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MENTAL ILLNESS AND MENTAL HEALTH CARE IN SOUTHWEST, NIGERIA

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ABSTRACT

Challenges of mental health care are multifarious and they are an indicator of a county's level of medical development. This study examined the influence of socio-cultural factors on mental illness and mental health care in Southwest, Nigeria. It identified socio cultural factors that influence mental illness and evaluated the various mental health cares available to people living with mental illness (PLWMI). It also examined the challenges facing people living with mental illness, explored the effects of these factors on the choice of care for mental illness. The target population was people with previous history of mental illness, families of people living with mental illness, mental health care providers (orthodox, spiritual and traditional), and members of the community. A total number of three hundred (300) respondents were selected from the target population. Data were generated through quantitative and qualitative methods. Findings showed that socio-cultural factors exert significant influence on the cause and treatment regime of mental illness. Majority of the respondents believed that orthodox care is more effective in the treatment of mental illness, but they are inadequate and inaccessible. The study further showed that PLWMI are economic burden on the society and are socially stigmatized. The study concluded that socio-cultural factors influence mental illness and mental health care which in turn influence perception of people about mental illness. The study advocated the integration of the various cares and need for community-based approach in the care of mental illness.

Key words: ***Socio-cultural factors, mental health, mental illness, orthodox, spiritual care.***

INTRODUCTION

The issue of mental illness has long been an object of concern for individuals, social scientists, health care providers and society at large. There is an ever growing awareness of mental illness as a significant cause of morbidity. This increased awareness is brought about by the steady decline of morbidity due to irrational disorders, communicable diseases and other forms of physical illness, especially in countries undergoing epidemiological transition. According to World Health Organization (WHO, 2011; 2001), mental illnesses are

common, accounting for 13 percent of the global disease burden and 25% of all people at some time during their lives. They are universal, affecting people of all countries and societies, regardless of age, gender and income. The role of socio-cultural factors in the prevention of mental illness and the care of People Living With Mental Illness (PLWMI) have been widely acknowledged and regarded as the most appropriate basis for the development of an holistic care of the mentally ill (Kabir, Iliyasu, Abubakar & Aliyu, 2004).

Mental illness is a disorder characterized by disturbances in a person's thoughts, emotions, or behaviour. This may range from those that cause mild distress to those that severely impair a person's ability to function. In a study conducted by Kabir, et.al (2004), socio-cultural factors were attributed to influence the causes and care of mental illness. They have been found to be essential ingredients to the realization of holistic mental health care. The recognition of mental illness depends greatly on a careful evaluation of the norms, beliefs, customs and social factors within the individual's cultural environment. Adebowale and Ogunlesi (1999) opined that people tend to attach strong cultural beliefs about the causes of mental illness which undoubtedly are based on prevailing socio-cultural factors. It was observed that these factors play a significant role in determining health-seeking behaviour and successful treatment of the people living with mental illness. Therefore, health-seeking behaviour becomes the pivotal link between mental illness and the provision of mental health care services.

In Nigeria, people with signs and symptoms of mental illness are treated by caregivers who are either orthodox practitioner, spiritual or traditional healers. Studies have also shown that among the underlying reasons of delays in seeking for treatment are the absence of services and programmes for the early diagnosis and treatment of mental disorders, stigma and the belief that mental disorders are untreatable with orthodox medical interventions which are even inadequate (Agara, Makanjuola & Morakinyo, 2008). Stigma has been described as one of the most important factors hindering the early identification of symptoms of mental disorders (Sartorius, 2007). Lasebikan, Owoaje and Asuzu (2012) observed that mental health care services are often sought as a last resort in Nigeria, thus, resulting in delayed treatment.

According to Adewuya and Makanjuola (2009), Nigerians believe in the supernatural causality of mental illness, irrespective of their educational status and that the most preferred treatment is usually obtained from spiritual or traditional healers. Erinosho (2010) posited that due to inadequate specialized care, religious and traditional healers tend to provide succor to people with mental health issues. These religious and traditional healers are easily accessible, being the first point of care engaged in the community, with people only patronizing specialist care when efforts of these healers have proved futile. It was further observed that service utilization data, such as care pathways used by service users, delays in treatment and access to mental health care are vital for planning service delivery strategies and are useful ways of studying health-seeking behaviour and understanding the pathways families and individuals explore before arriving at mental health care service (Jack-Ide, Makoro & Azibiri, 2013). Jilek (2001) was of the view that the choice of care at the disposal of the mentally ill is predicated on socio-cultural factors like poverty, poor accessibility to mental health facilities and hospital care, stigma or cultural beliefs in the causality of mental illness. Ajala (2010) attributed failure of the Nigerian state to provide accessible and equitable health care facilities for the mentally challenged to the reason why Nigerians prefer utilization of faith healing to modern health care due to what he described as "doctrinal attachment to religion and

spirituality". This is what is responsible for the ever growing advertisements on claims of spiritual power in the cure of mental illness. The rural-urban skew in availability and accessibility of specialized or orthodox care has been a major challenge in the care of people living with mental illness. Therefore, the effects of socio-cultural factors in form, cause, course and outcome of mental disorders cannot be underestimated. This study will further explore the pathways to mental health care with emphasis on socio-cultural factors that will guarantee effective planning of mental health care and programmes so as to ensure the provision of holistic care and support for people living with mental illness.

Mental illnesses are tremendously increasing as a leading cause of disability worldwide with mental disorders accounting for 13 percent of the global disease burden (WHO, 2011; 2008). According to Ogedengbe (1991), inadequate mental health care facilities that are accessible, affordable and equitable for the mentally disabled coupled with the widespread stigmatization associated with mental illness in Nigerian community have been a major concern for researchers. From the ever increasing hostile and unsecured environment and the tension laden conditions Nigerians find themselves, it can therefore be rightly posited that mental illness is likely to be on the increase. Mental health care remains one of the biggest unmet needs of our time, yet millions of people living with these conditions do not receive adequate and required care.

In most developing countries particularly in Nigeria, mental health care is still elusive to a significant proportion of the population. There is a state of inequality of health care distribution with almost 70 percent of the orthodox or specialized care facilities in urban areas while less than 30 percent are in rural areas. This accounts for the reason why people patronize traditional and spiritual healers either because of poverty, stigma or lack of belief in the efficacy of services provided by orthodox health facilities and socio-cultural factors relating to the cause of mental illness (Agara, et.al, 2008).

Challenges of mental health care in Nigeria are indeed multifarious and require very deliberate, specific and concerted actions. Poverty, psychological stresses associated with poor infrastructure in Nigeria, stigmatization, lack of human rights protection, the pervasive role of religion in many mental problems, accreditation and regulation of faith healers and traditional healers, availability and accessibility of orthodox mental health care facilities are the major challenges (WHO, 2009; Gureje, Olley& Kola, 2004).

According to Gureje and Alen (2002), the challenges of mental health care services in Nigeria include limited institutional infrastructure, lack of trained mental health professionals, poor access to medications, poor funding, inept mental health legislation, paucity of empirical data and the issue of stigmatization. It was observed that poor knowledge about the causality of mental illness pervades all segment of the Nigeria society irrespective of educational status. They further posited that people with mental illness were believed to be mentally retarded, public nuisance and dangerous to the society. According to Adelekan, Makanjuola and Ndom (2001), attitudes towards mental illness are strongly influenced by socio-cultural beliefs both in causation and treatment outcome. They further observed that unhealthy and unhelpful attitudes to mental illness are often responsible for delay in seeking appropriate care through early diagnosis and treatment. As a result of the importance people attach to these alternative sources of mental health care and because their caregivers are likely to share the beliefs held in

their domain in regard to the cause and care of mental illness, it would be helpful to study and fully evaluate the influence of socio-cultural factors in the care of mental illness in southwest, Nigeria.

Mental illnesses are widely attributed to supernatural or spiritual beliefs firmly rooted in customs and norms both as to causes and remedies. Most people regardless of their social status seek remedies from spiritual and traditional healers. In most cases, they see orthodox care as a last resort when the individual's mental health might have deteriorated. The spiritual and traditional healers are in most cases ignorant of which cases they should refer. The fact still remains that these groups of healers provide a significant portion of the care received by the mentally ill. In view of this, the study will sensitize the government on the need to develop a holistic plan for the care of mental illness in the country.

According to Urigwe (2010), there is the need for social scientists, to further beam their search light through appropriate research work that will increase investment in mental health, so as to integrate spiritual and traditional healers with orthodox mental health care services. He further posited that the only actual and observable result of mental health policy is a quality mental health care system with holistic approach and this must entails the socio-cultural background of those in need of the services. It is therefore essential that policies for mental health care should take into cognizance socio-cultural factors so as to ensure a holistic approach of care of the mentally ill in Nigeria.

Lambo (1961) opined that sense of belonging to the community with stronger family coercion, greater social support, as well as collective responses to suffering were features of socio-cultural factors seen as advantageous to a holistic care of mental illness. Odejide and Olatawura (1979) observed that the incorporation of mental health as one of the components of Primary Health Care by WHO has been a major initiative. The common problem of lack of adequately trained specialists in Nigeria makes this approach to the care of mental illness particularly important because of the easy access it provides for patients. They advocated the need to integrate traditional health care into orthodox service delivery, but one possible reason for the failure of this policy for integration is that it has not been well articulated.

Cultural variation is most pronounced in reactive and neurotic disorders but the influence of culture is also significant in the major psychoses and can even be recognized in organic brain syndromes. The influence of culture on symptom profiles, course and outcome of mental disorders has been demonstrated in systematic comparative research. Effects of socio-cultural factors are therefore co-determinants of form, course and final outcome of mental disorders like schizophrenia. However, most of these opinions were based on the thinking and findings of the developed economies. The fact however remains that the analysis of the findings carried out in the developed counties cannot be invoked with full confidence and are quite inadequate in dealing with situations in the developing nation like Nigeria

In terms of law and policy, it is the Lunacy Act, 1958 which has been considered derogatory that is still in force. The new mental health legislation that was introduced in the National Assembly in 2003 is yet to be passed. This is however a worrisome situation. Change in socio-cultural attitudes towards mental illness must begin with

individuals in the society. There is the need to develop an affinity for the mentally ill and mentally challenged in Nigeria. Currently, there is no existing policy making structure for a workable mental health care system in Nigeria and traditional and spiritual healers are not taken into account in any formulation of mental health policy.Since people living with mental illness and their caregivers are likely to share the beliefs held in their society as regards the causes and treatment of mental illness, it is therefore necessary to understand public perception about mental illness and care of mental illness so as to fully evaluate their health-seeking behavior.

There is no universal definition for mental illness. However, World Health Organization defined mental illness as a broad range of problems with different symptoms generally characterized by some combination of abnormal thoughts, emotions, behaviours and relationships with others (WHO, 2014). The definition of mental illness depends on a society's norms or rules of behaviour. Therefore, behaviours that are not acceptable in one particular society or which violates the norms of that society may be considered as signs of mental illness (Jegede, 1989). Since there are variations in norms between cultures, what may be considered normal in one society or culture may be considered as signs of mental illness in other culture. However, many behaviours are recognized across the globe as being indicative of mental illness. These include extreme social withdrawal, violence to oneself, hallucination (false sensory perceptions) and delusions (false ideas). Cohen and Kleiman (2007) observed that some maladaptive behaviours which may cause a person to experience problems in coping with common life demands may be seen as mental illness. For example, political dissidents could be considered mentally ill or psychopath for refusing to accept or conform to the dictates of the government.

The term mental illness therefore refers to a wide range of disorders characterized by disturbances in person's thoughts, emotions or behaviours. It ranges from those that cause mild distress to those that severely impaired a person's ability to function. Ewhrudjakpor (2009) contended that the concept of mental health or illness has a problematic definition because it is largely subjective since it can only achieve a near uniformity of meaning in the medical arena. However, a complete state of mental health or well-being is almost impossible to attain. The sufferers of mental illness are part of the society but are viewed differently by the society (Paterson, 2006; Murthy, 2002). According to Ewhrudjakpor (2009), mental illness is a disorder of one or more of the functions of the mind such as emotion, perception, memory or thoughts, which causes suffering to the person and embarrassment to the family and society. From the definition above, one can imagine the condemnation and stigma the mentally challenged people are subjected to by their families and the society where they live. In a study conducted by Gureje, Lasebikan, Oluwanuga, Olley and Kola (2005), it was reported that mental illness is easily recognized only when the sufferer roam the street or seen un-kept in a public place. They are referred to as 'mad' or 'kolo'. These cannot be conclusive on the meaning of mental illness since there are millions of people that are perceived as being mentally healthy but who are laboring under the burden of neurosis or personality disorders. However, those being referred to as 'mad' or 'kolo' are probably the psychotics.

Alo (2010) opined that mental illness is primarily manifested in behaviour. He further posited that mental disorder may be associated with a variety of physical symptoms or with no physical symptoms. To further strengthen the view that mental disorders manifest in behaviour, Rosenhan (1973) was of the view that the sane are not sane all the time and the insane are not always insane. In alluding to this fact, one continue to wonder how well to

describe rapists, political thugs, armed robbers, corrupt leaders, ritualists, murderers, sadists, *Boko-Haram* insurgents, kidnappers, hired assassins or husbands who turn their wives to punching bags in time of momentary rage. The question therefore is who is mentally ill? In providing answer to this question, it can be rightly said that any behaviour not accepted in a society is mental illness, since most of the people that perpetrate these heinous crimes move about without being labeled as insane not until they are caught in the act or when they are found in public places looking un-kept.

According to Cohen and Kleiman (2007), the symptoms of mental illness can be very distressing. For example, those who suffer schizophrenia may hear voices inside their brain (auditory hallucination) that either commands them to act in strange ways or say nasty things about them (running commentaries). Those with paranoia have deep conviction that everyone, including their closest family members wants to injure them. People suffering from major depression may feel that life is not worth living. Those with mania may indulge in acts that later cause them to feel guilty, shame and desperation. Other mental illnesses that though not debilitating but common and create certain problems in the day to day life of sufferers are personality disorders. People in this category may experience loneliness and isolation because their personality style interferes with social relations.

Attempts made in the past to measure the prevalence of mental illness in the general population have often produced inconsistent results since a true onset of mental illness is difficult perhaps even impossible to determine (Alo, 2010; Orley, 1970). There are numerous large-scale surveys on the prevalence of mental health disorders in the general population (Ewhrudjakpor, 2009; Gureje, Lasebikan, Ephraim & Oluwanuga, 2005;WHO, 2001; Awaritefe & Ebie, 1975).

The World Health Organisation (WHO, 2007) put prevalence of mental illness in Nigeria at 20 percent. With a population of over 150 million, this translates to the fact that about 30 million Nigerians are suffering from mental disorders. This is based on statistics covering psychiatric admissions and the number of people who receive out-patient treatment in a given year. Alo **(**2010) opined that this figure however may not be reliable and comprehensive since official statistics do not include those individuals who patronize private hospitals or spiritual and traditional healers. Also, Ogedengbe (1991) observed that if it is assumed that the population of Nigeria is about 140 million, and using some of the statistics which is generally acceptable to this figure, then it is likely that at least about 28 million people (20 percent of the population) are suffering from one form of mental illness or the other. He further posited that at any given time, about 14 million people (10 percent) are suffering from serious mental illness, about 1.4 million people (1 percent) are suffering from severely incapacitating mental illness and about 1.4 million people are suffering from epilepsy.

The concept about the etiology of mental illness among Africans generally and Nigerians in specific differs from that held by many in Western societies. Orley (1970) observed that in Nigeria or among Africans, there is a wide spread tendency to attribute mental illness to intervention of supernatural forces such as gods, spirits, witches and magicians. For instance, Yoruba conceive the supernatural powers as being either the malevolent or the benevolent. Mental illness is thought to be caused by malevolent supernatural powers that are perceived to be belligerent enemies of man. In Abimbola (1976), madness in Yoruba context is seen as a disease of the mind, and

that forces in the spiritual world can interfere with a person's soul, spirit or mind thereby disrupting its functioning and causing mental illness. However, the etiology of mental illness has been attributed to both biological and psychological causes. The biological perspective views mental illness in terms of body processes, whereas psychological perspectives emphasize the roles of a person's upbringing and environment.

History of madness in Colonial Africa is not a simple one. While the history of insanity in Europe is the history of the definition of the mad as 'other', in colonial Africa, the 'other' already existed in the form of the colonial subject, the African. There was no 'great confinement' in colonial Africa to match that of nineteenth century Europe and colonial psychiatric institutions since they have their own, rather separate history (Megan, 1991).

Despite the growing burden of mental illness and the resultant effect on the sufferers and societies, efforts to address the disability remain unsatisfactory. Thus, this study has been designed to ensure that mental health care is made accessible and affordable to people living with mental illness. The general objective of this study is to examine the socio-cultural factors influencing mental illness and mental health care in southwest, Nigeria while the specific objectives are to: identify the socio-cultural factors that influence mental illness; evaluate the various cares available to people living with mental illness; examine the challenges facing people living with mental illness; explore the effects of socio-cultural factors in the choice of care of mental illness; and assess the level of utilization of the various health care systems in the care of mental illness.

This present study exclusively from a sociological perspective focuses on the socio-cultural factors influencing mental illness and mental health care in southwest, Nigeria. This is because Nigeria as a country is yet to fully develop any holistic plan for the care of mental illness despite a steady growth in the number of people living with mental illness roaming the streets of the country as vagrants and the resulting dangers to the public and economy. Relatedly, empirical research efforts are in fact still passive in focusing on the predisposing factors of mental illness and mental health care in Nigeria. According to the report of Mental Health Leadership and Advocacy Programme, University of Ibadan on Mental Health Situation Analysis in Nigeria (mhLAP, 2012), mental health has become a formidable public challenge which suffers serious institutional and normative neglect. As such, there is an urgent need for social scientists to demystify mental illness as well as examine the various socio-cultural factors in the care of mental illness in Nigeria. This will go a long way in creating positive attitudes, correct misconceptions and encourage holistic approach to mental illness with better outcomes.

DATA AND METHODS

Data for this study was collected in Southwest Nigeria. Nigeria is located west of Africa (Latitude 5^0N and 14^0N, and Latitude 3^0E and 15^0E), and it occupies an area of approximately 913, 768 km^2 with a population of about 150 million people (Awaritefe, 2004). The country has, within the past five decades experienced tremendous changes as a result of the juxtaposition of the traditional and modern socio-economic mechanisms; such as a massive and rapid urbanization, industrialization and commercialization. The country is located north of the Atlantic Ocean and South of Niger Republic and Chad. It boarders Cameroon in the east and Republic of Benin in

the West. Southwest is one of the six geo-political zones in the country and it has six states, these are: Ondo, Oyo, Ogun, Osun, Ekiti and Lagos.

The study employed quantitative and qualitative methods to explore the patterns of relationship between socio-cultural factors on one hand, and mental illness and mental health care on the other hand. The sample size consist of three hundred (300) respondents comprising of one hundred and eighty (180), who were selected through multiple stage sampling technique across the six states which make up the southwest geopolitical zone of the country (thirty respondents per state). These set of respondents provided information through a carefully structured questionnaire for the quantitative aspect of the study. The questionnaire was structured around the subject matter of the research. The other one hundred and twenty (120) provided the data for the qualitative aspect of the study. They were selected purposely on a quota sampling technique across the six states and the distribution was as follows: thirty (30) respondents selected among people with previous history of mental illness; thirty (30) respondents from families of people with previous history of mental illness; twenty (20) respondents among orthodox mental health care professionals; twenty (20) respondents from spiritual/faith-based healers; and twenty (20) respondents selected among traditional healers.

Key Informant method was the major method employed for the qualitative segment of the study. The quantitative data were analyzed using Statistical Packages for the Social Scientist (SPSS) version 18, while the qualitative data were analyzed using ATLAS.ni. On ethical issues, the rules of research ethics as they relate to consent, confidentiality, anonymity, integrity and respect for the respondent's rights to privacy and personal dignity were strictly adhered to.

RESULTS AND DISCUSSION

This section presents data on the socio-demographic characteristics of the respondents. The key variables discussed are sex, age, religious affiliation, ethnicity and type of family/marriage. Others are marital status, residential area, level of education, employment status and monthly income in naira. These variables were viewed as explanatory attributes capable of shedding light on the peculiar features of the respondents.

Table 1: Distribution of the respondents by Socio-Demographic Characteristics

Variable		N = 180 SQ Percentage (%)	N = 120 KII Percentage (%)
Panel i	**Sex**		
	Male	33.3	41.7
	Female	66.7	58.3
Panel ii	**Age**		
	20-29	47.2	21.7
	30-39	33.9	33.3
	40-49	16.1	25
	50-59	2.8	20

Panel iii Religious Affiliation		
Christian	74	68.3
Muslim	15	20.0
Others	11	11.7
Panel iv Marital status		
Single	43.9	35
Married	48.8	52.5
Divorced	2.2	4.16
Widowed	5	8.3
Separated	---	
Panel v Level of Education		
No formal education	11.7	5.0
Primary school certificate	12.8	9.2
Vocational/Technical	5.5	3.3
Secondary school certificate	20.0	33.3
Post-Secondary	50.0	49.2
Panel vi Employment Status		
Unemployed	23	17.5
Self Employed	10.0	8.3
Civil servant	67	73.2
Panel vii Monthly Income (in Naira)	33.9	39.2
Less than 10,000	18.9	10.8
10,000-20,000	19.4	15.8
21,000-39,000	27.8	34.2
40,000 and above		

Information on the socio-demographic characteristics of the respondents were presented Table 1.Panel i reveals that female respondents constituted 66.7% of the total respondents, while male respondents accounted for 33.3%. This presents a ratio of 2:1 across the gender group, skewed in favour of female. This finding indicates that the study was female dominated. The sex distribution of participants interviewed through Key Informant Interview (KII) revealed that at least five out of ten respondents, that is, (58.3%) were females while the rest (41.7%) of the respondents were males.

Panel ii of the table is related age distribution of the respondents; almost half of the sample, that is, (47.2%) was within the age range of 20-29 years. This was followed by those who were between the ages of 30-39 years (33.9%) of the total sample. Respondents in the age group 40-49 years accounted for 16.1% of the total sample and a negligible few (2.8%) were within the age grade of 50-59 years. The age grade of the participants interviewed through Key Informant Interview (KII) indicates that 33.3% of the sample survey was within the age group of 30-39 years. This was followed by those who were between the ages of 40-49 years (25%). About one-fifth(21.7%) of the participants were between age group of 20-29 years while 20% were of the age group of 50-59 years.

Data on the religious affiliation of the respondents is presented in panel iii, the data shows that almost two-third of the respondents (74%) were Christians, 15% were Muslims while 11% claimed to belong to other religious groups. The religious affiliations of participants interviewed through Key Informant Interview guide were mostly Christians (68.3%); 20% were Muslims while 11.7% were members of other religious groups. This finding indicates that the study was predominantly dominated by Christians.

Panel iv is related to the marital status of the respondents. The information reveals that majority (48.8%) of the respondents was married, 43.9% were single, 5% were widows, and 2.2% were divorcees. None of the respondents claimed to be separated. The family/marriage distribution of participants interviewed through Key Informant Interview (KII) revealed that over half (52.5%) of the participants were married, 35% claimed to be single, 8.3% were widows while 4.16% were divorcees. None of the participants claimed to be separated. The finding implies that majority of the sample survey were married, followed by those that claimed to be single.

Level of formal education attained by the respondents is presented in panel v. The information shows that half of the respondents (50%) have tertiary education, 20% were secondary school certificate holders, 12.8% were with primary school certificates, and 5.5% were with Vocational/Technical certificates while 11.7% have no formal education. Data gathered with the use of Key Informant Interview shows that majority (49.2%) have tertiary education, 33.3% of the respondents have secondary school education, 9.2% were with primary school certificate, 3.3% with Vocational/Technical education while 5% have no formal education. This finding indicates that majority of the respondents in the sample survey possessed high level of literacy.

Panel vi presented the distribution of the respondents by employment status. The data shows that majority of the respondents (67%) were civil servants, 10% were self-employed while 23% of the respondents were unemployed. Data collected from participants through Key Informant Interview reveals that majority (73.2%) were civil servants, 17.5% were unemployed and 8.3% self-employed. This finding implies that majority of the respondents were gainfully employed.

Information on monthly income (in Naira) of the respondents is presented in panel vii of table 1. The information reveals that 33.9% of the respondents earn less than ten thousand naira per month. About 27.8% of the respondents earn above forty thousand naira per month, 19.4% earn between twenty-one and thirty-nine thousand naira per month while 18.9% of the respondents earn between ten and twenty thousand naira per month. Data generated through the use of Key Informant Interview guide shows that 39.2% earn less than ten thousand naira per month. 34.2% earn above forty thousand naira, 15.8% earn above twenty thousand naira, but less than forty thousand naira per month while 10.8% earn between ten thousand and twenty thousand naira per month. This implies that the economic power of majority of the respondents is very poor and below minimum living wage.

Socio-Cultural Factors and Mental Illness

This section presents data on socio-cultural factors that influence mental illness. The key variables discussed are beliefs in supernatural forces, cultural beliefs in heredity, psychological stress, use of hard drugs like Indian

hemps and cocaine, physical illness like head injury and socio-economic imbalance on employment and poverty. The variables were used to assess the knowledge and beliefs of the respondents on the causation on mental illness.

Table 2: Distribution of the respondents according to the perception of the causes of Mental Illness

S/N	Items	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	N	Mean $\bar{x}$	Ranking
		1	2	3	4	5			
I	Supernatural forces like witches, wizards and taboos	5 (2.8%)	21 (11.7%)	17 (9.4%)	134 (74%)	3 (1.7%)	180	3.61	4th
Ii	Inherited from parents or families	25 (13.9%)	68 (37.8%)	14 (7.8%)	62 (34.4%)	11 (6.1%)	180	2.81	6th
Iii	Psychological stress	0 (0%)	36 (20.0%)	35 (19%)	63 (35.4%)	46 (25.6%)	180	3.66	3rd
Iv	Use of hard drugs like Indian hemp and cocaine	1 (0.6%)	17 (9.4%)	0 (0%)	71 (39%)	91 (51%)	180	4.30	1st
Vi	Physical illness (head injury)	37 (20.6%)	44 (24.4%)	15 (8.3%)	56 (31%)	28 (15.6%)	180	2.97	5th
vii	Socio-economic imbalance like unemployment, poverty	9 (5.0%)	30 (16.7%)	1 (0.6%)	65 (36%)	75 (41.7%)	180	3.93	2nd

Data presented in Table 2 shows the perception of the respondents regarding the influence of socio-cultural factors on mental illness. From the Table, it was observed that majority (74%) of the respondents agreed that mental illness is caused by supernatural forces like witches, wizards and taboos, 1.7% strongly agree, 11.7% disagreed, 2.8% strongly disagreed while 9.4% of the respondents were undecided. The findings which emerged from the data analysis imply that the cause of mental illness is deeply rooted in cultural and religious beliefs of the respondents. As to inheritance from parents, just above one-third, that is, (34.4%) agreed that mental illness can be attributed to heredity, 6.1% strongly agreed, 37.8% disagreed, 13.9% strongly disagreed with 7.8% undecided. On the issue of psychological stress, at least six out of ten respondents, that is, (61%) agreed in an unequivocal terms, while 20% disagreed with 19% undecided. The implication of this is that factors that can constitute psychological stress such as bereavement, insecurity, loss of job, disasters especially the issue of Internally Displaced Persons (IDPs) will exert significant influence on mental illness.

The use of hard drugs like Indian hemp (cannabis) and cocaine were found to exert significant influence on mental illness. An overwhelming majority (90%) of the respondents agreed in both strong and mild terms, 9.4% only disagreed while the negligible (0.6%) strongly disagreed. These findings suggest that the extensive usage of hard drugs such as Indian hemp among the youths could lead to mental illness. Among the respondents, (31%) agreed, while 15.6% strongly agreed, 24.4% disagreed, 20.6% strongly disagreed, while 8.3% remained undecided on the influence of some physical illness (head injury) on mental illness. Majority (41.7%) of the respondents strongly agreed, 36% agreed, 16.7% disagreed, 5% strongly disagreed and 0.6% were undecided on

the influence of socio-economic imbalance like unemployment and poverty on mental illness. The implication of these findings is that socio-economic imbalance could create mental illness.

Using the mean value analysis in Table 2, the recorded mean score value for the total sample ranged from 2.81 (lowest) to 4.30 (highest) on a scale of 1 to 5 (strongly disagree to strongly agree) an indication of perceived high determinant factors, with all the six socio-cultural factors having mean score of <2.50. On the whole, use of hard drugs like Indian hemp and cocaine has the highest mean score of 4.30, thereby presenting this indicator as having the greatest influence on the causation of mental illness. In contrast, heredity from parents has the least mean score (2.81) and thus the least influence on the causation of mental illness and also the least on the ranking scale. The deduced reason for this finding is that use of hard drugs has been prevalent in the Nigerian society, particularly among the youths, resulting into mental illness.

Data generated through KII sheds more illumination into the causative factors of mental illness such as supernatural forces, inheritance from parents, psychological stress, effect of hard drugs like Indian hemp, physical illness like head injury and some socio-economic problems like poverty and unemployment. For instance, one of the participants interviewed stated that: *majority of mental illness is an affliction of the brain and mind by supernatural forces like witches and wizards.* This view was further corroborated by another participant who stated that: m*ental illness is a punishment imposed by supernatural forces on those that violate societal and cultural norms with impunity*.

Another KII participant further corroborated supernatural conception of mental illness by stating that: m*ental illness has something to do with spiritual attack. The attack usually comes from the principalities of this world*. A traditional healer in his response to causes of mental illness, stated that: p*eople with mental illness must have offended either the gods or as a vengeance from witches and wizards whom they must have unknowingly offended*.

One of the people with previous history of mental illness has this to say that: m*y ordeal started after I went to the village for the burial of my mother. It was when I came back that I started hearing some sounds in my ears. It is spiritual attack and nothing more*. Another person with previous history of mental illness has this to say that: *I became addicted to the extent that I can't sleep without a dose. I later discovered that my life just changed and people started complaining. I vowed not to take it again now that I am responding to treatment*.

To further corroborate the general beliefs that mental illness can be inherited, one of the participants said that: *I can't marry from a family of people with mental illness because is usually transferred from one generation to another*. Another participant has this to say that: m*ental illness is more rooted in socio-cultural factors than biological factors. This is the reason why sufferers are first taken to faith healers*.

Cares available to People Living with Mental Illness

This section presents findings on the various cares available to people living with mental illness. These available cares are pertinent to understanding the succor that people living with mental illness could receive from both the

orthodox, spiritual and traditional care givers. Quantitative data generated from respondents to evaluate the various mental health care available to people living with mental illness in the areas of preference, curability, accessibility and efficiency were presented in Table 3.

Table 3: Cares Available to People Living With Mental Illness

Variables	Response	Frequency N = 180	Percentage (%)
Preferred health care facility for mental illness	Orthodox	108	60.0
	spiritual	45	25.0
	traditional	27	15.0
Are there adequate numbers of psychiatric hospital?	Yes	5	2.8
	no	132	73.3
	don't know	43	23.9
Which of the mental health facility is more accessible?	Orthodox	31	17.2
	spiritual	101	56.1
	traditional	48	26.7
Which of the mental health care facility is more efficient and provides better treatment?	Orthodox	125	69.4
	spiritual	36	20.0
	traditional	19	10.6
What is your reason?	It is more scientific.	125	69.4
	God is the healer.	23	12.8
	It is the closest.	32	17.8

Data presented in Table 3 shows that majority (60.0%) of the respondents preferred orthodox care, 25.0% prefers spiritual care, while 15% prefers traditional care. This implies that despite the various challenges facing orthodox care, it is the best preferred. These findings suggest the reason why mentally ill are stigmatized. A significant majority (73.3%) of the sample responded that there are inadequate numbers of psychiatric hospital, 2.8% said there are adequate numbers of psychiatric hospital while 23.9% don't know. These findings may be a plausible reason why people resort to other alternative care. Majority of the respondents (56.1%) believed that spiritual mental health care facility is more accessible, 26.7% believed that traditional mental health care is more accessible while 17.2% believed that orthodox mental health care is more accessible. The picture emanating from this finding is that lack of accessibility to orthodox mental health care may be responsible for the high patronage of spiritual/faith-based healers. Majority of the respondents (69.4%) believed that orthodox mental health care facility is more efficient and provides better treatment, 10.6% believed that traditional mental health care facility is more efficient and provides better treatment, while 20.0% believed that spiritual mental health care facility is more efficient and provides better treatment. Most (69.4%) of the respondents agreed that orthodox mental health care is more scientific while 17.8% agreed that traditional is the closest to the population.

Extracts from the qualitative data generated from participants through KII alluded to the fact that though orthodox care may be the best treatment preferred, other alternative approaches to mental health care cannot be waived aside. One of the participants asserted that: *even though orthodox care is preferred but spiritual care is the best*

alternative since God has power over all ailments including mental illness. Another participant was of the view that: m*ental illness caused by spells from ancestors or supernatural forces can only be cured or countered by spiritual powers*.

One other participant has this to say that: t*he inadequate number of psychiatric hospitals accounts for the high patronage enjoyed by spiritual healers. Orthodox care is still the best and most preferred*. Another participant stated that: *Spiritual care is the most accessible because nearly every street has a church and the pastors are usually called upon to attend to people whom were thought to be acting strangely*.

A medical doctor was of the view that: t*he scientific approach in Orthodox care makes it most preferred because of the efficiency but there are inadequate psychiatric hospitals and skilled personnel*. Another family of PLWMI was of the view that: t*he general belief that mental illness occurs from spiritual attack, it can only be cured by spiritual or traditional healer who can command the spirits out of the sufferer*.

Challenges Facing People Living With Mental Illness

This section provides the result of the findings on the challenges facing people living with mental illness. The issues of discussion here are important to this study for purposes of understanding the problems facing people living with mental illness.

Table4: Challenges Facing People Living With Mental Illness

S/N	Items	Strongly Disagree	Disagreed	Undecided	Agree	Strongly Agree	N	Mean $\bar{x}$	sd	Ranking	kurtosis
		1	2	3	4	5					
1	People living with mental illness are economic burden on society	2 (1.1%)	37 (20.6%)	21 (11.7%)	57 (32%)	63 (35%)	180	3.79	0.531	1st	.654
2	People living with mental illness are socially stigmatized	9 (5.0%)	9 (5.0%)	44 (24.4%)	76 (42%)	42 (23.3%)	180	3.74	0.551	2nd	.635
3	Inability to access orthodox mental health care	8 (4.4%)	56 (17.8%)	9 (5.0%)	85 (47%)	22 (12.2%)	180	3.32	0.56	3rd	.583
4	Those people living with mental illness are not employable	8 (4.4%)	32 (17.8%)	17 (9.8%)	84 (47%)	39 (22%)	180	3.63	0.582	4th	.578
5	Mental illness cannot be totally cured	30 (16.76%)	10 (5.6%)	42 (23.3%)	65 (36.1%)	33 (18.3%)	180	2.73	0.641	5th	..562

Data presented in Table 4 shows the perspectives of the respondents on challenges facing people living with mental illness. From the table, it was observed that 35% strongly agreed, 32% agreed, 20.6% disagreed, 11.7% undecided while 1.1% strongly disagreed that people living with mental illness were economic burden on society. This implies that people living with mental illness were seen as unproductive and of no value to the society. Relatedly, most of the respondents (42%) agreed, 23.3% strongly agreed, 24.4% were undecided, while 5%

disagreed and 5% strongly disagreed that people living with mental illness were socially stigmatized. This suggests the negative views people have about mental illness and people living with mental illness. In the same vein, majority (47%) of the respondents agreed and 12.2% strongly agreed that inability to access orthodox mental health care was one of the challenges facing people living with mental illness. Only 17.8% disagreed, 5% undecided and 4.4% strongly disagreed. By implication, orthodox mental health care were not adequate and where available, they were often situated in urban cities, with cost of drugs unaffordable. Furthermore, majority (47%) of the respondents agreed while 22% strongly agreed that people living with mental illness were not employable. Only 17.8% of the respondents disagreed, 9.8% undecided and 4.4% strongly disagreed and therefore were of the view that people living with mental illness were employable. This finding reinforced the earlier result that people living with mental illness were highly stigmatized. Most of the respondents (54.4%) agreed in both strong and mild terms that mental illness cannot be totally cured. Only 16.76% of the respondents strongly disagreed while 5.6% disagreed that mental illness cannot be totally cured. The rest (23.3%) of the respondents were undecided. The picture which emanated from the totality of the findings portrayed that the challenges facing people living with mental illness have socio-cultural origin that has no verifiable scientific justification.

Regarding the mean score analysis of the challenges facing people living with mental illness, it is clear from the data presented in Table 4 that the general mean value of these problems were <2.5 at 5 point rating Likert scale of 1 (strongly disagree) to 5 (strongly agree) as there were relatively no significant lines of differentiation in the pattern of computed data. Findings showed that people living with mental illness are economic burden has mean score of 3.75 (sd= 0.531 and kurtosis .654), people living with mental illness are socially stigmatized has mean score of 3.74 (sd= 0.551 and kurtosis .635). People living with mental illness are unemployable has mean value of 3.63 (sd= 0.552 and calculated value of kurtosis .578). Inability to access mental health care has mean score value of 3.32 (sd= 0.561 and skewness .583). Lastly, the indicator that mental illness cannot be totally cured has mean score value of 2.73 (sd= 0.641 and kurtosis of .562). On the total five challenges used as indicators, the total sample of respondents indicated that the opinions of respondents on these challenges facing people living with mental illness were scattered towards the higher side of the standard scale of 2.50 while the calculated kurtosis portrayed the distribution of views as platykurtic, thus reinforcing strong challenges facing people living with mental illness.

Data from Key Informant Interview corroborated findings from the questionnaire survey. Majority of the participants in the KII were of the view that issue of economic burden is a major challenge. Other challenges identified by them include the belief that people living with mental illness are socially stigmatized, unemployable, inability to access orthodox mental health care and lastly that mental illness cannot be totally cured. One of the participants was of the view that: h*onestly, people living with mental illness suffer from double jeopardy. Apart from the burden of being mentally ill, they are often faced with stigmatization such as rejection by family members, avoidance in the area of marriage and employment*. Another participant stated that: p*eople with mental illness are burden on their families and communities at large. What contribution do you expect from someone that is mentally derailed*?

Above views was further corroborated by another participant who stated that: *... of what benefit is a mentally ill to himself, his family and community. I ask, of what use is a completely knocked engine to a vehicle? Someone that is mentally ill is like a vehicle without functioning engine*. Another participant responded that: w*ho will employ a mentally ill person? It is only a mad man that will ask another mad man to versee his business*. On the question as to whether mental illness can be totally cured, one of the participants retorted that: o*ne thing that I know is that once the brain which coordinates all activities of the body is defective, I doubt if it can be stabilized and not totally cured*.

As to the prognosis of mental illness, one of the participants stated that: *I don't believe mental illness can be totally cured. Like other diseases such as Diabetes or Hypertension mental illness can only be controlled*. This view was corroborated by another participant by saying that: m*ental illness runs in the brain and the moment it starts, it is often difficult to treat no matter the type of care*.

One of the participants has this to say that:

> *"After recovering from what was believed to be spiritual attack, I went back to my place of work with the hope of continuing with my job as an auxiliary nurse. To my surprise, the Matron-in-charge simply told me that she got the directive from Medical Director that I should not be allowed to work in the clinic again".*

On the accessibility of orthodox care, one of the participants stated that:

> *"Mental illness is on the increase daily due to the level of psychological stress occasioned by insecurity, poverty and unemployment. Mental health care should be made accessible to the citizens in terms of cost and distance if we are to reduce the rate at which people patronize unorthodox mental care givers".*

DISCUSSION OF FINDINGS

This section presents the discussion of the major findings of the study. From the findings majority of the respondents were of the view that some socio-cultural factors exerted significant influence on mental illness. Factors such as supernatural forces, psychological stress, use of hard drugs like Indian hemp, unemployment and poverty were found by majority of the respondents to have significant influence on mental illness. Most of the respondents in this study attributed mental illness to supernatural causes despite the fact that the socio-demographic parameters of the respondents revealed high literacy level. This corroborates the position of Adewuya and Makanjuola (2009) that Nigerians believed in the supernatural causality of mental illness irrespective of their educational status.

In this present study, use of hard drugs ranked highest with a weighted mean of 4.30 ($\bar{x} = 4.30$) as a perceived cause of mental illness. This gives credence to the position of Kabir, Ilyasu, Abubakar and Aliyu (2004) that the

finding may not be unconnected with high rate of delinquency among our youths and the use of hard drugs. The finding was further in conformity with the position of Gureje, Lasebikan, Ephraim-Oluwanuga, Olley and Kola (2005) as they opined that it is uncommon for the public in Nigeria to make assumption that anyone using hard drugs will have mental illness. However, this study deviated from those of Adebowale and Ogunlesi (1999) whose findings ranked supernatural forces as the highest causative factor of mental illness in south-west, Nigeria. Also, the study reveals from the findings that socio-economic imbalance such as unemployment and poverty exerted significant influence on mental illness. This finding partly mirrored the position of Cohen and Kleinman (2007) as to the fact that mental illness occurs more among people in the lower socio-economic classes, especially those living in severe poverty. It has been found that occurrence of mental illnesses declined as levels of income and education increases. The weight of evidence from this finding tends to deviate from the findings that poverty and unemployment are not the most common etiological factors of mental illness.

Substantially from the findings in this study, it can logically be deduced theoretically that mental illnesses are behaviourally caused and the more reason the victims are stigmatized. Weiner, Perry and Magnusson (1988) opined that people have more positive attitudes toward individuals with problems that are biologically caused than those that have behavioural etiology. This explains why stigmas attached to mental illness carry more weight than that of physical illness. Attribution theory is therefore an appealing model for understanding emotional reactions and behavioural responses to mental illness which often result in stigma and discrimination (Corrigan, 2000). Findings from this study further give credence to previous studies on attribution theory that stigmatizing views about mental illness has no boarder restrictions in Nigeria as it does not seem to be limited to uninformed members of the general public. Well-trained professionals and elites also subscribed to stereotypes about mental illness (Corrigan, 2000; Keane, 1990; Alisky & Iczkowski, 1990).

Consistent with attribution theory, causal attributions affect beliefs about persons' responsibility for causing their condition, beliefs which in turn leads to affective reactions, resulting in rejecting responses such as avoidance, coercion, segregation, withholding help and even punishment.

The findings further established the assumption that socio-cultural factors have significant influence on the various care available to people living with mental illness. Data in Table 3 shows that 60% of the respondents preferred orthodox care, spiritual care (25.0%) and traditional care (15%). To a very large extent, the findings are similar to a previous study by Olugbile, Zachariah, Kuyinu, Coker, Ojo and Isichei (2009) where they found that medical and psychiatric (orthodox) intervention emerged as the preferred treatment. Conversely, this finding is contrary to the finding in a previous study in the south west region of Nigeria by Lasebikan, Owoaje and Asuzu (2012), which found that religious and traditional healers were the first choice for treatment of mental illness. This finding is understandably so, given the total percentage of respondents for spiritual (25%) and traditional care (15%) in this study which is significant enough. Previous studies have shown that spiritual and traditional healers served a great proportion of mental health care consumers especially in the rural and semi urban communities (Odejide & Morakinyo, 2013; Erinosho, 2010).

It has also been found that religion plays a significant role in the life of most Nigerians with resultant effect on their health belief system (Jack-Ide, Makoro, Bip-Bari & Azibiri, 2013; Adewuya & Makanjuola, 2009; Kabir, et.al 2004). This is the reason why there is the need for integration of the various cares so as to ensure holistic care of the mentally sick especially in a developing society like Nigeria. As to the prognosis of mental illness, majority (74.5%) of the respondents were of the belief that mental illness is not curable. This belief is deeply rooted in their belief system about the causes of mental illness and the associated stigma.

Regarding the adequacy of orthodox psychiatric hospital, 73.3% of the respondents were of the view that orthodox psychiatric hospitals are grossly inadequate. This accounts for the reason why people living with mental illness and their families resort to other alternative care like spiritual or traditional healers. Empirical evidence from this study concurred with those of Ajala, 2010; Erinosho, 2010; Agara, Makanjuola & Morakinyo 2008; Gureje & Allen, 2002 that inadequate institutional infrastructure, lack of trained mental health professionals had been identified as being part of the challenges of mental health care services in Nigeria. Majority (56.1%) of the respondents believed that spiritual care is the most accessible of the various care followed by traditional (26.7%) and orthodox (17.2%). Substantial evidence from findings of the study further gives credence to the wide spread beliefs that orthodox psychiatric care is grossly inadequate and where they are available, they are inequitably located since most of them are located in urban cities, thus making their services inaccessible to the rural population (mhLAP, 2012; WHO, 2007; Klecha, Barke & Gureje. 2004).

Despite the inadequate orthodox care and its inaccessibility, most of the respondents (69.4%) believed in the efficacy of orthodox care and this was premised on the fact that it is more scientific. As such, what has emanated from the context of this study is that people are ready to patronize specialized orthodox care if they are adequate and made more accessible to the generality of the population. In the absence of this, there is the need for the integration of alternative care so as to fill the gap or vacuum created by inadequate orthodox care (Urigwe, 2010).

The study unraveled the fact that people living with mental illness faced various challenges. Majority (69%) agreed in both strong and mild terms that people living with mental illness are unemployable; burden on the society (67%), socially stigmatized (65.3%), inability to access mental health care (59.2%) and cannot be totally cured (52.9%). These findings have been buttressed by the position of Ewhrudjakpor (2009) that African societies have a peculiar attitude towards mental illness and this is evident in the rejection, scornful disposition and negative perception of the sick individual. People living with mental illness aside from suffering under the burden of the disorder often have to contend with these challenges, thus constituting double jeopardy for the sufferer. The notion expressed by respondents in this study corroborates that of Jegede (1989) to the fact that it is the common belief in Yoruba of Nigeria that mental illness cannot be totally cured. The findings further illuminated the opinion of Goffman (1968) that once someone is labeled as mentally sick then others treat them different or re-interpret what the mentally ill does or says. This culminated into more reason why labeling theory attributes the social consequences of mental illness to stigmatization and the anticipation and experience of social rejection that follows. In order to combat these challenges especially the social stigma, Roscio (2004) suggested that efforts be geared towards community-based and provision of humane and effective treatment.

Within the context of this study, it was also revealed that socio-cultural factors such as religious beliefs, traditional practices, poverty, level of education, level of income, unemployment and marital status have significant effects on the choice of care for mental illness. Most (46.7%) of the respondents agreed while, 35% strongly agreed that religious beliefs have effect on the choice of care for mental illness. The findings imply that in the choice of care for mental illness by significant others, religious beliefs play a major role. Also poverty with a mean value ($\bar{x}$= 3.79) was identified by majority of the respondents to have significant influence on the choice of care for mental illness. This finding may not be unconnected with the present economic meltdown in the country. Most of the respondents interviewed complained of inability to afford the cost of treatment as a major factor why they have to abandon follow-up care. This complaint was not limited to orthodox care alone. Spiritual and traditional healers charged exorbitant cost before taking up the management of the mentally ill individual.

The study further revealed that these socio-cultural factors such as religious beliefs, traditional practices, level of income, level of education, unemployment and marital status play a major role in the choice of care of mental illness with religious beliefs ranking first, followed by poverty and traditional practices while level of education has the least mean value. For instance, in a previous study by Ayobola and Nwokocha (2014), religious and traditional beliefs in causation, poverty, perception of efficacy of care were identified as major factors that determine the choice of treatment for mental illness. This further corroborates the findings in the study made by Adewuya and Makanjuola (2009) that Nigerians believed in the supernatural causality of mental illness, irrespective of their educational status and that the most preferred treatment is usually obtained from spiritual or traditional healers.

The urban-rural skewed in the distribution of orthodox care coupled with the inherent inadequacies made spiritual and traditional healers the alternative option or succor left for people with mental illness. Moreover, these spiritual healers are easily accessible and they are usually the first point of care engaged in the community, with people only patronizing specialist care (orthodox) when efforts of the unorthodox healers have proved futile. This finding was in conformity with the view of Erinosho (2010) that spiritual healers tend to provide succor to people with mental illness due to inadequate specialized care.

Consistent with the findings in the literature, community ideas, attitudes toward mental illness coupled with pervasive poverty occasioned by the down turn in the economy, exorbitant cost of treatment significantly affect the way people utilize the various mental health care in the country (Erinosho, 2010; Urigwe, 2010; Agara, et.al, 2008; Gureje & Allen 2002). This study ranked preference for orthodox care as first with (52.8%), followed by spiritual care (27.2%), and traditional care (10%). The empirical findings that emerged clearly indicated that people believe in the efficacy or treatment outcome and rehabilitation process of specialized care (orthodox).

The challenges facing orthodox care are so enormous to the extent that they have undermined its usefulness and level of utilization. People are often discouraged from patronizing this much preferred mental health care for various reasons such as inadequate facilities, accessibility in terms of distance, affordability in terms of cost, lack of personnel and stigmatization. It is a common knowledge that people prefer to take their relations to a faith-healing home than a Neuropsychiatric hospital just because of the stigma attached to mental illness. They often

feel comfortable and protected in the churches where they can easily attribute the cause of the illness to "spiritual attack" which may likely attract pity and assistance. These views seemed to deviate from the assertions of Weiner, Perry and Magnusson, (1988), uncontrollable behaviour evoke pity, sympathy and helping behaviour while controllable behaviour like mental illness, HIV/AIDS evoke anger and a refusal of assistance.

The issue of integration of the various mental health cares has been on for a long time. The recommendations of the Expert Consultation Committee of the World Health Organisation (1975) have achieved little or no success in the area of implementation. This failure has been attributed to inability to specify the socio-cultural elements of mental health that can be met through alternative approach, or to show how specific alternative (unorthodox) interventions are to be accessed for efficacy, or to give some ideas of how quality standards can be achieved and maintained in service delivery. It is also pertinent to know that despite the high patronage being enjoyed by the alternative mental health care, they are mostly characterized by unhealthy, inhuman and injurious methods (Gureje, Olley & Kola, 2004). Findings from this study have shown that there is need for the integration of the various mental health care services and that the system of care should be community-oriented. This finding is similar to that of Lambo (1961) where he concurred that families and communities formed the basis for mental health care in traditional societies like Nigeria with strong family coercion and cultural beliefs. The plausible reason for this is that the family in most part of African societies remains an important resource for the support of people with mental health problems. There have been mixed reactions on the contentious issue of integration of the various mental health cares in Nigeria. For instance, Offiong (1999) described it as not only being over ambitious but practically impossible to implement based on their level of divergence. Nwoko (2009) opined that such integration should be implemented either through assimilation or collaboration.

Health-seeking behaviours and understanding pathways families and individuals explore before arriving at a mental health care service are greatly influenced by socio-cultural factors. On the treatment option first to be employed, majority (48.3%) of the respondents preferred spiritual/faith-healing homes, followed by orthodox (36.1%) and traditional (5.6%). This finding is similar to the study of Aniebue and Ekwueme (2009). The reasons adduced for the first option were based on accessibility to church pastors because of the presumption that every unusual behaviour is as a result of "spiritual attack" which can only be countered with prayers. Also, the inadequate number of specialized care (orthodox) and the stigma attached to mental illness make spiritual care to be the first option.

CONCLUSION

The study examined the perception of influence of socio-cultural factors on mental illness and mental health care in southwest, Nigeria. The impact of socio-cultural factors in terms of marital status, unemployment, poverty, and religious beliefs on mental illness and mental health care in southwest Nigeria. The study also explored the pathways to mental health care so as to guarantee effective planning and assist in reducing the gap experienced in providing mental health care and support for people living with mental illness. The urgent need for social scientists to demystify mental illness by examining the various socio-cultural factors informed this research using southwest Nigeria as study area.

It was observed from findings that socio-cultural factors independently exert significant influence on the causation of mental illness, various cares available to people living with mental illness, challenges faced by people living with mental illness, effects on the choice of care and level of utilization of the various mental health care. It is pertinent to know that while some of the findings were similar to previous study carried out, some were contrary to the findings of other researchers. However, the bottom line of the findings is that socio-cultural factors such as poverty, traditional and religious beliefs, unemployment, peer groups, psychological stress and taboos have significant influence on mental illness and mental health care.

Mental health care remains one of the biggest challenges time in Nigeria. The recognition and care of mental illness greatly depend on a careful evaluation of norms, beliefs, customs and social factors within the individual's cultural environment. The inadequate orthodox hospitals that are mostly urban skewed makes it impossible for majority of rural population to access specialized care and the acceptance of spiritual and traditional care as alternatives to fill this void make this research study highly imperative.

From the findings of this study, the followings are hereby recommended; the ethnic and cultural diversity of people living with mental illness must be recognized and respected. This will guarantee holistic care that is qualitative in planning and service delivery. There is the need to increase public awareness through an aggressive advocacy programmes about mental health issues. It is quite unfortunate that Nigerians are familiar with media coverage of HIV/AIDS, cancer, hypertension and sickle cell disease but no one is ready to talk or propagate facts about mental illness. If we can be able to talk freely about HIV/AIDS and Cancer, then we should be able to talk freely about epilepsy, neurosis, psychosis and personality disorders. Education of the public about mental illness will discourage negative attitudes towards the mentally ill. Integration of orthodox mental care with alternative care through formal recognition of spiritual and traditional healing services is highly desirable. Community-based services must be encouraged with hospital support. Good quality community-based services have proved to be the most effective form of comprehensive mental care. This will promote evidence-based care through accessible and decentralized mental health care services.

The study further recommends the promulgation of laws that will protect the rights of people living with mental illness against social stigma, labeling, isolation and inhuman treatment. Never should mental health problems be seen as a sign of weakness, evil or character flaws. People with mental disorders must have the same rights to treatment and support as those with physical illness. And finally the health information system must be re-invigorated and made more functional in terms of empirical statistical data on issues relating to mental illness.

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