SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
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TOPIC:
SOCIO-ECONOMIC FACTORS INFLUENCING UTILIZATION OF MENTAL HEALTH SERVICES IN THE ASHIAMAN MUNICIPALITY OF GHANA.

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DECLARATION

I, Farouk-Umar Kassim, declare that except for other people’s research and investigations which have been duly acknowledged, this work is the result of, and remains my own original research, and that this dissertation, either in whole or in part has not been presented elsewhere for another degree. The study was conducted under the guidance and supervision of Dr. Paulina Tindana of the School of Public Health, University of Ghana.

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(Principal Investigator)

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Date: .............................................
DEDICATION

I dedicate this work to God Almighty for seeing me through it all, and to Dr. Kwabena Opoku-Agyeman, Mr. Michael Sakyi and Dr. Paulina Tindana.

God bless you all.

I am forever grateful.
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LIST OF ABBREVIATIONS

CG - Caregiver

CM – Community Member

CPN – Community Psychiatric Nurse

GHS – Ghana Health Service

HP – Healthcare Provider

MHGAP – Mental Health Gap Action Program

NAMI – National Alliance for Mental Illness

OPD – Outpatient Department

WHO – World Health Organisation
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ABSTRACT

Background
Mental Health, mostly overlooked as a non-communicable disease, is becoming an issue of national concern. Though the Mental Health Act 846 of 2012 was passed into law in 2012, mental health services seem to be virtually invisible in many communities. Persons with mental health disorders are mostly stigmatized and discriminated, suffering low quality of life in their diverse communities. This study sought to identify the factors influencing mental health utilization at the community level and to recommend solutions to improve both the service and its availability.

Objectives
The main objective of this study was to explore the socio-economic factors influencing the utilization of mental health services in the Ashaiman Municipality. The study also sought to ascertain whether mental health services were available within the community and whether the residents were privy to these services and the various socio-economic factors that influenced and affected mental health service utilisation.

Method
This study was an exploratory qualitative research involving face to face in-depth interviews with key stakeholders. Purposive sampling method was used to select 24 participants consisting of 7 health providers, 11 community members and 6 caregivers to participate the study. An interview guide was developed and used to collect data and participants were assigned codes and pseudonyms. Transcribed interviews were transported to NVIVO software version 11 for analysis. Thematic content analysis was applied in the data analysis
involving inductive and deductive coding. Participants were assured of privacy and confidentiality.

**Results**

The study revealed that various mental health services including counselling and public talks on mental health exist in the Ashaiman community. Factors like belief systems, economic status, and nearness of mental health facilities were found to influence mental health utilisation whiles less drugs and staff, and absence of facilities to admit patients and other challenges at the mental health facilities affected mental health service utilisation.

**Conclusion**

It was concluded in the study that, financial constraint is a major factor across board. This is evident in the inability of caregivers and members of the community to fully utilize the available mental health services. There also is not adequate information on mental health services to community members in health facilities.

**Recommendations**

Ghana Health Service (GHS) should educate and create awareness on mental health at the community level, making provisions for admission of mental patients. Also, the government should enhance human and capital resources to support mental health services and lastly, future studies should focus on the practices of traditional and religious healers and the potential for collaboration.
CHAPTER ONE

1.0 Background

Ghana has experienced a positive trend in its economic development over the past two decades and has seen a gradual strengthening of its democracy in recent years. This has led to its reclassification by the World Bank as a lower middle-income country, and as such, it is on track to meet the millennium development goal of halving extreme poverty by the year 2015 according to Eaton and Ohene (2016).

The Ministry of Health provides policy direction for all health-related issues in Ghana, and the Ghana Health Service is responsible for provision of public health services. The system is functionally divided into the 216 administrative districts covering 10 regions of the country. In Ghana, mental health services are provided in three large psychiatric hospitals, all located in coastal south, and in smaller psychiatric units in five regional hospitals, three teaching hospitals, one each in the southern (Accra), central (Kumasi), and northern (Tamale) parts of the country, providing services on a relatively small scale, each has at least one psychiatrist with services consisting of inpatient and busy outpatient departments (Eaton and Ohene, 2016)

According to Eaton and Ohene (2016), the psychiatric hospitals and CPN provide majority of psychiatric services in the country. The level of knowledge and standard of care offered to people with mental disorders by general practitioners and primary care services is generally poor. Most general practitioners avoid seeing people with psychiatric problems, preferring to refer them to few mental health care providers.

There are many reasons for the low level of interest in mental health. For instance, it is stigmatized and not seen as an income-generating field or a positive career choice. Thus, the
area has been generally neglected by professionals and the health service sector. Special schools meant for children with intellectual disabilities, one private and the other funded by Government exist in Accra. There is no dedicated forensic psychiatric facility in Ghana, yet, the mentally ill who violate the law are often kept in the Accra psychiatric hospital, some indefinitely. Prisons have high rates of mental illness with inadequate care provided (Eaton and Ohene, 2016).

Secondly, the treatment of mental health problems is generally perceived as spiritual, and often seen as punishment for doing wrong. As such, engaging faith leaders is important given their position of authorities in communities in health care. Efforts made to improve conditions proved futile as high levels of human right abuse in such areas remain a challenge. Also, access to biological treatments plays a huge role in determining whether the service would be utilized. Having professionals in the right place with the right skills to prescribe appropriate medications is important but cannot be done without a reliable supply of medications. This is particularly the case for severe mental disorders such as bipolar affective disorder, moderate and severe depression, and epilepsy. Such evidence-based interventions are advised in Mental Health Gap Action Program (MHGAP) intervention guide, a publication by WHO Mental Health Gap Action Program (MHGAP).

1.1 Importance of Mental Health

According to Patel, Minas, Cohen and Prince (2013), about 14% of the global burden of disease has been attributed to neuropsychiatric disorders, mostly due to chronically disabling nature of depression and other common disorders, alcohol and substance use, and psychoses. Such estimates according to them have drawn attention to the importance of mental disorders for public health. The human head is the only organ with all the five senses on it. It is the home of the brain which occupies a large portion of it. The brain coordinates all activities of
the human body which includes the cognitive and all physical activities. An individual cannot be said to be healthy if there is a short fall in mental health. There can be no health without a sound and normal functioning mind. A country with a good number of its working population suffering from various mental conditions is at a great economic loss. This is because there would be a decrease in productivity and skilled labour as well as increase in expenditure on mental health. It is for this very important reason that this study stresses on the need for a mentally healthy working population.

1.2 The State of Mental Health in Ghana

There are many factors and indicators that serve as determinants of mental health within a national jurisdiction. According to the World Health Organization (2014), mental health and many common mental disorders are shaped to a great extent by the social, economic and physical environments in which people live. It further states that social inequalities are associated with increased risks of many common mental disorders. Taking action to improve the conditions of the daily life from birth, during childhood, at school age, during family building and working ages to older ages provides opportunities both to improve mental population and to reduce the risk of those mental disorders that are associated with social inequalities. Ghana, as a developing nation, also has challenges in the health sector. Mental health is not spared the effect of these challenges and is not being prioritized. Very little awareness is being created about the phenomena. This is evidence to suggest that there is a steady increase in cases of mental health and disorders (World Health Report, 2014). Risk factors according to many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk. According to Allen et al (2014) the poor and disadvantaged suffer disproportionately but those in the
middle of the social gradient are also affected in developing countries, which Ghana is a clear example as a result of her socio-cultural and socio-economic states.

1.3 Mental Health System of Ghana

Various functioning units come together to form a holistic body in the form of the Mental Health System which is made up of institutions, resources and personnel. According to an article by Roberts, Mogan and Asare (2014), there were 123 mental health outpatient facilities, 3 psychiatric hospitals, 7 communities based psychiatric inpatient units, 4 communities’ residential facilities and 1 day treatment centre, which are well below what would be expected for Ghana’s economic status. Most patients were treated in outpatient facilities and psychiatric hospitals and most of the inpatient beds were provided by the latter in 2011. They further reported that for an estimated 2.4 million people with mental health problems, 67,780 (2.8%) received treatment in 2011, stating that there were 18 psychiatrists, 1,068 Registered Mental Nurses, 19 psychologists, 72 Community Mental Health Officers and 21 social workers working on mental health which is unbalanced with unbalanced emphasis on nurses compared to what would be expected. It was added that services were significantly underfunded with only 1.4% of the health expenditure going to mental health, and spending very much skewed towards urban areas.

1.4 The Journey of Mental Health Act to the Present State

The Mental Health Act of 2012, Act 846 after its enactment has been passed into law. This Legislative Instrument has been structured to replace the then outmoded Mental Health Legislature. In a study by Roberts, Mogan and Asare (2014), the Legislative Instrument was formed out of a renewal of the Ghana 5 year plan for mental health and it contributes to
international knowledge based on mental health. They went further to state that it provides a baseline to measure future progress in Ghana and personnel are a clear indication of the inequalities in the mental health system. Very little attention and resources are channelled to mental health. The Nurse to Patient ratio is also alarmingly huge leaving the existing trained professionals overburdened (ibid.).

The Mental Health Act was/is supposed to effectively regulate and transform the mental health system under the health sector. This has not been the case as the Legislative Instrument is yet to be passed to make it functional. This would enable the strengthening of health to the community level and grassroots communities.

1.5 The Ghanaian Context

In the Ghanaian context, Community Mental Health is simply an integration of primary health care and mental healthcare. It is to ensure that mental healthcare is accessible to individuals and groups from different ethnic and social background. Primary Health Care seeks to prevent discrimination in assessing health care for basic medical conditions. Thus, Community Mental Health seeks to bridge that gap of inequality in mental healthcare. This is to give groups in the lower income access to mental healthcare from trained medical professionals at the community level.

1.6 Mental Health Service Utilization

Globally there is no consensus on the definition of Utilization of Mental Health Services and this can be attributed to the insufficient research that have been carried out on Mental Health Services Utilization. Generally, mental health services are globally underutilized.
The factors attributed to this underutilization vary from one geographical location to another and from country to country. In the United States of America, the National Committee on Quality Assurance published in 2016 results from the 2015 National Survey on Drug Use and Health that, an estimated 43.4 million of U.S. adults — about 18% — experienced some form of mental health disorder. These mental health disorders were characterized by changes in behavior, thoughts and mood, and affect an individual’s ability to carry out daily activities and capacity to work, succeed in school and interact with others. Of the 43.4 million adults with a mental health disorder, less than half receive mental health services (Porter and Pemberton, 2016).

Ghana, as a developing middle-income country, like other emerging and thriving African economies, has its fair share of challenges in the health sector thereby affecting mental health care. This is evident in the very limited resources available to cover the ever growing demand for mental health services from the community level to the nation at large, though the general population is at risk of mental health disorders in various forms. Populations of developing economies tend to be at risk of mental health disorders.

1.7 Problem Statement

The life and experience of an individual who suffered a form of mental health disorder, in addition to the growing prevalence of mental health disorders in communities and how they can be countered influenced this study. It brought to the fore that many, if not most, had very little or no knowledge on mental health issues, pointing out that there were very few mental health facilities at vantage points in communities to serve as immediate sites to rush a mental patient in need of medical attention. The general perception on mental health disorders and illness in our communities that tend to alienate individuals in that state as they are seen not fit
to be integrated into the “normal” fold and managing the aggression in a mentally ill individual heightened the curiosity to venture into this field of research.

Research shows that mental illness poses numerous challenges in its management and it also acts as risk factors for other health problems. Globally, mental health disorders are considered the major causes of disabilities and they account for 37% of all healthy life years lost through diseases. This means that mental health conditions have associated problems such as significant costs to the patient in terms of personal suffering, to the families as a result of the shift of burden of care and life-time lost productivity, and on the society at large (Jack-Ide & Uys, 2014). It is reported that Neuropsychiatric conditions account for 13% of the global burden of disease and over 5% in Africa (WHO, 2014), meaning that despite the high prevalence of mental illness, mental health remains a low priority in Africa. Buor (2004) reports that the utilisation of health services in developing countries is generally low. The low rate of utilisation is attributable to long distance to health facilities, the unequal distribution of health facilities between the rural and urban areas, poverty, among others.

In Africa, studies conducted in Nigeria suggest that, less than 20% of persons with mental disorders receive treatment, of whom only 10% utilize public mental health service (Jack-Ide & Uys, 2014) and this evidently indicates that the health needs of majority of those with mental health conditions remain unmet and this deserves attention.

In Ghana, it is estimated that out of the 24.3 million people living in the country, 2.4 million suffer mental illness yet mental health in primary health care continues to be low (around 20%). This intensifies the tradition and general lack of facilities which encourage many patients to look for help from informal health services such as traditional and faith based practitioners (Fetish Priests and Pastors) who have very little or no training in the field of mental health (Roberts, Mogan & Asare, 2014). Consequently, in some of these traditional and
spiritual settings, aggressive psychiatric patients suffer abuses such as being chained or locked up (Asare, 2014).

Moreover, there are only a small number of existing studies which focus on mental health services in Sub Saharan Africa especially in Ghana. A PubMed search carried out by Roberts, Mogan and Asare (2014) for the years 2006-2011 revealed that only 1% of all health publications in Ghana were on mental health. The mental health research focused mainly on policy, programmes and financing, epidemiological studies in clinical samples and psychological interventions. Investigations into the utilisation of mental health service were unavailable. Hence, this study was aimed at investigating the factors that account for the underutilisation of mental health service in Ghana.
1.8 Theoretical Framework

Several factors influence the individual for utilization of mental health services in the Ashaiman. This factors include geographic factors, health facility related factors, society/community factors, and individual factors.
Geographic factors includes place of residence, road network, distance to facility, and means of traveling. People who live very far away from the health facility may sometimes find it difficult to utilize the services. People who are closer to the facility might be willing to utilize the services when the conditions more than those who are far away. Poor road network and accessibility can also hinder utilization of mental health services.

Health facility related factors can also play a major role in the utilization of mental health services. High cost of diagnosis and treatment may make it difficult for people to afford. Attitude of staffs is also very important in determining utilization. If the staffs are friendly and the patients and the families are satisfied with their services, people may not hesitate to go to the facilities when their relative are confronted with such cases. Nature of counseling also plays a major role in the utilization of mental health services. Since it is a problems that affect the emotions of not only the victims but also family members, there is the need for good counselling services.

Societal norms, Policies and stigma are some few factors that contributes greatly to the utilization of mental health services. Due to the stigma, relatives of victims may try to hide individual suffering from mental health conditions instead of taken them to health facilities to seek health care.

Individual factors such as age, educational status, financial standing, and access to mass media could influence one choice in seeking mental health services. People that are educated are more likely to get information and have good judgement on issues concerning mental health than those who are not. Access to mass also makes relevant information on mental easily available for people to take decision. People who are financially sound could be able to afford mental health services more than those who are not. Finally, the intensity of condition or type of diagnosis may also affect people’s decision on utilization. Some conditions may be considered not important by the family members and this will make them not to seek medical
care at mental health facilities. Others may also consider other conditions so severe that they think they cannot get treatment.

1.9 Research Questions and Objectives

1.9 a. Research Questions

- What mental health services are available within the primary healthcare system?
- What are the experiences of people in accessing mental health service?
- What are the challenges with accessing mental health services at the community level?

b. General Objective

- The general objective of this study was to explore the socio-economic factors influencing utilization of mental health in the Ashiaman municipality.

c. Specific Objectives

- To examine mental health services available at the community level
- To explore local concepts about mental illness and how these influence access to mental health services.
- To explore the socio-economic factors influencing access to mental health services
- To identify challenges with access to mental health services at the community level
CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

A literature search was carried out to explore factors affecting utilization of community mental health. In line with the study objectives though, the search was narrowed down to papers relevant to the mental health act, community mental health and the mental health system.

2.1 Mental Health

MedlinePlus.com, a US National Library of Medicine defines Mental Health as including emotional and psychological well-being. It affects how individuals think, feel and act as they cope with life and determines how they handle stress, relate to others and make choices. Medline plus goes on to state that mental health is important at every stage of life, from childhood and adolescence through adulthood. Mental state of individuals is very essential in individuals’ daily livelihood as it determines thinking ability, mood swings and behavioural changes.

According to Becker and Kleinman, “More than 75% of persons with serious mental illness in less-developed countries do not receive treatment for it. For the minority who do have access to mental health treatment in low- and middle-income countries, there are few data available to aid in the evaluation of the quality or effectiveness of the treatment. Major deficits in the provision of care include the size of the health care workforce and the training it receives; rigorous empirical evaluation of innovative, scalable models of care delivery; and the political will to support policy, research, training, and infrastructure as explicit priorities at the national, regional, and multinational levels”
2.4 Community Mental Health Service Delivery

The World Health Organisation (2014) reports that mental health services in Ghana are available at the most levels of care. However, majority of the care is provided through specialised psychiatric hospitals, with relatively less government provision and funding for general hospitals and primary health care based services. The few community based services being provided are private. In summary, most treatments and care are being provided by special hospitals, close to the capital, Accra, and servicing a small proportion of the population in need. The health system in Ghana is decentralised from national, to regional and district levels. There are three (3) public psychiatric hospitals in Accra, Ankaful and Pantang, and four (4) private psychiatric hospitals (WHO, 2014).

In a related study, Asare (2014) reports that, at the community level, there are Community Psychiatric Nurses (CPNS) who have been trained to provide aftercare to discharged patients in the community, undertake mental health promotion, and refer cases to regional hospitals or specialist facilities. He further indicates that there are 181 CPNs in only 94 of the 170 districts.

Another study conducted by Roberts, Mogan and Asare (2014) revealed that as at 2011, there were 123 mental health outpatient facilities, 3 psychiatric hospitals, 7 community based psychiatric inpatient units, community residential facilities and only 1 day treatment centre in Ghana, and this is considered to be below expectation for Ghana’s economic status. The nature and quality of mental health services existing in those existing community-based facilities are lacking. Besides, considering the limited nature of facilities and human resources to tackle the menace of mental health conditions, the nature and quality of mental health service at the community level becomes mind boggling. The present study therefore seeks to bridge the gap in knowledge concerning mental health service delivery at the community level in Ghana.
2.5 Perception about Mental Illness

There are various widely held perceptions about mental illness worldwide, with mostly negative attitudes towards those who are affected and to a large extent their families. Studies have shown that African Americans thought a person being hospitalised for mental illness as different, inferior to normal people and believed these patients should be restricted to society. Similarly in the Caribbean, psychiatric illness is associated with significant stigma and people with mental illness or intellectual disabilities are reportedly kept in their homes hidden away from the public because of psychotic behaviour. Patients are often treated in a humane way, but they are seen as a source of embarrassment to their families. Stigmatizing views include the fear that mental illness are contagious or reveals a character flaw which may support negative self-evaluations, harm individual mental health and also present a barrier to seeking appropriate help (Brown, 2017; Yorke, Voisin, Berringer & Alexander, 2016).

Negative attitudes and beliefs allow for individuals to fear, reject, avoid and discriminate against individuals who suffer from mental illness. Stigma has been identified to be the most prominent barrier to African Americans seeking professional help (Gaunt et al, 2018a; 2016b). In contrast with the major finding that stigma is considered the most prominent barrier to mental health utilisation among African Americans, Clement et al (2015) found that stigma only has small to moderate negative effects on help-seeking behaviour in Germany.

The recognition of stigma as a significant barrier to mental health utilisation has also been observed in Ghana. Tawiah, Adongo and Aikins (2015) reported a negative attitude and perception about mental illness in Ghana with stigma as a major source of suffering to mental health patients and their families. A study by Asare (2014) found that the stigma attached to the psychiatric profession deters people from joining it and the few mental health personnel who could have been fully trained, particularly the nurses, often emigrate, which counteracts the increase in the numbers trained.
Poor understanding of the nature and dynamics of mental disorders have been described as a major challenge to implementation of mental health services initiatives in Sub-Saharan Africa (Atilola, 2016). This finding is also supported by a study conducted in Nigeria which revealed that most people in Africa especially in Nigeria have lay perception of mental disorders which are still rooted in super-natural belief systems and therefore considered untreated by western medicine, so those affected with mental illness do not seek orthodox psychiatric care; however, there is little indication that perception about mental illness hinders the effective utilisation of mental health services in Ghana as majority of studies focusing on it are done outside.

2.6 Socio-Economic Factors Influencing Mental Health Utilisation

Mental health utilisation is generally considered to be low especially in Ghana as it was reported that an estimated 2.4 million people with mental health problems of which only 67,780 (2.8%) received treatment in 2011 (Roberts, Mogan & Asare, 2014). This poor utilisation was influenced by several factors such as religion, gender, level of income among others.

Religious communities are in a unique position to combat stigma and provide a message of acceptance and hope since a faith community may be the only place where a person with a mental illness truly feels accepted, valued, and loved. Gaunt et al (2018) advised that since religious leaders are seen as powerful men, they can play a role by referring congregants with mental illness to seek professional mental health services because the National Alliance for Mental Illness (N.A.M.I) has found that many African-Americans who suffered from mental illness turned to religious organizations when seeking strength and support during a particular crisis.
Similarly, it has been suggested and posited that the use of primary or alternative services such as religious leaders account for the underutilisation of mental health services among Asian Americans (Augsberger, Yeung, Dougher & Hahm, 2016) while reports indicate that some religious leaders operate ‘prayer camps’ and conduct ‘healing’ for the patients of mental disorders in various places including the prayer camps (Roberts, Mogan & Asare, 2014).

Gender is also seen as a critical factor that influences utilisation of mental health services. For instance a research conducted in Wa, in the Upper West region of Ghana, indicates that women do not have the autonomy to seek healthcare when ill because they have to ask for permission from their household heads (Farhan, 2018). Again, females with mental disorders are more often stigmatized at the work place and at the educational level. These contribute to the underutilisation of mental services especially among women in Ghana, (Tawiah, Adongo & Aikins, 2015).

2.7 Challenges Associated with Mental Health Utilisation

Mental health is greatly affected by several challenges which have since thwarted the effort to provide effective and efficient services to mental health patients and their families. Several studies have delved into some of the challenges that confront the delivery of professional help to patients. It has been established that one of the barriers to mental health services utilisation in Sub-Saharan Africa especially Nigeria is the absence of mental health service in rural areas. Orit (2016) explained that distance was an important factor determining care-seeking behaviour among patients in Ethiopian primary health care units. The situation of most of the mental health facilities in the capital, Accra poses a challenge to patients in the rural as well as the northern part of the country in seeking professional mental health service.

The utilisation of mental health service is also partly faced with the challenge of inadequate provision of mental health facilities and personnel. Julian and Eaton (2014) discovered that
Sub-Saharan Africa has a wide mental health treatment gap, with low levels of access to mental health services. The findings showed low levels of budgetary allocation to mental health, poor health infrastructure (especially at primary level) and unequal distribution of human and financial resources. It was further stated that the huge burden of mental illness is a major public health challenge, particularly in low-income countries, where 76–85% of people with severe mental disorders receive no treatment. This is clearly evident that the Sub-Saharan countries need to urgently strengthen their health system or give mental health the needed attention and priority it deserves due to its effect on development, or they can likely create separate and independent mental health systems. It is recommended that reforms be made to make mental health care more accessible.

2.8. Summary of Knowledge Gap

Even though extensive studies have been done on mental health, the focus on mental health service utilisation has been minimal especially in Sub-Sahara Africa and particularly in Ghana. As it can be seen from the literature reviewed above, most of the studies conducted in this domain were done outside Ghana. The few studies on mental health in Ghana have failed to focus on the factors that influence mental health service utilisation. After critical review of the available literature on mental health, it was identified that there are gaps in knowledge as far as the factors that influence mental health utilisation, especially among communities in Ghana is concerned, and that deserve investigation. This study aimed at investigating the socio-economic factors underlying mental health service utilisation in Ghana.
CHAPTER THREE

METHOD

3.0 Introduction

This chapter describes the research methodology and provides the scientific basis for the study and explains into detail the various procedures involved in the study. A total of thirteen sections are presented in this chapter. The first section elaborates on the knowledge paradigm used in the research. The second section captures the study design and the section three looks at the study area while the section four looks at the study population, together with inclusion and exclusion criteria. Sample size, sampling method and data collection method are presented in sections five, six and seven respectively. The eighth section looks at the data analysis and the ninth section talks about the quality control of the study. Section ten captures the ethical considerations of the study. The timeline is captured in section eleven and the thirteenth section presents the summary of the chapter.

3.1 Knowledge Paradigm

The knowledge paradigm of a research basically refers to the way the researcher develops knowledge, especially in relation to how data should be collected, analysed and applied (Bajpai, 2011). According to Cresswell (2012), this paradigm is guided by a basic set of beliefs which influence researchers to select either qualitative, quantitative or mixed methods approach in their study. The various types of research philosophies include post positivism, constructivism, pragmatism and transformative (Creswell, 2009). However, the researcher applied the constructivism/constructivist worldview based on the goals of this study.

This knowledge paradigm (constructivism or social constructivism) was chosen because of the objectives of this study and the paradigm which is basically an approach to qualitative
research. Under this paradigm, individuals are generally thought to seek understanding of the world in which they live and work and to develop subjective meanings of their experiences. Here, the researcher relies on experiences and views of the respondents and makes meaning out of the data being collected on the field, hence, making constructivism the best approach for this study (Cresswell, 2009).

3.2 Study Design

This study was a phenomenological qualitative research. According to Adongo et al. (2016), a qualitative research approach gives the researcher deeper understanding of the factors influencing utilization of mental health services and the researcher is able to do detailed exploration, hence, the choice of this study design.

Phenomenological research, a philosophical and psychological research design, deals with the description of individuals' experiences of a phenomenon and culminates in the experience of multiple people experiencing the same phenomenon (Creswell, 2009). It gives opportunity to participants to share their perceptions, feelings and lived experiences and how these affect their viewpoint about a given situation (Adongo et al., 2016). As a result, phenomenology was used in exploring the factors influencing mental health service utilization which this study aims to achieve.

3.3 Study Area

Ashaiman District

Often wrongly spelt Ashiaman, “ASHAIMAN” is the capital of the Ashaiman Municipality. It was named after its founder Nii Ashai, who settled in its present location in the 17th Century to farm. This location was first occupied by his friend, Nii Ataanya who also
doubled as a fisherman and farmer. As time went on, they brought in other members of their respective families to live with. Other settlers soon joined for agricultural purposes, trade and commerce as well as other purposes. Ever since, the population has steadily grown to become what it is in present times. The current population of Ashaiman is 235, 465 according to the Ghana Statistical Services official website. Ashaiman is located in the Greater-Accra Region, the national capital of Ghana, 5°42′North and 0°02′West according to the Google map; Ashaiman used to be part of the Tema Metropolis and there are 7 sub health districts, 3 hospitals, 30 CHPS and 18 clinics currently operating in this well-known locality.

Ashaiman was chosen for this study due to socio-economic reasons. Considering how people in some geographic locations have socio-economic challenges thereby making them stand vulnerable to mental crisis, it was concluded as more fitting to use the Ashaiman Municipality as a preferred choice for this study.
Figure 2: Map of Ashaiman

Credit: Google Map
3.4 Justification of the study

The purpose of this study was to examine the socio-economic factors affecting the utilization of mental health services. While there is a steady increase in prevalent cases associated with mental health diseases and conditions, there is a generally low patronage of the available facilities. This have been attributed in previous studies to stigmatization and societal perception of mental health on the part of caregivers and patients.

This study seeks to identify whether there are other factors affecting mental health services utilization that are socio-economically related. With limited number of facilities rendering mental health services, it is a matter of interest to note that these few available services are still not fully utilized.

As such, this study looks to ascertain whether socio-economic factors play a role in affecting mental health services utilization through the views of healthcare professionals who are the service providers as well as patients and care givers. The result of this study will provide insight into how challenges outlined could be well addressed by policy formulators and implementers to improve on the quality of mental health services and its utilization within communities and the nation as a whole.

3.5 Study Population

The research population included health care professionals in the selected hospitals. Staff with longer working experience who are permanent employees were considered for this study. Non-professional individuals considered were parents and guardians of patients with mental health problems and some selected members in the community. This is because they were considered to be in better positions to give credible information for the study.
3.5.1 Inclusion Criteria

For the inclusion criteria, full-time employees who are professional nurses, care-givers, psychologists, with adequate work experience participated in the study voluntarily. Parents and guardians who have children with mental health issues were also included in the study.

3.5.2 Exclusion Criteria

Nurses without mental healthcare specialization as well as nursing students under training or internship were excluded from this study due to their insufficient work experience to make this work more credible, although these individuals may have had fair knowledge in the area of study. Care givers and patients that refused to participate in the study were also excluded from the study.

3.6 Sample Size Determination

In this research, respondents were sampled until saturation was reached and no new information was achieved. In a phenomenological study, a sample size of 20 is enough to reach saturation (Green & Thorogood, 2014), however, 30 respondents were selected and additional 2 key informants were selected for/in this study.

3.7 Sampling Method

Purposive sampling was selected based on the various characteristics of the given population and the objective of the study. Purposive sampling is also known as judgmental, selective, or subjective sampling.
Per the available types of purposive sampling, various homogenous and heterogeneous groups were applied in this study from the study area. Below are the classifications of these groups.

- Health care professionals – 7
- Family members and guardians who have children suffering from mental illness or condition – 6
- Community members – 11

Permission was sought from the Heads of the various health facilities to sample and interview participants.

3.8 Data Collection

The data collection approach used in this study was qualitative and it gave the opportunity to select the few and best cases for in-depth interviews. The Heads of health facilities were contacted and approval letters were sent to the necessary authorities and frequent follow-ups were made until permission was granted to carry out the study at the selected areas and facilities. The various gatekeepers assisted in the selection of participants into the study. After a dialogue with them to reach a consensus, in-depth interviews were organized for respondents at their convenient locations and time. 24 participants were recruited consisting of 7 health providers, 11 community members and 6 caregivers. Interviews were audio-recorded and transcribed verbatim. Key Informant Interviews were also conducted with the various gate keepers. The in-depth and key informant interviews lasted for an average of 10 to 25 minutes.
3.9.1 Brief Description of Data Collection Tool

In-depth Interviews and key informant interviews were conducted with the use of a semi-structured interview guide. Three different interview guides were developed. The guides were developed in English and translated into the local language by language experts. The first interview guide was developed to interview mental healthcare providers. The second guide was developed to interview caregivers of mental health patient and the last interview guide was developed to interview some community members. Participants’ demographic information were captured and in addition to that, the in-depth interview guide also explored thematic areas such as mental health services available in the community, local concepts about mental illness and how these influence access to mental health services utilization, socio-economic factors influencing access to mental health services and the challenges with access to mental health services. Another guide also explored key informant’s view on the various thematic areas.

3.9.2 Data Processing and Management

Interviews were audio-recorded with permission sought from participants. Participants were assigned unique codes and pseudonyms. All interviews were conducted in languages that are best understood by participants. Field notes were taken each day after interviews. The field notes encompassed the initial interviewee’s reactions to the interview, and any relevant observations such as the demeanour of the respondent, body language and emotions, and other things that will not be captured by the digital recording. Audio recordings were deleted immediately after they have been transcribed. The data will be stored for a period of two years after which it will be discarded.
3.10. Data Analysis

The researcher familiarized himself with the data by reading the transcripts about three or four times. Interviews were coded using HP1-7 for health providers, CM1-11 for community members and CG1-6 for caregivers. They were then uploaded onto Nvivo software version 11 for analysis. Thematic content analysis was employed involving both deductive coding and inductive coding. Codes were initially generated then themes were formulated based on the codes. The themes were then reviewed by checking for coherence between the themes and extracts under those themes. The review also looked at the validity of the themes at the level of the entire dataset to see if the themes accurately reflected the entire dataset. Themes were then named and defined. Major and sub-themes emerged and the table of themes were then exported to word processor (Microsoft word) for further interpretation of the data. Also, each node was exported back into word for easy reading and selection of the best quotes which were presented in the results section of the work.

3.11 Quality Control

3.11.1 Training

Research assistants were recruited and given adequate training to better understand the aims and objectives of the study so that they help in an effective data collection. Their training was on how to conduct interviews in the local language of the participants, taking into consideration all the ethical principles of research.

3.11.2 Pretesting of Interview Guide

The data collection instrument was pre-tested. The pretesting served as an opportunity for practice before conducting the main study and helped in refining different aspects of the study including fieldwork procedures and the data collection tool (Yin, 2011). Additional
probe questions were added to the patients' In-Depth Interview guide after the conduction of the pre-test. This enhanced the quality of the responses that were obtained, which helped in answering the research questions. All ethical procedures were followed during pre-testing.

3.11.3 Supervision

The work of the research assistants during data collection period were supervised by the researcher. This was to ensure that data collection was carried out efficiently and ethically. The recorded interviews were replayed after each session on the field which ensured that the interviews are conducted appropriately.

3.11.4 Estimating Trustworthiness of the Qualitative Study

Qualitative trustworthiness was applied in this study which encompassed credibility, transferability, dependability and confirmed ability. Credibility, which talks about the confidence in the ‘truth’ of research findings, was guaranteed by ensuring that the researcher spent sufficient time on the field to learn about phenomenon of interest. Transferability, which is basically showing that research findings have applicability in other settings, was achieved by describing into detail the encounters on the field and how the research was conducted. Dependability, which evaluates the accuracy and evaluates whether or not findings, interpretations and conclusions are supported by data, was accomplished by using the external audit approach. Here, a researcher who is not part of the study was made to examine both the processes and product of the research study. Confirm ability was also ensured by using triangulation approach where data will be gathered from multiple sources.
3.12 Ethical Considerations

3.12.1 Sensitivities Around Mental Health

Every legally accepted study research must adhere to strict ethical principles and guidelines. A research like this, which is generally qualitative deals with the personal experiences of participants. Some of these participants might have had harrowing experiences or possess very delicate perspective on the subject matter. As a result, they might find this study a bit sensitive. This brings to the fore the necessity for ethical issues to be addressed stringently. In the course of this study, the rights and dignities of the participants were protected at all cost by assuring them duly of confidentiality.

Also, to make participants more comfortable, a more private and serene atmosphere was recommended to enable participants express themselves freely devoid of any undue influence or duress. Ethically, participants were free to pull out of the research and their participation voluntary. Data collected was coded to protect their identity.

The ethical considerations in this study included the study approval, informed consent, privacy and confidentiality, voluntary participation and withdrawal, risks and benefits, and results dissemination which have all been explained in detail in the subsequent sections.

3.12.2 Study Approval

The proposal was submitted to the Ethical Review Committee of GHS, Research and Development Division in Accra for approval to conduct the study. The Ethical Clearance certificate number is GHS/RDD/ERC/Admin/App19/555. Formal permission was sought from the Ashaiman Municipal Health Directorate as well as the security personnel of the selected health facilities and community. An introductory letter was written by the Head of
Department of Health Policy Planning and Management of School of Public Health, University of Ghana to the health directorate.

3.12.3 Informed Consent

The informed consent document, which contain the purpose of the study, the various procedures involved, potential risks and benefits of participating in the study and other important things, was adequately discussed with participants in a language they better understand. Participants received a detailed explanation of the study and were assured of its anonymous nature and all questions and sentiments pertaining to the study were answered and addressed appropriately to participants’ satisfaction before they were allowed to participate in the interview. Participants who agreed to participate in the study were given written informed consent and allowed to read and sign before interviewing them. Participation was voluntary and respondents were reminded of their liberty of refusal to answer any question when they feel uncomfortable as well as withdraw from the study at any time if they wish.

3.12.4 Confidentiality and Privacy

The privacy and confidentiality of participants in this study were assured. Their identities were kept secret in order to make it impossible for any third party to identify them. Any information shared was strictly confidential as it is for academic purpose and it was duly disclosed to the participants as such.

Audio recordings were transcribed and stored for any reference. Collected data were stored on the computer of the researcher with restricted access. The results were presented and discussed without revealing the identities of the respondents and their responses. Interviews
with participants and key informants were conducted outside their homes and in their chosen places.

3.12.5 Potential Benefits and Risk

There were minimal risks involved in the study and usually taking few minutes of participants’ time to answer the questions might be a form of distress to the participants. Results of the study could contribute to a robust policy that would ensure that mental health services are accessible in the community and Ghana at large.

3.12.6 Funding information

The study was self-funded.

3.13 Limitations

The study had its fair share of limitations. Time was a factor as there was not sufficient time frame to interview more participants for transcription and analysis. The available for the research was very limited.

Another limitation to this study was that the findings relied on individual testimony of subjective experiences and opinions in the context of mental health service utilisation and might not therefore be generalized to other mental health service users or other communities.

Funding was also a limitation as the study was self funded with limited support and this affected the procurement of logistics and other expenses. Funding is an integral part of every study but that did not come in handy.
One of the challenges faced by the researcher was the unwillingness and reluctance of majority of potential participants to take part in the study. Most of the participants, especially the caregivers were not ready to be part of the study. This affected the sample as the initial 30 participants for the study was reduced to 24.

Moreover, another limitation had to do with the language. Primarily, interviews were supposed to be in English but at some point, interviews had to be conducted in the local dialect (Twi) and afterwards translated to English for transcription. This may have affected the response of some participants, hence thwarting the rate of reliability of the findings.

3.14 Chapter Summary

This chapter captured the research method and provided the scientific basis for the study and explained into details the various procedures the researcher undertook to conduct the study. A total of thirteen sections are presented in this chapter. Section one elaborated on the knowledge paradigm used in the research. The second section captured the study design. Section three looked at the study area while the section four looked at the study population, together with inclusion and exclusion criteria. Sample size, sampling method and data collection method were presented in sections five, six and seven respectively. The eighth section looked at the data analysis and the ninth section talked about the quality control of the study. Section ten captured the ethical considerations of the study while section 11 presented the summary of the chapter.
CHAPTER FOUR
RESULTS

4.1 Mental Health Services Available at the Community Level

Generally, mental health services were found to be available at the community level. Mental health facilities performed functions such as reviewing clients, counselling, home visitation, health talks and administration of drugs. Some of the drugs reported to be administered in these facilities include Olanzipine, Carbamazepine, Phenobarb, Benzol, Sodium Viporate, Steraline, and Amithriptilin. It was also revealed that mental health facilities at the community offer treatment for conditions such as Schizophrenia, Epilepsy, Psychotic Anxiety disorder, Post trauma stress disorder, Postpartum psychosis etc. All health care providers (7) highlighted that these mental health services were available at their facilities. In what follows, a 38-year-old female Nursing Officer provided insight into the services available at the hospital.

Here at our unit, we review clients on Mondays, we do home visits on Tuesdays, and we give health talks, school health talks on Wednesdays. And then on Thursday we come to review clients here, Friday too we review them here. Then sometimes within the week, we will go into the community, we comb around, we work with the community health nurses to sometimes go and fish out clients ourselves.

However, community members are not aware of the existence of such mental health services in the community. 72.7% of community members interviewed indicated that they have no knowledge of places in the community where mental health services can be accessed.

Like I said, I have no idea, all I know is that you go to the hospital, any hospital and then maybe they will refer you to any mental health, if you need one but in Ashaiman here, I don’t know any, if there is any health centre for mentally challenged people (CM 2, business woman).
Also, few community members were abreast with mental health services existing elsewhere like Accra and Pantang. When asked the question: Do you know any place in Ashaiman here where mental health services can be accessed, participant CM 9 responded as;

*For here, there is no such place like a hospital for such service but rather I know of Accra Psychiatric hospital, that is where I know such treatment services are rendered.*

Regarding mental health services that were not provided, all healthcare providers and caregivers highlighted that the service that was not provided in the mental health facilities was admission of patients.

*Oh apart from ward admission, all other cases are provided. We don’t admit* (HP 6, female Nursing Officer).

### 4.2 Local Concepts about Mental Illness and How These Influence Access to Mental Health Services

Participants believed that mental illness have different causes that can be grouped into physical or medical causes and spiritual causes (witchcraft and Juju). For example:

*Ooh most often than not, they say it is witchcraft, they don’t believe in this our orthodox way of treating it but they believe in the spiritual realm* (38-year-old female nursing officer).

Community members largely hold the impression that mental illness stems from specific acts of the individual such as drug abuse, broken heart, depression, ‘excessive thinking’, stealing. Below are excerpts of respondents’ expression of how certain activities can result in mental illness:

*To me, it is caused by drug abuse and excessive thinking. Most of them are caused by the intake of substances such as wee and tramadol* (CM 9, a 62-year-old female resident of Ashaiman).
A lot of factors, mental distress, economic hardship, broken heart due to actions of others may result in excessive thinking (a 38-year-old trader who lives at Nsuba, Ashaiman).

Participants’ beliefs in the causes of mental illness influence their choice of treatment. Those who believed that mental illness has physical or mental cause are likely to seek treatment at the hospital. While those who attribute mental illness to spiritual and supernatural beings indicated that they will seek treatment at prayer camps and herbal centres. Those who are educated were more likely to seek treatment for mental illness at the hospital compared to those who have little or no education. Those who seek treatments at prayer camps and from herbalists may alternatively resort to the hospital for treatment if it is unsuccessful at their first attempt. When asked whether the community members’ conception about the causes of mental illness influence their choice of treatment, a health provider responded as follows:

Ooh, it (mental health utilisation) is very poor because of the stigma and that is one, the second one, I think is because people think is not eerm hospital-based something they should treat. They rather think of the conditions that are normally caused by witchcraft and all that so they don’t even access the hospital at all .......Normally, they go to the churches and mosques thinking maybe they can have their treatment there. It’s only a few that visits the hospitals (HP2, a 26-year-old mental health officer).

Eeerrm, because they think it is spiritual, most of them, they go and roam in a spiritual, faith-based healing centres before they come. So by the time they come here, it would be worse (HP1, a married female senior officer).

Moreover, community members and caregivers assert that people with mental problems can be identified primarily from their behaviour, such as the way they talk and the way they walk.
For that, I can personally judge from the behaviour of the person. Like the way the person talks or his actions (CM9, a 62-year-old caterer at Ashaiman).

4.3 Socio-Economic Factors Influencing Access to Mental Health Services

Economic status was the major socio-economic factor that reportedly influenced access to mental health services. This is because, participants indicated that mental health services were very expensive especially drugs that are needed to be bought periodically by patients. Most caregivers are old and are on pension hence they find it very difficult to purchase the drugs for their wards. When asked ‘how does your economic status influence your access to mental health services?’, a 73-year-old retired soldier asserted:

Yes, it’s a problem because as at now, I am not working and I have to buy drugs every month. Giving her money to go and buy medicine is a problem (CG6, Male caregiver).

Similarly, health care providers also reported that economic status of their clients affects their access to mental health services since most of the patients were not working and therefore were unable to afford drugs prescribed them. The cost of treatment is normally shouldered by relatives who sometimes are not financially resourced adequately:

Most of our clients don’t work, so most of them don’t have money. So when you write the medicine for them, now we don’t have medicine, when you write the medicine for them, they are not able to buy (HP1, female senior nursing officer).

Community members also expressed that income level of patients and their caregivers affect their access to mental health services. Most of the community members opined that the amount of money they needed to buy prescribed drugs for patients hindered their mental health utilisation. However, some expressed the view that they were not sure whether income
level influenced access to mental health since they were not much abreast with mental illness and the cost for treatment:

*Yes, it does influence access to mental health treatment. Some people do not have the money to purchase prescribed drugs (CM8, a male respondent).*

### 4.4 Challenges with Access to Mental Health Services at the Community Level

Health providers, community members and caregivers all face series of challenges that hinder effective utilisation of mental health services at the Ashaiman community. The challenges that bedevil the mental health facility include unavailability of drugs, inadequate staff and lack of provision for the admission of patients.

Most of the drugs that are needed at the facility are not adequate, meanwhile the few ones provided by the government are not supplied timely. One of the health providers highlighted:

*Like the drugs, mostly it is the drugs. The medications doesn’t come handy like that with them so sometimes you will write it for them, the person will not get the money to go and buy and the person comes back the next time in a very relapsed state (HP6, a female nursing officer).*

The health facilities are also faced with the challenge of inadequate staff and most importantly the absence of provisions for admission of patients. All the health providers interviewed affirmed that clients are not admitted in their facilities and this greatly affect the quality of service provided since they are not able to closely monitor patients who have severe mental problems:

*Ooh, there are various challenges because it’s only the community aspect that they can only access. They don’t have access to maybe being on admission and being taken care of by health professionals on admission. Usually, the community health,*
they just go and then seek help on OPD basis, they see them and they go, which I feel is not enough.....The health personnel also don’t get, because of how they run it on OPD basis, they don’t get the chance to monitor the patients then report or take very good care of them because you treat the person and the person goes home, maybe he goes back to his old ways so it’s like they are doing a cos 90 work (HP4, a male 24-year-old trained nurse).

Most of the community members admitted that they don’t even know whether mental health services existed in the Ashaiman community and therefore are likely to face challenges when they need it:

Yeah, like I don’t even know if there is one here so there is, there are challenges. I don’t even know where it is, yeah... Some of the challenges, for instance, if I know that this place, this hospital, they treat this type of issue, I meant mental issue, I will walk straight there or advice someone, okay go to this place and they will treat you but I don’t know of any one (CM2, a businessman at Ashaiman).

Almost all caregivers and some community members maintained that money to take care of medical bills was their greatest challenge they face in their quest to seek treatment for mental illness. They indicated that they did not have the money to purchase drugs and for transportation. Below, a 42-year-old patient as well as an 80-year old caregiver recounts the challenges they encounter with access to mental health:

Yes, the challenge I face is that they say I should come monthly and every time, I have to get drugs which are not free, they write the drugs for me to go and buy. Money for transportation and purchasing of the drugs discouraged me from going to the hospital at some point. I used to go there once a while but later I was told to come monthly for health check-up (CG4, a male mental health patient).
The challenges we are facing is how to get the medicine. They are not providing us the medicines at all... Yes, it does affect the quality because if you don’t have the money to give for her to go and buy the medicine maybe the sickness will reoccur (CG6, ma pensioner male caregiver).
CHAPTER FIVE

DISCUSSION

5.0 Introduction

In this qualitative study, data gathered through interviews to explore factors influencing the utilisation of mental health services in Ashaiman were carried out among health providers, community members, and caregivers. It was observed that services such as review of clients, public health talks, administration of drugs and referral services were available. However, it was further revealed that community members were unaware of these mental health services. The perception about mental illness was moderate even though health providers and patients sometimes experience stigmatisation. Participants believed that causes of mental illness could be spiritual and their economic statuses also influence their choice of treatment. The mental health facilities are faced with some challenges such as inadequate logistics, inadequate personnel, among others and this affect the accessibility and quality of mental health services in the Ashaiman community. The various findings are discussed in line with the available literature below.

5.1 Mental health services available at the community level

The present study found that there are health facilities that provide mental health services at the Ashaiman community. These services include review of patients, administration of drugs, public health talks, attending to referrals, among others. This finding is consistent with a study by Asare (2014) which reported that at the community level, there are Community Psychiatric Nurses (CPNS) who have been trained to provide aftercare to discharged patients in the community, undertake mental health promotion, and refer cases to regional hospitals or specialist facilities. There seems to be indication that there has been improvement in mental
healthcare since it was reported in 2011 that only 7 community-based psychiatric inpatients services were available in the country (Roberts, Morgan & Asare, 2014). The current study further revealed the types of services available at the various facilities. It is, however, unfortunate that majority of community members reported that they were not aware of mental health services in the Ashaiman community. Some of the community members and caregivers were aware of mental health services existing in Accra and Pantang with some of the caregivers being referred from bigger mental hospitals such as Pantang to the Ashaiman Community hospital with issues of proximity being the reasons for the referrals.

5.2 Local concepts about mental illness and how these influence access to mental health services

There are various widely held perceptions about mental illness worldwide, with most negative attitudes towards those who are affected and to a large extent their families. The present study found moderately negative perceptions about mental illness. Only few participants think that there are existing negative attitudes towards those who are mentally ill as well as mental health nurses. This is in line with a related study which indicated that in the Caribbean, psychiatric illness is associated with significant stigma and people with mental illness or intellectual disabilities are reportedly kept in their homes hidden away from the public because of psychotic behaviour.

In this study, a patient who constantly sought treatment and periodically went for medications at the community hospital expressed that she was particularly concerned about her condition in order not to exhibit psychotic behaviour that will embarrass her grown-up children. In other parts of the world, it is reported that patients were treated humanely but they are seen as embarrassment to their families (Yorke, et al, 2016).
Members of the communities also perceived those who are mentally challenged to be indifferent who need to be treated just like any other sickness which is in a stark contrast to African Americans who saw a person being hospitalised for mental illness as different, inferior to normal people and believed patients should be restricted to society (Brown, 2017).

Negative views and opinions (stigmatisation) such as fear that mental illness are contagious or reveal character flaw which may support negative self-evaluations are reported to harm individual mental health and also present a barrier to seeking appropriate help (Yorke et al, 2016).

Moreover, as opined by Atiola (2016) that people in Africa especially in Nigeria have lay perception of mental disorders, which are still rooted in super-natural belief systems and therefore considered untreatable by Western medicine, the present study found that a number of those affected with mental illness do not seek orthodox mental health care.

5.3 Socio-economic Factors Influencing Access to Mental Health Services

The belief in the causes of mental illness was found to influence the type of treatment sought by members of the community. Those who had the belief that mental illness has spiritual causes were likely to seek treatment at prayer camps. A similar study reported that some religious leaders operate ‘prayer camps’ and conduct ‘healing’ for patients of mental disorders in various places including prayer camps (Roberts, Morgan & Asare, 2014).

The use of primary or alternative services such as religious leaders accounts for the underutilisation of mental health services in societies but health providers indicated that, after mental patients visit prayer camps and herbalists, they later end up at the hospital for treatment if the illness is not cured at traditional facilities. However, the problem with such practice was that their conditions might have deteriorated by the time they get to the hospital.
Therefore, since religious leaders are seen as powerful men, they can play a role by referring congregants with mental illness to seek professional mental health services.

5.4 Challenges with Access to Mental Health Services at the Community Level

Like any other institution, the mental health system in the Ashaiman community is not without challenges. There are specific challenges faced by healthcare providers, community members and caregivers.

Mental health facilities at Ashaiman are bedevilled with the challenge of lack of provision for admission of patients. Patients have access to only OPD services and this affects the quality of their service since they are unable to observe patients. Patients normally come for treatment and go home. They also face the challenge of sometimes not meeting clients at home when they embark on home visitation. The various facilities reported inadequate health personnel. They further expressed worry on inadequate medical supply (drugs). In a related study by Julian and Eaton (2014), most countries in Sub-Saharan Africa are faced with the challenges of inadequate provision of mental health facilities and personnel. They further assert that these challenges accounted for low levels of access to mental health services.

However, a counter observation to the present finding was reported by Orit (2016) which explained that distance was an important factor determining care-seeking behaviour among patients in Ethiopian primary health care units. Caregivers and Patients reported that those who complained about distance from Pantang were directed to mental health facilities in Ashaiman which were closer to them (the patients).

Caregivers and community members expressed the view that their main challenge in accessing mental health services is financial constraint. Most of the caregivers interviewed were old and therefore not working. They indicated that money needed to buy drugs for their
wards every month was their greatest challenge to mental health care. This is supported by a study conducted by Jack-Ide and Uys (2016) which reported that mental health conditions have associated problems such as significant costs to the patients in terms of personal suffering, to the families as a result of the shift of burden of care and lifetime lost productivity and on the society.

According to them, the government previously assisted them by providing them with free drugs but that exercise has since stopped. The unequal distribution of mental health facilities between rural and urban areas coupled with poverty is also reported to account for the low rate of mental service utilisation.
CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

The study revealed that, the factors discussed above in this study influence mental health service utilisation in the Ashaiman community. Financial constraint was the major factor influencing mental health utilisation. The study also found that the mental health facilities face the challenge of inadequate resources. Caregivers and other community members alike were also unable to access mental health services due to economic problems. Other factors such as belief systems, educational level, and perception about mental illness influence mental health utilisation.

6.2 Recommendations

The following recommendations are made based on the findings:

1. Ghana Health Service should intensify education and awareness creation on mental health at the community level.
2. Ghana Health Service should make provisions for admission of mental patients at the facility to ensure close monitoring.
3. Government should improve both human and capital resources to increase access to mental health services.
6.3 Future Studies

Future studies should focus on the practices of traditional and religious healers and the potential for collaboration as the religious leaders are seen as powerful men who can refer their followers to seek professional mental health services when needed.
REFERENCES


APPENDICES

APPENDIX 1: PARTICIPANT INFORMATION SHEET

UNIVERSITY OF GHANA
COLLEGE OF HEALTH SCIENCES
SCHOOL OF PUBLIC HEALTH

Title of Project: Factors Influencing Utilization of Mental Health Services in the Ashaiman Municipality of Ghana.

Objective of the study: To determine the socio-economic factors influencing utilization of community mental health in the Ashaiman municipality

Institutional Affiliation

Department of Health Policy Planning and Management
School of Public Health,
University of Ghana
Legon

Background

Introduction: My name is Farouk-Umar Kassim and I am a graduate student from the School of Public Health, University of Ghana, Legon Accra. I am undertaking a research study on the topic “Exploration of Socio-Economic Factors Influencing Utilization of Mental Health Services in the Ashaiman Municipality of Ghana.” You are being invited to participate in this study to share your experiences and views about how members of your community utilize mental health services. This consent form explains the overall aims of the project, the procedure and content of the interview that will be conducted.
This information sheet is to ensure that you understand the purpose and your responsibilities in the research before you decide if you want to be part or not.

Before agreeing to participate, it is important that you understand the following explanation of the study.

**Procedure**

Taking part in this study will take about 20 minutes of your time and we expect your honest response in answering of the questions. The questions are about your experiences and views on how members of your community utilize mental health services.

The ethical considerations in this study will include the study approval, informed consent, privacy and confidentiality, voluntary participation and withdrawal, risks and benefits, and results dissemination and they have been explained below.

**Study Approval**

Proposal will be submitted to the Ethical Review Committee of GHS, Research and Development Division in Accra for approval to conduct the study. Formal permission will be sought from the Ashaiman Municipal Health Directorate as well as the gatekeepers of the selected health facilities and community. An introductory letter will be written by the Head of Department of Health Policy Planning and Management of School of Public Health, University of Ghana to the health directorate.

**Informed Consent**

The informed consent which will contain the purpose of the study, the various procedures involved, potential risks and benefits of participating in the study and other important things will be adequately discussed with participants in a language they better understand.
Participants will receive a detailed explanation of the study and assured of its anonymous nature and all questions and sentiments pertaining to the study will be answered and addressed appropriately to participants’ satisfaction before they are allowed to participate in the interview. Participants who will agree to participate in the study will be given written informed consent and allowed to read and sign before interviewing them.

Voluntary participation

Participation is voluntary and you have the liberty of refusal to answer any question when they feel uncomfortable as well to even withdraw from the study at any time you wish.

Confidentiality and anonymity

You are assured of privacy and confidentiality in this study. Please do not provide any identifying information like name during or after the interview. Your identity will be kept secret in order to make it impossible for any third party to identify them. Any information shared will strictly be confidential as it is for academic purposes.

Audio recordings will be deleted right after they are transcribed. Collected data will be stored on the computer of the researcher with restricted access. The results will be presented and discussed without revealing the identities of the respondents and their responses. Interviews with participants will be conducted outside your homes at a suitable lace for you.

Potential Benefits and Risk

There is minimal risk involved in the study and may usually come as taking few minutes of your time to answer the questions, which might be a form of distress to you. Results of the study could contribute to a robust policy that would ensure that mental health services are accessible in the community and Ghana at large.
Your rights as a Participant

This research will be reviewed and approved by the Ghana Health Service Ethics Review Committee. Your right as a research participant will not be affected in any way for taking part in this study.

Compensation

There will be no compensation given in this study.

Before taking consent

For further questions, you may contact me:

Farouk-Umar Kassim, School of Public Health, University of Ghana, Legon.

Tel: 0274113330.

If you have any question about your rights as a study participant, you can contact the Administrator of GHS Ethical Review Committee at the following addresses:

Hannah Frapping
GHS Ethical Committee
Research and Development Division
Ghana Health Service
P. O. Box MB 190
Accra.
Office: 030268109
Mobile: 0244516482. Email: Hannah.Frinpong@ghsmeal.org.
CONSENT FORM

PARTICIPANTS’ STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants’ Information Sheet read and satisfactorily explained to me in a language I understand (Asante Twi/Ga). I fully understand the contents and any potential implications as well as my right to change my mind (i.e. withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of this research.

Name or Initials of Participant……………..... ID Code………………………………

Participants’ Signature ………OR Thumb Print……….. OR Mark (Please specify)………….

Date:……………………………………

INTERPRETERS’ STATEMENT

I interpreted the purpose and contents of the Participants’ Information Sheet to the afore named participant to the best of my ability in the (Asante Twi/Ga) language to his proper understanding.

All questions, appropriate clarifications sort by the participant and answers were also duly interpreted to his/her satisfaction.

Name of Interpreter………………………………

Signature of Interpreter……………………….. Date:……………………..
STATEMENT OF WITNESS

I was present when the purpose and contents of the Participant Information Sheet was read and explained satisfactorily to the participant in the language he/she understood (Asante Twi/Ga)

I confirm that he/she was given the opportunity to ask questions/seek clarifications and same were duly answered to his/her satisfaction before voluntarily agreeing to be part of the research.

Name:..............................

Signature................. OR Thumb Print ............. OR Mark (please specify).....................

Date:.................................
INVESTIGATOR STATEMENT AND SIGNATURE

I certify that I have explained the procedure to be followed in this study to the respondent(s) in the language (Asante Twi/Ga) they best understand and they have agreed to participate in the study. All questions and clarifications raised by the participant have been addressed.

Researcher’s name……………………………………………….

Signature ……………………………………………………………

Date………………………………………………………………
APPENDIX 2

1. Interview guide for Healthcare Providers

Introduction

I am conducting a study to assess the socio-economic factors influencing utilization of mental health services in the Ashaiman municipality. I will be grateful if you could spend a little of your time to complete this interview with me. There are no right or wrong answers. Any information provided is private and confidential. This study is only for academic purposes. Your participation in this study is entirely voluntary. Please feel free to answer the questions being asked. Thank you.

Participant Code…………… Date of interview………………

Demographics

The following questions will be about your demographics characteristics (age, marital status, etc)

1. How old are you? …………
2. Sex
3. What is your ethnicity?
4. What is your marital status?
5. What is your highest educational level?
6. What is your job position?
7. Where do you live?
8. How long have you been working here?
9. Which religion do you belong to?
Mental health services available at the community level

10. Could you please tell me the mental health services that are being provided in this facility?
11. What other services are not rendered here?

Local concepts about mental illness and how these influence access to mental health services.

12. What do people think causes mental illness?
13. How does that influence their access to mental health services?
14. Where do they usually prefer to seek treatment for mental illness?
15. What motivates people to bring their wards to this facility to seek treatment?

Socio-economic factors influencing access to mental health services

16. How does the economic status of the people influence their access to mental health services here?

Challenges with access to mental health services at the community level

17. What are the challenges with access to mental health services here?
18. What challenges do you face that affect the quality of services you provide to client?
19. What has been done about those challenges?
20. Could you please tell me what you think needs to be done to overcome the challenges?
2. Interview guide for Caregivers of mentally challenged clients

Introduction

I am conducting a study to assess the socio-economic factors influencing utilization of mental health services in the Ashaiman municipality. I will be grateful if you could spend a little of your time to complete this interview with me. There are no right or wrong answers. Any information provided is private and confidential. This study is only for academic purposes. Your participation in this study is entirely voluntary. Please feel free to answer the questions being asked. Thank you.

Participant Code…………….. Date of interview……………….

Demographics

The following questions will be about your demographics characteristics (age, marital status, etc)

1. How old are you? …………
2. Sex
3. What is your ethnicity?
4. What is your marital status?
5. Do you have children? How many children do you have?
6. What is your highest educational level?
7. What is your occupation?
8. Where do you live?
9. Which religion do you belong to?
10. What is your relationship with this client?
11. How long have you been caring for this client?
Mental health services available at the community level

12. Could you please tell me the mental health services that are being provided in this facility?

13. What other services are not rendered here?

14. Where again in the community can mental health services be accessed?

Local concepts about mental illness and how these influence access to mental health services.

15. What do you think causes mental illness?

16. How would you know someone is mentally challenged?

17. Where do you usually prefer to seek treatment for mental illness? Why the choice?

18. What made you bring this client to this facility to seek treatment?

Socio-economic factors influencing access to mental health services

19. How does your economic status affect access to mental health services here?

Challenges with access to mental health services at the community level

20. Do you face any challenges with access to mental health services here? What are the challenges?

21. How do the challenges affect the quality of services being rendered?

22. What has been done about those challenges?

23. Could you please tell me what you think needs to be done to overcome the challenges?
3. Interview guide for Community members

Introduction

I am conducting a study to assess the socio-economic factors influencing utilization of mental health services in the Ashaiman municipality. I will be grateful if you could spend a little of your time to complete this interview with me. There are no right or wrong answers. Any information provided is private and confidential. This study is only for academic purposes. Your participation in this study is entirely voluntary. Please feel free to answer the questions being asked. Thank you.

Participant Code…………… Date of interview………………

Demographics

The following questions will be about your demographics characteristics (age, marital status, etc)

1. How old are you? ...........

2. Sex

3. What is your ethnicity?

4. What is your marital status?

5. Do you have children? How many children do you have?

6. What is your highest educational level?

7. What is your occupation

8. Where do you live?

9. Which religion do you belong to?

10. How long have you been living here?
Mental health services available at the community level

11. Could you please tell me the mental health services that are being provided in this community?

12. Where in the community can mental health services be accessed?

Local concepts about mental illness and how these influence access to mental health services.

13. What do you think causes mental illness?

14. How would you know someone is mentally challenged?

15. Where would you recommend someone seeks treatment for mental illness? Why the choice?

16. What can be done about someone who is mentally challenged?

Socio-economic factors influencing access to mental health services

17. How does economic status affect access to mental health services here?

Challenges with access to mental health services at the community level

18. Are there any challenges with access to mental health services here? What are the challenges?

19. How do the challenges affect the quality of services being rendered?

20. What has been done about those challenges?

21. Could you please tell me what you think needs to be done to overcome the challenges?
4. Key Informant Interview guide for Healthcare Provider

Introduction

I am conducting a study to assess the socio-economic factors influencing utilization of mental health services in the Ashaiman municipality. I will be grateful if you could spend a little of your time to complete this interview with me. There are no right or wrong answers. Any information provided is private and confidential. This study is only for academic purposes. Your participation in this study is entirely voluntary. Please feel free to answer the questions being asked. Thank you.

Participant Code…………… Date of interview………………

Demographics

The following questions will be about your demographics characteristics (age, marital status, etc)

1. How old are you? …………
2. Sex
3. What is your ethnicity?
4. What is your marital status?
5. What is your highest educational level?
6. What is your job position?
7. Where do you live?
8. How long have you been working here?
9. Which religion do you belong to?
Mental health services available at the community level

10. Could you please tell me the mental health services that are being provided at the community?
11. What other services are not rendered here?

Local concepts about mental illness and how these influence access to mental health services.

12. What do people think causes mental illness?
13. How does that influence their access to mental health services?
14. Where do they usually prefer to seek treatment for mental illness?
15. What motivates people to bring their wards to this facility to seek treatment?

Socio-economic factors influencing access to mental health services

16. How does the economic status of the people influence their access to mental health services here?

Challenges with access to mental health services at the community level

17. What are the challenges with access to mental health services in this community?
18. What challenges affect the quality of services provided to clients?
19. What has been done about those challenges?
20. Could you please tell me what you think needs to be done to overcome the challenges?
5. Key Informant Interview guide for Caregivers of mentally challenged clients

Introduction

I am conducting a study to assess the socio-economic factors influencing utilization of mental health services in the Ashaiman municipality. I will be grateful if you could spend a little of your time to complete this interview with me. There are no right or wrong answers. Any information provided is private and confidential. This study is only for academic purposes. Your participation in this study is entirely voluntary. Please feel free to answer the questions being asked. Thank you.

Participant Code……………………………………………………………………………………………
Date of interview…………………………………………………………………………………………

Demographics

The following questions will be about your demographics characteristics (age, marital status, etc)

1. How old are you? …………
2. Sex
3. What is your ethnicity?
4. What is your marital status?
5. Do you have children? How many children do you have?
6. What is your highest educational level?
7. What is your occupation
8. Where do you live?
9. Which religion do you belong to?
10. What is your relationship with this client?
11. How long have you been caring for this client?
Mental health services available at the community level

12. Could you please tell me the mental health services that are being provided in this facility?

13. What other services are not rendered here?

14. Where again in the community can mental health services be accessed?

Local concepts about mental illness and how these influence access to mental health services.

15. What do you think causes mental illness? What do the people think about mental illness?

16. How would you know someone is mentally challenged? How do they relate to someone who is mentally challenged?

17. Where do you usually prefer to seek treatment for mental illness? Why the choice? What about other people?

18. What made you bring this client to this facility to seek treatment? What makes other people bring their wards to the facility?

Socio-economic factors influencing access to mental health services

19. How does your economic status affect access to mental health services here?

Challenges with access to mental health services at the community level

20. Do you face any challenges with access to mental health services here? What are the challenges?

21. How do the challenges affect the quality of services being rendered?

22. What has been done about those challenges?
23. Could you please tell me what you think needs to be done to overcome the challenges?

6. Key Informant Interview guide for Community member

Introduction

I am conducting a study to assess the socio-economic factors influencing utilization of mental health services in the Ashaiman municipality. I will be grateful if you could spend a little of your time to complete this interview with me. There are no right or wrong answers. Any information provided is private and confidential. This study is only for academic purposes. Your participation in this study is entirely voluntary. Please feel free to answer the questions being asked. Thank you.

Participant Code…………………… Date of interview……………………

Demographics

The following questions will be about your demographics characteristics (age, marital status, etc)

1. How old are you? ………….  
2. Sex  
3. What is your ethnicity?  
4. What is your marital status?  
5. Do you have children? How many children do you have?  
6. What is your highest educational level?  
7. What is your occupation  
8. Where do you live?  
9. Which religion do you belong to?  
10. How long have you been living here?
Mental health services available at the community level

11. Could you please tell me the mental health services that are being provided in this community?

12. Where in the community can mental health services be accessed?

Local concepts about mental illness and how these influence access to mental health services.

13. What do you think causes mental illness? What do other people think about it?

14. How would you know someone is mentally challenged?

15. Where would you recommend someone seeks treatment for mental illness? Why the choice?

16. Where do community members usually seek treatment for mental illness?

17. What can be done about someone who is mentally challenged?

Socio-economic factors influencing access to mental health services

18. How does economic status affect access to mental health services here?

Challenges with access to mental health services at the community level

19. Are there any challenges with access to mental health services here? What are the challenges?

20. How do the challenges affect the quality of services being rendered?

21. What has been done about those challenges?

22. Could you please tell me what you think needs to be done to overcome the challenges?