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FACTORS INFLUENCING QUALITY OF LIFE OF PEOPLE LIVING WITH MENTAL ILLNESS ATTENDING OUT-PATIENT CLINICS OF FEDERAL NEUROPSYCHIATRIC HOSPITALS IN SOUTHWEST NIGERIA

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ABSTRACT: *Quality of life (QoL) is an essential element of health and an important aspect of human life. This study investigated the factors influencing quality of life of people living with mental illness attending outpatient clinics. A Descriptive cross-sectional survey design was employed. 487 clients participated in the study. WHO-QoL BREF was used to collect data, with a reliability of 0.81. The Data were analysed using descriptive statistics, T-test, and PPMC. The Health-Related Factors associated with QoL were depression, schizophrenia, drug addiction, seizure disorders affect their QoL. There is a significant gender difference in the patients QoL where female had more significant QoL than their male counterparts Conclusively, majority of the respondents had low level of QoL resulting from the mental illness, and the duration of illness was significant. The study recommended that mental health practitioners should create awareness on early diagnosis, prompt treatment and stakeholders' support to the mentally ill.*

KEYWORDS: Mental Illness, Quality of Life, Out-Patient Clinics, WHO-QoL BREF

INTRODUCTION

Quality of life is an essential element of health and an important aspect of human life. Measuring quality of life especially among people living with mental illness helps to ascertain the outcome of care which tends to be influenced by several factors either in health or illness; which could either be positive or negative (Mahmoud, Berma & Gabal, 2017). The diagnosis of a mental illness in an individual tends to affect such individual as well as his or her significant others in such a way that many areas of their lives are adversely affected. In this regard, mental illnesses have effects on the physical, psychological, material, emotional and social functioning of the sufferers which automatically have effects on their overall quality of life and may also likely affect the quality of life of their significant others (Shumye, Belayneh & Mengistu, 2019).

A mental illness which is also referred to as a psychiatric disorder or mental disorder is a mental or behavioral pattern that results in major distress or diminished functioning of a person (National Institute of Mental Health (NIMH), 2017). Mental disorders are health challenges that involve changes in thinking, behavior or emotion or a combination of these and may also be accompanied by difficulty functioning in family, social relationship or carrying out work activities (American Psychiatric Association (APA), 2018).

Socio-demographic characteristics of individuals include gender, household, ethnicity, religious affiliation, employment, age, marital status, migration, educational background, income; and all these can influence the lives of these individuals. Several factors have been

found to have influence on the Quality of life of people living with mental illness. They include the duration of illness, relapse, and type of social support available to the individual, type of mental illness and so on. However, the researcher having worked in a mental hospital for many years had observed the rate at which young, supposedly intelligent people who should be productive and contributing to the economic growth of the nation are seen going in and out of the hospital, leading dependent lives on their significant others. It was further observed that several factors in the patients as well as their environment tend to influence their quality of life.

It was on the basis of these observations that the researcher resolved to carry out a study on factors influencing quality of life of people living with mental illness attending outpatient clinics of the two Federal Neuropsychiatric Hospitals in South-West, Nigeria.

Many people living with mental illness do not appreciate living as they couldn't attach any significance to their existence (Brown, 2018), and the society does not provide them with conducive living condition; hence, they may not believe they are relevant in the society (Aloba, Fatoye, Mapayi& Akinsulore, 2015). Their immediate environment too may not give them a sense of belonging. Most of the times they are considered fiddle and of no value. Individual perceptions about his or herself differs but must be objective in nature; such that add value and significance in terms of goals, standards and expectations in life. QoL is complex and has different connotations. Within the field of healthcare, quality of life is often seen in terms of how a certain ailment affects a patient on an individual level; it describes the degree to which a person enjoys the important possibilities of his or her life. According to Ahmad and Khaldoon (2017), clinicians often measure QOL to ascertain the cost and effectiveness of the medical interventions rendered; and to improve on medical services being provided for the patient. QoL is measured both objectively and subjectively. It is usually a difficult task to determine the quality of life of an individual because of its subjectivity; and Qol has both economic and social domains. The social domain is termed subjective as it is about feeling good and being satisfied with things in general. The economic domain is considered objective as it has to do with fulfilling the societal and cultural demands for material wealth, social status and physical well-being. (McCall, 2015).

According to the World Health Organization (WHO)(2018), QoL is the perception of individuals about their position or condition in life in the premise of the culture and value systems in which they dwell as well as it relates to their expectations, goals, concerns, and standards. Quality of Life is a broad-range concept which affects the psychological state, personal beliefs, physical health, social relationships of an individual as well as the relationship to important attributes of his or her environment. Pinto, Fumincelli, Mazzo, Caldeira and Martins (2016) described QoL as the general well-being of individuals and societies; bringing out the positive and negative attributes of life that include everything from family to physical health, employment, education, religious beliefs, safety and security, wealth, and the environment. Quality of Life is the reflection of how individuals see themselves. . It is all-encompassing, as it depicts who one is, it is made manifest both in sickness and in health. For one to be complete as a whole being, the various dimensions of health namely, the physical, social, spiritual and biological dimensions have to be considered. (WHO, 2018).

Every individual has ways of rating his or her person and the value system, what he or she believes in and how the environment shapes or modifies his or her existence. The society that an individual finds himself and the existing structures in terms of living condition, social

support through the family, friends and co-workers, in addition to availability of amenities for daily living come together to determine an individual's quality of life. Helliwell, Layard, and Sachs (2016) reported that individuals suffering from mental disorders tend to have impaired quality of life which makes the appraisal of QoL an important task in the psychiatric setting. The areas being frequently appraised in QoL are family, health, work/study, leisure activities, and social relationships (WHO, 2020).

QoL is therefore based on the perception of an individual of what he or she adjudges QoL to be (Pathak, Prasad, & Chaturvedi, 2016). Determining the QoL of mentally ill patient begins by identifying the most important parts of his or her life in order of significance. It has been reported that only few patients with serious mental illness have been able to define their own individual QoL. According to WHO Health & Statistics (2016), evaluation of health and outcome of health care must include not only an evidence of changes in the prevalence and seriousness of diseases but also an assessment of well-being and this can be done by measuring the improvement in the quality of life in relation to health care.

Mental illness is a devastating state of ill health that if not identified early and treated promptly with adequate management may affect individual's quality of life. The primary concern of Health-Related Quality of Life (HRQOL) contains the following four (4) areas of functioning namely, psychological, social, physical and somatic functioning. Mental illness is an abnormal condition of the mind or dysfunction of the central nervous system, resulting in disintegration of personality, leading to difficulties in determining what is real from what is not real. According to the United States National Institute of Mental Health (NIMH) (2016), symptoms of mental illness may include false beliefs, false perceptions, irrational and excessive speech. Other symptoms may include irrational behaviours such as exhibitionism. The individual may also experience sleep problems, withdrawal to self, lack of motivation, and inability to carry on with activities of daily living.

Functional impairment such as depression and schizophrenia were said to relate to low quality of life (Cho, et al. 2019). Symptoms of anxiety have also been reported as most important to QoL. Numerous classifications of mental illness have been made through the International Classification of Diseases (ICD-10) and the U.S Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The use of psychotropic drugs along with other treatment modalities such as psychotherapy through individual and group counselling, psychodrama, family therapeutic sessions, occupational therapy sessions and recreation; as well as vocational activities have helped to improve the outcome of treatment in patients with mental illness, which brings about an improvement in their QoL.

Furthermore, Besadre, Busa, Landeza, Patual and Repayo, (2017) viewed quality of life as one of the commonly used self-assessment tools in measuring domains of life. These domains were classified as physical which has to do with body mechanisms; psychological such as thought or state of mind; social network such as families and friends support and environmental domain. They also stated that individual's life contributes to their self-satisfaction in terms of happiness, physical assessment, social and cognitive values. Quality of life can be influenced by numerous factors such as age, gender, support from families and other relevant agents in the network of the patients as well as environmental condition and cultural differences (Usha & Lalitha, 2016; Effat, Azzam, Shalash, Elkatan & Elrassas, 2016; Besadre *et al,* 2017).

Katschnig (2010) described QoL as a field of interest rather than corresponding to a single variable as in disease and that there is no single way of measuring QoL. According to him, measuring quality of life should be done holistically, considering the following: environment of the person, individual's physical and mental health status, his or her educational level, recreation and leisure time, life, as well as individual's social belonging and not necessarily limited to wealth and employment. Environment has been described to have an important place in determining an individual's quality of life. Just as reported by Kalonji, Ngongo , Ilunga,, Albert and Giet, (2017) on the study of prison inmates who were limited by space because of restriction of movement they were subjected to; and which resulted in statistically significant low correlation between the domains of quality of life which might be applicable to individuals confined to hospital admission for a considerable period of time by reasons of psychiatric illness.

In the opinion of Verloo, Salina, Fiorentino, and Cohen (2018), increased social support is capable of improving the QoL of persons suffering from mental illness. Social support serves to mitigate the impact of stressful experiences, such as those related to physical health (NIMH, 2016). Adequate social support also helps to reduce the effects of pain, some functional limitations as well as depression (NIMH, 2016). This also promotes recovery in people with severe mental illness. According to Healthy People (2020), the amount of assistance available to an individual is a predictor of subjective QoL in persons diagnosed as suffering from severe mental illness. There has been a shift in mental health services whereby emphasis is placed on reducing symptoms rather than focusing on treatment which is based on a narrow notion of health and disease, to a more holistic approach which takes into consideration both wellbeing and functioning (Healthy People, 2020).

Statement of the Problem

The researcher in the course of her practice had observed some degree of variations in people living with mental illness accessing care in her facility; where some patients were able to perform better than the others in some of the activities of daily living while others were mostly dependent on their relatives for same activities.

The researcher was therefore of the opinion that the differences might be related to certain factors that influence quality of life as a result of individuals being diagnosed with mental illness. These factors could be inability to access certain care needs, such as needed drugs, food, social support and economic power (Twahira, 2017). Some of the factors might actually relate to Stigmatization based on their diagnoses. According to Colillas-Malet, Prat, Espelt, and Juvinyà (2020), there are no reported statistically significant differences in the Health-Related Quality of Life (HRQOL) of male and female with severe mental illness (SMI). However, some factors are found to influence individual physical and mental components of QoL.

The researcher believes that a need exists that a study be embarked upon to determine those factors that may influence the quality of life of those individuals living with mental illness and attending the outpatient's department of the two hospitals under study.

Objective of the Study

The general objective of the study is to determine the factors influencing quality of life of people living with mental illness attending outpatient clinics of the two Federal Neuropsychiatric Hospitals in Southwest Nigeria.

The specific objectives are to:

1 Determine the quality of life of people living with mental illness who are attending the outpatient clinics of the selected hospitals

2 Assess the factors that are associated with quality of life of people living with mental illness attending outpatient clinics in the selected hospitals

3 Assess the differences in quality of life based on gender among people living with mental illness attending outpatient clinics in the selected hospitals.

Research Questions

1. What is the quality of life of people living with mental illness attending outpatient clinics in the selected hospitals?

2. What are the factors associated with quality of life of people living with mental illness attending outpatient clinics in the selected hospitals?

3. What are the gender differences in quality of life among people living with mental illness attending outpatient clinics in the selected hospitals?

Research Hypothesis

$H_0$1: There is no significant relationship between types of mental illness and quality of life of people living with mental illness attending outpatient clinics of the two Federal Neuro-psychiatric Hospitals

Scope of the Study

This study focused on factors influencing QoL of patients living with mental illness attending Outpatient Clinics of the two Federal Neuro-Psychiatric Hospitals in the Southwest of Nigeria specifically Neuropsychiatric Hospital, Aro Abeokuta and Federal Neuropsychiatric Hospital, Yaba, Lagos.

Significance of the Study

The findings of this study might be of great importance to healthcare practitioners generally but specifically for mental health care practitioners such as mental health nurses, social workers, clinical psychologists, psychiatrists, and other stakeholders in the care of people living with mental illness.

Identifying the factors influencing the quality of life of the respondents might enable the stakeholders to put in place measures to improve their care and involve in advocacy to solicit support to improve their wellbeing.

By studying QoL, it can hopefully improve the care they get and may lead to improvement in mental health services being rendered by health care workers.

It might also help the government and other stakeholders in policy formulation and implementation in the provision of social support system for the mentally-ill.

This study would hopefully provide evidence for mental health advocates to gain support from donors and equally provide direct line of focus in the rehabilitation of the people living with mental illness.

Findings from the study will contribute to the existing body of knowledge in the area of Quality of life of people living with mental illness.

Justification for the Study

Quality of life is dependent on individual's mental health, the outcome of care for the mentally-ill is reflective of their QoL since mental illness in itself is a devastating condition which affects the sufferers as well as their significant others. Many of the patients being managed for any form of psychotic disorders return to outpatient clinics for follow-up care in which many have been observed to either be inconsistent in their visit, some have history of poor family and social support, some experience loss of job or no job at all, some of them lack funds to purchase their drugs or in keeping up with appointment. Few of these patients appear to be dependent on others and would not return to previous or normal lifestyle.

Based on the aforementioned, it is needful to investigate the factors that are militating against these individuals in maintaining a state of well-being or attaining optimum wellness.

Operational Definition of Terms

Factors: These are the characteristics within or surrounding the patients that may affect their quality of life. These include patient socio-demographic variables like age; gender; educational background; diagnosis / type of mental illness; duration of illness and number of hospitalizations. Physical attributes, psychological attributes, socio-economic attributes and environmental attributes.

Quality of Life: An individual's perception of self and level of satisfaction in the essential areas of physical, social, psychological and spiritual life and capacity to function or otherwise. Using three scale categories, that is low, moderate and high to determine the level of QoL.

Mental Illness: A disorder of the mind which causes distortion in reality and warrants receiving treatment in the two hospitals.

People Living with Mental Illness: These are people who are diagnosed as suffering from one mental illness or the other and are receiving treatment in the Outpatient Clinics of the two hospitals under study.

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REVIEW OF RELATED LITERATURE

Mental Health

WHO definition of health included mental health which is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Mental health is not the absence of mental illness. It is defined as a state of well-being whereby individuals recognise their abilities, can cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities. Mental health should be what everyone should aim to achieve.

Mental health problems affect society as a whole and not an isolated group of people. It is a major setback to global development. Mental, physical, and social health is interrelated and is vital elements of life. Therefore, the pursuit of mental health cannot be over-emphasized. However, in most parts of the world, mental health and mental health problems are not given the same priority with physical health and illnesses, neglecting this crucial aspect of health (WHO 2003).

According to WHO (2003) about 450 million people suffer from a mental or behavioural disorder. According to WHO's global burden of disease, 33% of the years lived with disability (YLD) and 13% of disability-adjusted life years (DALYs) are due to neuropsychiatric disorders. In the United Kingdom, mental health problems are responsible for the largest burden of disease; 28% of the total burden (Edwards, 2015.) In Africa, mental illness accounts for 5% of the total burden of disease and 19% of all disability. Approximately 1 in 4 persons in Africa experience common mental disorder such as anxiety and depression. This enormous burden results in economic loss from the cost of care and disability from illness. The world economic burden from mental disorders is estimated as 1.6 trillion pounds or 2.5 trillion U.S. dollars which is greater than cardiovascular diseases, chronic respiratory diseases, cancer, diabetes individually(Edwards,2015). The economic impact of mental illness affects personal income from the inability of the affected individual to work, decreased productivity in the workplace, utilization of treatment and support services

In addition, mental health problems increase the risk of having physical illnesses and negative illness behaviour such as poor adherence to medication and clinic attendance (WHO, 2020).

People with mental disorders are stigmatized and deprived of their fundamental human right along with some of their relatives. They are denied of employment, educational opportunities; health insurance and housing policies. In some countries, they are denied the right to vote and membership of professional associations. As a result, they do not gain access to appropriate care, further deteriorating their mental health and cannot integrate into society (Edwards, 2015).

Despite these negative impacts of mental illness, there is a huge gap between the need for treatment and the resources available. In developed countries, between 44% and 78% do not receive treatment while treatment gap in developing countries is close to 90% (WHO, 2018).

Mental Health in Nigeria: Nigeria the largest country in West Africa has an approximate area of 924,000 square kilometres and a population of about 200 million. (Olisa & Amedu, 2019). The proportion of the population under 15 years is 44% and the proportion above 65 years is 5 % (Gureje, 2015). The life expectancy at birth of both sexes is 55.2 years (Olisa & Amedu,

2019). It is a country with various ethnic groups and over 200 languages, but 3 major languages are spoken: Yoruba, Ibo, and Hausa. Administratively, it is divided into 36 states and a federal capital territory. It operates a federal system of government with constitutional responsibilities allocated to the various tiers of government- federal, state and local (Saxena & Gureje 2003). Psychiatric service delivery started early 20th century in Nigeria when the first asylum was established in 1904 at Calabar and the second in 1907 at Yaba. These asylums were run by medical officers who provided essentially custodial care. (Saxena & Gureje 2015). Mental health services became evident with the establishment of the Aro Mental Hospital in Abeokuta, South-west Nigeria in 1944 when Dr Lambo, the first trained psychiatrist returned from the United Kingdom. The Aro Mental Hospital was established by the British colonial government in order to improve mental health care in Nigeria. This hospital later became the Neuropsychiatric Hospital Aro. (Saxena & Gureje 2015).

Nigeria's mental health policy was first developed in 1991 and it includes the following components: advocacy, promotion, prevention, treatment and rehabilitation It has 14 laudable declarations, some of which include: persons with mental, neurological and psychosocial disorders have the same rights as individuals with physical illnesses; integration of mental health care services at all levels of health care; elimination of stigma through the promotion of positive attitudes towards the mentally ill in the population; periodic review of legislation governing the care of the mentally ill (Gureje, 2015). This policy is backed with a National Mental Health Programme and Action plan which has not been fully implemented. The Nigerian law concerning the mentally ill are obsolete. The country operates the lunacy Act of 1916 which was based on the Lunacy Acts 1890-1908 of the United Kingdom. These laws fail to recognise the present-day view of mental disorders as treatable and also did not give consideration to an individual who breaches the laws of the land when he is unable to make a reasoned judgement (Saxena & Gureje, 2015). However, there is some hope as these laws have been revised in the mental health bill and awaiting its passage into law by the legislators (Gureje et al, 2015).

Overview of Mental Disorders: There is dearth of adequate report on mental health challenges in Nigeria which was evidenced by World Health Organization (WHO) – AIMS Report (WHO, 2018) but efforts need to be made on campaign for accurate statistical records and reporting of mental disorders statistics to the nation's bureau of statistics unit. Internationally, there were records of occurrence of mental illnesses. The National Institute of Mental Health (2019), Statistics report of United State of America survey; puts the lifetime prevalence of any diagnosable psychiatric disorder in the United States population as 46.6 percent. Also, a lifetime standpoint revealed that the most common mental disorders reported for the 12-month prevalence rates were with anxiety disorders being the most common (28.8%), followed by impulse-control disorders (24.8%) and mood disorders (20.8%) being the least. This implies that in the United States population, anxiety disorders are the most common psychiatric disorders from a 12-month as well as a lifetime point of view. Both in the United States and Europe, the most common mental disorders in primary care settings are mood disorders, anxiety disorders as well as somatoform disorders (Leon, 2018), this might also be a similar case in many other places including Nigeria.

Types of Mental Disorders: Mental illnesses or mental disorders are conditions that have effects on individuals' feelings, thinking and behaviours. The conditions affect or alter the ability of individuals to relate with people, work or acquire education or carry out normal

roles and responsibilities. There are several types of mental disorders and some of them are: Anxiety disorders, mood disorders, dementia, schizophrenia and other psychotic disorders.

Mood Disorders: It is a part of normal experience to feel unhappy when adversity comes. Mood disorders are so called because one of the main characteristics is the abnormality of mood. Mood disorders include the experience of low moods, slowness of activities as seen in depressive syndromes or state of elation as can be found mania. It should be noted also that a degree of elated mood is part of normal experience at times of good fortunes. Generally speaking, mood disorder can be in form of depressive disorder or manic disorder.

Depressive Disorder: This disorder is more common in women than men. It is a common mental disorder and it is a leading cause of disability worldwide. Depressive disorder has as its major characteristic, low mood or sadness, loss of interest in activities being previously enjoyed, feelings of low self-worth, and lack of interest in enjoying pleasure. Other features include guilt feelings, decreased sleep and appetite, feelings of tiredness, poor concentration. People suffering from this disorder may also present with several physical complaints with no apparent underlying cause. Depression can equally present with reduced energy levels, lack of enjoyment, pessimistic thinking, which can lead to diminished functioning. Patients present with characteristic appearance, may neglect dressing, grooming and personal hygiene in general. The patient's mood is one of misery which may not improve even in circumstances where ordinary feelings of sadness should be alleviated; for example, when good news are shared or when in a pleasant company. Depressive patient tends to have pessimistic thought which can be with regards to the present in which the patient sees the unhappy side of every event. He has a sense of failure in whatever he or she does (Kaplan and Sadock 2015).

The pessimistic feelings can also be concerned with the future. The patient foresees failure in his work, he foresees the ruin of his finances, misfortune for his family and deterioration in his health. He has the ideas of hopelessness that his life is no longer worth living which may be responsible for the patient to plan to commit suicide. The third group of thought is concerned with the past. They often feel an unreasonable sense of guilt and blame themselves for trivial matters that existed in the past.

Bipolar Affective Disorder: This is a disorder of mood formerly referred to as "manic depressive disorder''. It is a disorder that causes swinging of mood from depression to a state of elation (mania). When one becomes depressed the individual may feel sad or hopeless and he may lose interest or pleasure in most activities. When the mood changes to mania or hypomania, the individual feels euphoric, is full of energy or may be irritable. The swing in mood tends to affect the individual's energy, activities, sleep pattern, behaviour, judgement and the ability to think clearly.

Certain prevention programs have been put in place to reduce the rate of depressive disorders. These include psychosocial support and assistance following conflicts and disasters for adults; as well as psychological support in form of counselling and rehabilitation, and protection following sexual and physical abuse in children. To manage depressive and Bipolar Affective disorders, talking therapies, cognitive behavioural therapies as well as psychotherapies are of tremendous effect. Antidepressants can be effective in the management of moderate to severe depression although they are not the first line of treatment in mild depression. An important aspect in the management of depression is the psychosocial aspect which includes identifying the stress factors in an individual's life such as difficulties at work, mental or physical abuse,

financial problems, and identifying sources of support in form of friends, family members and philanthropists who can be of help in ameliorating the problems of the victims. These can be achieved through social networks and social activities. To treat Bipolar disorders, mood stabilizers can be used to reduce symptoms, stabilize the moods while psychosocial support can be integrated as an important component of management (Gelder, Gath, Mayou& Cowen, 2015).

Neuroses and other Anxiety Disorders: Anxiety disorders are mental disorders that are characterized by feelings of fear, worry or apprehension that are severe enough to interfere with the daily activities of an individual. It is a very common disorder as it affects more than 1.5million people per year. (Bhandari, 2017). Anxiety disorders include different conditions like panic disorders, social anxiety disorder, specific phobias and generalized anxiety disorders. The general symptoms of anxiety disorders include, but not exhaustive; the following: uneasiness, fear, panic feelings, sleep problems, inability to stay calm and still, cold, sweaty, numb or tingling hands or feet, shortness of breath, heart palpitations, dry month, nausea, muscle tension, dizziness.

The cause of anxiety disorders is unknown but like other forms of mental illness, a combination of things; which includes brain changes or abnormalities, environmental stress and genetic abnormalities. Anxiety disorders can run in families and it could be traced to faulty circuits in the brain in areas where fear and other emotions are controlled. Treatments of this disorder include psychotherapy in form of counselling to address emotional responses to mental illness; Cognitive Behaviour Therapy that teaches people on how to recognize and change thought patterns and behaviours that tend to trigger anxiety or panic symptoms. Medications in form of anxiolytics help to lower anxiety, antidepressants can also work for anxiety disorders, and low-dose antipsychotics can be added to the medications to make them work better. (Bhandari, 2017).

Schizophrenia and other Psychotic Disorders

Schizophrenia is the most common of all psychiatric disorders and it is common in all cultures of the world. It is a complex syndrome that inevitably has a devastating effect on the lives of the persons affected as well as their family members. The peak ages of onset range from 15 to 25 years for men and 25 to 35 years for women (Sreevani, 2016). These ages of onset have implications for recovery in this disorder. The disorder disrupts the sufferer's perception, thought, speech and movement. Major characteristic features of the condition include hallucinations, delusions, disorganized behaviors and speeches. It has the ability to interfere with the work, study, and other vital aspects of the life of the individual suffering from the disorder including activities of daily living; depending on the severity of the condition. The types of Schizophrenia include disorganized, catatonic, paranoid, undifferentiated and the residual type. The stigma attached to mental illnesses especially schizophrenia has made it difficult for this group of people to seek and access prompt and appropriate treatment, which always result in poor prognosis. However, evidences abound that with early and appropriate diagnosis, prompt treatment with the use new generation psychotropic medications, adequate psychosocial support in form of supported employment and housing, recovery goals can be achieved and patients can be reintegrated into the society with assurances of reduction in relapse rates. (Basavanthapa, 2013).

Dementia

Dementia is a degenerative disorder usually of a progressive nature resulting in deterioration of cognitive function (i.e. the ability to process thought) usually beyond the expectation of what obtains in the normal ageing process. The memory, comprehension, calculation, thinking, orientation, language, judgment and learning capacity of the individual concerned are affected. Deterioration in emotional control, motivation or social behaviour, usually accompany or occasionally precede impairment in cognitive functioning. Dementia occurs more in the elderly than in the middle-aged increasing with age. Many causes have been attributed to dementia among which are serious head injury especially in early adulthood, degenerating disorders of the CNS, Alzheimer's disease, pick's disease, parkinson's disease, metabolic disorders like hepatic failure, intracranial space occupying lesions, intoxication for example alcohol intoxication and so on. Alzheimer's type dementia is an irreversible one occasioned by impairment in personality, cognitive function and memory. Treatment of dementia depends on the cause but in the case of most progressive dementias like Alzheimer's disease, there is no cure and no treatment has been found to slow down or stop the progression of the disorder although there are medicines to improve the symptoms temporarily. Regardless of this fact, much can still be done to support those suffering from this disorder; to improve their lives and as well support those caring for them (Sreevani, 2016).

Developmental Disorders

Developmental disorder is an umbrella term covering intellectual disability and pervasive developmental disorders including autism. Developmental disorders usually have a childhood onset but tend to persist into adulthood, causing impairment or delay in functions related to the central nervous system. They generally follow a steady course rather than the periods of remissions and relapses that characterize many other mental disorders. Intellectual disability is characterized by impairment of skills across multiple developmental areas such as cognitive functioning and adaptive behaviour. Lower intelligence diminishes the ability to adapt to the daily demands of life.

Symptoms of pervasive developmental disorders include impaired social behaviour, communication and language, a narrow range of interests and activities that are both unique to the individual and are carried out repetitively. Developmental disorders often originate in infancy or early childhood. People with these disorders occasionally display some degree of intellectual disability. Family involvement in care of people with developmental disorders is very important. Knowing what causes these people both distress that affect their wellbeing is an important element of care, as well as finding out what in their environments are most conducive to better learning. Structuring daily routines help prevent unnecessary stress, with regular times for eating, playing, learning, being with others, and sleeping. Regular follow-up of healthcare services for these individuals are also very important.

Concept of Quality of Life: Quality of life (QoL) reflects the nature of man and it is what an individual perceives of him/herself, but recently it is being viewed by many clinical researchers as both subjective and objective perceptions of individual's being, way of life, relationship, state of mind, health condition and feelings of worth. This implies that one's value and belief system are contributing factors to one's quality of life. According to World Health Organization (2018), QoL is the perception of individuals about their positions in life based on the premise of culture and value systems in which they live as well as they relate to their

expectations, goals, concerns, and standards. Quality of life is an all-encompassing concept; it's the totality of an individual's life.

Barcaccia (2013) describes QOL as the general well-being of individuals and societies; bringing out the positive as well as the negative attributes of life. It entails consciousness of human existence, which connotes the totality of the human person. Quality of life is viewed as a subjective entity as it is described by individual's satisfaction with his/her life that cuts across job, physical, social, mental health, family harmony, level of education and acquired wealth. Quality of life is better understood in terms of being objective, subjective and its functionality (Cho, Lee, Kim, Park, Choi, Kim, et al., 2019) which is concluded based on individual perception and interpretation. Quality of Life is concerned with the dreams, desire and proposition of an individual; and for the person to live in reality of the dreams, desires and plan for life.

Health has been identified as an integral domain of measuring quality of life alongside other domains such as housing, culture, job, living environment, education, spirituality and values. Efforts to increase individual, national and economic quality of life raised the need for studies on health-related quality of life (HRQOL). Centre for Disease Control (CDC), 2017) defined Health Related Quality of Life as the way "an individual or group perceive the physical and mental health as time passes". HRQOL is the measure of assessing the individual's status across both mental and physical health perceptions, their correlation to health risk factors, functional and socioeconomic status, and the social support system available to them. The community as well has its own share of HRQOL through community-level resources, state of the community's condition of living, practices and policies that influence the health perceptions and functional status of a population. Samartzis and Talias, (2020) opined that quality of life is concerned with the impact of impairment in limiting the ability of people living with mental illness and as such determines the quality of services needed.

According to Passerini and Marchettini (2018) in their report on sustainable development goalsin Italy, they maintained that the concept of QoL is perhaps more important in those disorders that are of chronic nature and run a debilitating course; and in which the treatment is targeted not towards curative but manageable level and of long duration. QoL research in mental health/ psychiatry is still in its developing state, although recently, efforts are being made to generate measures of QoL. Quality of life is the sum total of individual's perception of themselves based on their culture, psychosocial status, environment in which they live and their achievements in life. These would be enhanced by the level of their education, job, family status, social support and social relationships.

Disease conditions are very strong and mitigating factors to be considered when considering quality of life. Mental disorders have been identified as a factor that lowers quality of life. It is imperative to differentiate quality of life from standard of living, state of wellbeing or wellness, safety, security to freedom and religious beliefs. In psychiatric practice, the concept of quality of life is essential and considered an important part of mental health. In the opinion of O'Brien and Kuhaneck (2019), in their book on occupational therapy for children and adolescent, theymaintained that the use of atypical antipsychotics has greatly improved the QoL of patients with psychiatric disorder. Major mental illnesses such as affective disorder (manic illness, depressive illness, and bipolar affective disorder), schizophrenia, substance abuse and other organic brain dysfunctions suffered by patients have greatly exposed them to decreased level of QoL.

Measurement and Framework of Quality of Life: There are several frameworks and instruments that can be used to measure quality of life in individuals, popular among such instruments are the WHO QOL-BREF (1991) developed by the World Health Organization (1991), also the Area of Quality of Life-8D **(**AQoL-8D) developed by World Health Organization (1995). These measuring instruments provide opportunity to determine what individuals feel about their QoL in the areas outlined in the table 2.1 below.

Table 2.1: Quality of Life Framework

WELL-BEING	INDEPENDENCE	SOCIAL PARTICIPATION
Emotional well-being	**Personal development**	**Interpersonal Relations**
Contentment	Education	Interactions
Self-concept	Personal Skill	Relationships
	Competence	Supports
	Performance	
Material well-being	**Self-determination**	**Social inclusion**
Financial status	Autonomy and personal control	Community integration and participation
Housing	Goal and personal values	Community roles
Employment		Social supports
Physical well-being		**Rights**
Health		Human
Activities of daily living		Legal
Leisure		

The description of the domains according to Robertson (2012) and Schalock and Verugo (2012) are as follows:

a. Well-Being

Emotional Well-Being: this includes happiness, safety, and the ways individuals feel about their lives. It further includes spirituality, freedom from stress, self-concept and contentment.

Material Well-Being: relates to personal possessions that are of value to individuals, how much individuals can utilize money for the things they want or are in need of. Material wellbeing encompasses ownership, financial security, access to food, having employment. It includes socio-economic status and shelter.

Physical Well-Being: it includes energy levels, ability to get medical help, lifestyle and health of the individual. It further includes healthy nutrition, recreation, mobility, health care, health Insurance, leisure, Activities of Daily Living.

b. Independence

Personal Development: this implies those things that individuals are interested in learning about, those things they enjoy and are of importance to them. They include education, skills acquired, fulfilment, personal competence, purposeful activities and advancement.

Self-Determination: these are the choices and decisions that individuals make about important areas in their lives. These include areas such as autonomy, choices, decisions, personal control, self-direction, personal goals/value.

c. Social Participation

Interpersonal Relations: these include the types of help and support available to individuals, their relationships with family and friends, the types of activities they engage in with people in their lives, intimacy, affection, family interactions, friendships and Support.

Social Inclusion: these are activities and the thing these individuals do and would like to do in the community, the people individuals do things with and places they visit in their community. This includes acceptance of the individual, his or her status, supports, work environment, roles, volunteer activities, residential environment.

Rights: these include individual's right to privacy, how individuals are treated by people, how much people listen to individual's opinion. Among these are access to voting, due process, ownership of things; and being able to perform civic responsibilities.

In the opinion of Besadre, Busa, Landeza, Patual and Repayo, (2017) QoL is one of the commonly used self-assessment tools in measuring domains of life. However, for the fact that quality of life is both subjective and objective in nature, it is imperative that its measurement should involve both subjective and objective assessments using globally acceptable assessment scale. Sainfort (2014) suggested that measures should include information from both patients and their families, as measures taken subjectively are incomplete. Malm (2013), also believe that QoL measured in purely subjective terms is incomplete. There is no record of acceptable measures to be used in assessing QoL in psychiatric or chronically mentally ill patients but available instruments have been subjected to series of validation and reliability testing. Multiple scales have been validated to evaluate the construct of life quality (Richardson, Lezzi, Khan & Maxwell, 2013).

Equally, in the reviews of several instruments in measuring QOL among people with Severe Mental Illness (SMI), Wu (2017) commented on the work of Korr and Ford (2003) who opined that SMI might cause lowered expectation in the persons thus affecting their subjective assessment of their QOL. Another concern of theirs is that the illness might affect their thinking and judgment; and impair ability to report correct assessment in their QoL. The authors reviewed and compared fourteen (14) QoL instruments, identifying features present and those absent in each. The paper finally zeroed in on the World Health Organization QoL instrument which recognizes that it is in order for the QoL measure to be in line with 'individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns in life. Therefore, even if the expectations of the people with SMI is lowered, the measure will still be valid for that "particular" person(s). It is also reported that WHO recommends that QoL instrument must not be disease specific, therefore WHO has produced a QoL instrument that is applicable to healthy population and any population of ill individuals. It covers physical health, psychological states, and level of independence, social relationships and relationships to features of the environment.

Factors Influencing Quality of Life

Influence of Family and Living Condition: According to Verloo, Salina, Fiorentino, and Cohen (2018), living condition and the freedom of moving about without restriction or impediment are important factors influencing QoL of the elderly with cognitive defects. Family as a career is found to be an important factor in maintaining patients' quality of life, especially

with patient with dementia (Farina, Page, Daley, Brown, Bowling, Basset, Livingston, Knapp, Murray & Banerjee, 2017).

Health Related Factors: Some identifiable factors that influence QoL of people living with mental illness include but not limited to the individual's physical health, psychological state, and level of dependence, social relationships, belief and environmental supports (Farina, Page, Daley, Brown, Bowling, Basset, Livingston et al., 2017). Physical health is vital to individual's state of wellness, interruption to physical health affects activities of daily living, patients' energy to adapt to given situation and state of helplessness. According to Colillas-Malet, Prat, Espelt, and Juvinyà (2020), gainful employment enhances physical health, having a means of livelihood and is a strong factor in determining Qol. (Vives-Cases, Eriksson, Goicolea, & Öhman, 2015).

Verloo, Salina, Fiorentino, and Cohen (2018); affirmed that QoL of chronic psychiatric patients (such as schizophrenia, chronic affective disorders, personality disorders, substance abuse, etc.) is impoverished especially in the domains of housing conditions, family environment, social network, financial circumstances, safety and practical skills. Psychological state is a relevant index in measuring the QoL of people. Individuals with psychological disorders are at greater risk for decreased quality of life according to World Health Organization, (2020).

Socio-Economic Situation: Also, socio-economic situation of individuals on the lower socio-economic status such as lower income, lower educational level, and unemployment/under-employment are impediments to good QoL. Chronic physical comorbidities and low socioeconomic conditions have been reported to have negative impact on QoL (Cho,Lee,Kim, Park, Choi, Kim, 2019)

Duration of Mental Illness: Verloo, Salina, Fiorentino, and Cohen (2018) reported that the longer the duration of illness, prolonged stay in the hospital especially for patients with dementia resulted in low QoL.

Environmental conditions: Environmental conditions such as housing, natural disaster, pandemic problem and so on, not only affect QoL directly but indirectly as well (Streimikiene, 2015). Environmental factor is also a measuring index in determining QoL and support or services needed by individuals with mental illness.

Empirical Review

Colillas-Malet, Prat, Espelt, and Juvinyà (2020) reported in their study "Gender differences in health-related quality of life in people with severe mental illness" that there is difference in factors that influence the QoL of the genders, though there is no reported statistically difference in HRQOL of male and female with severe mental illness.

Choo, Chew, Ho, and Ho, (2018) in a study "Quality of Life in Patients with a major mental disorder in Singapore" asserted that psychotic disorders such as schizophrenia and depression have highest rate of low QoL however, minor mental illnesses such as anxiety and phobias were recorded by Treichel *et al* (2017) as having good quality of life. Koivumaa-Honkanen et al (2017) reported that in comparison with other mental illnesses; schizophrenia has lower QoL.

Choo *et al* (2019) found several factors including education, age, and duration of illness and severity of the condition correlate with QoL and determined the outcome of the condition. They asserted that there were consistent negative relationships with QoL across all samples studied and treatment settings. Verloo, Salina, Fiorentino, and Cohen (2018) reported that prolonged stay in the hospital especially for patients with dementia resulted in low QoL. Furthermore, QoL of chronic psychiatric patients (such as schizophrenia, chronic affective disorders, personality disorders, substance abuse, etc.) is impoverished especially in the domains of housing conditions, family environment, social network, financial circumstances, safety and practical skills.

Twahira (2017), in a study in a Kenyan psychiatric health facility reported on the nature of their illnesses, found that; 18.8% had depressive disorder, 16.7% had schizophrenia, 9.9% suffered from bipolar disorder while 9.6% reported drug/alcohol abuse with psychosis. This evidence shows that psychiatric disorders do affect the wheel of individual's wholeness. Koivumaa-Honkanen (2017) reported that personality traits appear to have a relationship with QoL. "Patients with higher "neuroticism" scores have a lower life quality, while those with traits of extroversion and openness, as measured by the Neo-Pi, has a higher subjective QoL". In patients with psychotic symptoms, quality of life study is not widely reported and so little information is readily available. However, Mahmoud *et al* (2017), in their study among 115 psychiatric patients in an Egyptian hospital using a descriptive correlational design reported that factors such as social support and social ties of the sufferer were correlated with their QoL either negatively or otherwise and further affirmed that the stronger the social ties, the higher the QoL of the patient.

Another study conducted by Abdalla, Nyabola, Mathai, Abdalla and Khasakala (2018) involving 384 participants living with mental illness and on follow-up using WHOQoL-BREF and socio-demographic questionnaire to collect data from them; found that QoL was lower among them than the general population but were specifically related to the mental status of the patient and income level. In the opinion of Treichel*et al* (2017) affirmed that QoL is being influenced by social ties which reflects on all areas of life such as physical, psychological and health behaviours. Social ties help to enhance the individual wellness. Schizophrenic patients however, were particularly found to be incapacitated in their self-evaluation of the quality of life (Kalonji *et al*, 2017). This was attributed to reduced recognized cognitive capacity; poor judgment and insight to their mental status and distortion from reality.

Lehman (2013) was of the opinion that married patients had higher global satisfaction with life. The gender proportion and schizophrenia were found out to be 29.2% in males and 70.8% in females according to Omitogun and Adebayo (2018). Also, 29% of the patients were diagnosed with schizophrenia for less than a year, 41.7% were unemployed. Audi, *et al*, (2017) on factors affecting health related quality of life in hospitalized patients with heart failure reported that living alone, not being a professional and not owing a personal house correlated with low QoL. Furthermore, respondents perceived their QoL to be low with amount of pain and worries in their mind with mean scores of 2.5 and 2.9 against 3.5 and low social support from friends and religious group with mean scores of 2.5 and 2.8 against 3.0 respectively.

Also, Twahira (2017) in respect of gender, reported a higher percentage of male respondents 67.2% while 32.8% were females. Furthermore, age of onset was found to be higher among females (34.5years) than male respondents. On their marital status, two-thirds of the respondents were single 63.8%, 28.9% were married, and 0.8% were divorced while 5.2%

were separated. Age is an area that has not been so clear in determining the QoL of the mentally ill; as there were records of negative and no correlation (Koivumaa-Honkanen *et al*, 2017).Twahira, (2017) discovered that 16.9% of his study participants had mental illness for a period of less than a year, 83.1% had history of more than a year duration while 63% reported episode of illness between 1-7years.Concerning associated factors in depressed patients, Cho, *et al,*(2019), opined that mental health problems can affect QoL by themselves independent of other socio-demographic or health-related factors of QoL.

Environment has equally been described to have an important place in determining an individual's quality of life. Just as reported by Kalonji, Ngongo, Ilung. Albert and Giet (2017), on the study of the prison inmates who were limited by space because of restriction of movement they were subjected to; and which leads to statistically significant low correlation between the domains of quality of life. Although there was no relationship between the patient's environment and their mental health, they considered their quality of life as negative. Another important factor found relevant to determining the QoL of the mentally ill is the social support being enjoyed. Many investigators have identified the relationship between housing and QoL. The aspect of QoL that has recorded greater negative report is homelessness, and lack of autonomy (Kalonji *et al*, 2017)) which is common among the chronically mentally ill who suffer lack of support and same is responsible for lack of funds even to maintain health care.

Theoretical Framework for the Study

Health-Related Quality of Life Model

Quality of life theory was initially conceived as Health-related Quality of Life (HRQoL) model by Wilson and Cleary (1995). This integrated middle range theory was further developed into full theory by Ferrans, Zerwic, Wilson and Larson (2005). Unlike Maslow's theory of needs which emphasizes satisfaction of need and developed towards happiness and well-being in a healthy individual (Moakumla, 2018), this theory explains HRQoL with clinical variables focusing on the individual and the interplay with environment and expected outcome. It has been widely accepted among scholars in the field of psychiatry and nursing in particular owing to its polyvalent approaches in usage and application to varying clinical variables (Ojelabi, Graham & Ling, 2017). The components of HRQoL are individual characteristics, environment characteristics and measurement of patient outcome.

Also, patient outcome was further subdivided into five areas for effective measurement of clinical variables. Biological functions, symptoms, functional status, general health perceptions and overall QoL.

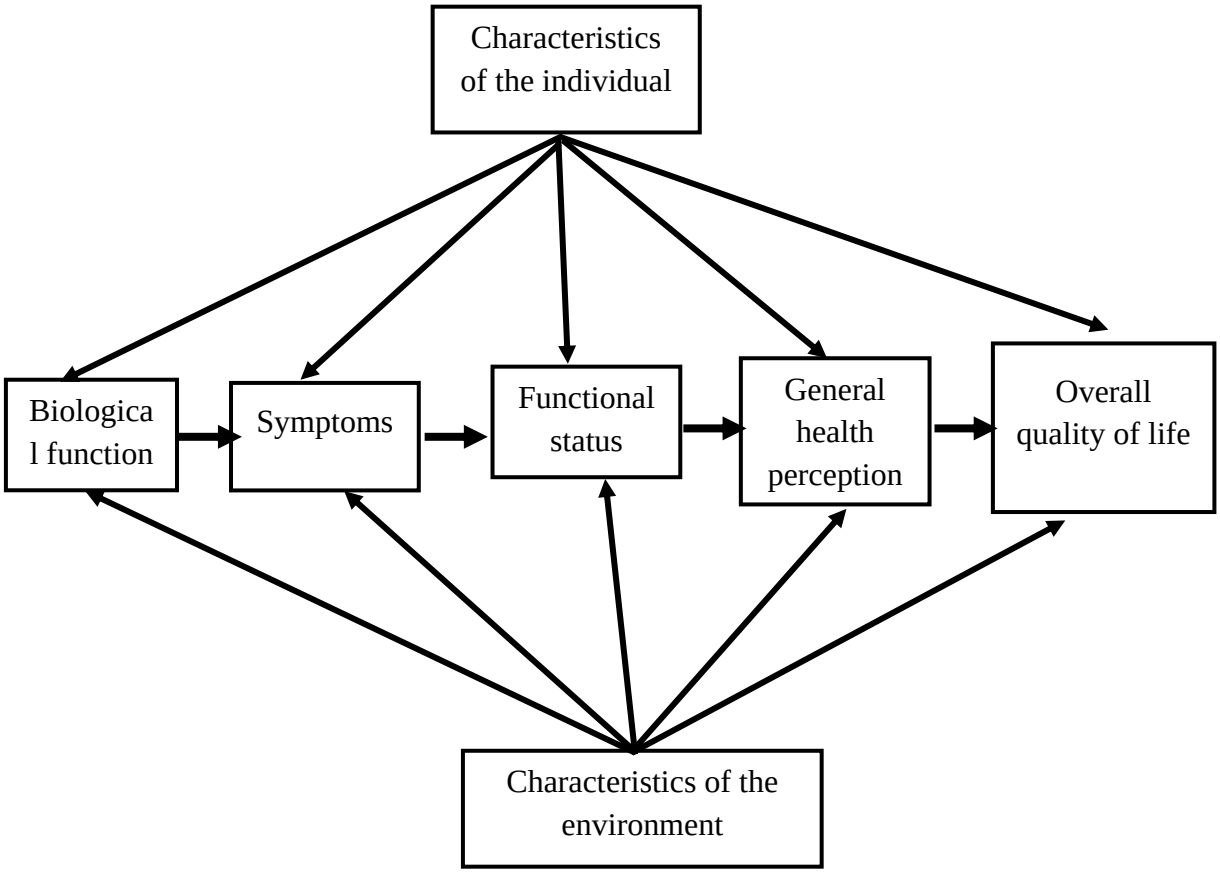

Figure 2.1: Health-Related Quality of Life Model by Ferrans, *et al*. (2005).

Individual Characteristics: Characteristics of the individual explain those variables that are inherent in individuals such as genetic disposition, hereditary factors, developmental and demographic factors. Individual qualities such as body mass index, hereditary factors that are directly linked to disease development, age, marital status, parity, pregnancy, breastfeeding, hematological indices and so on; are factors that cannot be modified by an individual (Omitogun, 2018). Psychological values and epidemiological variables such as beliefs, cognition, perception, intelligence, cleft palate and mutation are also essential in determining individual characteristics and disposition to life (Ryan & Cael, 2000).

Environment Characteristics: Environment was described as those variables within an individual that influence clinical decision and other areas of life. The characteristics of the environment can also be exerted in the measurement of patients' outcome. These influences can be directly or inversely proportional to the state of the outcome. Family support, social and demographic characteristics such as tribe, marriage, housing, level of income, educational

status were among the variables that constitute the characteristics of the environment (Omitogun& Adebayo, 2018).

Measurement of Patient's outcome: Ferrans et al (2005) advanced that the following areas are essential when measuring the outcome of the individual based on its interplay with characteristics of the environment.

Biological Symptoms: Ferrans et al (2005) maintained that biological symptoms are those factors inherent in an individual and are capable of determining the health outcome. The state of tissue vitality, intrinsic factors like sickling trait or diabetes mellitus, presence of chromosomal abnormalities, neurotic features, seizure traits and so on (Omitogun& Adebayo, 2018).

Symptoms: Individuals perception of health status either negatively or positively in the recent time. These feelings might affect any domain of individual's life such as physical, psychological, social, emotional and spiritual which as such determine their wellbeing, level of independence and social participation.

Functional Status: Wilson and Cleary [1995] advanced the individual's ability to perform multiple tasks in view of personal disabilities. Furthermore, functional status was explained in four framework; firstly, functional capacity which means level of individual capability in performance of a given task (for example performance of activity of daily living during period of hospitalization); secondly, functional performance that explains the capacity of the individual to actually perform the necessary activities in different domains; thirdly, functional capacity utilization described whether or not the individual was able to utilize his/her functional capacity to achieve the objectives and lastly, functional reserve referred to as the residual strength of the individual after functional capacity utilization has been utilized from original functional capacity. Ferrans et al (2005) affirmed that functional reserve is an integral aid for the sick individual to regain their normal health.

General Health Perception: This evaluates the uniqueness of the individual in perceiving their health status. Two components described measurement of General health perception; (a) Health perception based on integration and subjectivity (Wilson and Cleary, 1995), (b) Based on the level of severity in terms of virulence, threats, chronicity contagion and so on (Besadre, Busa, Landeza, Patual and Repayo, 2017).

Overall QoL: Is the last component of the theory that evaluates how various domains; physical, social, psychological as well as intervening variable, such as background, environment, family support, economic status influences the individual's health-related quality of life.

Application of the Model to the Study

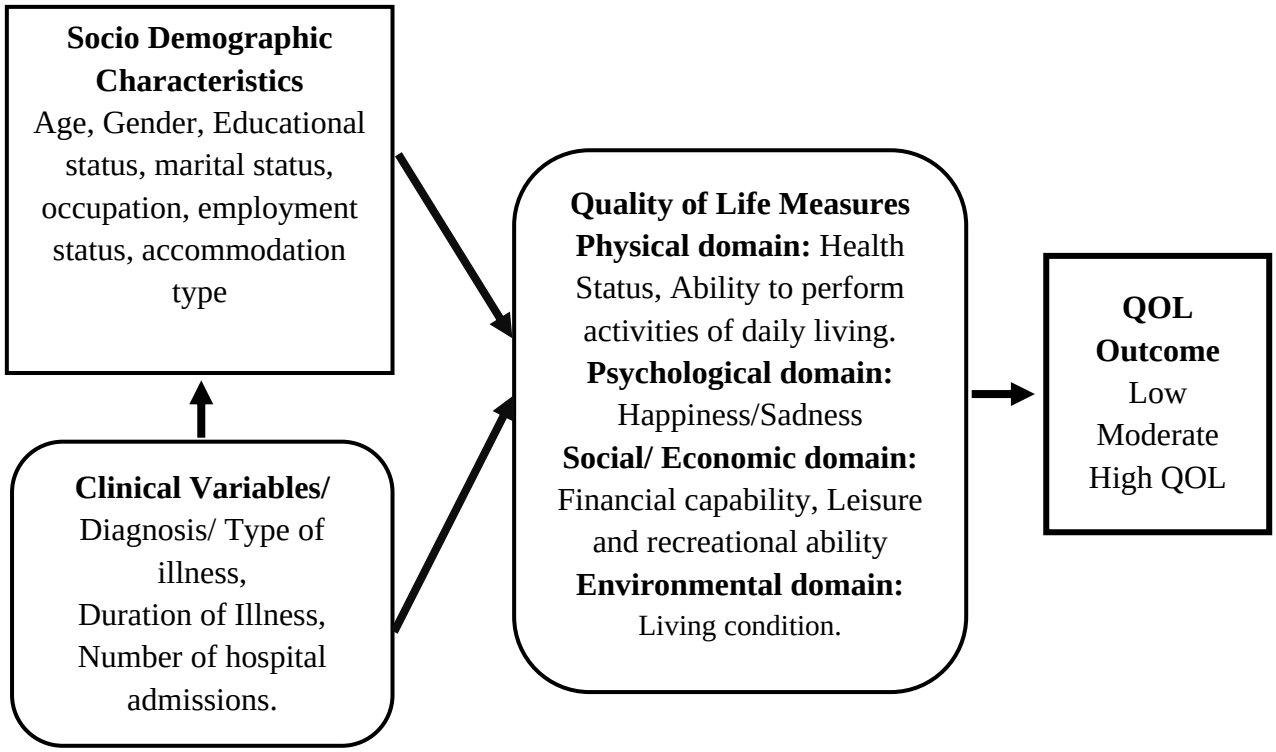

Figure 2.2: Application of the "Conceptual Model of Health-Related Quality of Life," to the Study, adapted from Ferrans *et al,* (2005)

Components of the Model identify the individuals, environment, and clinical variables that determine the outcome of the QoL. The individuals are the patients attending psychiatric hospitals in south-west Nigeria. Their characteristics include nature of their sickness, psychoses, neuroses and personality disorder. These also include the level of severity and morbidity that militate against their wellness and social integration. It has been proved that psychotic illness follows familiar trait and such can be important when describing epidemiological review of the illness.

Mental illnesses are of different types and can be influenced by some other variables within the individual- consumption of alcohol or use of other psychoactive substances, economic status and level of compliance with treatment regimen. Characteristics of the environment are very important in determining the QoL of the population under study. Variables such as family support, income, housing, rehabilitation programmes, and cost of transportation, medication, reaction to neuroleptics and societal support or discrimination have the tendency to influence the patient's outcome.

The application of this model to the study is relevant because it reiterates the fact that despite the characteristics of the individuals such gender, age, marital status and so on; clinical variables such as types of illness/diagnoses, duration of illness, number of hospital admission and so on, are factors determining their QoL. Environmental characteristics can equally make

or mar the outcome of their treatment and can determine the level of their quality of life as well.

RESEARCH METHODS

Research Design

The study employed a survey design which is of the descriptive cross-sectional type. Survey research design is a quantitative approach that features the use of self- report measures on carefully selected samples (Trochim, 2020).

Study Settings

The study was carried out at Neuropsychiatric Hospital Aro Abeokuta, Ogun State and Federal Neuro-Psychiatric Hospital, Yaba, Lagos State. The choice of these hospitals was based on the fact that they are well-known hospitals with good reputation and are both federal government owned specialist hospitals whose main concern is for the treatment and care of those with mental illness.

Neuropsychiatric Hospital, Aro, Abeokuta

Neuropsychiatric Hospital Aro started at her annex in Lantoro in 1944 as an administrative prison/asylum which was established by colonialists for mentally ill soldiers repatriated home after World War II. Initially, it was under the supervision of Mr. Leonard Oliver, an expatriate psychiatric nurse who oversees the treatment of the mentally ill in a modern way devoid of crude traditional care which involved inflictions of pains on the victim with the resultant exclusion from the society.

The need for modern psychiatric hospital led to the establishment of Neuropsychiatric hospital along Lagos- Abeokuta Road near Ita-Oshin and the hospital at inception was referred to as Aro Mental Hospital. The selection course for the training in Mental Health Nursing was improved upon in 1954 at the arrival of Professor Adeoye Lambo who came into Lantoro asylum and Aro mental hospital from England to render modern psychiatric services to the nation and this heralded the beginning of the premier School of psychiatric nursing in 1955 with 27 male and female student nurses in attendance under the tutorship of Mr. Maxwell.

At present, Lantoro Annex caters largely for mentally abnormal offenders and the chronic cases while Aro cares for the acutely and chronically ill patients as well as those with alcohol and substance abuse problems. The hospital has a total bed capacity of 526 (Aro and Lantoro Annex) and renders qualitative services to patients from all over the county and from some neighbouring Countries as well as conduct research in the field of mental health. Abeokuta North Local Government Area is among the 20 Local Government areas (LGA) in Ogun State. The headquarters is at Akomoje. The Local Government first came into existence in 1981as Abeokuta South Local Government but was merged with the sister Local Government in 1983 to make up the defunct Abeokuta Local Government area. However, on the 27th of September, 1991, the local Government was recreated by the Federal Military Government to bring governance closer to the grassroots. The Local Government area shares boundary with Imeko-Afon Local government, Abeokuta South Local government, Odeda Local government,

Ewekoro Local Government, Yewa North Local government and Obafemi-Owode Local Government areas.

The local Government Area has an estimated population of 214,420 inhabitants according to 2006 population census. The Local Government is made up of 16 wards and administratively Hon.Adebayo Ibukun was appointed as chairman of the transitional committee. The famous Neuropsychiatric hospital, Aro, Abeokuta, Crescent University, a private university, Ayetoro road, Abeokuta among others, are some important structures situated in the Local Government Area.

Federal Neuropsychiatric Hospital, Yaba Lagos State

Psychiatric Hospital, Yaba came into existence on October 31, 1907 when the hospital was set up as an asylum under the British Colonial rule. The first batch of 48 inmates was admitted in a disused Nigeria Railway Building in Yaba, Lagos. Over the years, the hospital has witnessed four developmental stages. The first stage, (1907-1950) was purely an asylum state. The function of the hospital was custodial i.e. keeping the mentally ill away from the society. During this period, there were padded cells and drugs such as paraldehyde, mist alba etc. were prescribed by the doctors and administered by the asylum attendants. There were no nurses, no beds and beddings, no uniform and no form of psychiatric treatment. However, medical doctors from the Ministry of Health paid occasional visits to give minimal treatment. The buildings were dilapidated and the inmates lived in appalling sanitary conditions. It was truly an asylum and its name at that time was the Yaba Lunatic Asylum.

The second stage (1951-1971) witnessed the arrival of qualified psychiatrists, nurses and pharmacists. There was an outpatient department and it also marked the beginning of Occupational Therapy in the hospital. The name of the institution was changed from asylum to Yaba Mental Hospital. This stage marked the beginning of the progressive development of the hospital as emphasis shifted to therapy in which apart from tranquilizers, ECT and deep Insulin therapy were used. During this period, the third stage saw the introduction of qualified psychiatrists. At this time, although buildings were still substandard, treatment then was the best and the name changed from mental hospital to Psychiatric Hospital. During this stage more professionals like nurses and pharmacists started working in the hospital. The Out Patient department was established and Occupational therapy was well developed. The fourth stage marked the coming of the first female psychiatrist in Nigeria as the medical director of the hospital. It witnessed the beginning of improvement in the infrastructure and treatment in the hospital. Postgraduate training for resident doctors in Psychiatry also began during this period. At the apex of the decision-making chain in the hospital is the Federal Ministry of Health which also represents the interest of the owner i.e. Federal Government of Nigeria.

The Psychiatric Hospital Yaba Management Board is the next in line and it is responsible for formulating broad policies for the organization and ensuring that Government policies and programmes on mental health are faithfully implemented. The Medical Director, head the Management team and he is responsible for the day to day governance of the hospital subject to directions of the Board (www.fnphyaba.gov.ng).

Study Population

The population for the study were mentally- ill patients attending the outpatient clinics of both hospitals. It was observed that an estimate of 2,525 and 1,954 patients were in attendance at FNPH, Yaba, Lagos and NPH, Aro, Abeokuta respectively.

Inclusion Criteria

1. All Patients diagnosed with a mental disorder based on the ICD-10 diagnostic criteria between the ages of 18-65 years and being seen at the outpatient clinics of the two Neuropsychiatric Hospitals.

2. All patients who meet the inclusion criteria and are willing to participate in the study within the calculated sample size.

Exclusion Criteria

1. Patients with chronic and disabling physical conditions (e.g. cerebrovascular disease) or any acute medical disorder as determined in the case note documentation and clinical observation of the interviewer.

2. Patients who are not clinically stable enough to participate in the study.

3. Individual patients who do not meet the inclusion criteria

Sample Size Determination

The sample size was determined using the Fischer's exact formula which measures population less than 10,000 (Mutinda &Wagoro, 2017).

$$nf = \frac{n}{1 + \frac{n}{N}}$$

Where

$\mathrm{nf} = \text{Desired sample size when population is less than } 10{,}000$

$\mathrm{n} = \text{Desired sample size when population is more than } 10{,}000$

$\mathrm{N} = \text{Estimated population size, } 2525 \text{ (FNPH, Yaba)}$

$$\mathrm{n} = \frac{\mathrm{z}^2\mathrm{pq}}{\mathrm{d}^2}$$

Where

$\mathrm{z} = \text{Normal deviate at } 95\% \text{ confidence interval p}$
$= \text{Prevalence from previous similar study, taken as } 22\%$

$q = 1 - p$

$d = 0.05$, with level of significance set at 0.05

$$n = \frac{1.96^2 \times 0.22 \times 0.772}{0.05^2}$$

$$= 260.98$$

$$nf = \frac{260.98}{1 + \frac{260.98}{2525}}$$

$$= \frac{260.98}{1 + 0.1033}$$

$$= \frac{260.98}{1.1033}$$

$$= 236.5$$

$$= 237$$

None response rate = $237\ x\ \frac{10}{100}$

= 23.7

= 24

Therefore, sample size for FNPH, Yaba = 237 + 24 = 261

Neuropsychiatric Hospital Aro, Abeokuta N = Estimated population size, 1954

$$nf = \frac{260.98}{1 + \frac{260.98}{1954}}$$

$$= \frac{260.98}{1 + 0.1335}$$

$$= \frac{260.98}{1.1335}$$

$$= 230.2$$

$$= 230$$

A 10% non-response rate anticipated = $230\ x\ \frac{10}{100}$

= 23

Therefore, the adjusted sample size is 253 for NPH,Aro, Abeokuta.

Considering the above which was also applicable to Federal Neuropsychiatric Hospital Yaba, attending to over 2000 outpatients per month, the researcher therefore decided to apply the use of sample size from the table of samples for continuous data. According to Robson (2011), population size of 2000 @ alpha level of significance (0.05) sample size of 112 is appropriate which has a universal acceptability. Hence, the sample size used was 514 that is 261 and 253 respectively.

Table 3.1: Table for Sample Size

Neuropsychiatric Hospital, Aro	Federal Neuropsychiatric Hospital, Yaba	Total
253	261	514

Sampling Technique

Simple random sampling technique was employed to select respondents who met the criteria for inclusion in the study. Balloting method without replacement was used in which the patients who met the inclusion criteria were asked to pick ballots from a basket, those who picked "Yes" were the ones who took part in the study and those who picked "No" did not take part. This had been explained to them earlier.

Instrument for data collection

World Health Organization Quality of Life BREF-Scale was the instrument used in data collection. The instrument was adapted to fit into the purpose of this study. It was divided into two sections. Section A contained information to measure the Socio-Demographic characteristics of the respondents and Section B specifically developed to gather data from the QoL domains. The WHOQOL-BREF scale developed by World Health Organization has 26-items that measure the following broad domains: physical domain (7items), psychological domain (6 items), social relationships domain (3 items), and environmental domain (8 items), general health and overall QoL (2items). The 26 items have only three negative questions and the remaining 23 questions are positive questions. The score ranges are 1(Not at all), 2 (A little), 3 (A moderate amount), 4 (Very much), and 5 (An extreme amount). The patient's QoL was categorized using 1-43 (low), 44-86 (moderate) and 87-130 (high). The researcher developed the socio-demographic and clinical characteristic questionnaire from the review of the related literature. The socio-demographic data included patient's age, gender, marital status, educational level, current employment status, family income; while clinical variables were clinical diagnosis, duration of illness and numbers of admission.

Psychometric Properties of the WHOQOL BREF

Analyses of internal consistency, item-total correlations, discriminant validity and construct validity through confirmatory factor analysis, indicate that the WHOQOL-BREF has well to excellent psychometric properties of reliability and performs well in preliminary tests of validity. These results indicate that overall, the WHOQOL-BREF is a sound, cross-culturally

valid assessment of QOL, as reflected by its four domains: physical, psychological, social and environment (Skevington, O'Connell, & Lofty 2015)

Validity of Research Instrument

Content and face validity method was used to ensure the validity of the research instrument. The face and content validity of the instrument was ensured through the help of researcher's supervisor and other professors in the field of nursing. Their observations were used to correct the items in the research instrument.

Reliability of Research Instrument.

The psychometric properties of the instrument, the WHOQOL-BREF) has be determined but notwithstanding, the instrument was subjected to a pilot testing among twenty (20) outpatients of Community Psychiatric Centre, Oke-Ilewo Abeokuta, Ogun State. This was to test and improve on the proposed questionnaire used for the study. All the 20 copies distributed were recovered. A reliability coefficient of 0.81 was obtained after subjecting the instrument to a reliability test.

Procedure for Data Collection

After getting approval from the selected hospitals' ethical committees and familiarization with health team members in each setting; the researcher and two research assistants in each study area obtained informed consent (written) from selected patients and/or their relatives for their cooperation in completing the instruments after explaining the purpose and promise of confidentiality was established. The respondents without formal education were interviewed using the questionnaire. The respondents with formal education completed the instruments on their own. The patients were given the instrument to complete while their clinical data were completed from their personal records. For the respondents who could complete the questionnaire on their own, the instrument was given to them for completion while those who were not capable of doing so were assisted to do so by interviewing them.

The instruments were administered to the respondents while waiting to see their doctors for consultation (that is, during the waiting period)

The process took up to four weeks; two weeks respectively at each Federal Neuropsychiatric Hospital's Outpatient Clinic. The researcher and the assistants visited the clinics four times a week; total of eight visits per hospital.

Method of Data Analysis

Data collected were subjected to proper sorting, invalid questionnaires were eliminated leaving 487 questionnaires suitable for analysis. These were collated, organized, tabulated and statistically analysed with Statistical Package for Social Sciences 23.0 computer software statistical package. The data was then analysed using descriptive statistics in form of frequencies and percentages for quantitative variables including means and standard deviations. The hypothesis was tested using inferential statistics that is; Pearson products moment correlation coefficient to determine whether there are statistically significant relationships between the types of illness and quality of life while T-test was used to determine the statistically significant difference in the quality of life of male and female patients living

with mental illness attending outpatient clinics of the two Federal Neuro-psychiatric Hospitals. The statistical significance was considered at P-value ≤ 0.05.

Ethical Considerations

Ethical clearance certificate was obtained from Babcock University Health Research Ethics Committee (BUHREC). Ethical approval was obtained from Health Research Ethics Committees of each of the institutions where the study was carried out- that is Federal Neuropsychiatric Hospital, Yaba, Lagos and Neuropsychiatric Hospital, Aro, Abeokuta. Also informed written consent was obtained from the respondents (Informed consent form attached).

Ethical Principles Observed in the Study Include:

a) **Informed consent**: Consent form available

b) **Confidentiality**: Participants were assured of confidentiality of the information given. They were assured that there shall be no identifiers to trace them in connection with the information supplied.

c) **Beneficence**: Participants were assured that no harm will come to them as a result of participating in the study, and that information gathered will only be used to further enhance their care.

d) **Freedom from exploitation**: Participants were assured that their participation in the study will not place them at a disadvantage or expose them to situations for which they are not prepared i.e. their participation or information that might be provided to the researcher will not be used against them in any way.

e) **Voluntariness and Right to sell self-determination**: Participation in the study was voluntary. Any patient who was not willing to participate was not coerced into taking part and refusal to take part was not and will not be used against them in accessing care in the facilities.

f) **Fairness to All**: All participants in the study were treated equally and with fairness.

g) **Justice:** This principle deals with the concept fairness. The participants were not included merely because they were accessible, available or vulnerable but because it is hoped that the findings will benefit them. Hence, there was no discrimination in the recruitment or enrolment process.

h) **Risk/Benefit Ratio:** There was no foreseeable risk in the study, as the study did not expose the respondents to any risk and they stand the chances of benefitting from the findings of the study as stated in the benefit above.

Benefits to Participants/Group/Mental Health Profession and the Society

There are benefits that may be accrued to the patients, mental profession and the society as the findings of the study will help mental health practitioners in giving holistic care to the patients as there will be improvements in the way they discharge their duties, taking into cognizance the uniqueness of each patient thus translating into benefitting the patients who are the

members of the society. It might also help the government and other stakeholders in policy formulation and implementation in the provision of social support system for the mentally ill and include provision for the cost of mental illness and promotion of mental health for the citizenry. This study would hopefully provide evidence for mental health advocates to gain support from donors and equally provide direct line of focus in the rehabilitation of the mentally ill.

DATA ANALYSIS, RESULTS AND DISCUSSION OF FINDINGS

The results of data analysis are presented in this chapter. Data presentations of this study are done based on the research questions and hypothesis earlier set. It should be noted here that four hundred and eighty-seven respondents participated in this study.

4.1 Preliminary Analysis

Table 1: Respondents' Socio-Demographic Data

N	Variable		Yaba (N = 249)		Aro (N = 238)	
			Frequency	%	Frequency	%
1	Age	Below 25	49	19.8	42	17.6
		26-35	91	36.4	76	31.9
		36 Above	109	43.8	120	50.4
		Mean age:	38.1 ± 2.47(SD)		40 ± 3.03(SD)	
2	Gender	Male	137	55.0	123	51.7
		Female	112	45.0	115	48.3
3	Marital Status	Single	131	52.6	140	58.8
		Married	89	35.7	78	32.8
		Separated/Divorced	29	11.6	10	4.2
		Widow	-	-	10	4.2
4	Religion	Christianity	191	76.7	167	70.1
		Islam	51	20.5	60	25.2
		ATR	7	2.8	1	0.4
5	Tribe	Yoruba	173	69.5	188	79.0
		Igbo	68	27.3	41	17.2
		Hausa	7	2.8	5	2.1
		Non-Nigerian	1	0.4	4	1.9
6	Educational Status	No formal Educ.	19	7.6	20	8.4
		Pry/Sec	100	40.2	107	45.7
		NCE/HND	60	24.1	52	21.8
		BSc	60	24.1	48	20.2
		Others	10	4.0	6	2.5
7	Occupation	Unemployed	50	20.1	72	30.3
		Artisan	33	13.3	22	9.2
		Public Servant	48	19.3	24	10.1
		Trading	79	31.7	61	25.6
		Farming	2	0.8	11	4.6
		Others	37	14.9	48	20.2

Source: Researcher's field survey, 2020

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The socio-demographic profile of the study population based on the gender in both centres revealed that majority 109 (43.8%) and 120 (50.4%) of the respondents were male. The respondents were within the age of less than 25 to 36 years above with a mean age of 38.1 ± 2.47(SD) in Yaba and 40 ± 3.03(SD) in Aro. The majority 131 (52.6%) and 140 (58.8%) were single in Yaba and Aro respectively. The study revealed further that majority of patients were Christians, Yorubas', and had primary or secondary school education in both centres.

Table 2: Common mental illnesses among patients attending outpatient clinics

	Variable		Yaba		Aro	
			Freq.	**%**	**Freq.**	**%**
1	Types of Mental illness	Neuroses	10	4.0	12	5.0
		Depression	99	39.8	74	31.1
		Schizophrenia	83	33.3	94	39.5
		Drug Abuse	30	12.0	47	19.7
		Seizures	15	6.0	3	1.3
		Others	12	4.8	8	3.4
		Total	**249**	**100.0**	**238**	**100.0**
2	Duration of Illness	Less than 1yr	50	20.1	72	30.3
		1-2yrs	52	20.9	33	13.8
		3-4yrs	19	7.6	20	8.4
		Above 5yrs	128	51.4	113	47.5
		Total	**249**	**100.0**	**238**	**100**

In Federal Neuropsychiatric Hospital, Yaba, the common diagnosis among people living with mental illness showed that majority 99 (39.8%) suffered from depression and 83 (33.3%) suffered from schizophrenia while in Neuropsychiatric Hospital, Aro majority 94 (39.5%) suffered from schizophrenia and 74 (31.1%) suffered from depression. Duration of illness reported among the respondents of this study was 128 (51.4%) and 113 (47.5%) above five (5) years respectively at Yaba and Aro. It could be said from the result presented in Table 2 that majority of the patients in the treatment centers suffered from schizophrenia and depression while most of the patients have been on their ailment for more than five years.

Answering of Research Questions

Research Question 1: What is the level of quality of life among people living with mental illness?

Table 3: Descriptive data showing the level of quality of life among people living with mental illness

Category	Criteria	Yaba		Aro		Remark
		Frequency	**%**	**Frequency**	**%**	
1-43	Low	102	41.0	107	45.0	Respondents with low level of quality of life
44-86	Moderate	91	36.5	85	35.7	Respondents with moderate level of quality of life

87– 130	High	56	22.5	46	19.3	Respondents with high level of quality of life
Total		249	100.0	238	100.0	
Mean ± SD (%)		56.81 ±8.59 (43.7%)		59.47 ±7.64 (45.8%)		

Table 3 shows the level of quality of life (QoL) among people living with mental illness in Federal Neuropsychiatric Hospital, Yaba and Neuropsychiatric Hospital, Aro. One hundred and two (41%) patients in Yaba had below average score, 91 (36.5%) and 56 (22.5%) had QoL scores at average and above average respectively. In the Neuropsychiatric Hospital, Aro, 107 (45%) had low score on QoL, 85 (35.7%) and 46 (19.3%) had QoL scores at average and above average respectively. The level of quality of life mean score among people living with mental illness in Yaba was 56.81±8.59 (43.7%) and 59.47±7.64 (45.8%) in Aro.The implication of this results is that the level of quality of life among people living with mental illness is low in both Neuropsychiatric Hospitals.

Research Question 2: What are the health factors associated with quality of life of people living with mental illness attending outpatient clinics?

Table 4(a): Health-related factors associated with quality of life of patients at Federal Neuropsychiatric Hospital, Yaba

	Quality of Life					**Total**	**X^2**	**Sig**
	Not at all	**A little**	**Moderate amount**	**Very much**	**Extreme amount**			
Neuroses	3 (30.0)	5 (50.0)	2 (20.0)	-	-	10 (100)	3.59	.044
Depression	13 (13.1)	35 (35.4)	27 (27.3)	19 (19.2)	5 (5.1)	99 (100)	7.56	.000
Schizophrenia	-	28 (33.7)	41 (49.4)	14 (16.9)	-	83 (100)	9.91	.009
Drug Addiction	-	11 (36.7)	17 (56.7)	2 (6.6)	-	30 (100)	11.93	.000
Seizures	1 (6.7)	8 (53.3)	6 (40.0)	-	-	15 (100)	5.73	.047
Others	3 (23.1)	5 (41.6)	4 (33.3)	-	-	12 (100)	6.66	.018

Table 4(a) shows that the chi-square value obtained for neuroses (x^2 = 3.59, p = .000), depression (x^2 = 7.56, p = .000); schizophrenia (x^2 = 9.91, p = .009); drug addiction is (x^2 = 11.93, p = .000); seizures is (x^2 = 5.73, p = .047); and others is (x^2 = 6.66, p = .018), all are significant at levels less than 0.05. Since these p-values were less than 0.05 values, it could be said that they were factors associated with quality of life of people living with mental illness attending outpatient clinic of Federal Neuropsychiatric Hospital, Yaba, Lagos.

Table 4(b): Health-related factors associated with quality of life of patients at Neuropsychiatric Hospital, Aro

	Quality of Life							
	Not at all	**A little**	**Moderate amount**	**Very much**	**Extreme amount**	**Total**	**X^2**	**Sig**
Neuroses	-	5 (41.7)	2 (16.6)	5 (41.7)	-	12 (100)	6.93	.000
Depression	5 (6.8)	19 (25.7)	27 (36.5)	20 (27.0)	3 (4.0)	74 (100)	7.66	.000
Schizophrenia	-	24 (25.5)	32 (34.0)	30 (31.9)	8 (8.5)	94 (100)	15.81	.000
Drug Addiction	-	12 (25.5)	28 (59.6)	7 (14.9)	-	47 (100)	13.07	.000
Seizures			2 (66.7)	1 (33.3)	-	3 (100)	7.00	.011
Others	-	-	5 (62.5)	3 (37.5)	-	8 (100)	6.93	.032

Table 4(b) shows that the chi-square value obtained for neuroses (x^2 = 6.93, p = .000), depression (x^2 = 7.66, p = .000); schizophrenia (x^2 = 15.81, p = .000); drug addiction is (x^2 = 13.07, p = .000); seizures is (x^2 = 7.00, p = .011); and others is (x^2 = 6.93, p = .032), all are significant at levels less than 0.05. Since these p-values were less than 0.05 values, it could be said that these were factors associated with quality of life of people living with mental illness attending outpatient clinic of Neuropsychiatric Hospital, Aro, Abeokuta.

Research Question 3: What are gender differences in quality of life of people living with mental illness attending outpatient clinics in the selected hospitals?

Table 5: Results of t-test on the differences between quality of life of male and female people living with mental illness attending outpatient clinics

		Gender	**N**	**Mean**	**Std. Dev.**	**Std. Error Mean**	**t-value**	**Df**	**P**
QoL	**YABA**	Male	137	85.21	16.77	1.21	2.778	247	.000
		Female	112	90.38	17.10	1.17			
	ARO	Male	123	87.51	16.73	1.09	3.289	236	.000
		Female	115	91.27	17.31	1.17			

The results presented in Table 5 on the differences between quality of life of male and female people living with mental illness attending outpatient clinics revealed that the obtained value of t is 2.778 and 3.289 at the t-critical value of .000 for Yaba and Aro respectively. This implies that there are significant differences between quality of life of male and female people living with mental illness attending outpatient clinics in the selected hospitals. Further analysis of the result based on the respondents' mean scores reveal that female people living with mental

illness Yaba and Aro with average mean score of 90.38 and 91.27 respectively has significant quality of life more than their male counterparts with mean scores of 85.21 and 87.51.

Test of Research Hypothesis

There is no significant relationship between the type of mental illness and quality of life of people living with mental illness attending outpatient clinics of the two Federal Neuro-psychiatric Hospitals.

Table 6: Pearson Product Moment Correlation Coefficients of the types of mental illness and quality of life among people living with mental illness attending outpatient clinics of the two Federal Neuro-psychiatric Hospitals

		QoL	Neuroses	Depression	Schizophrenia	Drug Addiction	Seizures
QoL	Pearson Correlation	1	.557**	.347**	.506**	.396**	.219**
Neuroses	Pearson Correlation		1	.539**	.110**	-.106	.298**
Depression	Pearson Correlation		.539**	1	.222**	-.147**	.215
Schizophrenia	Pearson Correlation		.110**	.222**	1	.255**	.110**
Drug Addiction	Pearson Correlation		-.106**	-.147**	.255**	1**	-.014**
Seizures	Pearson Correlation		.298**	.215**	.110**	-.014**	1**

***. Correlation is significant at the 0.01 level (2-tailed).*

The results in Table 6 indicated the relationship between types of mental illness and quality of life among people living with mental illness attending outpatient clinics of the two Federal Neuro-psychiatric Hospitals. On the relationship of QoL, the table above depicts positive correlation between QoL and neuroses to be positively correlated (r = .557, p = .000). QoL was positively correlated with depression (r = .347, p = .000), schizophrenia (r = .506, p = .000), drug addiction (r = .396, p = .000), and seizures (r = .219, p< .000). Therefore, the hypothesis that stated "There is no significant relationship between types of mental illness and quality of life among people living with mental illness attending outpatient clinics of the two Federal Neuro-psychiatric Hospitals" cannot be sustained since a significant relationship exists.

DISCUSSION OF FINDINGS

Discussion on the Types of Mental Illness and Duration of Illness Among People Living with Mental Illness

It was observed that the types of mental illness among people living with mental illness in this study are schizophrenia, depression, drug addiction, neurosis, and seizure disorders while the

duration of illness reported among the respondents of this study on the average was five (5) years and above. The implication of this common diagnoses observed is characterized by behavioural or psychological impairment of functioning. Mental illness is usually associated with distress, disease, response to a particular event, or limited social relations. These diagnoses and duration of illness bring about medical or psychological conditions that disrupt person's moods, thinking, ability to cope with others and daily functions thus diminishing one's capacity for coping with ordinary demands of life. This therefore affects their quality of life.

The finding of types of mental illness and duration of illness among people living with mental illness in this study resonates with the findings of Mahmoud, et al. (2012) that identified an important consequence of schizophrenia treatment, yet the determining factors of QoL for individuals with this condition are not well known. In the submission of Huppert and Smith (2011), psychopathology appears to have the strongest link with QoL due to the heterogeneity of symptoms which falls within 'general psychopathology' category. The study further lends credence to Koivumaa-Honkane *et al* (2017) who low QoL among schizophrenic patients compared with other disorders. Similarly, Twahira, (2017) reported 83.1% of the respondents in a Kenyan study had the history of mental illness above one year. Symptoms of anxiety have also been reported as most important to QoL (Clarks & Kissane, 2017).

Discussion on the Level of Quality of Life Among People Living with Mental Illness

The outcome of this study revealed the level of quality of life among people living with mental illness. Majority of the respondents living with mental illness were found to have low level of quality of life. This is because mentally ill patients experience loss of support from family, friends or partners, resulting in small or restricted social support resources which predominantly consist of family members or mental health professionals. This social support network has been associated with isolation and depression, it also threatens psychological and emotional well-being, quality of life (QOL), and increase the likelihood of psychiatric re-hospitalization. Individuals living with mental illness experience functional impairments in daily living skills and social skills. This is in line with the findings of other researchers that many people living with mental illness do not appreciate living as they couldn't attach any significance to their existence (Brown, 2018), the society does not provide them with conducive living condition; hence, they do not believe they are relevant in the society (Aloba, Fatoye, Mapayi & Akinsulore, 2015). Their immediate living environment too does not give them a sense of belonging. Most of the times they are considered fiddle and of no value (Corring, 2015). The study further buttresses the findings of Hanson, (2017) and Baumeister, (2016) who in their separate studies affirmed that people who experience support and have sense of belonging have better QoL, those with feelings of demoralization do experience chronic distress and possible suicide (Clarks & Kissane, 2017).

Discussion on the Health-Related Factors Associated with Quality of Life

The outcome of this study revealed that all the identified health-related factors were associated with quality of life of people living with mental illness attending outpatient clinics in Neuropsychiatric Hospitals. This is because types of illness affects people living with mental illness and make them have double problem facing them that are associated with their illnesses - stigmatization (which affect poor help seeking behaviour, social exclusion, being unemployed, economical/social ruin and premature death) and subjective experience which

entails happiness, life satisfaction, well-being, social functioning and living condition. Therefore, health-related factors are correlates of quality of life.

This outcome is in line with the findings of Hsiao, Lu, and Tsai (2017) in their study who reported that lower Quality of Life (QoL) had been associated with major mental disorders, such as depression and schizophrenia. Both mental disorders are of concern to clinicians working in mental health services: Schizophrenia is the most common diagnosis among hospitalized psychiatric patients, and it is a chronic mental disorder with a debilitating course (Chi, Jeong, Lee & Kim, 2016). Functional impairment is high, leading to lost wages and work impairment, with related personal, societal, and economic burdens (Aloba, Fatoye, Mapayi & Akinsulore, 2015). Also, depression is a leading cause of disability worldwide, with depressed patients reporting lower QoL compared to other mental disorders, including schizophrenia. Similarly, the study resonates Twahira, (2017) who found depressive disorder, schizophrenia, bipolar disorder and drug abuse/alcoholism as clinical diagnoses that affect QoL.

Discussion on the Differences Between Quality of Life of Male and Female People Living with Mental Illness

The results presented in this study indicated the differences between quality of life of male and female people living with mental illness attending outpatient clinics. Further analysis of the result based on the respondents' mean scores revealed that female people living with mental illness have significant quality of life more than their male counterparts. Gender difference observed in favour of female in this study could be as a result of the fact that female tends to seek health information more than males. Also, psychological and psychosomatic illness tends to show faster in males than females. This corroborates the findings of Twahira (2017) in their separate studies reported that female schizophrenic patients who are not on psychotropic medications have higher quality of life than the males. Furthermore, findings from the study revealed positive relationship between types of mental illness (neuroses, depression, schizophrenia, drug addiction, and seizures) and quality of life among people living with mental illness attending outpatient clinics of the two Federal Neuro-psychiatric Hospitals. Many surveys have shown that quality of life especially in the area of social functioning is generally affected. Jarema et al. (2013) proved that the quality of life was correlated with schizophrenia, neuroses (Olurotimi, 2017), and depression, drug addiction, and seizures (Peltzer & Phaswana-Mafuya, 2013) Also, Choo *et al*, (2019) reported that this might be due to the high tendency to come into a state of acceptance towards themselves and their lives (Heider, et. al., 2017) hence, affecting their QoL.

SUMMARY, CONCLUSION AND RECOMMENDATIONS

Summary of Findings

Majority of the respondents in this study suffered from schizophrenia. This is followed by depression, drug addiction, neurosis, seizure disorders, and other diagnoses. Most respondents have been battling with these ailments for five (5) years and above. Majority of the respondents had low level of quality of life. Health-related factors were associated with quality of life of people living with mental illness. The common types of illness diagnosed were depression, schizophrenia, drug addiction and seizures. There is a significant difference between quality of life of male and female people living with mental illness attending outpatient clinics, which

is in favour of female people living with mental illness than their male counterparts. There is a significant relationship between types of mental illness and quality of life among people living with mental illness attending outpatient clinics of the two Federal Neuro-psychiatric Hospitals

Conclusion

From this study it can be concluded that majority of the respondents had low level of quality of life; depression, schizophrenia, drug addiction, and seizures are the illness related factors associated with quality of life of people living with mental illness attending outpatient clinics; age, gender, marital status, and religion are good correlates of quality of life of people living with mental illness attending outpatient clinics; and there is a significant difference between quality of life of male and female people living with mental illness attending outpatient clinics.

It can also be concluded that family and significant others are key to the recovery of people living with 'illness of the brain'; this included support in terms of finance, listening, being involved and identification of triggers and symptoms of the illness.

Recommendations

On the basis of the theoretical and empirical evidence provided in this study, the following recommendations are made:

1. Following the findings that people living with mental illness experience tension within themselves, it is important that those working with this group provide empathetic, non-judgemental support. This means strengthening and/or teaching counselling skills to mental health professionals, and all who support those with such experiences.

2. Rather than diagnosis, staff should have good insight into what led to the person's admission, their story forming the core of the assessment, with account being taken of their emotional state, feelings and experience of the illness.

3. Empowering patients, through information sharing regarding the illness, interventions, and the development of coping strategies to deal with the challenges they face.

4. Patients' personal values and beliefs should be supported, with emphasis being placed on helping them to achieve their aspirations.

5. The Populace should be enlightened and educated on the effect of stigmatisation of the People Living with Mental Illness (PLWMI) irrespective of the gender. Anti-stigma efforts should include interventions for People Living with Mental Illness (PLWMI) and not completely giving attention to public attitudes. There should be the conduct of awareness creation programmes through the media, colloquiums, seminars, Government and Non-Government Organisations (NGOs) about nature and management attitudes to mental illness on the general public.

Implication for Nursing Education

Basic education of nursing should include detailed aspect of reminiscence therapy with proper training on the practical application, so the nursing students will develop proper knowledge and skill on how to provide reminiscence therapy for elderly.

1. Nursing curriculum should focus on developing skills in identifying the quality of life of people living with mental illness and its management.

2. Add this subject in Complementary Alternative Modalities treatment measure to be learned by student nurse.

3. Arrange in-service education to update their knowledge regarding mentally ill clients their life facing problems in the home and in the society.

Implications of Findings to Nursing

1. The results of this study imply that nursing interventions to combat mental illness within our society must put into consideration demographic, social, and psychological factors when designing interventions for people living with mental illness. Mental health professionals and the healthcare teams to include medical doctors, nurse practitioners, and physician assistants who provide care for this population need to address the growing concern for the wellness of the people living with mental illness and their acceptability by the family as well as the community at large.

2. For patients who are being treated for mental illness, these results will better equip a nurse to provide care that is more contextually relevant. Nurses can provide more informed counselling or guidance to patients as well as the public when required, on how best to maintain wellness. Additionally, improved treatment protocols need to be in place for managing mental illness, and more data need to be analysed for predicting the future trends and treatment needs of the patients.

3. This study supports the argument for a change in health professionals' way of thinking about patients. Mental health practice in Nigeria appears to be mostly dominated by the biomedical model, and this is likely to have an influence on professionals' way of interacting with patients, but it also seems to influence participants' perception of their recovery from illness of the brain. Professionals who view people living with the illness of the brain as having potential to fulfil their dreams, goals and desires have actually helped them accomplish their dreams, and instilling hope. Therefore, changing practice in Nigeria mental health services to one whereby the medical, psychosocial and cultural aspects of peoples' lives become the focus for providing care, hopefully maximising patients' potential and enhancing their recovery.

Suggestion for further Studies

Keeping in view, the findings and limitations of the present study, the following recommendations are offered for further research:

1. The study mainly covered patients of two Federal Health Institutions in South-West; further studies can include patients of other health facilities. The research can be extended to other geo political zones in the country and also comparisons of patient in different geopolitical zones can be considered.

2. A similar study can be undertaken on a large sample in different settings.

3. A similar study can be done for destitute in homes.

4. The study can be carried out on particularly people living with mental illness on admission in both Government and Private Hospitals settings.

Contributions to Knowledge

This research work contributed to existing knowledge in the following ways:

1. This study has succeeded in widening knowledge about quality of life among people living with mental illness.
2. The study expanded the scope between male and female differences in mental health, by contributing significantly to gender role and the treatment of mental illness.
3. Academically, the study contributed significantly to the field of Nursing Sciences
4. Academically, the study widened the frontiers of quality of life among people living with mental illness
5. As regard policy formulation, the study serves as a pointer for policymakers in addressing the issue of mental illness in Nigeria.
6. The study also contributed in addressing the common diagnoses and duration of illness among people living with mental illness.
7. The study also serves as an addition to the practical knowledge of healthcare experts such as nurses in the area of awareness and sensitization about illness related factors associated with quality of life of people living with mental illness.

Limitation to the Study

This study was limited in database for mental disorders collectively, most of the data found were on specific diagnosis such as schizophrenia, mood and anxiety disorders. Also, the study area is populated by the Yoruba ethnic group who pride privacy and as such made data gathering demanding and herculean.

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