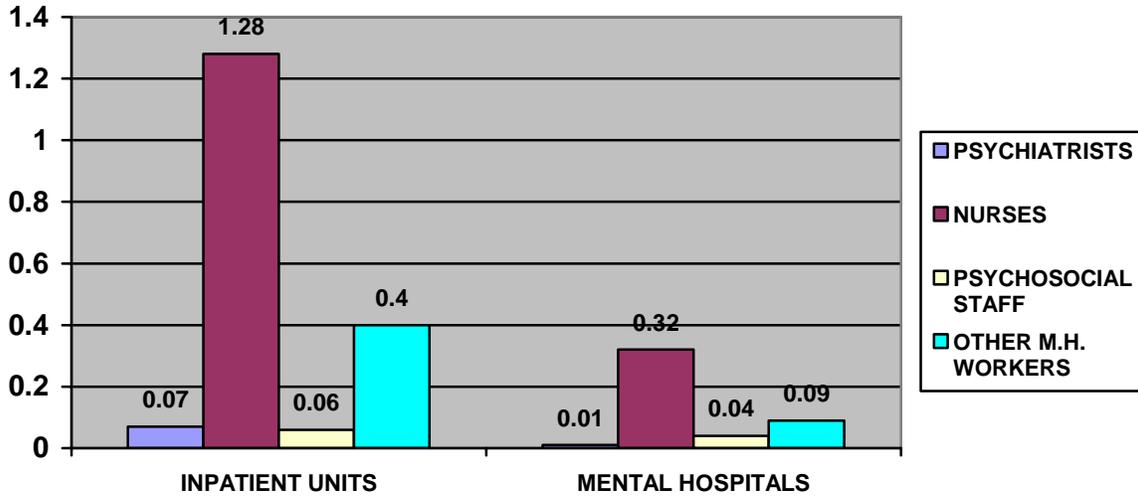
totaling about twenty, work in outpatient facilities, eight community-based psychiatric inpatient units and forty-one in mental hospitals. There were three hundred other health or mental health workers working in the outpatient facilities, fifty in community-based psychiatric inpatient units and one hundred in mental hospitals (Graph 4.2).

**GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES**  
(percentage in the graph, number in the table)



In terms of staffing in mental health facilities, there are 0.07 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.01 psychiatrists per bed in mental hospitals. As for nurses, there are 1.28 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.32 per bed in mental hospitals. For psychosocial staff (e.g., psychologists, social workers, and occupational therapists) there are 0.06 per bed for community-based psychiatric inpatient units and 0.04 per bed in mental hospitals. Finally, the numbers for other health or mental health workers is 0.4 per bed in inpatient units and 0.09 per bed in mental hospitals (Graph 4.3).

**GRAPH 4.3 - RATIO HUMAN RESOURCES/BEDS**

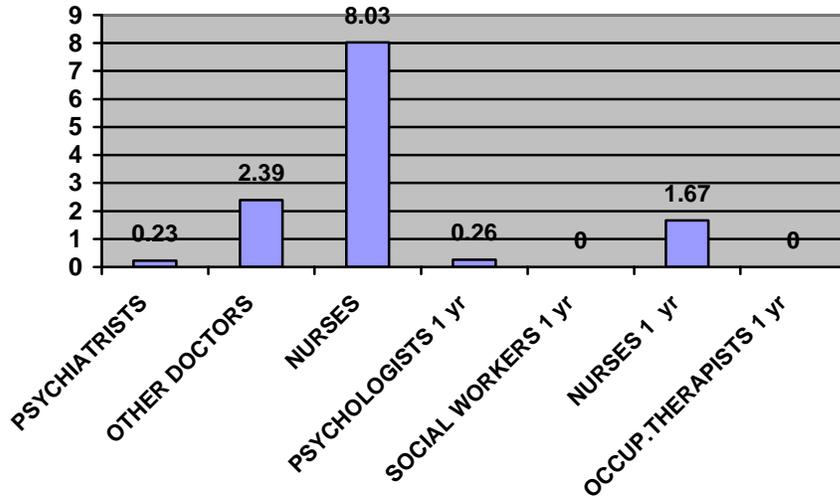


Urban areas as represented by the largest city have a greater number of resources per capita than rural areas in Nigeria. The density of psychiatrists in or around the largest city is 1.16 times the density of psychiatrists in the entire country. The density of nurses is 3.42 times greater in the largest city than the entire country.

### **Training professionals in mental health**

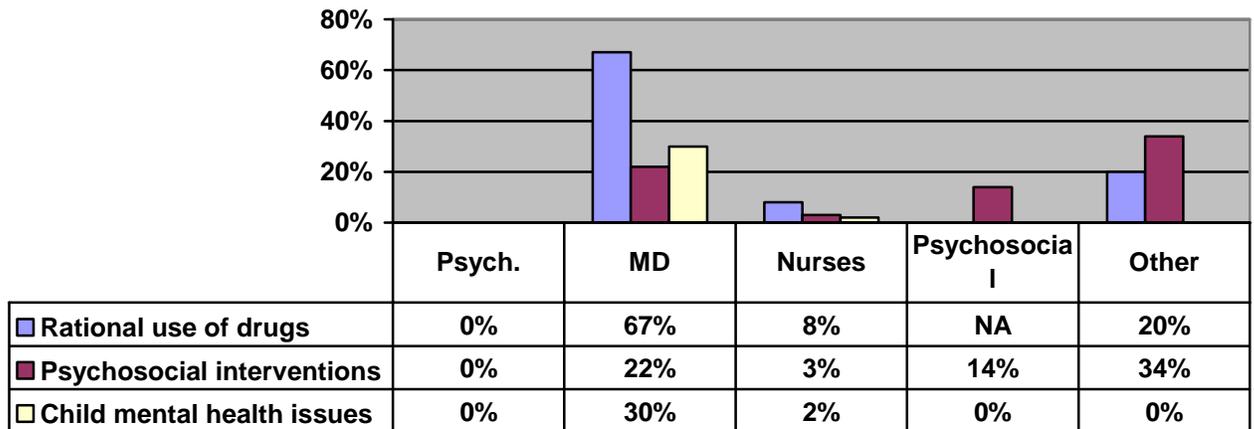
The number of professionals graduated last year in academic and educational institutions is 3,189 (11.65 per 100,000): 8 psychiatrists (0.03 per 100,000), 654 other medical doctors, not specialized in psychiatry (2.39 per 100,000), 2,200 general health care nurses (8.03 per 100,000), 320 nurses with at least 1 year training in mental health care (1.17 per 100,000), 7 psychologists with at least 1 year training in mental health care (0.02 per 100,000), no social worker with at least 1 year training in mental health care, and no occupational therapists with at least 1 year training in mental health care (Graph 4.4).

**GRAPH 4.4 - PROFESSIONALS GRADUATED**  
(rate per 100.000 population)



At least 25% of psychiatrists migrate to other countries within five of the completion of their training. Graph 4.5 shows the percentage of mental health care staff with at least two days of refresher training in the rational use of drugs, psychosocial interventions, and child/adolescent mental health issues.

**GRAPH 4.5 - PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR**



Psych = psychiatrists; MD =other medical doctors not specialized in psychiatry; Psychosocial = psychologists, social workers, and occupational therapists. Other = other health and mental health workers

### **Consumer and family associations**

There are no consumer or family associations specifically focusing on mental disorders or mental health issues. However, at least one of the hospitals in the surveyed areas has an association of “friends of the hospital”, an association of public-spirited persons that work to raise funds and support the hospital. Consequent on their non-existence, consumers (or users) associations have not been involved in the formulation or implementation of mental health policies, plans, or legislation at anytime in the country. In addition, no NGOs in the country are involved in individual assistance activities such as counselling, housing, or support groups.

## **Domain 5: Public Education and Links with other Sectors**

### **Public education and awareness campaigns on mental health**

There is no coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. Government agencies, NGOs, professional associations, and international agencies have promoted public education and awareness campaigns in the last five years. These campaigns have targeted the general population, children/adolescents and other vulnerable or minority group such as the homeless and social deviants. In addition, there have been public education and awareness campaigns targeting professional groups including: health care provides, teachers and other professional groups lined with the health sector.

### **Legislative and financial provisions for persons with mental disorders**

Presently no legislative or financial provisions exist to protect and provide support for users.

### **Links with other sectors**

The primary health care agency at the national level has at times involved psychiatrists in the development of training programmes. In terms of support for child and adolescent health, it is unknown if any primary or secondary schools have either a part-time or full-time mental health professional. However, a few primary and secondary schools (less than 20%) have school-based activities to promote mental health and prevent mental disorders.

The percentage of prisoners with psychosis is 2–5%, while the corresponding percentage for mental retardation is less than 2%. Regarding mental health activities in the criminal justice system, some prisons (21–50%) have at least one prisoner per month in treatment contact with a mental health professional. As for training, less than 20% of police

officers, judges and lawyers have participated in educational activities on mental health in the last five years. In terms of financial support for users, many mental health facilities (51–80%) have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, no persons receive social welfare benefits for a mental disability.

## Domain 6: Monitoring and Research

There is no structure in place for regular transmission of patient and clinical service data to the health ministry. Consequently, no mental health facility transmits admissions or patient contacts data on a regular basis to health department. However occasionally, there are requests from bodies such as the National Law Enforcement Agency for their own specific use.

Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information.

	<b>MENTAL HOSPITALS</b>	<b>INPATIENT UNITS</b>	<b>OUTPATIENT FAC.</b>
<b>N° of beds</b>	100%	100%	████████████████████
<b>N° inpatient admissions/users treated in outpatient facility.</b>	100%	100%	100%
<b>N° of days spent/user contacts in outpatient facility.</b>	0%	0%	100%
<b>N° of involuntary admissions</b>	0%	0%	████████████████████
<b>N° of users restrained</b>	0%	0%	████████████████████
<b>Diagnoses</b>	86%	20%	100%

In terms of research, an estimated 3% of all health publications in the country were on mental health. The research focused on:

- Epidemiological studies in community samples
- Epidemiological studies in clinical samples
- Non-epidemiological clinical/questionnaires assessments of mental disorders
- Services research
- Biology and genetics
- Policy, programmes, financing/economics
- Psychosocial interventions/psychotherapeutic interventions
- Pharmacological, surgical and electroconvulsive interventions

## **CONCLUSION**

This report has presented the profile of mental health service in Nigeria in the year 2005/2006 using six states in the country selected on the basis of their geopolitical distribution and location of some of the country's main psychiatric hospitals. This report shows that the mental health services in these areas are quite limited. Also, the existing mental health policy for Nigeria was formulated in 1991 and it has not been updated. There are no family or patient associations in these areas and there are no mechanisms to protect patients rights. Similarly, there is no provision for interactions between mental health providers and primary care staff. This report suggests that there should be a comprehensive review of how mental health service is provided and that there should be a plan for addressing any systemic issues. It is the hope of the authors that the report will be an impetus for making the necessary improvements in the mental health system in Nigeria.

### **Dissemination**

This report will be disseminated to government ministries of health and those of social welfare. It will also be disseminated to mental health facilities in the country. An extract

of the report will be prepared for publication in a scientific journal. This report will be useful for administrators in the Federal and State Ministries of Health as well as those of Social Welfare. Non-governmental organizations (NGOs) interested in mental health will also receive copies.

## **Ideas for planning**

### **Two specific actions can be taken, based on the current report.**

1. With the support of the Ministries of Health and the WHO, outreach programs can be planned whereby specialists, currently located in tertiary hospitals, are encouraged and supported to provide supervisory visits to designated secondary and primary health centres. Such visits will be to help clinicians working at those centres identify and treat common mental disorders presenting to them. The planning and execution of such a program can be accomplished within 6 months of its adoption.
2. Training programs to build mental health skills among providers in secondary and primary health care centres can be designed and implemented at regional levels. Such a training will be designed and conducted by psychiatrists working at designated tertiary centres. The involvement of the Association of Psychiatrists in Nigeria will be sought and obtained. The Federal Ministry of Health, working in liaison with State Ministries of Health, will facilitate this through provision of resources for the training. Training materials can be built around templates for the training of primary health workers designed by the WHO. The program can be designed and started within 2 years of its adoption.



There is very limited information about mental health services in Nigeria. Using the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS), this report presents a comprehensive analysis of the system, focusing on resources and services available for the population of Nigeria. This report is based on data from the country's six geopolitical units in which are located six of the eight federally-funded psychiatric hospitals. This report will be useful for a broad range of policy makers and stakeholders in mental health. The results highlight the considerable neglect of mental health issues in the country. A Mental Health Policy first formulated in 1991 remains substantially unimplemented and has not been revised. Though a list of essential medicines exists, they are not always available at the nation's health centers. Crucially, there are no designated desks for mental health administration in the country's ministries of health and estimates suggest that no more than four per cent of the central government expenditures on health is earmarked for mental health. No admission beds are set aside for children and adolescents in the public psychiatric facilities studied. Many of the admissions to community-based inpatient psychiatric units and mental hospitals are involuntary but there are no extant laws to regulate admission policies and protect patients' rights. Gross shortages exist in regard to mental health personnel across all relevant professions. No formal support exists for family caregivers of the mentally ill. Mental health issues have also received no direct attention from non-governmental organizations, possibly reflecting a low national priority. It is hoped that the information contained in this report can provide baseline data required in the identification of specific targets and goals for the development of a comprehensive mental health service that is evidence-based and meets the needs of the Nigerian population.