

THE BLURRED BOUNDARY BETWEEN SUBSTANCE-INDUCED PSYCHOSIS (SIP) AND SCHIZOPHRENIA IN SOUTHWEST NIGERIA: CHALLENGES FOR DIAGNOSIS AND SOCIAL WORK PRACTICE.

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Abstract

The diagnostic boundary between substance-induced psychosis (SIP) and primary schizophrenia presents a profound challenge in mental health practice globally, yet this challenge acquires distinctive dimensions in Southwest Nigeria, where rising substance abuse rates intersect with severe shortages of psychiatric professionals, deeply embedded cultural interpretations of madness, and the near-absence of integrated social work services. This conceptual paper examines the clinical, cultural, and structural factors that render this differential diagnosis particularly problematic in the region, while also exploring the implications for social work intervention. Drawing on secondary data from epidemiological reports, clinical studies, and policy documents, the paper argues that the SIP-schizophrenia distinction which is already contested in psychiatric literature becomes further complicated in Southwest Nigeria by distinctive patterns of polysubstance abuse involving cannabis, tramadol, codeine, and methamphetamine; by traditional causal frameworks that attribute psychotic symptoms to spiritual attack or moral failure; and by a healthcare infrastructure that precludes the longitudinal observation essential for accurate diagnosis. The analysis reveals that social work practice in Nigeria remains strikingly underdeveloped in this domain, with fewer than 150 psychiatric social workers serving a population exceeding 200 million. The findings underscore that resolving the diagnostic boundary question requires not merely enhanced clinical protocols but a fundamental reconfiguration of how Nigerian communities understand, respond to, and support individuals experiencing substance-related psychotic phenomena. The paper proposes a culturally attuned, multi-tiered framework for assessment and intervention that leverages existing community structures while advocating for systemic workforce development.

Keywords: substance-induced psychosis, schizophrenia, differential diagnosis, social work practice.

1. Introduction

Globally, 15% of the population experienced mental health issues in 2023, 71% of global

mental health disorder will be avoided if patients access the appropriate treatment, and 17% of the total years lived in disability are caused by mental health disorders. The Global Burden of Disease's data showed that mental health disorders have moved in rank from 12th to 5th among disease-causing health loss worldwide between 1990 and 2023. The prevalence of this disease had become more evident immediately after the COVID-19 pandemic in 2020, and researchers are preparing for the next shock that may affect the mental health of the world population, like an economic shock or conflict shock (war), as it is evident right now Institute of Health Metrics and Evaluation (IHME 2026),

According to a Ferrari (2023), an associate professor at the IHME "It's important for us to learn from [COVID-19] so we're better prepared for the next population shock that comes along, whether it's an economic shock or a shock around conflict, war, and violence – all these things that we already know do impact the prevalence of mental disorders." (*Mental Health*, 2023). Mental disorders have been a significant public health issue and the leading cause of the global health-related burden. Psychosis is defined as a loss of contact with reality that is mostly characterized by hallucinations and delusions. Schizophrenia is a type of mental disorder that involves the continuous occurrence of psychosis, with hallucinations, delusions, and disorganized thinking (these are called the positive symptoms) that last for at least 6 months. Patients are often socially withdrawn, presenting decreased emotional expression and reduced motivation (positive symptoms). Symptoms normally commence gradually at the adolescent stage and for some people, never resolve (Moini et al., 2021)

Notably, schizophrenia is a chronic and severe mental illness with a considerably high percentage in the global disease burden and was ranked among the top 15 leading causes of disability worldwide in 2016. Schizophrenia is a divergent condition with many different symptomatic presentations. Its origin is unknown but likely involves genetic and environmental factors. There are multiple different neurotransmitters involved, including dopamine, glutamate, and serotonin. Schizophrenia is an umbrella nomenclature with several different neurobiological causes, and what we consider to be schizophrenia has several distinct conditions. (Faden and Citrome 2022).

Moreno-Küstner et al. (2018) noted that although schizophrenia is classified as a low-prevalence disorder, its economic burden was estimated to range from 0.02% to 1.65% of gross domestic product, and this brings us to the perspective of the high-income countries (HICs) on schizophrenia. Deinstitutionalization is applicable in HICs, and this involves taking care of schizophrenia patients in an organized community rather than psychiatric facilities, that is, simply moving care and treatment from psychiatric hospitals to community-based settings. Dell and Kinlaw (2007) describe this as a complex process in which the reduction of beds in stand-alone mental hospitals is associated with the implementation of a network of community alternatives that can avoid the institutionalization of individuals with mental illness. The bottom line is the fact that HICs possess the capacity to support the sophisticated machines and methods, up-to-date diagnostic tools needed, for instance DSM-5 and ICD-11, and the human resources required for efficiency.

Conversely, in low and middle-income countries (LMICs), the narrative is different. According to a study carried out by Te Lee et al. (2018), a strong association was discovered between low income and schizophrenia, a study carried out among the Taiwanese population. Further studies by Sach et al. (2024) highlight several costs associated with schizophrenia that may make LMICs lack the capacity to care for this severe mental disorder, and more, these

include both direct and indirect costs. Direct costs consisting of hospitalizations, outpatient visits, medication, long-term care; Indirect costs like unemployment, productivity loss, premature mortality, informal caregiving, disability, reduced quality of life, stigma, caregiver stress etc. The cost of bearing this burden is high for an economy stricken with poverty, insecurities, famine, inflation, and other issues that characterize most LIMCs.

Belief and cultural systems determine a lot of issues associated with schizophrenia in sub-Saharan Africa (SSA), a research on Psychosocial rehabilitation of individuals with schizophrenia by Oyelade and Nkosi-Mafutha (2022) report that the belief in schizophrenia being self-inflicted always affect the intervention plan by caregivers and carers, other issues as treatment gaps, unavailability of the state of the art machines in the available psychiatric hospitals and other factors shaped the disposition to mental disorder in SSA. In Africa, mental illness accounts for 18% of a life lived with disability. If an individual has a mental illness for 10 years, the person will be utterly dependent for 2 years of his/her life. Moreover, there is a 40–60% chance of premature death in people with schizophrenia.

In the Nigerian perspective, the attitude towards schizophrenia or any other mental disorder is pluralistic as the illness is approached through the medical, traditional, and spiritual angles. There is a shortage of both mental health facilities and psychiatric doctors in Nigeria. Falodun (2022) corroborates that aside from the exorbitant medical bills, several factors plague Nigeria's mental health system. The data on mental health professionals is hard to come by, but there are only 250 registered psychiatrists. Meanwhile, 1 in every 4 Nigerians is reported to be mentally ill, and with only 8 federal neuropsychiatric hospitals in Nigeria, a country with a population of over 200 million. An important factor to consider is the causal factor of schizophrenia. Falodun, in his interview with a traditional healer, believes that schizophrenia is caused by three major factors: heredity, intake of illicit drugs, and spiritual attack (perhaps the individual is being punished for offending some persons.)

In the southwestern part of Nigeria, the exposure to illicit drugs and other substances is high and mimics the positive symptoms of schizophrenia. The co-occurrence of psychoactive substance use and other mental disorders is a major challenge to the management of both conditions in several parts of the world. There is relatively insufficient data on co-morbidity and its predictors in Nigeria. (Okpataku et al., 2014). Several factors contributes to this blurry line between schizophrenia and substance induced disorder, they include: non accessibility to proper diagnosis, preference for traditional healers, according to Anjorin and Wada (2022) reported that almost 80% of people going through mental health disorders cannot afford the medical and financial burden attached to it and this is worse in the rural setting where accessibility is limited.

A substantial global body of evidence is showing an association between adolescent use of cannabis and the onset of schizophrenia. Research findings in Nigeria also corroborate this global research that schizophrenia is common among users of cannabis. Lasebikan and Aremu (2016). There are two major categories of causal factors of schizophrenia: the biological and the social determinants. Biological includes the genetic aspect of the causes, while the social aspect involves the environmental factors that are external and avoidable. Under the environmental causes would be family dynamics, trauma, and the use of drugs or other harmful substances. The essence of the study is to shed light on the thin line between the primary causes of schizophrenia and substance-induced disorder since they present with the same symptoms of psychosis on several occasions. Substance abuse is prevalent in the south-

western Nigeria currently, and this could be a trigger for those who were already at risk of developing this mental disorder; thus, an upsurge in the cases of schizophrenia is recorded. This problem of non-definition between schizophrenia and substance-induced disorders will lead to misdiagnosis, which in turn slows or hinders recovery, stigmatization, and wrong intervention or treatment plans.

2. CONCEPTUAL CLARIFICATION

Schizophrenia

Barnhill et al. (2023) posit that “Schizophrenia is the prototypical psychotic disorder. Not only is it the most common psychosis, but schizophrenia tends to involve abnormalities in all five of the emphasized symptom domains: hallucinations, delusions, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms.” The Diagnostic and Statistical Manual of Mental Disorders DSM-5 (2013) explains the symptoms clearly, firstly, delusions are fixed beliefs that don’t change in the light of conflicting evidence, and delusions are many, including Persecutory (belief that someone or an organisation is out to harm one), Referential (beliefs that comments, cues, or gestures are directed at oneself). These are the two most common presented by patients.

Secondly, Hallucinations are perception-like experiences that occur without external evidence or stimuli. Auditory hallucinations are hearing voices, either familiar or unfamiliar, that seem distinct from one’s own thoughts. Thirdly, Disorganized thinking or speech, which is presented as a lack of coherence and is most of the time incomprehensible to the listeners. Fourthly, grossly disorganised and abnormal motor behaviour, which may present from silliness to agitation and catatonia, which is a lack of reaction to the immediate environment, and lastly, the negative symptoms, which are all forms of social withdrawal, including decreased emotional expression and avolition (decreased involvement in activities that give pleasure) (DSM-5 2013).

Research has not identified a single cause of schizophrenia. However, it is thought that an interaction between genetic and environmental factors may be responsible for schizophrenia. Psychosocial factors may also trigger the onset and aggravation of the disorder; heavy use of cannabis is associated with its elevated risks (WHO, 2025). It can be inferred that biopsychosocial factors both cause and trigger the disorder.

The Ancestral African Population (2026), “no single gene causes schizophrenia. Rather, many different genes are involved, with each patient carrying one or more severe mutations. Most genetic studies of schizophrenia to date have been carried out in people of European and Asian descent. However, African populations harbor the greatest genetic diversity because most of human evolution occurred there. A relatively small number of people, 50,000 to 100,000 years ago, emigrated to establish other populations.” (Genes Linked to Schizophrenia Identified in Ancestral African Population, 2026). Based on further research and an autopsy report, there is evidence of dopamine dysfunction and an increased number of dopamine receptors in the brains of patients. Most antipsychotics have affinity for dopamine receptors. This is a hormonal factor that is part of the biological factors that cause schizophrenia. Also, prenatal stress, for example, pregnancy complications, and oxygen deprivation to the brain at birth, can be a determining factor for the disorder (Seeman, 2001).

Early childhood trauma is a psychological factor that can lead to psychosis (Popovic et al. 2019). The connection between childhood trauma, familial liability, and the onset of psychosis is increasingly being labelled as one of the key mechanisms of the proposed “affective pathway” to psychosis. This reiterates that childhood abuse, neglect, and trauma correlate with the onset of psychosis in some individuals. Urbanization comes with stress and lots of adjustment, migration, discrimination, isolation, stigmatization, and substance abuse are all social factors that trigger schizophrenia, particularly at the adolescent stage, which is the common onset stage of the disorder. (Vassos et al. 2012). Gove (2024) defined Substance-Induced-Psychosis (SIP) as a temporary drug-related mental health condition that involves the development of psychotic symptoms such as hallucinations, delusions, and disorganized thinking as a result of the use or withdrawal of the use of some substances. The specific symptoms of a substance-induced psychotic disorder can vary depending on the type of substance involved, the amount consumed, and the individual’s unique physiology and mental health history. However, the symptoms can make it difficult to evaluate if it is the onset of schizophrenia or the impact of the substance or illegal drugs.

Some people who experience substance-induced psychosis later develop an enduring psychotic disorder such as schizophrenia. In the south-western region of Nigeria, there are a couple of illegal substances that could trigger psychosis in adolescents and adults, respectively, for example, tramadol, an opioid medicine used for short-term pain relief, and for chronic pain. Tramadol works directly on opioid receptors in the central nervous system and reduces feelings of pain by interrupting the way nerves signal pain between the brain and the body. It also increases the amounts of serotonin and noradrenaline in the brain, which helps with pain relief (Health direct Australia, 2023). Gove (2024), classified them as Stimulants (e.g., cocaine, methamphetamine, amphetamines), Hallucinogens (e.g., LSD, PCP, psilocybin), Cannabis (marijuana), Opioids (e.g., heroin, prescription painkillers), Alcohol, certain prescription medications (e.g., corticosteroids, antidepressants) and stressed that users with family history of mental health conditions are likely to develop schizophrenia or bipolar affective disorder.

3. Theoretical Framework

Consequent to establishing a relationship between schizophrenia and substance-induced psychosis, there is a need to adopt theoretical perspectives that will explain these disorders and their interconnectivity. This paper adopts the Diathesis-stress Model as a framework to explain the relationship between biological disposition and environmental exposure. The Vulnerability Stress Model also called Diathesis-Stress Model is a psychological theory that explains how biological dispositions and environmental stressors can determine the onset and severity of mental disorders. This theory is not the work of a single person but the evolution of thoughts showing the relationship existing between individual susceptibility and influence of environmental stress. Sussman (2023) posits that the Diathesis-Stress Model suggests that mental disorders arise from the interaction of an underlying vulnerable condition e.g. genetics, hormone and neurochemistry (diathesis) and external stressors. An individual may have a predisposition to a disorder, but it’s the combination of this vulnerability and adverse life events that triggers its manifestation. It is concerning that patients with schizophrenia have a five-times greater likelihood of suffering from a Substance Induced Psychosis compared to the general population.

Substance-induced psychosis could be externally triggered, but it does not happen in isolation. Susceptible individuals are more likely to present persistent psychotic symptoms following substance use (Volkow et al. 2019). Thus, the vulnerability stress model provides a comprehensive explanation for the blurred boundary between schizophrenia and substance-induced psychosis. This model also explains why some people, like 25%, recover from substance-induced psychosis, and others end up with schizophrenia

4. Methodology

This paper employs a conceptual and content research design grounded in the systematic synthesis and critical analysis of secondary data sources. The methodology aligns with established approaches for conceptual papers in the social and health sciences, which prioritise the integration and theoretical interrogation of existing knowledge to generate new insights, frameworks, or “problematizations” (Jaakkola, 2020). Data sources included peer-reviewed journal articles identified through searches of PubMed, PsycINFO, Scopus, and African Journals Online (AJOL) using combinations of search terms including "substance-induced psychosis," "schizophrenia," "cannabis psychosis," "Nigeria," "Yoruba mental health," "social work Nigeria," and "global mental health Africa."

The Clinical Landscape in Southwest Nigeria: A Critical Analysis

The clinical reality of diagnosing and managing psychosis in Southwest Nigeria has little resemblance to the theoretical approach obtained in psychiatric textbooks. Consider a typical pathway - an individual experiencing psychotic symptoms is brought by family members to one of the region's psychiatric facilities. In the public sector, these include the Neuropsychiatric Hospital, Aro (Abeokuta), the Neuropsychiatric Hospital, Yaba (Lagos), and the psychiatry departments of teaching hospitals in Ibadan, Ife, Lagos, and Ekiti. In the private sector, a different mix of formally registered psychiatric clinics, faith-based healing centres, and traditional herbalist compounds offer services of varying quality and philosophical orientation. At the public hospitals, the clinical process is cumbersome where a consultant psychiatrist may see forty or more patients during a typical outpatient clinic session, with timing of assessments rarely exceeding fifteen to twenty minutes (Lebimoyo, 2025), - we can infer from this example that with such time constraints, the medical observation to distinguish SIP from schizophrenia is simply lost.

Moreover, collateral history from family members is often fragmented because the family member accompanying the patient may not be the one with the most comprehensive knowledge of the patient's substance use or premorbid patterns. Toxicology screening can confirm recent substance use but cannot establish whether that use is causally related to the psychosis or a mere coincidence. In this jammed clinical environment, diagnostic decision can become a herculean task. On the other hand, the presence of a positive substance use history, particularly for cannabis, frequently leads to a working diagnosis of SIP with the clear expectation that symptoms will resolve with abstinence in addition to the introduction of brief antipsychotic treatment, yet this expectation is mostly disappointing.

Patients with genuine SIP who would recover fully with abstinence and time-limited treatment may initially receive a schizophrenia diagnosis, and this comes with attendant implications of long-term medication and social stigma, in a cultural context where mental illness carries profound stigma that extends beyond the individual to the entire family lineage, the consequences of this misdiagnosis cascade through marriage prospects, employment opportunities, and community standing (Labinjo et al., 2020).

The Specific Challenge of Polysubstance Use

The challenge of diagnosis is compounded by the pattern of polysubstance use that characterises substance abuse in contemporary Southwest Nigeria. The era of single use of substance (the patient who only smoked cannabis or only drank alcohol) has given way to combinations involving cannabis, tramadol, codeine, benzodiazepines, alcohol, and methamphetamine (Nelson et al., 2022). Each of these substances carries its own psychotic potential and its own characteristic effects and temporary course, making it extraordinarily difficult to attribute a psychotic episode to any single agent and predict its likely trajectory. Tramadol has emerged as a substance of concern. Initially diverted from legitimate pharmaceutical channels for its analgesic use, presently a high-dose tramadol (often 200mg to 500mg daily is far exceeding therapeutic ranges) is now widely available in street markets across Southwest Nigeria. Chronic high-dose tramadol use is associated with a distinctive neuropsychiatric symptom that includes psychosis, seizures, and cognitive impairment (Bassiony et al., 2021). Yet because tramadol is frequently used in combination with cannabis, the relative contribution of each substance to psychotic presentations becomes a matter of conjecture rather than confident clinical determination (Dumbili & Ebuonyi, 2022).

The synthetic cannabinoid phenomenon adds yet another layer of complexity. Products marketed as "Colorado," "Loud," or "Black Mamba" circulate in urban centres, containing synthetic cannabinoid receptor agonists of varying potency and purity. These compounds, originally developed as research chemicals, can produce psychotic reactions of extraordinary severity and persistence, sometimes lasting months beyond the period of intoxication (Cohen et al., 2020). Their exact composition is unknown and standard urine toxicology screens do not detect them, their role in psychotic disorders is underestimated. Clinicians in Lagos and Ibadan report seeing young men with severe, treatment-resistant psychosis and the only identified risk factor is the use of these synthetic products, yet the absence of confirmatory testing leaves the diagnostic picture permanently blurry (Odeigah et al., 2025).

Cultural Dimensions of the Diagnostic Boundary

The diagnostic distinction between substance-induced and primary psychosis is clinically meaningful within a medical world but intersects in complex ways with Yoruba cultural understandings of altered mental state. These intersections create challenges and opportunities for diagnostic practice and social work intervention. Among the Yorubas, the concept of "*were*" often interpreted as "madness" in English encompasses a range of behavioural display that would be classified in Western psychiatry as psychotic disorders, substance intoxication, personality disorders, or symptoms of acute stress. Crucially, Yoruba

medicine attends closely to causation and moral valence in ways that DSM criteria do not. A psychotic episode attributed to spiritual attack (*ogun*) carries different implications for the affected individual's moral status and prospects than an episode attributed to hereditary predisposition (*aisan idile*) or to the consequences of personal sins (*ese*) (Adeyemi, 2024).

Substance use occupies an ambiguous position within these cultural frameworks. On one hand, deliberate intoxication with psychoactive substances is generally understood as a choice for which the individual bears some measure of responsibility. A family may be less obliged to extend support to a relative whose psychosis is perceived as self-inflicted through drug use than to one whose psychosis is understood as an affliction from external spiritual forces. On the other hand, the medical explanation that connect psychosis to brain disruption is available as an alternative explanation among educated urban populations, and this may water down some of the moral disapproval associated with substance-related presentations.

The cultural diagnosis can also shape the perceived boundary between substance-induced and primary psychosis in ways that divert from psychiatric understanding. Hallucinations and delusions with spiritual content, hearing the voice of a deceased ancestor, believing oneself to be under spiritual attack may be interpreted differently depending on the social context and the individual's original standing. Among Yoruba communities, such experiences are not inevitably misdiagnosed; they may under certain circumstances be understood as genuine spiritual communications or as signs of emerging spiritual giftedness rather than as symptoms of illness (Adewuya et al., 2022). A young person who reports hearing voices after using cannabis may be taken to a spiritualist or aladura church rather than a psychiatric clinic, the family might interpret the substance use as an "opened a door" to the spiritual realm rather than having a case of psychosis.

These cultural dynamics carry direct implications for the social work role. Social workers operating in Southwest Nigeria must develop sufficient cultural competence to engage respectfully with families' explanatory models while also providing accurate information about the physiological understanding of substance-psychosis relationships. This is not a matter of replacing traditional methods with Western ones, but of facilitating a dialogue in which multiple methods can coexist and inform practical decision-making about care and support (Ikwuka et al., 2020).

Barriers to Accurate Diagnosis

Beyond the clinical and cultural scopes, structural features of the Nigerian mental health system systematically impede accurate differential diagnosis between SIP and schizophrenia. These structural barriers operate at multiple levels: workforce, infrastructure, policy, and financing. The workforce deficit in Nigerian mental health care is well-documented. With approximately 250 psychiatrists serving a population exceeding 200 million, the ratio of roughly 1 psychiatrist per 800,000 population is among the lowest globally (WHO, 2021). The distribution is heavily skewed toward urban centres in the southern regions, with Southwest Nigeria relatively better served than other zones, yet still grossly inadequate relative to need. The numbers for other mental health professionals are disastrous; fewer than 150 psychiatric social workers, perhaps 300 clinical psychologists, and an uncertain but small number of psychiatric nurses with specialised mental health training (Federal Ministry of Health Nigeria, 2023).

This workforce deficit translates directly into the diagnostic practices described earlier, compressed clinical appointments, limited opportunity for longitudinal observation, and reliance on heuristic shortcuts. Even when a psychiatrist suspects that a patient initially diagnosed with SIP may have schizophrenia, the system provides few mechanisms for systematic follow-up and diagnostic revision. Patients discharged from inpatient care may be scheduled for outpatient follow-up in three or six months, but attendance rates are low, driven by the costs of transportation, the need to take time from work, and the diminishing urgency once acute symptoms have subsided (Akinyemi et al., 2023).

The infrastructure for diagnostic clarification is also insufficient. While the major neuropsychiatric hospitals in Abeokuta and Lagos have access to basic laboratory services and, neuroimaging machines, these resources are not available at the general hospital psychiatry units or primary care centres where many patients first present. Urine toxicology typically screens only for a limited panel of substances and cannot detect synthetic cannabinoids or reliably quantify levels of prescription medications like tramadol. The advanced neuroimaging techniques that have illuminated structural and functional brain differences between SIP and schizophrenia in research settings are entirely unavailable for routine diagnostic purposes in Nigeria.

Policy and financing arrangements further compound these challenges. Nigeria's Mental Health Act, finally signed into law in 2023 after decades of advocacy, establishes a framework for mental health service delivery, but implementation remains in its earliest stages (Federal Republic of Nigeria, 2023). The National Health Insurance Scheme covers only a limited package of mental health services, and most of the mental health expenditure is out-of-pocket, borne directly by families (Ugochukwu et al., 2024). This financing model creates perverse incentives for diagnostic practice. Families paying out-of-pocket for psychiatric care are eager for a clear diagnosis and a defined treatment plan; the ambiguity inherent in the early stages of SIP when statement like "we need to observe over time to know whether this is drug-induced or a longer-term condition" can feel evasive and unsatisfactory, pressuring clinicians toward premature diagnostic closure too.

Social Work Practice: Current Realities and Untapped Potential

Social work occupies a peculiar position within Nigerian mental health care. Acknowledged in policy documents as an essential component of the multidisciplinary team, but almost absent from most clinical settings. This section examines the current state of psychiatric social work in Southwest Nigeria, identifies the distinctive contributions that social workers could make to addressing the diagnostic boundary challenge, and analyses the barriers that constrain the profession's development. The origins of psychiatric social work in Nigeria trace to the colonial period, when the first social welfare officers were appointed to address juvenile delinquency and family disruption in urban centres. The profession developed gradually through the post-independence decades, with the establishment of social work training programmes at the University of Ibadan (1968), the University of Nigeria, Nsukka, and subsequently other institutions. Yet the integration of social workers into mental health services has remained limited. A 2021 survey of mental health facilities in Southwest Nigeria found that only three of eighteen facilities surveyed employed a designated psychiatric social worker, and in each case, the social worker's role was confined to discharge planning and family liaison rather than the fuller scope of psychosocial assessment and intervention (Okafor

& Anyaegbu, 2021).

Where psychiatric social workers do practice in Nigeria, their potential contributions to the SIP-schizophrenia diagnostic challenge are substantial. First, social workers are trained to conduct comprehensive psychosocial assessments that situate clinical presentations within the broader context of family dynamics, housing stability, employment status, and community relationships. Such assessments could illuminate factors relevant to identify initial signs of social withdrawal before substance use, the quality of family relationships, the availability of community supports for abstinence that are rarely explored in compressed psychiatric consultations.

Second, social workers possess skills in motivational interviewing and brief intervention that could be deployed to address the substance use that complicates the diagnostic picture. Rather than simply advising patients to abstain, social workers could engage patients in exploring the effects of substance use in their lives and developing alternative coping strategies. For patients whose psychosis proves to be substance-induced, effective substance use intervention is the definitive treatment; for those with underlying schizophrenia, addressing comorbid substance use improves medication adherence and reduces relapse risk (Oluwoye et al., 2022).

Third, social workers are uniquely positioned to navigate the cultural dimensions of the diagnostic challenge. Their training in systems theory and cultural competence prepares them to engage families respectfully around their explanatory models while also providing accurate information about the biomedical understanding of psychosis. In a context where families often shuttle between psychiatric clinics, traditional healers, and religious leaders, the social worker can serve as a cultural broker, facilitating communication across these domains and helping families integrate diverse forms of knowledge into coherent care plans.

Fourth, social workers could address the follow-up deficit that undermines diagnostic clarification. Community-based social workers, operating from primary health centres or non-governmental organisations, could maintain contact with patients discharged after acute psychotic episodes, monitoring for symptom recurrence, substance use relapse, and functional outcomes. Such longitudinal monitoring, even if conducted by non-specialist workers with appropriate training and supervision, could substantially improve diagnostic accuracy by documenting the trajectory that distinguishes SIP from schizophrenia. Yet the realisation of this potential, faces formidable barriers. The absolute number of trained social workers in Nigeria remains grossly inadequate, with fewer than 5,000 registered social workers nationwide across all fields of practice (Nigeria Association of Social Workers, 2022). The subset with specialised mental health training is vanishingly small. Social work education in Nigerian universities, while generally sound, provides limited exposure to psychiatric and substance use disorders, leaving graduates ill-prepared for the complexities of mental health practice (Amadasun, 2021).

Perhaps more fundamentally, social work in Nigeria lacks the professional recognition and legislative protection that would secure its place within the mental health system. Unlike medicine, nursing, or pharmacy, social work is not regulated by a statutory council with powers to set standards, accredit training programmes, and discipline practitioners. The Social Work Profession Bill, which would establish such a regulatory framework, has languished in the National Assembly for years, leaving the profession without the institutional infrastructure that would enable systematic deployment to mental health settings (Ajibo & Chukwu, 2020). The

financing of social work positions within mental health services presents an additional barrier. In a context where even core clinical positions go unfilled due to budget constraints, an addition of social workers whose contributions receives low priority, and the few psychiatric social workers in practice are typically employed in tertiary neuropsychiatric hospitals.

5. Findings

This conceptual analysis yields several interconnected findings regarding the SIP versus schizophrenia diagnostic boundary in Southwest Nigeria and its implications for social work practice.

The diagnostic boundary is rendered particularly problematic in Southwest Nigeria by the convergence of clinical, cultural, and structural factors. Clinically, the distinctive pattern of combining cannabis, tramadol, codeine, and synthetic cannabinoids produces complex psychotic symptoms that resist simple attribution to any single substance or mechanism. Culturally, Yoruba frameworks for understanding altered mental states intersect with biomedical categories in ways that shape help-seeking, family responses, and the perceived legitimacy of different diagnoses (Alabi, 2026). Extreme personnel shortage; shortened clinical visits, and a lack of follow-up infrastructure make it difficult to perform the kind of monitoring required for accurate difference between SIP and schizophrenia.

The consequences of diagnostic misclassification are substantial and asymmetrical. Substance-induced psychotic disorder, as defined in the ICD codes, is transient, lasting from 7 to 20 days, but not more than one month. Symptoms lasting more than 30 days would generally be classified as a more chronic psychosis type, such as schizophrenia (Macdonald et al. 2023). Both false-positive schizophrenia diagnoses (applied to substance-induced presentations) and false-negative SIP diagnoses (applied to emerging schizophrenia) carry significant harms, but these harms manifest differently across clinical and social domains. The harms of misdiagnosing SIP as schizophrenia include unnecessary long-term antipsychotic exposure, the internalisation of a chronic illness identity, and profound social stigma that extends to family members and future generations. The harms of misdiagnosing schizophrenia as SIP include premature treatment discontinuation, failure to prepare families for the likely chronic course, and the moral censure associated with attributing the condition to "self-inflicted" drug use.

Social work represents a critically underutilised resource for addressing the diagnostic boundary challenge. The skills that social workers bring comprehensive psychosocial assessment, substance use intervention, family engagement, care coordination, and cultural brokerage directly address the gaps that render the SIP-schizophrenia distinction so problematic in current practice. However, the development of psychiatric social work in Nigeria is constrained by inadequate training capacity, the absence of professional regulation, and financing models that fail to recognise the value of psychosocial intervention. Resolution of the diagnostic boundary problem requires not merely enhanced clinical protocols but a fundamental reconfiguration of how communities and health systems respond to substance-related psychosis. The three-tier framework proposed in Section 5.6 emphasising honest communication about diagnostic uncertainty, structured community-based follow-up, and integrated care planning represents a culturally attuned and structurally realistic approach that merits further development and empirical evaluation.

Implications for Practice: Toward a Culturally Attuned Framework

The preceding analysis suggests that addressing the diagnostic boundary challenge in Southwest Nigeria requires more than simply importing protocols developed in well-resourced settings. What is needed is a framework for assessment and intervention that is clinically informed, culturally attuned, and structurally realistic a framework that acknowledges the constraints under which Nigerian mental health professionals operate while still striving toward more accurate differentiation and more appropriate care. Such a framework might be organised around three tiers of intervention, corresponding to different levels of available resources and different points in the care continuum.

Immediate Clinical Assessment. Given that the distinction between SIP and schizophrenia cannot be made with confidence at initial presentation, the immediate clinical priority should shift from diagnostic certainty to careful documentation and risk management. This tier would include: systematic recording of substance use history, including types of substances, frequency, recency, and duration of use; documentation of the temporal relationship between substance use and symptom onset; screening for features suggestive of underlying psychotic illness (negative symptoms, cognitive disorganisation, premorbid social impairment); and explicit communication to patients and families that the diagnosis is provisional and will be refined through longitudinal observation. This approach, while not resolving the diagnostic ambiguity, at least acknowledges it honestly and establishes expectations for ongoing monitoring.

Structured Follow-Up. The critical diagnostic information distinguishing SIP from schizophrenia emerges over weeks and months, not hours. Tier 2 would establish mechanisms for structured follow-up after acute stabilisation. In the Nigerian context, where specialist follow-up is constrained by workforce shortages, this tier might leverage task-sharing approaches that have shown promise in other domains of mental health care (Gureje et al., 2019). Community health extension workers, peer support specialists, or trained family caregivers could be equipped with simple monitoring tools to track symptom persistence, substance use relapse, and functional recovery. Social workers, where available, would coordinate this follow-up and serve as the bridge between community monitoring and specialist review.

Integrated Care Planning. Regardless of the eventual diagnostic determination, individuals who have experienced a psychotic episode in the context of substance use require comprehensive support that addresses both mental health and substance use domains. Tier 3 would involve the development of integrated care plans that include: evidence-based substance use intervention (motivational enhancement, relapse prevention, referral to mutual support groups where available); family psychoeducation that addresses both the psychiatric and substance use dimensions of the presentation; vocational and educational support to address the social determinants that often underlie both substance use and psychosis vulnerability; and coordination across the formal health sector and the traditional and faith-based sectors that families will likely continue to consult.

6. Conclusion

This paper has examined the blurred boundary between SIP and schizophrenia as it manifests in Southwest Nigeria, attending to the clinical complexities, cultural dimensions, and structural constraints that render this diagnostic distinction particularly challenging in the

region. The analysis has also explored the implications for social work practice, identifying both the distinctive contributions that social workers could make and the formidable barriers that currently limit their deployment.

Several broader implications emerge from this analysis. The diagnostic boundary problem illuminates the limitations of categorical diagnostic systems when applied in contexts for which they were not designed. The DSM and ICD frameworks for distinguishing SIP from schizophrenia presuppose access to longitudinal observation, toxicological confirmation, and specialist follow-up that are simply unavailable in most Nigerian clinical settings. This is not an argument for abandoning diagnostic categories, but rather for recognising that their application must be adapted to local realities and that diagnostic humility is a clinical virtue in contexts of uncertainty. The analysis underscores the importance of attending to cultural frameworks for understanding altered mental states. The biomedical distinction between SIP and schizophrenia, while clinically meaningful, does not map neatly onto Yoruba understandings of madness, spiritual affliction, and moral responsibility. Effective intervention requires engaging respectfully with families' explanatory models while also providing accurate information about substance-psychosis relationships. Social workers, with their training in cultural competence and their ecological perspective, are ideally positioned to navigate these cultural dimensions.

This paper highlights the urgent need for workforce development in Nigerian mental health care generally and psychiatric social work specifically. The Mental Health Act of 2023 provides a policy foundation, but implementation will require sustained investment in training, recruitment, and retention of mental health professionals across disciplines. The passage of the Social Work Profession Bill would represent an important step toward establishing the regulatory infrastructure necessary for the profession's growth. Finally, the analysis suggests that resolving the diagnostic boundary question requires shifting attention from the moment of diagnosis to the longitudinal process of care. Whether a given psychotic presentation ultimately proves to be substance-induced or the first manifestation of schizophrenia, the individual and family require ongoing support that addresses substance use, promotes functional recovery, and navigates the cultural and spiritual dimensions of the illness experience. This is the work that social workers are trained to do, and it is work that Nigerian mental health services currently do not do well. Addressing this gap through workforce development, task-sharing approaches, and community-based follow-up mechanisms represents the most promising path toward better outcomes for individuals and families affected by substance-related psychosis in Southwest Nigeria.

7. Recommendations

Based on the preceding analysis, the following recommendations are offered for policy, practice, education, and research.

1. Accelerate implementation of Nigeria's Mental Health Act (2023), with specific attention to provisions for community-based mental health services, task-sharing, and integration of mental health into primary care.
2. Prioritise the implementation of the Social Work Profession Bill to establish a regulatory council for social work, set standards for education and practice, and facilitate the systematic deployment of social workers to mental health settings.

3. Develop financing mechanisms whether through the National Health Insurance Scheme or dedicated mental health funding streams that support psychosocial interventions, not merely pharmacological treatment.
4. Implement structured follow-up protocols for patients discharged after acute psychotic episodes, leveraging task-sharing approaches where specialist follow-up is unavailable. Integrate substance use intervention into routine psychiatric care for all patients with psychosis, regardless of presumed aetiology.
5. Develop culturally attuned psychoeducation materials that explain substance-psychosis relationships in terms that resonate with Yoruba frameworks for understanding illness and misfortune.
6. Strengthen mental health and substance use content in Nigerian social work curricula, including supervised field placements in psychiatric settings. Develop continuing professional development programmes in psychiatric social work, potentially delivered through partnerships between Nigerian universities and international institutions with established mental health social work programmes.

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