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Health Workers' Preparedness towards Integrating Mental Healthcare into Primary Health Settings: Evidence from Nigeria

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Abstract

Background: The global drive to scale up mental health services and eliminate the treatment gap requires incorporating mental health services into primary health care (PHC). Primary health care provides comprehensive, continuous, and coordinated care and if need be provides referrals to higher levels of care. However, for these services to meet the basic objective of PHC, it is necessary to determine healthcare workers' preparedness for caring for the mentally ill. Therefore, this study aimed to examine health workers' preparedness for integrating mental healthcare into primary settings in a rural community in Nigeria. **Methodology**: A descriptive research design was used to conduct the study among all 215 primary healthcare workers within Nkanu West Local Government Area (LGA). The instrument for data collection was a structured questionnaire constructed by the author. A pilot study was conducted on 10% of the sample population. Cronbach's Alpha formula was used to estimate the reliability coefficient (0.85). The collected data were analysed with descriptive statistical frequencies and percentages. **Results**: Data were analyzed using the Statistical Package for Social Sciences (SPSS) version 20. Findings show that healthcare workers' preparedness to care for the mentally ill at the primary healthcare centre is quite low. It was also found that mental illness is still shredded by stigma as a result of poor awareness. Consequently, there is still a persistent pervasive belief system that Mental illness is a form of retribution from the gods for one's wrong deed in the study area. **Conclusion**: It was concluded that few of the respondents were prepared for the care of the mentally ill which might be a result of poor awareness about mental health and the negative stereotype given about mental health. From the analysis, it can be deduced that health workers exhibit some degree of positive attitude towards care of the mentally ill, though, mental illness is associated with stigmatization due to a lack of public understanding of mental disorders.

There was strong support for integrating mental health into primary health care by health care providers. Therefore there is a need for community education and building of the capacity of healthcare workers for integration of the care of the mentally ill to be feasible in PHC centres.

Keywords

Mental Health, Primary Healthcare, Health Workers, Stigma

1. Introduction

Mental, neurological, and substance-use (MNS) disorders are extremely common worldwide [1] [2]. Untreated mental diseases represent 13% of the worldwide disease burden, with the treatment gap being highest in poor and middle income nations [3]. Mental diseases also account for 7% of the global burden of disease assessed in disability-adjusted life-years (DALYs) and up to 19% of all years lived with disability [4]. As a result of the aforementioned, MNS are substantial contributors to disease, untimely death, and disability throughout the world [5]. They're also regularly linked to social stigma and human rights violations, especially in low- and middle-income nations (LMICs).

Despite this, treatment care for MNS still lags behind LMICs, especially in Africa. According to the WHO's World Mental Health Survey, the treatment gap for serious mental disorders in those climes has been estimated to be up to 75% [6]. According to Espinosa-Jovel, Toledano, Aledo-Serrano, García-Morales, and Gil-Nagel [7], over 80% of people with epilepsy live in LMICs, and about 6 out of 10 do not receive any therapy. By 2050, "substantial population growth and aging are expected to result in an estimated 130 percent rise in the impact of mental and drug use disorders" in Sub-Saharan Africa [8]. The situation is even more alarming in a highly populated African country like Nigeria. Only 20% of patients with very common mental disorders in the country received treatment in the previous year, and even when they did, it was frequently below basic ethical and clinical standards [6] [9].

No doubt, the society faces grave consequences from the lack of available mental health professionals especially doctors and nurses to render the needed services [10]. This emphasizes the need to expand mental health services, particularly in low- and middle-income countries (LMICs), to enhance access to care. On the other hand, efforts to expand mental health support in LMICs must struggle with a current scarcity of mental health specialists and health facilities capable of providing specialized care for mental, neurological, and substance use disorders (MNS).

As part of the global drive to scale up mental health services and eliminate the treatment gap, incorporating mental health services into primary health care has been identified as the most practicable strategy to enhance access [11]. Primary

health care (PHC) is a community-based management method for providing healthcare services. Primary health care provides care at the point of contact for people with health problems, as well as comprehensive, continuous, and coordinated care and rapid referrals to higher levels of care. Various countries have made different amounts of progress in implementing the notion since it was first published in 1978 [12].

However, in the majority of LMICs, this expectation is rarely met when it comes to MNS problems in primary care. The sophistication of PHCs in dealing with health care challenges at the grassroots level implies that mental health services could be delivered by health services providers close to them in the community rather than the tertiary approach that relies solely on professional psychiatrists. This way, the PHC model easily comes into play.

Primary healthcare is required to provide first contact and, in addition to providing comprehensive, ongoing, and coordinated treatment for people with health problems, it should also demonstrate the ability to refer patients to a higher level of care quickly. However, in the majority of LMICs, this expectation is rarely met when it comes to MNS problems in primary care. Although some reasons have been advanced, such as poor training of primary care providers, a lack of support and supervision, and uncoordinated referral pathway through the multiple levels of the health service, and policy neglect manifesting itself in the form of poor financing, infrequent supply of medications for MNS conditions, and weak health systems [13]. There is however a need for context-specific empirical evidence to inform policy and plan of action towards integration of mental healthcare into PHC. Therefore, the study aimed to determine the healthcare workers' preparedness for the care of the mentally ill, the knowledge of the care of the mentally ill among health workers, the attitudes of health workers towards mentally ill patients, and the health workers' perception of integrated mental healthcare.

2. Methodology

2.1. Design

The descriptive survey research design was used as it explains in detail the characteristics of the study phenomenon in a given setting and accurately unveils information about the study as it appears without manipulation.

2.2. Setting

The study setting was Nkanu West Local Government Area in Enugu State. Enugu State, historically known for its coal deposits that attracted miners and others is a major city in South Eastern Nigeria. The state is pivotal in the South Eastern part of Nigeria, with its major city, Enugu, having historically borne an identity as the capital city of the then Eastern Region, East Central State, old Anambra State and present Enugu State. Nkanu West is one of the suburban/rural local governments in the eastern part of Enugu.

2.3. Population and Sample

All the 226 health workers who consented to the study in the study setting were enrolled. This was possible because of the relatively small population. It has been opined [14] that all respondents can be and should be included in small populations.

2.4. An Instrument for Data Collection

The instrument for data collection was a structured questionnaire developed by the researcher. The instrument was made up of closed-ended questions. Items of the instrument were generated based on the set objectives of the study. The questionnaire is comprised of four sections. There were five demographic questions about the participants in section A, and there were eleven preparedness questions regarding how to care for people with mental illnesses and sources of information in Section B, Section C and D, cover attitudes toward people with mental illnesses and perceptions of the integration of mental health treatment into PHC, had 10 and 9 items, respectively. The main items had a Likert scale rating ranging from 4 to 1. Four (4) respondents strongly agreed, three (3) agreed, two (2) agreed, and one (1) disagreed (D). Based on predetermined goals, the instrument's psychometric qualities were evaluated for face and content validity. A Cronbach's alpha coefficient of 0.85 was obtained, indicating that the instrument had very high dependability.

2.5. Data Collection

Before data collection, approval and administrative permit were obtained from Nkanu West LGA Secretariat and the head of PHC's that participated in the study. Informed consent was obtained from the respondents before the administration of the questionnaires. Data were collected through the use of a pretested questionnaire, copies of which were distributed to the health workers in their workplaces but in between shifts or at the end of work to avoid interrupting their jobs. Data collection lasted for three weeks.

2.6. Data Analysis

Basic descriptive statistics of frequency and percentages were used to analyse and present the data collected. The variables that informed the basis of data collection include: PHC workers' level of preparedness of care for mentally ill persons, source and knowledge of care of the mentally ill persons, as well as attitudes and perceptions of PHC workers towards mentally ill persons were presented in tables.

3. Results

Of 226 distributed questionnaires, two hundred and fifteen (215) were correctly completed giving a 95% return rate. The majority of the participants (46%) were in the age range of 50 years and above while the age 39 and below are the lowest

in the population. Based on the highest academic qualification, a preponderant (48%) showed that the majority of the participants were Diploma holders. Those who had 16 years of working experience (32%) were higher than other categories.

3.1. Reported Preparedness for the Care of the Mentally Ill at the PHC Level

The findings of the study showed that respondents' reported preparedness/ ability for the treatment of mentally sick people at the PHC level is not very high. An average item-by-item mean of 1.65 on a four-point scale is low, indicating self-reported inability or poor preparedness of the primary health workers to care for the mentally ill at the PHC. From Table 1, 17.2% of the respondents agreed that community-based child mental health care training they received was sufficient to enable them to practice in PHC, 20.9% agree that they were aware of referral protocol for mentally ill patients. A proportion of 9.3% agreed that they had received some training on the assessment of mentally ill patients, whereas 13% agreed that they were particularly trained to identify patients with mental health problems. Among the respondents also, 11.1% agreed that they had adequate occupational mental health training skills; 17.2% indicated that the kind of training skills they had acquired prepared them for MHC; and 16.7% agreed that they were adequately trained for drug prescription for the mentally ill in the community settings. On the adequacy of clinical care for mentally ill patients, 21.8% of the respondents answered in the affirmative. 15.3% agreed that they could provide counselling services for the mentally ill, while 19.6% indicated that they were disposed to providing therapies for a family of the mentally ill (Table 2).

3.2. Sources of Knowledge for Mentally Ill Care

The results, reported in Table 3, indicate that the respondents acquired their knowledge of mentally ill care from diverse sources. Up to 30.2% reported that they acquired such knowledge were seminars/Workshop/Conferences, 47.9% from classroom lectures were their source and 26.9% from personal experience. Other sources of information about mentally ill care, according to the respondents, proportionately include 30.7% from the textbook, 37.7% from social media networks, and 67.9% from educational articles.

3.3. Attitudes of Health Workers towards Mentally Ill Patients

Table 4 below reported the respondents' reactions to their attitudes toward mentally ill patients. Of the 215 total respondents, 33.4% agreed that they were afraid of caring for the mentally ill, while 42.7% consented to non-stigmatize against the mentally ill. Notwithstanding, 6% agreed that they would detest caring for the mentally ill. 45.1% responded that they would not discriminate against the mentally ill, but 45.5% said that they would not have a restricted at-

titude toward the mentally ill. 25.1% agree that they will feel comfortable caring for the mentally ill and 17.6% agree that it is strange having contact with the mentally ill. On their receptiveness to mentally ill care training, 42.3% agreed that they would be willing to undergo training on MHC to prepare me for the care of the mentally ill; and 39% confirmed that they were happy with integrating into PHC even without undergoing further training.

From Table 5 below, the findings of the study reveal that 41.3% of the respondents posited that PHC workers were not adequately trained for mental health care, 14.8% agree that mental health care is solely the responsibility of the specialist mental health facilities, and 30.2% agreed that there exist lack of human resources and workforce in PHC to accommodate MHC. Among them, 11.6% agreed that there was no need for the training of PHC workers on MHC; 35.8% agreed that financial resources for the care of the mentally ill would be a major barrier, and 33% agreed that community awareness of the treatment of mental illness was a major barrier. 41.3% agreed that mental illness was associated with stigmatization due to a lack of public understanding of mental disorders; 46% indicated that they needed basic training to improve their expertise and abilities in the field of mental health care, and 37.2% believed there was insufficient government commitment for incorporating mental health into primary care.

Table 1. Socio-Demographic data.

Characteristics	Frequency	Percentage
Age (years)		
50 and above	99	46
40 - 49	71	33
39 and below	45	21
Gender		
Male	17	8
Female	198	92
Highest Educational Qualifications		
B.Sc	19	9
Diploma	189	88
Masters and above	7	3
Years of experience		
Less than 5 years	12	6
6 - 10 years	50	23
11 - 15 years	62	29
16 years-above	91	32
Training on mental health		
Yes	3 1	
No	212 99	

Table 2. Preparedness for care of the mentally ill as perceived by primary healthcare workers.

Indicate if you received any of the following training listed below	SA	A	D	SD	Mean ± SD
I received Community-based child mental health care training sufficient to enable me to practice in PHC.	19 (8.8%)	37 (17.2%)	78 (36.2%)	81 (37.8%)	2.04 ± 0.98
I am aware of the protocol for mentally ill patients.	28 (13%)	45 (20.9%)	72 (33.4%)	70 (32.7%)	2.33 ± 0.87
Training on assessment of mentally ill patients have been undertaken by me.	35 (16.2%)	20 (9.3%)	95 (44.1%)	65 (30.4%)	1.34 ± 0.73
I am trained to identify patients with mental health problems.	42 (20.9%)	28 (13%)	84 (39%)	61 (27.1%)	1.22 ± 0.56
I have adequate occupational mental health training skills.	38 (17.6%)	24 (11.1%)	91 (42.3%)	62 (29%)	1.54 ± 0.77
The kind of training skills i have acquired prepared me for MHC.	25 (11.6%)	37 (17.2%)	84 (39%)	68 (32.2%)	1.32 ± 0.65
I can provide adequate clinical care for mentally ill patients.	19 (8.8%)	47 (21.8%)	65 (30.2%)	84 (39.8%)	1.84 ± 0.88
I can provide counselling services for the mentally ill.	27 (12.5%)	33 (15.3%)	77 (35.8%)	78 (36.4%)	2.13 ± 0.76
I can provide therapies for families of the mentally ill.	35 (16.2%)	42 (19.6%	61 (28.3%)	77 (35.9%)	1.34 ± 0.73
I am adequately trained for drug prescription for the mentally ill in the community settings.	29 (13.4%)	36 (16.7%)	55 (25.5%)	95 (44.4%)	1.43 ± 0.86

Table 3. Sources of knowledge of care of the mentally ill among health workers.

My source of knowledge of care of the mentally ill include the following	Frequency	Percentage (%)
Seminar/Workshop/Conferences	65	30.2 (%)
Classroom Lectures	103	47.9 (%)
Personal Experience	58	26.9 (%)
Textbook	66	30.7 (%)
Social media network	81	37.7 (%)
Published educational article	146	67.9 (%)

Table 4. Attitudes of health workers towards mentally ill patients.

To what extent do you agree or disagree with the following statement	SA	A	D	SD	Mean ± SD
I am afraid of caring for the mentally ill.	85 (39.5%)	72 (33.4%)	24 (11.1%)	34 (16%)	2.11 ± 0.88
I will not stigmatize the mentally.	74 (34.4%)	92 (42.7%)	11 (5.2%)	38 (17.8%)	2.33 ± 0.89
I detest caring for the mentally ill.	11 (5.1%)	13 (6.0%)	80 (37.2%)	111 (51.7%)	1.53 ± 0.76
I am willing to accept undergoing training on MHC to prepare me for the care of the mentally ill.	87 (40.4%)	91 (42.3%)	24 (11.1%)	13 (6.2%)	1.32 ± 0.76
I am happy with integrating into PHC even without undergoing further training.	71 (33%)	84 (39%)	35 (16.2%)	25 (11.8%)	1.54 ± 0.77
I will not discriminate against the mentally ill.	85 (39%)	97 (45.1%)	14 (6.5%)	19 (8.9%)	2.12 ± 0.85
I will not have restricted behaviour toward the mentally ill.	67 (31.1%)	98 (45.5%)	38 (17.6%)	12 (5.8%)	1.74 ± 0.89
I have a tolerant disposition towards the mentally ill.	84 (39%)	65 (30.2%)	37 (17.2%)	29 (13.6%)	2.33 ± 0.76
I will feel comfortable caring for the mentally ill.	51 (23.7%)	54 (25.1%)	49 (22.7%)	61 (28.5%)	1.74 ± 0.73
It is strange having contact with the mentally ill.	14 (6.5%)	38 (17.6%)	84 (39.0%)	79 (36.9%)	1.43 ± 0.86

Table 5. Health workers' perception of the process for integrating mental healthcare into primary health care settings.

What do you think about integrating PHC in the care of mentally ill patients?	SA	A	D	SD	Mean ± SD
PHC workers are not adequately trained for mental health care.	74 (34.4%)	89 (41.3%)	22 (10.2%)	30 (14.1%)	1.99 ± 0.58
Mental health care is solely the responsibility of the specialist mental health facilities.	41 (19%)	32 (14.8%)	84 (39%)	58 (27.2%)	2.13 ± 0.84
There is a lack of human resources and workforce in PHC to accommodate MHC.	80 (37.2%)	65 (30.2%)	34 (15.8%)	36 (16.8%)	2.34 ± 0.93
There is no need for the training of PHC workers in MHC.	14 (6.5%)	25 (11.6%)	91 (42.3%)	85 (39.6%)	1.52 ± 0.56
Financial resources for the care of the mentally ill will be a major barrier.	75 (34.8%)	77 (35.8%)	42 (19.5%)	21 (9.9%)	1.64 ± 0.77
Community awareness of the treatment of mental illness is a major barrier.	84 (39%)	71 (33%)	14 (6.5%)	46 (21.5%)	2.32 ± 0.75
Mental illness is associated with stigmatization due to a lack of public understanding of mental health disorders.	91 (42.3%)	89 (41.3%)	18 (8.3%)	17 (9.1%)	1.64 ± 0.78
Basic training is required in order for me to improve my knowledge and skills in providing mental health care.	81 (37.6%)	99 (46%)	11 (5.1%)	24 (11.3%)	2.13 ± 0.76
There is no strong government support for integrating mental health into a primary health care setting.	79 (36.7%)	80 (37.2%)	25 (11.6%)	31 (14.5%)	1.34 ± 0.73

4. Discussion

As evidenced in the results of this study, less than 20% of the participants consented to the position that they had sufficient community-based child mental health care training, awareness of referral protocol for mentally ill patients, and assessment of mentally ill patients have been undertaken by them, identifying patients with mental health problems, adequacy of occupational mental health training skills, and preparedness for MHC. The findings also imply that there is a lack of awareness regarding mental health and the prejudice that comes with it. Within the context of this study and in line with the position of Abimbola [15], there is still a pervasive belief system that mental illness is a form of retribution from the gods for one's the wrong deed thus they try as much as possible to avoid contact with such person. The outcome of the work is in line with a study [16] in which health workers were observed to have very poor knowledge of depression. The work is equally in tandem with the work of Abera, Tesfaye, Belachew, and Hanlon [17] where the participants were found to have poor knowledge of mental illness (23.4%). Yet, this disagrees with realities found in other parts of the world like Australia [18]. The implication is that developed countries are more knowledgeable about mental illness.

Analysis revealed that the major source of the respondent's knowledge of mental health was published educational articles, classroom lectures, social media networks, seminars and personal experience. Published educational articles are reliable means of circulating medical information. Classroom lectures and

social media are equally other powerful means of circulating information which might be responsible for the study outcome. The result of the study is in line with the report by Gureje, Abdulmalik, Kola, Musa, Yasamy and Adebayo [3] where social media and published educational articles were found to be the major sources of awareness of mental health. The study is equally in line with related studies [19] [20] where seminars and manuals were reported as the major source of the respondent's knowledge of mental illness respectively. The study thus indicates that such knowledge sources as in-service training are conspicuously missing.

A greater number of the study participants have favourable attitudes towards the mentally ill for instance 39% and 45% strongly agree and agree that they will not discriminate against the mentally ill. This might be a result of the awareness some have concerning mental illness. It might equally be a result of knowledge gained through experiences acquired over years of nursing practice. The findings are similar to a study that investigated attitudes regarding mental health and the incorporation of mental health support into primary health care in Cambodia's Lave En District [21]. Approximately 81 percent of those polled said they were personally interested in providing mental health care in their units. Similar optimism was recorded among nurses rendering care to remote communities of Australia [22]. In a study that investigated the perceived barriers and opportunities associated with integrating mental health into primary care in south-west Ethiopia [17], almost all PHC employees in their survey said mental health treatment was important in Ethiopia, and the proportion of the respondents said they wanted to give mental health care. Contemporaneously, a good number of study participants have negative attitudes toward the mentally ill and this will have a substantial effect on the care they will render irrespective of their knowledge base. As revealed, 39.5% and 33.4% strongly agreed and agreed that they'll not be comfortable caring for the mentally ill while 22.7% and 28.5% affirmed that they are afraid of caring for the mentally ill.

It is general knowledge that lowering stigma and promoting human rights for persons with mental illnesses could go a long way toward improving the quality of life of those who suffer from mental illnesses. Yet study reveals that about a third to a half of the respondents still perceived that lack of community awareness and stigmatization of the mentally ill as a major barrier to the achievement of the successful integration of the mentally ill. Also, approximately half of the respondents perceived that they require basic training, adequate staffing and improved Government support to provide health care to those who are suffering from mental illnesses. The findings matched a study that investigated public health professionals' opinions of mental health programs in Equatorial Guinea, Central-West Africa [23]. According to those interviewed, the current mental health system does not match the demands of the community. Professionals cited infrastructure capacity, stigmatization, and a lack of other resources such as training programmes, knowledgeable staff, medications, and data as key fac-

tors limiting the efficacy of mental healthcare [20] [24].

5. Conclusion

Evidence from this study supports that there is a need for community education and the building of capacity of health care workers for integration of the care of the mentally to be feasible in PHCs. The major source of the respondent's knowledge of mental health was published educational articles hence a reliable means of circulating medical information. Meanwhile, classroom lectures and social media were equally other powerful means of circulating information and thus might be responsible for the outcome. In addition, the study aimed to determine the attitudes of health workers toward mentally ill patients. From the analysis above, it can be deduced that health workers exhibit some degree of positive attitude towards the care of the mentally ill. This might be as a result of the awareness some have concerning mental illness and as a result of knowledge gained while in school or experience gained over the years of practice. Finally, the researchers investigated how health care providers felt about the process of integrating mental health care into primary care settings. Due to a lack of public knowledge of mental diseases, mental illness is related to stigmatization. This means that there is a need to deepen the knowledge and information access of mentally ill care providers to ensure that they are abreast with evolving techniques and relevant evidence. Care providers expressed significant support for incorporating mental health within primary health care, which would help to reduce stigma and promote human rights for persons with mental health concerns. Basic training for mental health care providers is required to improve their knowledge and skills.

6. Limitation

The self-reported surveys utilized in the study had a propensity to underestimate reality, particularly in issues involving substance use among adolescents, however, the instrument had adequate face validity was acceptable reliability.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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