PACIFIC JOURNAL OF MEDICAL SCIENCES

{Formerly: Medical Sciences Bulletin}

ISSN: 2072 – 1625

Pac. J. Med. Sci. (PJMS)

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# ABUSE AND NEGLECT OF MENTALLY ILL DESTITUTE AND THE BURDEN OF REHABILITATION IN BENIN METROPOLIS, SOUTHERN NIGERIA

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**ABSTRACT:**

The incidence and prevalence of mentally ill destitute in metropolitan Benin, Nigeria has become a subject of public discourse particularly as they appear to lack care and the desired attention from their relatives, society and the government. Apart from the Lunacy Act (1958), Nigeria currently does not have any Act of parliament dealing with mental health and rehabilitation. This study therefore examined the abuse and neglect of mentally ill destitute and the burden of rehabilitation in Benin Metropolis, Southern Nigeria. Though a onetime survey design, the quantitative technique was adopted with the aid of both purposive and snowballing sampling methods to gather data from 610 respondents made up of medical practitioners, nurses, staff of Ministry of Women Affairs, Benin City, care givers and social workers, personnel in traditional and prayer houses, relations, friends and neighbours of mentally ill persons in Benin Metropolis. Informed consent was individually obtained from all the respondents before the commencement of the study. The data collected were analysed with the aid of inferential and descriptive statistics and the three null hypotheses formulated were rejected while the alternate hypotheses were accepted. The study found that mentally ill destitute were not only abused and neglected due to prejudice, beliefs and attitude of the people, but that there were no social or legal policy on their rehabilitation. The findings indicate that enlightenment of the populace should be done to change their negative beliefs, attitude and prejudice against the mentally ill destitute. The government on its part should enact legislation on mental health and rehabilitation.

**Key words:** Vagrant psychotics, rehabilitation, abuse, neglect, stigmatization
*Submitted April 2018, Accepted June 2018*

## INTRODUCTION:

Nigeria is reported to be the most populous country in the continent of Africa with a population of approximately 196 million people (National Population Commission Annual Report, 2018). Statistics however revealed that about 20-30 percent of its population suffers from some kind of mental illness [17] and the most worrisome is the fact that mental health services are grossly inadequate, leading to

destitution. Interestingly, recent records reveal that the incidence and prevalence of mental health is on the increase [13] and quite unfortunately, Nigeria has failed to live up to the global treatments standards adopted by the world on mental health policy [18].

The concern over mental health of Nigerians predates even the pre colonial period as many mentally ill persons were left unattended to or at best, chained or locked up without medication, especially, as there were no mental health institutions then in Nigeria. However, during the colonial era in Nigeria, the British colonial masters burdened by this state of affairs and the need to provide adequate treatment and care for mentally ill persons, enacted the Lunacy Act [6]. Although, prior to the enactment of this Act, there was traditional mental health practice for treating persons with mental illness and destitution, the treatment was mainly limited to confinement, as those with mental illness were seen as dangerous, suspicious, irresponsible and homicidal [1]. Till date, no well-defined regulation of mental health exists, let alone welfare or rehabilitative provisions for mentally ill persons in Edo State, Nigeria. What exist at best are adhoc provisions [14]. This situation seems worsened because some citizens of the state see mental illness as caused by evil spirits and the gods. This belief has in no small measure affected people's attitude towards the mentally ill destitute and their rehabilitation. There is therefore the need to investigate the abuse and neglect of the mentally ill destitute and their rehabilitation in Benin metropolis, Southern Nigeria.

Objective of the study:

The study investigated the abuse and neglect of the mentally ill destitute and the burden of rehabilitation in Benin metropolis, Southern Nigeria.

Hypothesis

Three hypotheses were generated for the study and these are: (1) There is no association between belief and attitude towards mentally ill destitute and their rehabilitation in Benin metropolis, Southern Nigeria. (2) There is no relationship between abuse and neglect of mentally ill destitute and their rehabilitation in Benin metropolis, Southern Nigeria. (3) There is no correlation between government social and health policy towards mentally ill destitutes and their rehabilitation in Benin metropolis, Southern Nigeria.

Conceptual issues: mental illness, destitute and rehabilitation

Mental illness is a medical concept covering a broad range of mental conditions-which imparts how a person feels, thinks, behaves and interacts with others. McNailly [7] sees it as the disease of the brain which is complex and

multifaceted. Destitute according to Alisiobi [27] refers to individuals who cannot cope with the demands of society and so are left without food, clothes, shelter and other basic necessities of life. A destitute is one without any means of subsistence; not having something; and poor enough to need help from others. A mentally ill destitute therefore refers to an individual with a mental condition that is down and out, not having any means of subsistence and is in fact, homeless. On the other hand, rehabilitation according to Odinaka [10] is a whole system approach to recovery from mental illness that maximizes an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and leading to successful community living through appropriate support.

Nwaopara [9] noted that there is considerable statistics to show that persons with mental illness have limited access to real care and attention as would be desirable and mentally ill destitute are even more affected. Studies in Nigeria have shown that most mentally ill individuals are not cared for due to some reasons ranging from the harsh economic situation, as the lean resources available to the family is more often than not, directed at the healthy members of the family due to the fact that severe mental illness may deplete the resources of even the most willing and stable families [5]. Worse still is that the mentally ill are often rejected, labeled and segregated against, even by their own relations, for fear of being dangerous and harmful. Benin metropolis still harbours the relics of ancient traditions, customs and beliefs and so derogatory words are still commonly used on the mentally ill, as they are branded with false and superstitious names [16, 1, 12, 11]. The result is lack of care and neglect, instead of rehabilitation. Presently, abuse, neglect and particularly discrimination is not well addressed in law, especially as there is no legislation on mental health in Nigeria. Although the constitution of Nigeria [3] prohibits discrimination, it however does not in clear terms identify health status as one of the grounds on which discrimination is prohibited.

This problem of human rights violation and stigmatization of the mentally ill persons/destitute was the concern of WHO [19] when it stated that mankind is besieged with human rights emergency in mental health because many countries do not have the basic legal framework to protect persons with a disability.

Onyemlukwe [13] noted that the lack of a legal framework for protecting the human rights of people with mental disability in Nigeria is also emblematic of the gross neglect of mental disability.

Rehabilitation and treatment of mentally ill destitute

The concern over the abuse and neglect of mentally ill destitute over the years has given rise to interest in how they can be rehabilitated. In Benin metropolis, the mentally ill destitute are commonly treated and rehabilitated in traditional homes, prayer houses and in the mental health institutions presently available in Benin metropolis.

Trado-medical centres:

These centres are privately owned by traditional healers who claim to have powers to heal mentally ill persons no matter the degree of psychosis. As part of the healing process, they offer sacrifices to the gods as well as give herbs to these ill persons. Unfortunately, the healing process in these centres sometimes involve the confinement and chaining of the mentally ill persons while at other times, they are severely beaten , burnt and made to drink smelly concoction or substance [2].

Interestingly, the Edo State government through the Ministry of women affairs and social welfare seem to have given its nod to the existence of trado-medical practitioners' treatment and rehabilitation of mentally ill destitute in Benin metropolis as it from time to time gives grants to Omo-Oleabhiele traditional healing centre [14].

Christian prayer houses:

In Nigeria, there are several churches and Christian prayer houses, some of which are reputed for praying for the sick, potential immigrants to Europe and the mentally ill persons/destitute. They adopt various items in their spiritual warfare like the Holy bible, rosary, holy water, candles of all sizes and colours, incense, olive oil (anointing oil) and handkerchiefs [2].

The mental health institution:

Although there are several health institutions in Benin metropolis, the Federal Neuro-psychiatric hospital, Uselu, Mile 18 and Idunmwunwina are reputed centres for treatment and rehabilitation of mentally ill persons/destitute. The University of Benin teaching hospital also attends to mentally ill persons but the centre for mental health treatment and rehabilitation in Benin metropolis is the Federal Neuro-psychiatric hospital [14].

Theoretical explanation of mentally ill destitute and rehabilitation

In explaining the topic under study, the study adopted as its theoretical framework, the functionalist perspective. As a theory, functionalism essentially sees the society as a whole which is made up of different independent parts or units that work together for the smooth running of the whole system. The theory holds that a malfunctioning of any

part or unit of the whole, significantly affects the other parts even though they are supposed to be independent. This consequently leads to disequilibrium in the entire system. Proponents of functionalism as a theory argue that the society or system must always be or remain in a state of equilibrium which entails that all the parts or units must be functional [4, 15].

In relation to the topic under investigation, functionalism sees the health, political and family institutions as different independent units or parts of the society whose functionality ensures that the society is in a state of equilibrium. However and in line with the postulation of this theory, the malfunctioning in the political, health and economic institutions has caused disequilibrium in the functionality of the society. Specifically, the lack of political will on the part of successive governments at both the state and federal levels have impacted negatively on the mental health, rehabilitation and the health institution generally. Adequate funds are not made available to the few mental health institutions in Nigeria and so, the ability to effectively treat, care for and rehabilitate mentally ill persons has been most inadequate and epileptic.

The depressed Nigerian economy has on its part affected relatives and friends of mentally ill persons from actually caring for them. Most times, relatives tend to abandon them, due to lean finances.

**METHODS AND SUBJECTS**:

This is a cross-sectional descriptive research which was done in Benin metropolis, the capital of Edo state. Benin metropolis is located within latitude 60 14'N and 60 21'N of the equator and longitude 50 35'E and 50 44'E and covers approximately 1125 square kilometers.

It cuts across four local government areas: Oredo, Egor, Ikpoba-Okha and Ovia North-East. The 2006 population census puts the population of Benin metropolis at 1,085,676 million [8] and as at 2015, the National Population Commission annual report puts the figure at 1,496,000 million.

Primary and secondary data were used for the study with the primary data mainly sourced through the administration of structured questionnaires. A self designed 'Mentally ill Destitute Questionnaire' (MDQ) was employed to collect important information needed to achieve the objective of this study.

The questionnaire was made up of 28 questions which covered both the socio-economic characteristics of the respondents, abuse, neglect and rehabilitation of the mentally ill destitute. The reliability of the instrument administered on the respondents was determined through test-retest method while the validity was done through face validity by three resource persons in the University of Benin who are vast in the subject matter.

To complement the primary data collected, additional information were gotten from secondary sources which included; textbooks, journals, articles, seminar papers, news papers, magazines, official gazettes, official statistics and internet materials.

Due to the nature of the phenomenon under investigation, the purposive and snowballing sampling techniques were adopted to select respondents in the population that were interviewed. This consisted of a total of 610 respondents made up of medical practitioners, nurses, staff of Ministry of Women Affairs, Benin City, care givers and social workers, personnel in traditional and prayer houses, relations, friends and neighbours of mentally ill persons. Data obtained from the administered questionnaire were analysed using both descriptive and inferential statistics. Frequency count and percentage were employed to analyse the demographic data section of the research instrument while the chi-square statistics technique was used to test the three hypotheses generated for the study.

Based on the required ethical standards of studies involving human subjects, appropriate approvals or consents to be part of the sample population were obtained from all individual participants and their privacy was well protected. Respondents were before the commencement of the interview, briefed about the study and its expected outcomes or benefits.

**RESULTS**:

The results of the demographic characteristics of the respondents are presented in table 1. Of the 610 respondents, 68% (415/610) were male and 32% (195/610) were female. For marital status, 20% (120/160) were single, 75% (460/610) were married and 5% (30/160) were divorced. The distribution according to age group (120/610) is presented in table 1. On educational level, 34% (210/610) had post primary and 60% (365/610) had tertiary education. For their religion, 93% (568/610) were Christians, 2% (12/610) Muslims and 5% (30/610) practiced African Traditional Religion. For their occupation, 13% (80/610) were in private business, 57% (350/610) were health workers, 11% (65/610) were in social welfare and 19% (115/610) were unemployed.

Table 2 shows the result of the calculated chi-square from the observed data (0)- 467 respondents agreed that there is a significant relationship between belief and attitude towards mentally ill destitute and their rehabilitation in Benin metropolis while 143 disagreed. It is expected that, of the 610 respondents, (E) - 305 that is, half of the total respondents (610) were supposed to agree to the question asked while same number of

respondents should disagree. Therefore, we subtract the expected from the observed (0-E) and the result is squared (0-E)2 and then divided by the expected which sum gives 172.08 (the calculated chi-square).

**Table 1**: Demographic characteristics of respondents

| | **Frequency** (%) |
|---|---|
| **Gender** | |
| Male | 415 (68.0) |
| Female | 195 (32.0) |
| **Marital Status** | |
| Single | 120 (19.7) |
| Married | 460 (75.4) |
| Divorced | 30 (4.9) |
| **Age range (yrs)** | |
| 14 - 26 | 60 (9.8) |
| 27 - 36 | 280 (45.9) |
| 37 - 46 | 150 (24.6) |
| 47 - 56 | 85 (13.9) |
| 56 and above | 35 (5.7) |
| **Educational level** | |
| No formal education | 10 (1.6) |
| Primary education | 25 (4.1) |
| Post primary education | 210 (34.4) |
| Higher education | 365 (59.8) |
| **Religion** | |
| Christianity | 568 (93.1) |
| Islam | 12 (2.0) |
| ATR | 30 (4.9) |
| **Place of origin** | |
| Indigenes | 430 (70.5) |
| Non-indigenes | 180 (29.5) |
| **Occupation** | |
| Private business | 80 (13.1) |
| Health worker | 350 (57.4) |
| Social welfare | 65 (10.6) |
| Unemployed | 115 (18.9) |

**Table 2:** Relationship between belief and attitude towards mentally ill destitute and their rehabilitation in Benin metropolis

| 0 | E | 0- E | $(0-E)^2$ | $(0- E)^2$ |
|---|---|---|---|---|
| 467 | 305 | 162 | 26 244 | 86.04 |
| 143 | 305 | -162 | 26 244 | 86.04 |
| **610** | **610** | **0** | | **172.08** |

**Table 3:** Relationship between abuse and neglect of mentally ill destitute and their rehabilitation in Benin metropolis

| 0 | E | 0-E | $(0- E)^2$ | $(0- E)^2$ |
|---|---|---|---|---|
| 518 | 305 | 213 | 45369 | 148.75 |
| 92 | 305 | -213 | 45369 | 45369 |
| 610 | 610 | 0 | | 297. 50 |

**Table 4:** Relationship between government social and health policy towards mentally ill destitute and their rehabilitation in Benin metropolis, Southern Nigeria

| 0 | E | 0-E | $(0- E)^2$ | $(0- E)^2$ |
|---|---|---|---|---|
| 430 | 305 | 125 | 16625 | 51/22 |
| 180 | 305 | 125 | 16625 | 51.22 |
| 610 | 610 | 0 | | 102.44 |

Table 3 above indicates the result of the calculated chi-square from the observed data (O) -518 respondents agreed that there is a significant relationship between abuse and neglect of mentally ill destitute and their rehabilitation in Benin metropolis while 92 disagreed. It is expected (E) that, of the 610 respondents, 305 (50%) were supposed to agree to the question asked while same number of respondents should disagree. Therefore, we subtract the expected (E) from the observed (O) and then the result is squared (0-E)2 and then divided by the expected which sum gives 297.50 (the calculated chi-square).

Table 4 above indicates the result of the calculated chi-square from the observed data (O)-430 respondents agreed that there is a

relationship between government social and health policy towards mentally ill destitute and their rehabilitation in Benin metropolis, Southern Nigeria while 180 disagreed. It is expected (E) that, of the 610 respondents, 305 (50%) were supposed to agree to the question asked while same number of respondents should disagree. Therefore, we subtract the expected (E) from the observed (O) and then the result is squared (0-E)2 and then divided by the expected which sum gives 102.44 (the calculated chi-square).

**DISCUSSION**:

Considerable evidence in this current study indicate that, the calculative value stands as 172.08 and the critical value (table) 3.84, degree of freedom of 1 and significant level of 0.05. This indicates that the calculated value is higher than the table (critical) value hence; we reject the null hypothesis and accept the alternative hypothesis which states that there is an association between belief and attitude towards mentally ill destitute and their rehabilitation in Benin metropolis, Southern Nigeria. This finding is in tandem with Wahl [17], who found in his study that beliefs and attitudes of even the enlightened persons affect the way people handle, treat and relate with mentally ill persons or destitute.

Result obtained in the present study further indicates that, the calculative value stands as 297.50 and the critical value (table) 3.84, degree of freedom of 1 and significant level of 0.05. This indicates that the calculative value is higher than the table (critical) value hence; we reject the null hypothesis and accept the alternative hypothesis which states that there is a relationship between abuse and neglect of mentally ill destitute and their rehabilitation in Benin metropolis, Southern Nigeria. This current finding further lends credence to World Health Organization [17] and Ogundipe's [11] studies which revealed that mentally ill destitutes are not only discriminated against but are also abused in different ways ranging from physical to denial and violation of their rights in relation to rehabilitation.

Result obtained in the present study indicate that, the calculative value stands as 102.44 and the critical value (table) 3.84 degree of freedom of 1 and significant level of 0.05. This indicates that the calculated value is higher than the table (critical) value hence; we reject the null hypothesis and accept the alternative hypothesis which states that there is a correlation between government social and health policy towards mentally ill destitute and their rehabilitation in Benin metropolis, Southern Nigeria.

The finding of this study is further supported by the works of Nwaopara [9] and Onyemelukwe [13] where they noted that mentally ill

persons/destitutes do not receive the desired attention and care by society, especially, as there is no social or legal policy in relation to mental illness in Nigeria.

**CONCLUSION**:

Little or no research has been carried out specifically on mentally ill destitute and rehabilitation in Benin metropolis. The only visible concern of the Edo state government in relation to mentally ill destitute has always been to keep them off the streets through repeated evacuation and occasional grant to trado-medical practitioners. This effort is quite inadequate and might have helped in improving the wellbeing of these unfortunate vagrant psychotics if there were a social/mental health policy, not only in place but fully executed. Based on the findings of this study, there is the need to re-orient the populace in Benin metropolis not only on the need to change their negative beliefs and attitude towards mentally ill persons, but to desist from their unwanton abuse and neglect.

Efforts should be made to encourage relatives of mentally ill destitute to seek rehabilitation for them instead of abandonment. Since there is a relationship as indicated in the findings of this study, between government social and health policy towards mentally ill destitute and their rehabilitation in Benin metropolis, there is the need for government to enact a law or policy on mental health in Nigeria.

**ACKNOWLEDGEMENT**:

Many thanks to Dr Wilson Imongan, former Commissioner for Health, Edo State and presently Executive Director, Women Health and Action Research Centre, Benin City, Edo State. Dr. Arthur Efe of Faith Mediplex Hospital, Benin City, Edo State for their useful help and suggestions on this article

Author's declaration: no conflict of interest in relation to this research work.

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