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Full Length Research Paper

An exploratory study of mental health service of families and persons with psychological health issues in the Niger Delta region, Nigeria

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Despite having appropriate mental health policies, mental health services are excluded from Nigeria's primary health care approach. This study explored the pathways to mental health service of families and persons with mental health issues in the Niger Delta region, to enable effective planning of programs to reduce the gap experienced in accessing care and support. Participants were 50 service users (30 family caregivers, 20 persons living with mental health issues) attending the outpatient clinic at the neuropsychiatric Rumuigbo Hospital, Port Harcourt, Rivers State. Semi-structured interviews obtained demographic details and information about three domains: first place visited for treatment, reasons for that choice, and factors that influenced decision to visit the Rumuigbo clinic. 20% had poor knowledge of mental health services, 64% were advised by friends and close relatives to visit the clinic, 20% were referred by a religious healer and 16% by general physicians. People who consulted general practitioners made use of mental health service earlier than those who consulted religious and traditional healers. Policies are needed to support collaborations with religious/traditional healers to educate them about benefits of prompt mental health care, their role in being referral point to appropriate services, as well as a rehabilitative and support network.

Keywords: Help-seeking, mental health services, mental disorders, care pathway, spiritual/traditional healers.

INTRODUCTION

Help seeking behavior is the critical link between the emergence of mental health issues and the provision of mental health care services (Mkize and Uys 2004). Pathway studies are increasingly recognized as important to plan mental health services, provide appropriate training and human resource for service delivery, and implement efficient referral system from lower levels of health care and other care providers to specialist institution (Gater et al.,2005; Fujisawa et al.,2008; Steel et al.,2006). In developed countries, general practitioners and mental health professionals are central in the pathway of care with the majority of persons receiving services at mental health facilities are being referred from primary care/general hospital (Gater et al.,2005; Wynaden et al.,2005).

In Nigeria, evidence shows that people presenting with signs and symptoms of mental health issues are missed at primary care centres, including general physicians, religious/traditional healers, who as a result, play minor roles in the mental health care services pathways (Aneibu and Ekwueme 2009; Ogusemi et al.,2010; Odejide and Morakinyo 2003). Family caregivers and persons with mental health issues therefore refer themselves directly to federal/state owned mental health services, as there is lack of these services at primary health care level in the communities (Jack-Ide et al., 2012a). This centralized model of care, with mental health care services only being provided at twelve facilities (eight federally funded and four state owned) across the country, impacts on all citizens' access to mental health care.

Nigerian National Mental Health Policy and Action Plan were formulated to integrate mental health care into primary health services in 1991 (Federal Ministry of Health (FMOH), 1991). By promulgating this policy, mental

health became the ninth component of the nation's primary health care (PHC) services, (promote, protect, prevent, restore and rehabilitate) that will ensure a socially and economic productive and fulfilling life to every individual. PHC is rendered with increasing levels of specializations from the primary to tertiary levels of care. Despite the 1991 policy, mental health care services have been systematically excluded from Nigeria's PHC facilities (Gureje 2003; WHO-AIMS 2006), with no trained psychiatric health professionals being stationed at community sites. Public service mental health care facilities are only provided at twelve hospitals in the country, with eight schools of psychiatric nursing and twelve medical schools to serve a population of over 150 million people (Jack-Ide et al., 2012b).

Studies have shown that mental health services are sought as a last resort in Nigeria, resulting in delayed treatment (Aneibu and Ekwueme 2009; Lasebikan et al.,2012). Among the underlying reasons of delays are the absence of services and programmes for the early diagnosis and treatment of mental disorders, stigma and the belief that mental health issues are untreatable with orthodox medical interventions (Agara et al.,2008; Gureje and Alem 2000; Makanjuola 2003). Stigma has been described as one of the most important factors hindering the early identification of symptoms of these disorders (Sartorius 2007). Nigerians believe in the supernatural causality of mental health issues, irrespective of their educational status (Ani 2004; Odejide et al.,1989) and the most preferred treatment is therefore spiritual/traditional healers (Adewuya and Makanjuola 2009; Kabir et al.,2004). This is compounded by poor public knowledge about mental health issues and the benefits of prompt medical care (Kabir et al.,2004; Gureje et al.,2005). Service utilization data, such as care pathways used by service users, delays in treatment, and access to mental health services, are vital for planning service delivery strategies (Gater et al.,2005; Fujisawa et al., 2008), and are useful ways of studying help-seeking behavior and understanding the pathways families and individuals explore before arriving at a mental health service.

Nigeria is a country of ethnic diversity with a population of over 150 million people (National Population Commission 2006), and over 200 local languages, with English being the common official language. The country has 36 states with the Federal Capital City (FCT) in Abuja. It has a federal system of government, with constitutional responsibilities allocated to the various tiers of government; central, state and local. The study was undertaken in Port Harcourt, the capital city of Rivers State, situated in the southern Niger Delta region of Nigeria. Rivers State has a high population of 3,187,864 people, a population density of 284 persons per square kilometer (compared with the national average of 96 per square kilometer) with the majority living in a few towns and the capital city Port Harcourt. Most of the nation's oil wealth comes from Rivers State, which ethnic diversity as reflected in it's over 15 local languages, and while they are predominantly Christian, traditional religions are still practised by some people (idols or ancestral worship). The state has 36 Local Government Authorities (LGAs), with most people earning a living from public sector, trading, fishing and farming. The family system is an extended or communal type, with members of the family living closely together and sharing the duties of nurturing and training its members collectively.

The mental health needs of Rivers State inhabitants are served by the neuropsychiatric Rumuigbo Hospital, and have provided all inpatient and outpatient mental health services since 1977, and serves as a primary, secondary and tertiary facility (Jack-Ide et al.,2012a). This means that rural people have to travel great distances for specialized care and when hospitalized are separated from home, family and place of employment. Due to the absence of these services outside of the hospital, religious and traditional healers tend to provide succour to people with mental health issues (Erinosho 2010; Odejide and Morakinyo 2003). These religious and traditional healers are easily accessible, being first point of care engaged in the community, with people only access specialist care when the efforts of these healers seem to have failed. This study therefore explored the pathways to mental health service of families and persons with mental health issues in the Niger Delta region of Nigeria before they arrive at mental health care services. This will enable effective planning of mental health services and programmes to reduce the gap experienced in accessing care and support for those in need.

METHOD

Approval for this study was gained from the State Ministry of Health and the Neuro-Psychiatric Hospital Research Ethics Committee. The study was carried out in February through June 2010.

Participants

A purposive sample was used to recruit 50 service users, 30 being family caregivers providing care for ill relatives, and 20 being persons living with mental health issues attended the outpatient clinic of neuropsychiatric Rumuigbo Hospital. They were invited to participate in the study by the clinic nurse at the outpatient department. Information sheets about the study and the implications of participating were given. There were no exclusion criteria for family caregivers but for persons living with mental health issues, the inclusion criteria were those who had maintained a steady improvement in their mental state and were keeping their follow-up appoint ments for at least one year. Those who agreed to participate in an audio recorded interview were requested to complete

Table 1. Social demographic characteristics of participants

Variable	N	%
Gender		
Male	23	46
Female	27	54
Age (years)		
20-29	9	18
30-39	27	54
40-59	8	16
60 and above	6	12
Marital status		
Single	17	34
Married	11	22
Separated/divorced	15	30
Widowed	7	14
Educational status		
No formal education	8	16
Formal education	42	84

Table 2. Domains and themes arising from the interview transcripts and percentage.

Domains/Themes	N	%
Place of first visit for treatment		
Religious healers	24	48
Traditional healers	10	20
General/Private hospital	10	20
Psychiatric hospital	6	12
Reasons for choice of first place of treatment		
Spiritual/traditional beliefs about causality	24	48
Poor knowledge of psychiatric hospital	16	32
Stigma and discrimination	10	20
Reasons for use of psychiatric hospital		
Physician referral	10	20
Religious/spiritualists referral	8	16
Advice from friends/relatives	32	64

the consent form, were advised that they could withdraw from the study at anytime and also assured of anonymity. In-depth interviews were carried out at the hospital after their clinic appointments with the semi-structured interviews schedule containing both demographic and open-ended questions addressing the following three domains: first place visited for treatment, reasons for choice of first place for treatment and factors that influence their decision to use the Rumuigbo Hospital mental health services (see Table 1 and Table 2).

Participants were encouraged to discuss and reflect upon their experiences of seeking help and treatment, each interview beginning with a description of the history of onset of illness and their pathway to accessing the current mental health service. For persons with mental health issues, example of question asked were: Where did you first go for treatment at onset of illness? For caregivers: where did you take your relative for treatment when you first notice the illness? Depending on the reply, the follow-up question may have addressed: How long did you notice the changes before seeking help?

Procedure

Interviews took an average of 45 minutes to one hour, were tape recorded, transcribed verbatim and coded using content analysis (Green and Thorogood 2004). Interview transcripts were first read through several times to attain a picture of the whole, and later, themes were identified which involved listing patterns of experience identified from the transcribed interviews (Creswell 2007), identifying data that are related to the three interview domains and cataloguing these patterns into sub-themes. NVivo version 8 software (QSR International, Doncaster, Victoria, Australia) aided the process, and each theme

was further reclassified to identify key themes, numbers were assigned for identification purposes and example quotations for each theme were noted, an ellipsis points (…) indicate where material was omitted in the flow of participants' speech. The researchers independently coded and catergorised the data, a very close level of agreement being observed between researchers, and the final themes were reached by consensus based. NVivo was useful in retrieving words and phrases for a structured content analysis, however it was restrictive for annotating data, with considerable loss of formatting, particularly paragraph sections. To maintain credibility after the data analysis has been done, members check was carried out through two focus group discussions, one with 14 family caregivers and the other with 8 persons living with mental health issues who had participated in the study to validate the conclusions reached during data analysis and the results presented were confirmed by the participants. Any information that might compromise participants' confidentiality including their names has been removed.

RESULTS

The demographic details of the participating family caregivers and persons living with mental health issues are presented in Table 1 and shows that 30% were separated/divorced, 54% were female, 84% had formal education and 64% lived in rural areas.

Of all participants, 48% consulted religious healers as their first place of choice for treatment as they held religious/spiritual beliefs about treatment of mental health issues. Twenty percent had poor knowledge of available mental health services, and 20% were influenced by stigma and discrimination from seeking specialist care. Reasons for accessing care at the Rumuigbo mental health service were that 64% were advised by friends and close relatives due to the deteriorating condition of the illness, 20% were referred by religious healers and only 16% by general physicians. Domains and themes arising from the three areas of interest are presented in Table 2: first place visited for treatment, the associated reasons for that choice, and reasons for current use of mental health service at Rumuigbo Hospital.

1). First place visited for treatment

This domain refers to the sources of help first accessed for treatment at the onset of mental health issues. The results indicate that many first sought treatments from religious healers (48%), followed by traditional healers (20%), general/private hospital (20%) and lastly, the psychiatric hospital (12%).

A). Religious healers (Churches)

Almost half of the participants (48%) first sought healing for mental health issues from religious leaders (commonly referred to as men of God), primarily through prayers. The ease of access and low cost were important factors, with healing being freely given as long as they exercised faith in Jesus Christ. According to Interviewee 10 (Caregiver) "*At first we have to pray, you see we belong to the…church, actually we do not take medicine, so we have to pray, we also asked the brethren to help us in praying for healing".* Similarly Interviewee 41 (Client) indicated that "*The illness started in the church…I started shouting and they took me to the pastor and he prayed with me. I continue to go for prayers and it look as if everything became normal, but after a few months the illness still started again…"*

B). Traditional healers (herbalist)

One fifth (20%) believed that mental health issues were caused by charms from an enemy or supernatural powers that can only be treated by appeasing the gods' necessitated traditionalist/herbalist performing certain cleansing rituals and sacrifices. As interviewee 11 (Caregiver) indicated: "*We went for traditional treatment, we have taken her to so many places herbalist or whatever. We have done so many things because of this illness…at a point the healer asked us to bring various denomination of money from N5 to N1,000 each, we brought them and these monies were burnt as sacrifice in the name of treating her".* Interviewee 16 (Client) explained that: "*The first place we went was traditional healers. We were told someone is responsible for his illness and so we went for native treatment, somebody in the village was treating him in the house"*

C). General/Private hospital

Only 20% of the participants who sought treatment from general practitioners thought that the symptoms were of a physical ailment that could be treated by the doctor, the others being unaware that it was of a mental health issue. As Interviewee 5 (Caregiver) indicated: "*She use to have malaria almost every other month, we thought it was malaria. It was the doctor that said I should go to the psychiatric hospital that her condition is above him and since then 2005 I've been coming here".* Interviewee 40 (Client) was involved in a traffic accident and was referred by the private clinic in which they were hospitalized: "*I was involved in a road traffic accident and was hospitalized in a private clinic, after series of treatment for some months with complains of headache*

and sleeplessness I was referred to *psychiatric hospital…then we said oh no how can I come to psychiatric, I am not mental, its only an accident, the physician insisted that I should, so we came".*

D). Psychiatric hospital

Past experiences of the use of mental health services and its benefits by friends and relatives influenced 12% of the participants to go directly to the hospital at the onset of illness. Interviewee 19 (Caregiver) indicated: "*We, because it's the tradition that it has been the story in the family line, we don't go to any other place apart from the psychiatric hospital, we are from…and there is a very formidable psychiatric hospital so we go straight there".*

An urban participant who worked with shell oil company (Caregiver 9) indicated: "*We brought him straight to this hospital because I know it is the right place, I belief my son can be treated here and that is why I brought him immediately I notice the changes in him".*

2). Reason for choice of first place of treatment

This domain deals with factors that influenced their first choice of treatment and indicates the role that belief systems play in treatment seeking pathways. Four reasons were indicated influencing their choice of first treatment; religious beliefs about treatment, traditional beliefs about causality of mental health issues, poor knowledge of mental health service, stigma and discrimination.

A). Religious beliefs about treatment

Forty eight percent of the participants indicated that, their beliefs in the power of God, the availability of churches and the low cost of getting healed by men of God influenced their visiting a religious healer. Interviewee 42 (Caregiver) indicated that: *"This illness I don't know where it is coming from, as somebody from this area I believe someone who is envious of the family's progress can harm you, to a great extent it happens, it happens…but I strongly believe that God is greater than all of that and that was why we took her to church for healing"*

B). Traditional beliefs about causality

Mental health issues were attributed to the handiwork of witches, spiritual attacks such as `black magic' and `evil spirits' by 28% of participants requiring care and treatment from a traditional healer or herbalist. Interviewee 35 (Client) outlined commonly held beliefs: "*In our belief system traditionally, we have believe for witchcraft, an enemy can put a spell on someone and the person become insane. This believes cannot be scientifically proved but we have belief for witchcraft… that is why mostly we seek traditional interpretation for the cure…"* Interviewee 49 (Caregiver) noted: *"You know we all have our superstitions beliefs…and these beliefs are true because a whole family can be afflicted, witchcraft has connection with all of this… it does my dear, it does except you don't belief in witchcraft but I do".*

C). Poor knowledge of psychiatric hospital

Poor knowledge of psychiatric of participants who expressed poor knowledge about mental health care services and its benefits, 20% cited lack of available mental health services in the community as the reason for delays in seeking prompt treatment. The rest (80%) indicated that poor awareness about mental health services is linked to traditional beliefs regarding the causes of mental health issues, with health services not considered a priority for the treatment of such illnesses. A rural caregiver (7) indicated that: "*I don't know there is a place like this, a hospital like this, somebody asked me to go to this…go to that…I've gone to so many places, performed many rituals and sacrifices before we came here and since we started coming there is difference. Anybody that goes to other places is wasting time really you are just wasting your time".*

D). Stigma and discrimination

Twenty percent of the participants agreed that stigma and discrimination were common and as a result, many families hide their illness due to shame, with treatment being sought in secret from churches and traditional healers. There were fears that disclosure would negatively impact on other family members' social status, their chances for marriage or political aspirations. A concerned caregiver (24) indicated: "*The stigma, it's like you want to ridicule your family it is not something you tell people. When you think of the kids, family, politics and stuff like that...I don't think it's something I want to tell anybody, it is not news so why should I tell others".* A client (31) also observed: "*My mother used to be like that, she used to hide it and I will tell her what are you hiding? I think she hides it because of society, the fear of what people think or will say… I find out that she has tried to change, but she continues to hide it".*

3). Reasons for using mental health service

This section outlines the route service users take which resulted in them using the Rumuigbo Hospital. The three groups of referrals in the service users care pathway were

were mainly friends/relatives and the deteriorating condition of the illness, religious healers and physicians.

A). Advice from friends, relatives and deteriorating condition of the illness

The current use of the mental health service was influenced by the advice of friends and close family relatives of 64% of the participants. These concerned persons who knew about the benefits of professional management of mental health issues and importance of preventing the illness from the deteriorating state. A Client (34) indicated that: "*My parents, my brothers and sisters brought me here in 2002, some relations told my people about this hospital and they brought me here for treatment".* Caregiver (1) who has been caring for her ill relative since 1985 reported: "*when the illness started, we've been using traditional method but no improvement. A friend advised us to bring him to this hospital and since we started coming, his condition has improved. He is stable and is able to go back to his work, sometimes for a year and he will be okay, he speaks very well and you will not know he has mental problems, as long as he takes the medications".*

B). Religious/spiritualists referral

The belief that mental health issues will be solved through spiritual and prayerful ministration plays an important role in defining many service users care seeking pathways. However, only 20% of the participants who sought help from men of God were advised by their church pastors to seek professional treatment from mental health care service. Interviewee 3 (Caregiver) was advised by their pastor: "*We took her to church for prayers and deliverance, the church prayed to no avail. After some time the Pastor directed us to this hospital and that was how we brought him here and since then we have been coming for treatment".*

C). Physician referral

Service users observed that early detection of mental health issues helped to reduce the duration of an episode reduced the direct and indirect costs of managing the disorder and resulted in far less social impairment in the long term for the family. Sixteen percent of the participants were referred to psychiatric hospital by their general physicians (GPs) who were consulted earlier by family/friends for treatment. Interviewee 18 (Caregiver) indicates that: "*I was advised to bring her here by a doctor at…a medical doctor referred us to this place and that was how we got here. Since then she has improved greatly, the changes are amazing".* Interviewee 38 (Client) illustrates: "*I was very uncooperative according to my wife, I refused every suggestion or advice given on where and what to do…I was forced and taken to the …hospital, but the doctor told us that hospital is not the right place for my treatment so he referred us to psychiatric hospital and that was how I was brought here".*

DISCUSSION

It is evident from the results that religious and traditional healers are the first choice for treatment of mental health issues. The finding is similar to a previous study in the south west region of Nigeria by Lasebikan et al. (2012) which indicated that 78.9% of the respondents' first sought treatment from spiritual healers due to their confidence in the cure. Evidence shows that religion plays a significant role in the life of most Nigerians and their health belief system (Adewuya and Makanjuola 2009; Aneibu and Ekwueme 2009: Kabir et al., 2004). In this study, participants reported that religious/spiritual model of care provided a sense of hope with God being 'in control' and having the power to overcome all evil spells from an enemy. This is similar to a previous study in India by Rammohan et al. (2002), which showed that 85% of clients attending mental health services had consulted religious healers prior to their visit to the hospital. Previous studies in Nigeria have shown that many semi urban and rural communities are served by the large number of these healers (Erinosho 2010; Odejide and Morakinyo 2003). A Nigerian study on management of mental health problems by spiritual healers (Agare et al., 2008) reported that only 6% of the spiritual healers' clients were referred to specialist mental health services.

The strength of religious/traditional beliefs was acknowledged and incorporated into the training of traditional birth attendants to recognise complicated child delivery in Nigeria (Apantaku 2005; WHO et al.,2005), and this can also be incorporated into the training of religious and traditional healers to identify severe mental health issues and refer appropriately. Their involvement in mental health care and decision-making process related to the families and persons living with mental health issues may be effective in preventing unnecessary suffering and seeking appropriate treatment. Religious and traditional healers, given the opportunity to collaborate with professionals about the care of persons with mental health issues, may be better able to enhance early referral to specialist mental health care service, and could significantly influence treatment outcomes for the disorders in Nigeria.

In this study, poor knowledge about mental health services was observed to have contributed to non-utilization of services at the onset of illness. This finding is similar to a study in eastern Nigeria by Aneibu and

Ekwueme (2009), with 14.6% of their sample being ignorant of the existence of a mental health facility. Ganasen et al., (2008) argues that poor knowledge of mental health issues and services in developing countries can be an obstacle to providing treatment for those in need, and is of particular concern in a poor resource environment. Furthermore, the few mental health institutions in Nigeria are located in urban areas, with no service provision for the rural and semi-rural areas where the majority of the citizens resides (Jack-Ide et al., 2012a; WHO-AIMS 2006). Nigeria's PHC approach has been used successfully to deliver general and midwifery services, particularly in rural communities (Federal Ministry of Health 2004; 1988). A similar approach should be used for mental health services delivery. This would increase community knowledge of mental health services, have positive treatment outcomes and also reduce the cost associated with transport and accessing care.

The study showed that stigma and discrimination attached to mental health issues deters people from accessing and using relevant services. The participants also reported that the shame of being seen using these facilities was responsible for none utilization, thereby compounding the disease outcomes. This finding is confirmed in a study of community knowledge and attitude of mental illness in Nigeria by Gureje et al.,(2005), which show that 96.5% of their participants held negative views towards people with mental health issues. Stigma and discrimination towards people with mental health issues is based on the societal perception of such persons as being evil and responsible for their disorders (Ani 2004; Gureje et al., 2006; Jack-Ide et al.,2012b; Kabri et al.,2004). As a result, families and persons with the illness tend to shield themselves and their families from this discrimination, by hiding their illness and avoiding visiting mental health services (Corrigan 2004; Larson and Corrigan 2008). They attribute the illness to the influence of supernatural forces, the handiwork of an enemy and results in their choosing spiritual healers for treatment rather than seeking professional support. The consequence of not receiving proper treatment further creates a vicious cycle of social isolation, unemployment and abandonment, and decreases the chances of recovery and reintegration into normal life.

Some participants reported that their decision to use of mental health service was influenced by friends, close family relations and the deteriorating condition of illness. This finding is similar to a study of social network as a determinant of pathway to mental health service utilization in Nigeria by Lasebikan et al., (2012), which showed 51.1% of the participants were influenced by friends and relatives to access and use mental health services. In another study of pathway to mental health service in Enugu, Nigeria by Aniebue and Ekwueme (2006), 44.8% eventually chose to use specialist mental health service after persuasion by friends and relatives. The significant role friends and other support groups can play in advising and assisting with mental health service referral pathways need to be recognized by policy so as to develop activities and programmes to involve this group in the support of people living with mental health issues and their families.

The implications of findings for nursing practice is that, nurses play an important role in policy development through advocacy and research, within the domains of health service delivery and a broader public policy that extend beyond traditional health agencies and government health departments to bring together sectors such as finance, agriculture, education, transportation, energy and housing (Reutter and Duncan 2002) . As the principal group of mental health professionals providing care in these large psychiatric institutions, nurses has responsibility towards improving access to mental health care through lobbying and advocacy (International Council of Nurses 2006), in addressing needs of families/clients as to develop a clear understanding of how the public health policy can act to reduce mental health inequities thereby giving voice to the voiceless.

Limitation of the Study

The study was conducted in one facility, as mental health services are not provided in other hospitals in the state. The results may therefore not transferable to the rest of the country. The small sample size may not have canvassed people from all ethnic and geographical regions of the state. However, the strength of the study was the use of in-depth interviewing that allowed for new themes to emerge in order to provide a thorough understanding of the factors that influence the care pathway of families and persons living with mental health issues.

RECOMMENDATIONS

Policies should address the roles religious and traditional healers play in the care pathway, and provide for educating them on basic aspects of mental health care as a relevant referral points and as a rehabilitative and support network.Government should undertake a national education campaign on causes of mental health issues, benefits of treatment and availability of services.

Information ministry should embark on the dissemination of information about mental health services among the population and health workers at all levels.

Improving access to services should be a priority at community levels to reduce the treatment gap and enable individuals and families to have physical access to mental health.

Mental health professionals should undertake community awareness campaigns to reduce stigma and discrimination and promote acceptance of persons affected with mental health issues.

Undertake further research in other parts of the country to establish whether they experience similar difficulties accessing care.

CONCLUSION

This study shows that families' religious/spiritual beliefs, the availability of churches and the low cost of receiving healing from men of God influenced the visiting of a spiritual healer as the first choice of treatment in the Niger Delta region of Nigeria. The extent to which people will benefit from mental health services is influenced by their knowledge about causation and effective treatment outcomes, and highlights the need for community education programmes to identify how best to improve pathways to appropriate care. Unless the pathways to mental health care services are improved, the use of alternative care model, stigma and discrimination will not be overcome, people in need will remain marginalized and hidden, unable to live

full and productive lives. Every effort should be made to improve the quality of life of persons affected by mental health issues and their families, given that necessary policies exist. Political will and commitment, supported by national campaigns and staff training, will bring much needed mental health services close to those who need it most.

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