HEALTH SEEKING BEHAVIOURAL PATTERN AMONG PATIENTS OF NEURO-PSYCHIATRIC HOSPITALS IN AKURE: IMPLICATION FOR HEALTH PROMOTION EDUCATION

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ABSTRACT

This study validated the enormity of mental illness as a challenge that is prevalent among people of all ages in Nigeria, regardless of other demographic factors including education, gender, wealth index, marital status among others. A more challenging situation is the negligence of seeking treatment and the prevalence of seeking help from only spiritual places. This shows that there is dire need for enlightenment and health promotion programs. Consequently, the study recommends, intense attention for quality reorientation for a cultural shift in the way mental illness is perceived, so that correct avenues will be sought for treatment; it also encourages the government to pay more attention to providing more facilities for such treatment to be accessible to all. Health insurance scheme can be used to cover for the cost of treatment under the universal health coverage system among others.

Keywords: Health-Seeking Behaviour, Neuro-Psychiatric Patients, Mental Health, Health Promotion.l Media, Face to Face Communication, Interpersonal Communication

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1 | Introduction

The definition of health as given by the World Health Organization since 1948, emphasizes that health does not indicate the absence of illness, rather, it is a holistic state of well-being that includes physical, mental, and social aspects. It recognizes the fact that good health is not just the absence of diseases but also involves harmonious emotional well-being, social connections, and a positive quality of life (Muele, *et al.,* 2023). This definition brings us to the understanding of how crucial it is for individuals to live in harmony with their mental wellbeing for optimum productivity. However, a lot of people have mental disorders that do not only hamper their wellbeing and quality of life but much more, affect the society in important ways (Fadele *et al.,* 2024).

The World Health Organization (WHO) reported in 2022 that mental health disorders account for a significant proportion of the global burden of disease, contributing to disability, morbidity, and even premature mortality (WHO, 2022). Overcoming mental health disorders is one of the all-encompassing agenda of the Sustainable Development Goals (SDGs) as entrenched in Goal 3. SDG 3.4 was set to pursue the reduction of premature mortality from

noncommunicable diseases and the promotion of mental health and wellbeing, while target 3.5 seeks to strengthen the prevention and treatment of substance abuse, including narcotic drug misuse and harmful use of alcohol. Despite concerted efforts at achieving mental health for all, it was reported by the WHO in 2025, that around 1 billion people live with a mental disorder, and one person dies every 40 seconds due to mental health-related causes (WHO, 2025).

In many parts of the world, including Africa, mental health illnesses are common and impact people of all ages and socioeconomic backgrounds (Bezerra *et al.,* 2021). The Royal African Society asserted that mental illness situation is critical in Low & Middle-Income Countries (LMIC) specifically in African region due to limited resources and the negligence of the African nation in paying due attention to the mental wellbeing of her people (Royal African Society, 2020). Equally, the WHO reports declared the poor state of mental wellbeing in LMIC when it revealed that in such countries, more than 75% of people with mental health disorder, receive no treatment for their conditions. The report equally added that Nigeria has the highest prevalence of depression cases in Africa and ranks 15th globally in suicide rates (WHO, 2025).

Extant studies have validated mental health disorders among people of all ages in Nigeria. For instance, research conducted in Umuahia, South-East Nigeria, revealed that 11.7% of school children exhibited mental health disorders (MHD), with peer relationship issues being the most common (Atilola *et al.,* 2022). Another cross-sectional study at the University of Calabar found that 39.2% of medical students reported poor mental health status (Oku *et al.,* 2015). In the same vein, Babasola, et al (2023) revealed from their studies among the youth's cohort in Ogun State, Southwest Nigeria, that different types of mental disorder, ranging from anxiety to depression, schizophrenia and many more complicated mental illnesses were rampant among them.

Mental disorder situations and treatment seeking behavior is affected in different ways and impacted by important socio-cultural cum economic factors (Pushpalata, & Chandrika (2017). Whereas Onuoha, *et al* (2024) identified beliefs, values, traditions and social norms as major influences on willingness to go for treatment, Latunji, & Akinyemi, (2018) noted that demographic factors including level of education, wealth index, age and place of residence are predominant indices as revealed from their studies. The family and community attitude were as well identified as very germane in considering the health seeking behaviour (HSB) of mentally ill patients (Kumar, & Geetha, 2023). Other factors identified include political climate, distance and accessibility, as well as cost of treatment among others (Adongo & Asaarik, 2018; Fadeke, *et al.,* 2024). Addressing these myriads sets of influences adequately to ensure that persons with mental illness conditions seeks appropriate interventions is the bedrock of this study.

1.1 | Socioecological Model

The socioecological model, which addresses behavior change at multiple levels and considers the inter-relationship between behavior and the environment is adopted for the desired change towards prompt and satisfactory HSB expected among the person that are mentally unstable. This model, identifies five basic levels of influence that can help improve health behaviour (Stokols, 1996; McLeroy *et al.,* 1988; Glanz *et al.,* 2002). The first among them is the intrapersonal factors which encompasses the individual characteristics such as knowledge, beliefs, and self-concept. The second

level of influence is what is termed, interpersonal processes and primary groups which include the individual's social environment such as family, friends, peers, and co-workers that surround the individual and influence his/her behavior in important ways. Third level among these influences is the institutional or organizational factors which signifies the workplace, places of worship, and any other organized social institutions. These institutions shave formal or informal policies and structures. Another important influence is Community factors which describe the relationships among organizations and institutions. This includes community norms. The last on the continuum is public policies which encapsulate all policies or regulations concerning healthy practices.

Consequently, health seeking behaviour at all levels particularly with mental illness is affected by the above five level factors. Socio-cultural cum demographic indices are imperative determinants to healthy living by all standards (Adebola, 2020). Similarly, the significant others and societal values have been found to play crucial part in people's attitude to healthy behaviour choices (Adebola, Ewemooje & Adebola, 2022). Government interventions/policies including availability and affordability of care facilities have also been recognized as a major factor (World Health Organization (W.H.O), 2021). Health promotion programs and education using the tenets of this model will achieve a mind shift towards better health benefits that outweigh other factors in decision making for mentally distressed people.

2 | Materials and Methods

2.1 | Study site

This study was conducted at the **Neuro-Psychiatric Hospitals** in Akure South Local Government Area, a public tertiary healthcare facility specializing in mental health service. The facility is located along Oda Road in Akure South Local Government Area of Ondo State, Nigeria, and operates 24 hours a day, six days a week (Monday through Saturday), providing care for individuals with various neuropsychiatric conditions and is well attended by both in- and out-patients of different mental challenges.

2.2 | Research Design

We used the mixed method research designs including both quantitative and qualitative procedures. The quantitative study was carried out using a semi-structured self-administered questionnaire for the patients while the qualitative study was done using the Key Informant Interview (KII) for the health providers and workers. Informed consent was obtained from the respondents before participation in the survey.

2.3 | Research Population and Sample Frame

Patients and healthcare providers of Neuro-Psychiatric Hospitals in Akure South Local Government Area make up the population where respondents were drawn for the study. The population of the patients at the time of this research was put at 250, while the workers were about 15 health personnel with different qualifications including the Chief Medical Director. The hospital also has medical students on training who were fully engaged as care givers too. A total of 100 copies of questionnaire were administered to the patient over a period of two weeks. With the help of the care givers as well as an assistant research fellow. Key Informant In-depth Interviews were also conducted over another three days among the hospital workers.

2.4 | Method of Data Collection

Data was collected using a semi-structured interviewer-administered questionnaire and key

Informant Interview. The Questionnaires was divided into 4 sections. Section A focused on Socio-demographic data while section B fixated Patterns of Mental illnesses, section C adequate attention was given to respondents' knowledge of health seeking behaviour and section D inquires was a Barriers affecting Health seeking behavior. For the qualitative study, a Key Informant Interview was conducted among the major stakeholders at the facility. For the quantitative study, all copies of the questionnaire were serially numbered to guarantee easy identification, entry and recall. The data collected was checked for errors and missing data, cleaned and entered into the Statistical Package for Social Science (SPSS version 27) software. Descriptive analysis of frequency counts, percentages and grand score to analyze the demographic data while Inferential statistics of chi-square was used to analyze other factors associated with mental health status and also to analyze the postulated null hypothesis at 0.05 alpha level.

3 | Results and Discussion

The result from Table 1, revealed the demographic characteristics against the different types of mental disorder identified at the health facility in the study. The first significant outcome as seen here is the fact that all the age cohorts under study have all forms of mental distresses though to different degrees by age and other factors. The result certified that mental illness is most common among the age cohorts of youths and young adults with age 24-35 years having the highest at 32% strictly followed by age bracket 35-44. This finding corresponds with earlier research works. For instance, studies by Oku *et al.* (2015) as well as Bezerra *et al.* (2021) which asserted that in many parts of the world, including Africa, mental health illnesses are common and impact people of all ages and socioeconomic backgrounds. Atilola, *et al.* (2022) and Babasola, *et al.* (2023) also confirmed the prevalence of mental disorder among the young adults, calling for interventions to reduce it. The gender distribution affirmed that almost 70% of those mentally ill were men while a little above 30 and the single were more affected (64%) than the married (36%). In a twist, however, the most educated (tertiary) were shown to carry more mental disorder burden than other lower level of education and those who are self-employed than the employed.

Figure 1 relays common barriers to seeking help when in mental distress, and as seen, the most prevalent barrier is societal stigmatization of the mentally disordered persons. Other factors include lack of awareness, cost of treatment, and lack of family support among others. Relatedly, Zaman, *et al (*2022) and Berhanu, (2023) reported similar results from their finding that barriers preventing actions for treatment in Mental illness included self-stigma, perceived stigma, costs of seeking treatment, lack of awareness and availability of support, negative career implication and confidentiality.

3.1 | Multinomial Logistic Regression

The report from the multinominal logistic regression revealed that majority of the persons who are mentally ill, do not seek help at all or seek help more from religious and prayer house. Not seeking treatment at all or finding help for religious places were significant across other factors including age, education, income level, gender, among others. As revealed in Table 2, revealed that more than 50% across all age groups do not go for any treatment, while on the average another 50% prefers prayer houses for treatment. While about 50% female that are sick, do not attend to treatment, about 38% goes to prayer centers, for the males, the report shows that 53% do not receive

Table 1 | Characteristics of Respondents by Mental Distress Types

Age in years	Types of Mental Illness						Total %
	Anxiety	Bipolar disorder	Depression	Schizophrenia	Sleep disorder	Substance use	
15-24	3 (3.0%)	1 (1.0%)	5 (5.0%)	2 (2.0%)	0 (0.0%)	4 (4.0%)	15.0%
25-34	10(10.0%)	3 (3.0%)	7 (7.0%)	0 (0.0%)	4 (4.0%)	8 (8.0%)	32.0%
35-44	13(13.0%)	0 (0.0%)	6 (6.0%)	2 (2.0%)	6 (6.0%)	0 (0.0%)	27.0%
45-54	4 (4.0%)	0 (0.0%)	6 (6.0%)	5 (5.0%)	0 (0.0%)	2 (2.0%)	17.0%
55-64	2 (2.0%)	0 (0.0%)	1 (1.0%)	3 (3.0%)	0 (0.0%)	0 (0.0%)	6.0%
65+	0 (0.0%)	0 (0.0%)	1 (1.0%)	2 (2.0%)	0 (0.0%)	0 (0.0%)	3.0%
Gender							
Female	12 (12.0%)	0 (0.0%)	8 (8.0%)	10 (10.0%)	2 (2.0%)	0 (0.0%)	32.0%
Male	20 (20.0%)	4 (4.0%)	18 (18.0%)	4 (4.0%)	8 (8.0%)	14 (14.0%)	68.0%
Mar. Status							
Married	12 (12.0%)	0 (0.0%)	10 (10.0%)	8 (8.0%)	2 (2.0%)	4 (4.0%)	36.0%
Single	20 (20.0%)	4 (4.0%)	16 (16.0%)	6 (6.0%)	8 (8.0%)	10 (10.0%)	64.0%
Education							
No formal education	2 (2.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (2.0%)	0 (0.0%)	4.0%
Primary	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (2.0%)	2.0%
Secondary	8 (8.0%)	2 (2.0%)	10 (10.0%)	4 (4.0%)	6 (6.0%)	2 (2.0%)	32.0%
Tertiary	22 (22.0%)	2 (2.0%)	16 (16.0%)	10 (10.0%)	2 (2.0%)	10 (10.0%)	62.0%
Employment							
Civil Servant	2 (2.0%)	2 (2.0%)	4 (4.0%)	6 (6.0%)	0 (0.0%)	0 (0.0%)	14.0%
Self-employed	22 (22.0%)	2 (2.0%)	16 (16.0%)	6 (6.0%)	8 (8.0%)	8 (8.0%)	62.0%
Unemployed	8 (8.0%)	0 (0.0%)	6 (6.0%)	2 (2.0%)	2 (2.0%)	6 (6.0%)	24.0%

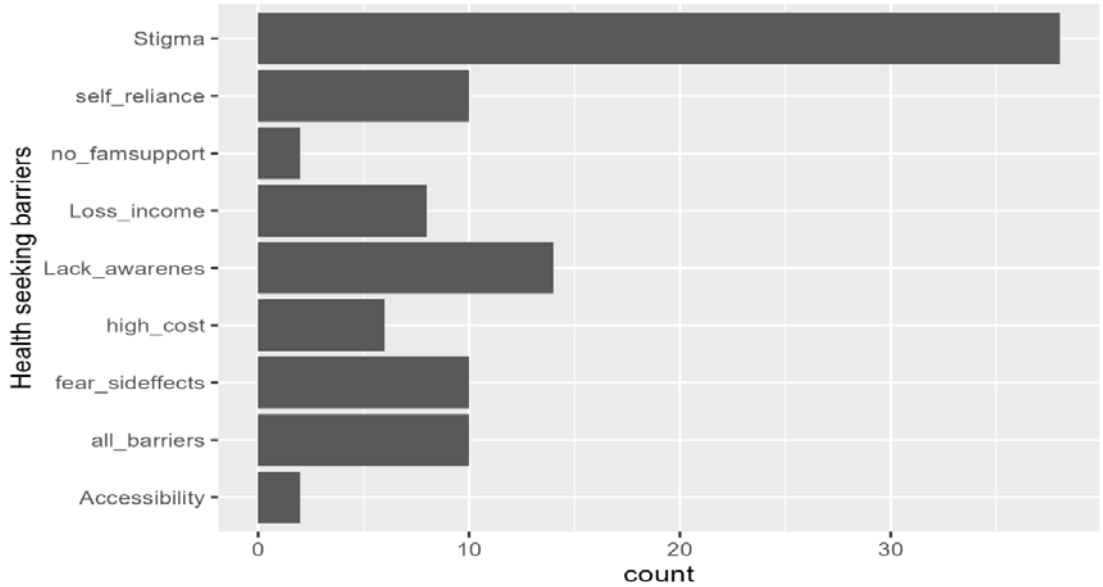

Figure 1 | Health Seeking Barriers

Table 2 | Multinomial Logistic Regression for Age

Covariates	Health-seeking behaviour	Estimate	Odds ratio	Percentage/Prevalence level
Age		Intercept Covariance effect		
15-24	General hospital	Ref	1	0%
	None			53%
	Others			0%
	Prayer house			33%
	Psychiatric hospital			13%
	Traditional healer			0%
25-34	General hospital			0%
	None	197.634002	6.781979e+85	53%
	Others	64.014062	6.323449e+27	0%
	Prayer house	197.400560	5.369995e+85	28%
	Psychiatric hospital	-175.735126	0.000000e+00	13%
	Traditional healer	-25.774458	0.000000e+00	6%
35-44	General hospital			0%
	None	154.487159	1.238571e+67	56%
	Others	41.768461	1.379788e+18	7%
	Prayer house	153.804244	6.256544e+66	22
	Psychiatric hospital	-65.496952	0.000000e+00	7%
	Traditional healer	121.636881	6.702336e+52	7%
45-54	General hospital			12%
	None	-53.459847	0.000000e+00	41%
	Others	-131.001387	0.000000e+00	0%
	Prayer house	-53.842160	0.000000e+00	47%
	Psychiatric hospital	-388.970132	0.000000e+00	0%
	Traditional healer	-61.415245	0.000000e+00	0%
55-64	General hospital			0%
	None	52.073577	4.123512e+22	33%
	Others	10.066064	2.353076e+04	0%
	Prayer house	50.342870	7.305173e+21	67%
	Psychiatric hospital	-75.441437	0.000000e+00	0%
	Traditional healer	33.123726	2.429133e+14	0%
65-above	General hospital			0%
	None	187.230048	2.055781e+81	100%
	Others	23.603154	1.781228e+10	0%
	Prayer house	-91.175568	0.000000e+00	0%
	Psychiatric hospital	-47.462378	0.000000e+00	0%
	Traditional healer	-70.191248	0.000000e+00	0%

any treatment while 29% also attend spiritual places. The results indicated that women are the most reluctant to attend psychiatric hospitals while 12% of the men gets treated in a psychiatric facility. This line of result is the same for the married and the unmarried, including those educated and regardless of the wealth quantile.

The findings as seen from the multinomial logistic regression is a true representative of what happens to mentally disordered individuals in Nigeria.

While it may be easier to seek help for other forms of sicknesses, cultural norms and belief systems are more pervasive in determining the definition around mental issues as well as seeking help or treatment. Early research has shown that in Africa generally and Nigeria in particular health seeking behaviour depends on such factors, thus limiting access to adequate care.

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