impact International Journals and Publications

© IIJP 2026 | Volume 2, Issue 4, pp. 969-985 | ISSN: 2636-4484

AVAILABILITY OF FAMILY-BASED SOCIAL WORK INTERVENTIONS FOR ADULTS LIVING WITH DEPRESSION AND SCHIZOPHRENIA IN RIVERS EAST SENATORIAL ZONE OF RIVERS STATE, NIGERIA

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ARTICLE INFO
Article No.: 0697
Accepted Date: 11/10/2026
Published Date: 09/11/2026
Type: Research

ABSTRACT

Family-based social work intervention is not a single procedure but a set of related practices, and the forms it takes in any setting depend on what the local service system can provide. This study identified the family-based social work interventions available to adults living with depression and those available for the care of adults living with schizophrenia in Rivers East Senatorial Zone of Rivers State, Nigeria. Two objectives, two research questions and two null hypotheses guided the study, which was anchored on the stress-vulnerability model. A descriptive survey design was adopted. The population was 17,153 adults (9,053 living with depression and 8,100 living with schizophrenia) receiving treatment at the psychiatric hospital, Rumuigbo, and the Rivers State University Teaching Hospital, Port Harcourt. A sample of 391 family members was determined with Taro Yamane's formula and selected through simple random, purposive and accidental sampling, and 300 correctly completed copies of the questionnaire were analysed. The instrument was validated by the supervisor and four other experts, and its reliability coefficient was 0.82 using Cronbach's alpha. The research questions were answered with mean and standard deviation, and the hypotheses were tested with the chi-square goodness-of-fit test at the 0.05 level of significance. The findings revealed that family adaptability, emotional and practical support, family counselling, and awareness creation with rapport building are available to adults living with depression (cluster mean = 3.39; $\chi^2 = 831.94$, $p < 0.001$), and that family support groups, psychoeducation, emotional support and education, and intervention resources are available for the care of adults living with schizophrenia (cluster mean = 3.40; $\chi^2 = 850.32$, $p < 0.001$). Family counselling for depression and intervention resources for schizophrenia were the least consistently available, and the pattern of availability did not differ significantly between the two conditions. The study concluded that the less intensive forms of family-based intervention are widely available in the study area, while the forms that require sustained professional contact or material support reach families unevenly. It was recommended, among others, that the two facilities formalise family-based intervention through a written protocol, that family counselling be offered routinely to households of adults living with depression, and that the Rivers State Ministry of Health provide resources for medication, transport and welfare support to families of adults living with schizophrenia.

Keywords: Family-based social work intervention, depression, schizophrenia, psychoeducation, family counselling, support groups, Rivers State

Introduction

Depression and schizophrenia are among the mental disorders that place the heaviest demands on the people who live with them, on their families and on the communities in which they live. Depression is marked by persistent low mood, loss of interest or pleasure, disturbed sleep and appetite, fatigue, poor concentration and feelings of worthlessness, and in its severe forms it is associated with suicide (Malhi & Mann, 2018). Schizophrenia is a chronic psychotic disorder characterised by hallucinations, delusions, disorganised thinking, negative symptoms such as blunted affect and loss of motivation, and cognitive impairment that often persists after the acute symptoms have settled (Marder & Cannon, 2019). Both conditions disrupt relationships, work and self-care, and both are shaped in their course by what happens inside the household. Analysis of the Global Burden of Disease Study 2016 put the number of people living with schizophrenia at about 20.9 million worldwide and showed that the disorder accounted for 13.4 million years lived with disability (Charlson et al., 2018), while the World Health Organization estimated that about 7.08 million Nigerians, or 3.9 per cent of the population, were living with depression (World Health Organization [WHO], 2017). These figures describe a burden that is carried mainly outside hospital walls, in households that receive little organised help.

The burden is compounded in low- and middle-income countries by weak mental health systems. The Lancet Commission on global mental health and sustainable development observed that the gap between need and provision is widest in these countries, where the share of health budgets allocated to mental health is small and most of it is spent on a few psychiatric hospitals (Patel et al., 2018). Nigeria fits this description closely. Specialist services are concentrated in federal neuropsychiatric hospitals, teaching hospitals and a small number of state psychiatric hospitals, financing is inadequate, and most costs are paid by households (Abdulmalik et al., 2019). The Association of Psychiatrists in Nigeria has reported that fewer than 200 psychiatrists serve a population of well over 200 million, and that three of every five specialists trained leave within a year of completing their programme (Ihejirika, 2025). Social determinants such as poverty, unemployment, insecurity and weak social protection add to the risk of mental disorder and to the difficulty of recovery (Lund et al., 2018). Because formal services are thin, relatives become the principal providers of day-to-day care: they supervise medication, meet the cost of treatment and transport, provide food and shelter, accompany the person to clinic and manage acute episodes at home.

There is good evidence that working with families improves outcomes. Family intervention after a first episode of psychosis reduces relapse and hospitalisation and improves functioning over 24 months (Camacho-Gomez & Castellvi, 2020), psychoeducation for carers of people with psychosis reduces caregiving burden and improves carers' wellbeing (Sin et al., 2017), and for depression there is preliminary evidence that family psychoeducation improves patient functioning and carers' wellbeing (Brady et al., 2017). In Nigeria and Ghana, a collaborative care programme linking traditional and faith healers with primary health care workers produced better outcomes for people with psychosis than enhanced usual care (Gureje et al., 2020). In its fullest form, family-based social work intervention includes structured psychoeducation, family counselling, emotional support for caregivers, practical help with medication and daily routine, linkage to support groups, welfare provision and vocational rehabilitation, and crisis planning. Each of these makes different demands on staff time, professional training and institutional support, and it cannot be assumed that all are equally available. In Nigerian psychiatric facilities, where social work establishments are small and

caseloads heavy, the range of interventions actually offered may be much narrower than the range described in the international literature. Establishing which interventions are available to families of adults living with depression, and which are available to families of adults living with schizophrenia, is therefore the first step in any assessment of family-based practice in the study area.

Statement of the problem

In the Rivers East Senatorial Zone of Rivers State, depression and schizophrenia represent significant mental health concerns. Families play a central role in providing care, yet cultural beliefs often frame these disorders as spiritual weaknesses or moral failings rather than medical conditions, and families frequently consult traditional and faith healers before, alongside or instead of hospital services (Esan et al., 2019). Knowledge about depression is limited, and many young Nigerians do not recognise it as an illness requiring treatment (Aluh et al., 2018). Schizophrenia is associated with high caregiver burden, emotional strain and economic hardship, and caregivers in Ghana spent an average of US$273 a month on the care of a relative with schizophrenia, with medication and transport accounting for most of the direct costs (Opoku-Boateng et al., 2017). Families who do not understand the illness, who cannot meet its costs or who have no one to turn to are likely to blame the person, to abandon treatment or to become exhausted themselves. Family-based social work intervention exists to prevent these outcomes, but its value depends on whether it actually reaches families.

The evidence on family intervention comes largely from structured programmes evaluated in service systems different from those of Rivers State, such as Australia, Japan, Hong Kong, India and Ethiopia (Brady et al., 2017; Katsuki et al., 2018; Chien et al., 2018; Patel et al., 2017; Asher et al., 2018). These studies show what family intervention can achieve when it is delivered with adequate resources, but they do not describe the family-based interventions that are routinely available in Nigerian psychiatric facilities. Without such a description, it is not possible to judge whether families of adults living with depression and schizophrenia in the study area receive the forms of support that the evidence recommends, whether some forms are missing, or whether families of adults living with one condition are better served than families of adults living with the other. No known study has identified the family-based social work interventions available to adults living with depression and schizophrenia in Rivers East Senatorial Zone of Rivers State, and this is the problem the present study set out to address.

Aim and objectives of the study

The aim of the study was to examine family-based social work interventions and adults living with depression and schizophrenia in Rivers East Senatorial Zone of Rivers State, Nigeria. Specifically, the study sought to:

1. identify the family-based social work interventions available to adults living with depression in Rivers East Senatorial Zone of Rivers State, Nigeria; and
2. identify the family-based social work interventions available for the care of adults living with schizophrenia in Rivers East Senatorial Zone of Rivers State, Nigeria.

Research questions

The following research questions guided the study:

1. What family-based social work interventions are available to adults living with depression in Rivers East Senatorial Zone of Rivers State, Nigeria?
2. What family-based social work interventions are available for the care of adults living with schizophrenia in Rivers East Senatorial Zone of Rivers State, Nigeria?

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Hypotheses

The following null hypotheses were tested at the 0.05 level of significance:

H_{01}: Family-based social work interventions are not significantly available to adults living with depression in Rivers East Senatorial Zone of Rivers State, Nigeria.

H_{02}: Family-based social work interventions are not significantly available for the care of adults living with schizophrenia in Rivers East Senatorial Zone of Rivers State, Nigeria.

Literature review

Concept of family-based social work intervention

Family-based social work intervention refers to the organised activities through which social workers engage the family of a person with mental illness as a partner in assessment, treatment, rehabilitation and recovery. The family is treated neither as a cause of the illness nor as a passive bystander, but as a system whose knowledge, relationships and resources can be strengthened for the benefit of all its members. The intervention is best understood as graded in intensity. At the most basic level it involves connecting with the family, welcoming relatives into the treatment process and providing general information about the disorder and its management. At an intermediate level it involves structured psychoeducation, practical assistance and referral to support groups and welfare services. At the most intensive level it involves family therapy or structured family intervention over several months, delivered by trained practitioners with regular supervision (Sin et al., 2017). The lower levels are inexpensive and can be delivered by any competent social worker; the higher levels require specialist training, protected time and institutional commitment. This graded conception is useful in Nigerian conditions because it allows the practice actually available in a facility to be described accurately rather than measured against an ideal that few facilities can meet. The roles of the social worker include assessment of the family's needs, strengths, beliefs and resources, education of relatives about the illness, counselling for caregivers under strain, mediation of family conflict, advocacy, linkage to welfare and community resources, and coordination with psychiatrists, nurses and psychologists, consistent with the global statement of ethical principles of the social work profession (International Federation of Social Workers [IFSW], 2018).

Family-based social work interventions for adults living with depression

Family-based interventions for depression are less developed than those for schizophrenia, but the rationale for them is strong. Depression affects the whole household, relatives often misunderstand the illness as laziness or lack of willpower, and family conflict and criticism predict relapse. Family psychoeducation provides relatives with information about depression, its symptoms, causes, course and treatment, and teaches them how to respond helpfully, so that blame and frustration are replaced with understanding (Brady et al., 2017). Couple and family therapy address relationship patterns that maintain depression, such as marital conflict, poor communication and shifts in roles within the household. Emotional and practical support is the most widely available form of family-based intervention in low-resource settings: social workers counsel relatives on how to offer encouragement without criticism, how to maintain routines of sleep, meals and activity, and how to share caregiving tasks, while behavioural activation, which encourages the person to re-engage gradually with rewarding activities, is particularly suited to family involvement (Patel et al., 2017). Social support interventions aim to rebuild the person's network of relationships, since social disconnectedness and perceived isolation predict depression (Santini et al., 2020). Awareness creation and rapport building are the foundation of family engagement, because many families first encounter mental health services after a crisis and do not understand the diagnosis they have been given.

Adaptation of the family to the illness is a further goal, since families cope best when they are flexible enough to adjust roles, routines and expectations while the person is unwell and to restore them as recovery proceeds.

Family-based social work interventions for adults living with schizophrenia

Family intervention for schizophrenia is one of the best-established psychosocial treatments in psychiatry. It emerged from research showing that patients returning to households with high levels of criticism, hostility or emotional over-involvement relapsed more often than those returning to calmer households, and that educating and supporting families could reduce relapse. Psychoeducation is the core component: relatives learn about the symptoms of schizophrenia, the role of medication and its side effects, early warning signs of relapse and what services are available, which reduces self-blame and blame of the patient and makes relatives partners in treatment (Sin et al., 2017). Communication and problem-solving training help families to express concerns without criticism and to solve practical problems together (Ma et al., 2018), and family interventions in early psychosis are associated with fewer relapses (Claxton et al., 2017). Family support groups bring together families facing similar problems, reduce isolation and allow the exchange of practical advice (Chien et al., 2018). Intervention resources for families include information materials, access to affordable medication, financial and welfare support, and links to vocational rehabilitation. Their availability is uneven in Nigeria, and without practical resources even well-informed families may be unable to sustain care (Opoku-Boateng et al., 2017).

Mental health services and social work practice in Nigeria

Mental health care in Nigeria is delivered mainly through a small number of federal neuropsychiatric hospitals, psychiatric departments of teaching hospitals and federal medical centres, state psychiatric hospitals and a growing number of private facilities. Services are concentrated in cities, community-based care is limited, and the legal framework was long criticised as outdated and not compliant with international human rights standards (Ugochukwu et al., 2020). Traditional and faith healers form a large parallel system of care; they treat many people with severe mental illness, sometimes with practices that could be harmful, but many are willing to collaborate with formal services (Esan et al., 2019). Social workers in Nigerian psychiatric facilities assess the social circumstances of patients, trace and engage families, counsel patients and relatives, support discharge and rehabilitation, and link families to welfare and community resources. They also mediate between the biomedical understanding of mental illness held by the clinical team and the explanatory models held by families, and they are often the professionals with the most time to listen to families' accounts of the illness. Their work is constrained by small establishments, heavy caseloads, limited specialist training, low recognition within medically dominated hospitals and scarce resources for practical support such as transport assistance or subsidised medication. These constraints help to explain why some family-based interventions may be available to some families and not to others.

Theoretical framework

The study was anchored on the stress-vulnerability model, also known as the diathesis-stress model. The model was formulated for schizophrenia by Joseph Zubin and Bonnie Spring in 1977 and has since been extended to depression and other disorders. It proposes that individuals differ in their underlying vulnerability to a disorder and that the disorder becomes manifest when environmental stress exceeds the threshold set by that vulnerability. Vulnerability may be genetic, neurodevelopmental or acquired through early adversity, while stress may arise from life events, chronic difficulties, substance use or the emotional climate of the household.

Contemporary research supports the model. Pruessner et al. (2017) review evidence that genetic and early environmental risk alter the brain's stress response systems, so that later stress more readily triggers psychosis, Howes et al. (2017) describe how genes, early adversity and adult stress converge on the dopamine system in schizophrenia, and in depression the interaction between vulnerability and stressful life events is a central theme of research on causation (Hammen, 2018).

The model rests on three assumptions. Vulnerability is relatively stable and differs from one person to another. Stress, whether it comes from life events, daily strains or the emotional climate of the household, varies over time and can be reduced. Illness appears, or returns, when stress rises above the threshold that the person's vulnerability allows, and protective factors such as medication, coping skills and social support raise that threshold (Pruessner et al., 2017; Hammen, 2018). The model relates directly to the two objectives of this study. Because vulnerability cannot be changed by social work, the contribution of family-based intervention lies in reducing household stress and strengthening protective factors. For depression, interventions such as family adaptability, emotional and practical support, counselling and awareness creation can lower conflict and criticism in the household, correct the belief that depression is laziness, and restore routines and relationships that protect against recurrence. For schizophrenia, psychoeducation, support groups, emotional support and intervention resources can help relatives recognise early warning signs, support medication, which protects vulnerable people against stress-triggered relapse, and reduce the financial strain that itself becomes a source of stress. Its limitation is that it treats the family mainly as a source of stress or protection acting on the individual, rather than as an interacting system whose members are all affected by the illness, and it says little about how practitioners should work with families.

Empirical review

Brady, Kangas and McGill (2017) conducted a systematic review of family psychoeducation for major depressive disorder at Macquarie University, Sydney, Australia. Ten studies based on nine distinct samples met the inclusion criteria: four single-family studies, four multifamily studies, one study comparing the two formats and one peer-led study involving mixed diagnoses. Seven of the studies measured patient functioning and six reported positive outcomes, while six measured the wellbeing of family carers and four reported positive outcomes. The authors concluded that there was preliminary evidence that family psychoeducation improves functioning for people with depression and wellbeing for their carers. Katsuki et al. (2018) carried out a randomised controlled trial in Japan in which 49 patients with chronic major depression and their families were assigned either to four sessions of brief multifamily psychoeducation or to a single counselling session. The intervention did not significantly reduce family members' psychological distress at 16 weeks, but it reduced their depressive symptoms at eight weeks and improved several dimensions of family functioning, which suggests that the intensity and duration of family psychoeducation for depression matter. Patel et al. (2017) evaluated the Healthy Activity Program, a brief behavioural activation treatment delivered by lay counsellors, among 495 adults with moderately severe to severe depression in ten primary health centres in Goa, India. Participants who received the programme had lower symptom severity and higher rates of remission than those who received enhanced usual care alone, and the programme was cost-effective, which indicates that structured support for the resumption of daily activities, in which families can take part, is a practical route to recovery where specialists are scarce.

Sin et al. (2017) conducted a systematic review and meta-analysis of psychoeducational interventions for family carers of people with psychosis and found that psychoeducation improved carers' wellbeing and reduced caregiving burden, with no significant association between the modality, duration or contact time of interventions and outcomes. Chien, Bressington and Chan (2018) randomly allocated 210 families of outpatients with recent-onset psychosis in three clinics in Hong Kong to a family-led mutual support group, a family psychoeducation group or treatment as usual; over a four-year follow-up, the mutual support group improved patient and family functioning and reduced re-hospitalisation. Asher et al. (2018) piloted community-based rehabilitation for ten people with schizophrenia and their caregivers in Sodo district, southern Ethiopia, delivered by lay workers through home visits covering psychoeducation, adherence support, family intervention and crisis management, together with family support groups. Median disability scores fell from 57.5 to 18.4 over twelve months and caregiver burden fell over the first six months, but the unaffordability of medication was a major barrier. In Ghana, Opoku-Boateng et al. (2017) studied 442 family caregivers of patients with schizophrenia in the three public psychiatric hospitals and found that the total monthly cost to caregivers averaged US$273.28, that medication and transport were the main drivers of direct costs, and that 49 per cent of caregivers reported high burden. Taken together, these studies show that family intervention is most beneficial when it is structured, sustained and accompanied by practical support, but they leave open the question of which interventions are actually available to families in routine Nigerian services, which this study addressed.

Methodology

The study adopted a descriptive survey design, which collects data from a defined group of people in order to describe the characteristics, opinions, practices or conditions that exist among them without manipulating any variable (Creswell & Creswell, 2018). The design was appropriate because the family-based social work interventions available to adults living with depression and schizophrenia already existed in the study area and could only be described as they were. The study was carried out in the Rivers East Senatorial Zone of Rivers State, Nigeria, one of the three senatorial districts of the state, which comprises eight Local Government Areas: Port Harcourt, Obio/Akpor, Okrika, Ikwerre, Emohua, Etche, Omuma and Ogu/Bolo. The zone contains Port Harcourt, the state capital, and the adjoining urban areas of Obio/Akpor, and it was chosen because it contains the two principal public psychiatric facilities in the state, which receive patients from across the district.

The population of the study consisted of 17,153 adults living with depression and schizophrenia who were receiving treatment at the psychiatric hospital, Rumuigbo, and the psychiatric department of the Rivers State University Teaching Hospital, Port Harcourt. Of these, 9,053 were adults living with depression and 8,100 were adults living with schizophrenia, as shown in Table 1. Because the respondents were the family members who accompanied these adults to hospital, each patient in the population was represented by one accompanying relative.

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Table 1: Population of Adults Living with Depression and Schizophrenia at the Study Facilities

Category	Psychiatric Hospital, Rumuigbo	RSUTH, Port Harcourt	Total	% of Total
Adults living with depression	8,053	1,000	9,053	52.8
Adults living with schizophrenia	8,000	100	8,100	47.2
Total	**16,053**	**1,100**	**17,153**	**100.0**

RSUTH = Rivers State University Teaching Hospital. Source: Fieldwork (2026).

The sample size was determined with Taro Yamane's formula for a finite population at a 95 per cent confidence level and a 5 per cent margin of error (Adam, 2020), which gave n = 17,153 ÷ [1 + 17,153 $(0.05)^2$] = 391. A multistage sampling procedure was used. In the first stage, simple random sampling by ballot was used to select two of the eight Local Government Areas in the zone, and Port Harcourt and Obio/Akpor were drawn. In the second stage, purposive sampling was used to select the psychiatric hospital, Rumuigbo, and the psychiatric department of the Rivers State University Teaching Hospital, because they are among the public facilities in the two Local Government Areas that provide care to the largest numbers of adults living with depression and schizophrenia. In the third stage, accidental sampling was used: the researcher and a trained research assistant administered the questionnaire to family members whom they met at the two facilities on clinic days and who consented to take part, until the required number had been reached. Of the 391 copies administered, 300 (76.7 per cent) were correctly completed and used for analysis. Of the 300 respondents, 180 (60.0 per cent) were female and 120 (40.0 per cent) were male, 174 (58.0 per cent) were under 28 years of age, 144 (48.0 per cent) held the West African Senior School Certificate as their highest qualification, and 170 (56.7 per cent) were single; 156 cared for adults living with depression and 144 for adults living with schizophrenia.

The instrument was a structured questionnaire titled the Family-Based Social Work Interventions and Adults Living with Depression and Schizophrenia Questionnaire (FBSWIADSQ), developed by the researcher from the objectives of the study and the literature. This paper uses Cluster B1 (items 1 to 4), which addressed the family-based social work interventions available to adults living with depression, and Cluster B2 (items 5 to 8), which addressed those available for the care of adults living with schizophrenia. All items were rated on a four-point scale of Strongly Agree (4), Agree (3), Disagree (2) and Strongly Disagree (1), used deliberately without a neutral midpoint so that respondents would indicate a direction of opinion, since relatives might otherwise be reluctant to appear critical of a service on which their family member depends. The face and content validity of the instrument were established by the researcher's supervisor and four other experts in the Department of Social Work, University of Port Harcourt, and reliability was established through a pilot study with 30 family members who were not part of the main study, which yielded a Cronbach's alpha of 0.82. Approval was obtained from the management of the two facilities, informed consent was obtained from every respondent, and respondents were told that they could withdraw at any stage without any effect on the care received by their relative.

The research questions were answered with mean scores and standard deviations. The criterion mean was (4 + 3 + 2 + 1) ÷ 4 = 2.50; an item with a mean of 2.50 or above was regarded as agreed, and a low standard deviation was taken to indicate close agreement among respondents. The hypotheses were tested with the chi-square goodness-of-fit test at the 0.05 level of significance (Field, 2018). For each hypothesis, the responses to the four items in the matching cluster were pooled, giving 1,200 responses, and the observed frequency in each response category was compared with the frequency expected if responses were spread evenly across the four categories (300 per category), using $\chi^2 = \Sigma (O - E)^2 / E$ with 3 degrees of freedom. A null hypothesis was rejected where the computed value exceeded the critical value of 7.81 and the probability value was less than 0.05, and the effect size $w = \sqrt{(\chi^2 / N)}$ was reported. As a supplementary analysis, the pooled responses for the two clusters were compared with a chi-square test of independence to establish whether the pattern of availability differed between the two conditions. The observed frequencies are those reported in Tables 2 and 3, and no additional data were collected for these tests.

Results

Research question One: What family-based social work interventions are available to adults living with depression in Rivers East senatorial zone of Rivers State, Nigeria?

Table 2: Mean Scores of the Family-Based Social Work Interventions Available to Adults Living with Depression (n = 300)

S/N	Item	SA	A	D	SD	Total	Mean	Std. Dev.	Remark
1	Family adaptability in social work interventions is available for the care of adults living with depression	218	73	8	1	300	3.69	0.53	Agreed
2	Families are offered emotional and practical support interventions which are crucial for the recovery of adults living with depression	158	127	14	1	300	3.47	0.60	Agreed
3	Family counselling services are available as an intervention for adults living with depression	152	57	52	39	300	3.07	1.09	Agreed
4	Awareness creation and rapport building with depressed adults is available to families	165	77	50	8	300	3.33	0.85	Agreed
	Cluster mean						**3.39**		**Agreed**

Key: SA = Strongly Agree (4); A = Agree (3); D = Disagree (2); SD = Strongly Disagree (1). Criterion mean = 2.50. Source: Fieldwork (2026).

Table 2 presents the mean scores of respondents on the family-based social work interventions available to adults living with depression. For item 1, respondents agreed that family adaptability in social work intervention is available for the care of adults living with depression, with a mean of 3.69 and a standard deviation of 0.53, the highest mean and the

lowest dispersion in the cluster; only 9 of the 300 respondents disagreed. For item 2, respondents agreed that families are offered emotional and practical support interventions for the recovery of adults living with depression, with a mean of 3.47 and a standard deviation of 0.60. For item 3, respondents agreed that family counselling services are available, with a mean of 3.07 and a standard deviation of 1.09; the comparatively high dispersion shows that access to counselling was uneven, and 91 respondents (30.3 per cent) disagreed or strongly disagreed that counselling was available. For item 4, respondents agreed that awareness creation and rapport building with depressed adults is available to families, with a mean of 3.33 and a standard deviation of 0.85, although 58 respondents (19.3 per cent) disagreed. All four items recorded means above the criterion mean of 2.50, and the cluster mean was 3.39. Respondents therefore identified family adaptability, emotional and practical support, family counselling, and awareness creation with rapport building as family-based social work interventions available to adults living with depression in the study area. Family adaptability was the most widely reported intervention and counselling the least consistently reported.

Research question Two: What family-based social work interventions are available for the care of adults living with schizophrenia in Rivers East senatorial zone of Rivers State, Nigeria?

Table 3: Mean Scores of the Family-Based Social Work Interventions Available for the Care of Adults Living with Schizophrenia (n = 300)

S/N	Item	SA	A	D	SD	Total	Mean	Std. Dev.	Remark
5	Family support groups are available which enable families to feel less isolated and better equipped to navigate the complexities of living with schizophrenia	166	76	46	12	300	3.32	0.87	Agreed
6	Psychoeducation is available to family members on schizophrenia, including its symptoms, treatment options and coping strategies	175	88	21	16	300	3.41	0.84	Agreed
7	Emotional support and education interventions are available to families of adults living with schizophrenia	196	86	18	0	300	3.59	0.60	Agreed
8	Intervention resources are available to families to manage adults living with schizophrenia	165	69	52	14	300	3.28	0.91	Agreed
	Cluster mean						**3.40**		**Agreed**

Key: SA = Strongly Agree (4); A = Agree (3); D = Disagree (2); SD = Strongly Disagree (1). Criterion mean = 2.50. Source: Fieldwork (2026).

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Table 3 presents the mean scores of respondents on the family-based social work interventions available for the care of adults living with schizophrenia. For item 5, respondents agreed that family support groups are available to help families feel less isolated and better able to manage life with schizophrenia, with a mean of 3.32 and a standard deviation of 0.87. For item 6, respondents agreed that psychoeducation on the symptoms, treatment options and coping strategies for schizophrenia is available to family members, with a mean of 3.41 and a standard deviation of 0.84. For item 7, respondents agreed that emotional support and education interventions are available to families of adults living with schizophrenia, with a mean of 3.59 and a standard deviation of 0.60, the highest mean and the closest agreement in the cluster; no respondent strongly disagreed with this item. For item 8, respondents agreed that intervention resources are available to families to manage adults living with schizophrenia, with a mean of 3.28 and a standard deviation of 0.91, the lowest mean and the widest dispersion in the cluster, and 66 respondents (22.0 per cent) disagreed. All four items recorded means above the criterion mean, with a cluster mean of 3.40. Respondents therefore identified family support groups, psychoeducation, emotional support and education, and intervention resources as family-based social work interventions available for the care of adults living with schizophrenia. Emotional support and education was the most widely reported and the provision of intervention resources the least widely reported.

Test of hypotheses

H_{01}: Family-based social work interventions are not significantly available to adults living with depression in Rivers East Senatorial Zone of Rivers State, Nigeria.

Table 4: Chi-square Goodness-of-Fit Test on the Availability of Family-Based Social Work Interventions to Adults Living with Depression (Items 1 to 4)

Response	O	E	O − E	$(O - E)^2$	$(O - E)^2/E$
Strongly Agree	693	300	+393	154,449	514.83
Agree	334	300	+34	1,156	3.85
Disagree	124	300	−176	30,976	103.25
Strongly Disagree	49	300	−251	63,001	210.00
Total	**1,200**	**1,200**			**831.94**

$\chi^2 = 831.94$; df = 3; critical value at 0.05 = 7.81; $p < 0.001$; w = 0.83. Decision: H_{01} rejected. Observed frequencies are the pooled item responses in the matching table. Source: Fieldwork (2026).

Table 4 shows that the computed chi-square value of 831.94 exceeds the critical value of 7.81 at 3 degrees of freedom, and the associated probability value is less than 0.001. The null hypothesis is therefore rejected. Strongly Agree responses (693) exceed the expected frequency of 300 by 393, while Disagree (124) and Strongly Disagree (49) responses fall well below it, so that 85.6 per cent of the 1,200 responses lie in the two agreement categories. Family-based social work interventions are therefore significantly available to adults living with depression in Rivers East Senatorial Zone of Rivers State. The effect size of 0.83 is large.

H_{02}: Family-based social work interventions are not significantly available for the care of adults living with schizophrenia in Rivers East Senatorial Zone of Rivers State, Nigeria.

Table 5: Chi-square Goodness-of-Fit Test on the Availability of Family-Based Social Work Interventions for the Care of Adults Living with Schizophrenia (Items 5 to 8)

Response	O	E	O − E	$(O - E)^2$	$(O - E)^2/E$
Strongly Agree	702	300	+402	161,604	538.68
Agree	319	300	+19	361	1.20
Disagree	137	300	−163	26,569	88.56
Strongly Disagree	42	300	−258	66,564	221.88
Total	**1,200**	**1,200**			**850.32**

$\chi^2 = 850.32$; df = 3; critical value at 0.05 = 7.81; $p < 0.001$; w = 0.84. Decision: H_{02} rejected. Observed frequencies are the pooled item responses in the matching table. Source: Fieldwork (2026).

Table 5 shows that the computed chi-square value of 850.32 exceeds the critical value of 7.81 at 3 degrees of freedom, and the associated probability value is less than 0.001. The null hypothesis is therefore rejected. Strongly Agree responses (702) exceed the expected frequency of 300 by 402, while Disagree (137) and Strongly Disagree (42) responses fall well below it, and 85.1 per cent of responses lie in the two agreement categories. Family-based social work interventions are therefore significantly available for the care of adults living with schizophrenia in Rivers East Senatorial Zone of Rivers State. The effect size of 0.84 is large.

Table 6: Comparison of Pooled Responses on the Availability of Interventions for Depression and Schizophrenia

Cluster	SA	A	D	SD	Total
Interventions for depression (items 1 to 4)	693	334	124	49	1,200
Interventions for schizophrenia (items 5 to 8)	702	319	137	42	1,200
Total	**1,395**	**653**	**261**	**91**	**2,400**

Chi-square test of independence: $\chi^2 = 1.59$; df = 3; $p = 0.66$. Decision: no significant difference. Source: Fieldwork (2026).

Table 6 compares the pooled responses for the two clusters. The chi-square test of independence gave a value of 1.59 with 3 degrees of freedom and a probability value of 0.66, which is greater than 0.05. The pattern of responses on the availability of interventions for depression therefore does not differ significantly from the pattern for schizophrenia, which is consistent with the almost identical cluster means of 3.39 and 3.40.

Discussion of findings

The first finding is that four family-based social work interventions are available to adults living with depression in the study area: family adaptability in social work intervention, emotional and practical support, family counselling, and awareness creation with rapport building, a result confirmed by the test of the first hypothesis. The pattern within the cluster is revealing. Family adaptability recorded the highest mean and the lowest dispersion, which indicates broad agreement that services work with the household's capacity to adjust its arrangements, while counselling recorded the lowest mean and much the highest dispersion, and

close to a third of respondents did not consider it available. This pattern is consistent with the graded conception of family-based intervention, in which the less intensive forms of engagement, such as connecting with families and providing information and encouragement, are widely delivered because they are inexpensive, while the more intensive forms that require sustained professional contact are delivered inconsistently (Sin et al., 2017). It also reflects the constraints of mental health services in Nigeria, where underfunding, a small workforce and the concentration of resources in a few hospitals limit what can be offered to families (Abdulmalik et al., 2019; Ihejirika, 2025).

The finding that emotional support and awareness creation are available agrees with the review by Brady et al. (2017), which found that family psychoeducation for depression, of which information and support are the core, improves patient functioning and carers' wellbeing. At the same time, the trial by Katsuki et al. (2018) suggests that brief psychoeducation alone may not reduce relatives' distress, which implies that the uneven availability of counselling in the study area is a real limitation rather than a minor gap. The availability of practical support and encouragement for the resumption of daily activity is supported by the evidence from Goa, where a brief behavioural activation programme delivered by lay counsellors improved severe depression (Patel et al., 2017), and by evidence that combined psychological and pharmacological treatment is more effective than medication alone (Cuijpers et al., 2020). From the standpoint of the stress-vulnerability model, these are protective inputs: adaptability and practical support restore routines, and awareness creation corrects the belief that depression is laziness, both of which lower the stress in the household that can push a vulnerable person past the threshold of relapse (Hammen, 2018). Counselling, which works most directly on conflict and criticism in the household, is the protective input that families are least likely to receive.

The second finding is that four interventions are available for the care of adults living with schizophrenia: family support groups, psychoeducation, emotional support and education, and intervention resources, a result confirmed by the test of the second hypothesis. Emotional support and education recorded the highest mean and intervention resources the lowest, which suggests that what services supply most readily is information and encouragement rather than material or practical help. The reported availability of psychoeducation is important given the weight the literature places on it. Psychoeducation for families of people with psychosis reduces caregiving burden and improves carers' wellbeing (Sin et al., 2017), family intervention after a first episode of psychosis reduces relapse and hospitalisation for up to two years (Camacho-Gomez & Castellvi, 2020), and family-led mutual support groups reduced re-hospitalisation and improved patient and family functioning over four years in Hong Kong (Chien et al., 2018). The finding that support groups are reported as available is encouraging, since such groups are relatively inexpensive and can be sustained by families themselves.

The relatively low rating and wide dispersion of intervention resources, however, point to a practical limitation that the African literature has repeatedly identified. In Ethiopia, community-based rehabilitation improved functioning through family support and access to care, but the unaffordability of antipsychotic medication was a major barrier (Asher et al., 2018), and in Ghana medication and transport accounted for most of the direct costs borne by caregivers (Opoku-Boateng et al., 2017). The stress-vulnerability model explains why this matters. Medication is the principal protective factor against stress-triggered relapse in schizophrenia (Howes et al., 2017; Pruessner et al., 2017), and the cost of treatment is itself a chronic source of strain on the household, so that a family that understands the illness but cannot afford medication or transport remains exposed on both counts. The supplementary comparison showed that the

pattern of availability did not differ significantly between the two conditions, which suggests that the two facilities offer families of both groups a similar level of support, built mainly from information, encouragement and adaptation.

Limitations of the study

The findings should be read in the light of some limitations. First, availability was measured through the reports of relatives who accompany adults to hospital, so households that have disengaged from care are absent from the sample, and the reports do not show how often or how intensively each intervention was delivered. Second, all 300 respondents rated both clusters, so that relatives of adults living with depression also rated the interventions for schizophrenia and the reverse; their ratings of the condition that does not affect their own household may reflect what they observed at the facility rather than what they received. Third, the chi-square tests pooled the responses to all the items in each cluster, so that each respondent contributed more than one response to each test; the results describe the overall direction of opinion and should not be read as proof that every intervention reaches every family.

Conclusion

The study concludes that family-based social work interventions are significantly available to adults living with depression and for the care of adults living with schizophrenia in Rivers East Senatorial Zone of Rivers State. For depression, family adaptability, emotional and practical support, family counselling, and awareness creation with rapport building are available; for schizophrenia, family support groups, psychoeducation, emotional support and education, and intervention resources are available. The forms of intervention that are inexpensive and can be delivered in the course of routine contact are widely available, while family counselling for depression and intervention resources for schizophrenia, which require sustained professional time or material support, reach families unevenly. Because these two forms bear most directly on household conflict and on access to medication, the protective inputs that the stress-vulnerability model identifies as most important are the ones families are least certain to receive.

Recommendations

Based on the findings, the following recommendations were made:

1. The management of the psychiatric hospital, Rumuigbo, and the Rivers State University Teaching Hospital should formalise family-based intervention through a written protocol that specifies the interventions to be offered to every family of an adult living with depression or schizophrenia.
2. Family counselling should be offered routinely, and not only on request, to households of adults living with depression, with attention to communication, criticism and the sharing of caregiving tasks.
3. The Rivers State Ministry of Health should provide intervention resources for families of adults living with schizophrenia, including subsidised medication, transport support and links to welfare and vocational rehabilitation, and should include mental health care in the state health insurance scheme.
4. Social workers in the two facilities should strengthen family support groups and structured psychoeducation, delivered in local languages and integrated with routine clinic visits, so that every contact with the family becomes an opportunity for education.
5. The Rivers State Government should strengthen the social work establishment in psychiatric facilities, so that the more intensive forms of family-based intervention can be delivered to all families who need them.

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