



RC451.G45

At 4

blthr C.1

G364056

The Balme Library



3 0692 1079 4192 2

PATIENTS' PERCEPTION OF THE QUALITY OF PSYCHIATRIC SERVICES: A STUDY AT THE ACCRA PSYCHIATRIC HOSPITAL

BY:

ATINDANBILA SAMUEL



**SUBMITTED TO THE DEPARTMENT OF PSYCHOLOGY
UNIVERSITY OF GHANA, LEGON, IN A PARTIAL
FULFILMENT OF THE REQUIREMENTS FOR THE
AWARD OF THE M.PHIL DEGREE IN
CLINICAL PSYCHOLOGY**

**DEPARTMENT OF PSYCHOLOGY
UNIVERSITY OF GHANA
LEGON**

APRIL 2000

DECLARATION

I, Samuel Atindanbila, do hereby declare that except for references to other people's work which have been duly acknowledged, this thesis is my original research presented to the Department of Psychology (Legon)

This work has never been submitted in whole or part for any degree in this University or any other University.



.....
SAMUEL ATINDANBILA
(CANDIDATE)

DATE: 30/05/2001

.....
PROF. S.A. DANQUAH
(SUPERVISOR)

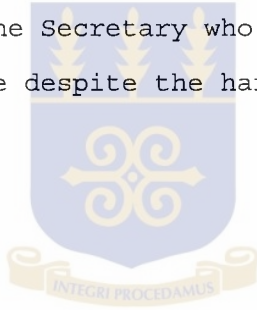
DATE: 8-6-2001

DEDICATION

All Emotionally and Psychologically disturbed clients. They should be given a 'listening' ear to.

My wife (Mama Law) and children (Maggie, Philip, Francis, Tina and Greg) who missed me a lot during the two years as a student.

Becky the Secretary who added smiles and courage to me despite the hard times.



ACKNOWLEDGEMENTS

I would like to extend my profound gratitude to my supervisors Dr. A.L. Ofori-Atta and Prof. S.A. Danquah both at the Psychology Department, University of Ghana, Legon, who have been highly instrumental in diverse ways in bringing this thesis to a successful fruition.

The two supervisors jointly spent their precious time correcting the manuscripts, directing me to the appropriate source and authorities and offering the necessary constructive criticisms. I am therefore, greatly indebted to them.

Furthermore, my heartfelt thanks go to all the Lecturers at the Psychology Department, course mates, floor members of Akuafo Hall Q Block especially Mr. Francis Kpemile (alias Statistic Guru) who contributed in one way or the other to equip me with the requisite knowledge, skills and patience to embark on this study.

I would also like to use this opportunity to spread my tentacles of acknowledgement to the Management of Agricultural Development Bank (ADB) for offering me a fellowship to pursue the M.Phil programme. This financial assistance greatly helped me to be able to carry out an indepth study into this area that has not been studied in Ghana before.

I cannot bring these acknowledgements to an end without expressing any word of appreciation to Dr. J.B. Asare, the Psychiatrist-in-Charge and his staff and the clients of Accra

Psychiatric Hospital who participated in the study for giving me the necessary co-operation to carry out the study.

I would also like to extend a word of appreciation to Mr. K.K. Etsibah, Computer Analyst (ISSER) and Ms. Rebecca Atisu, Secretary (RIPS) who worked conscientiously in analysing and typing the results. In fact without them, the thesis would not have seen the day light.

Lastly, the tentacles of the acknowledgements should be spread to my better-half, the whole family and the Almighty God for providing me with a favourable emotional climate and moral support to embark on this comprehensive work.

To all these people and those for whom space would not permit their names to be mentioned, I say more grease to your elbows and may God bless you.

Samuel Atindanbila

TABLE OF CONTENTS

	Page
DECLARATION	i
DEDICATION	ii
ACKNOWLEDGEMENTS	iii
TABLE OF CONTENT	v
LIST OF TABLES	vii
LIST OF FIGURES AND APPENDICES	viii
ABSTRACT	ix
 CHAPTER 1: INTRODUCTION	
1.1 Background	1
1.2 Statement of the Problem	4
1.3 Research Questions	8
1.4 The Significance of the Study	9
1.5 Hypothesis of the Study	10
1.6 The Operational Definitions	11
 CHAPTER 2: THE LITERATURE REVIEW	13
2.1 Indigenous Ghanaian Beliefs on the Aetiology and Management of Mental Illness	13
2.2 Psychiatric Services in Ghana	25
2.3 The Clients' Expectations of the Quality of Psychiatric Services from the Service Providers	28
 CHAPTER 3: RESEARCH METHODOLOGY	51
3.1 The Research Setting	51
3.2 The Type of Research Design	52
3.3 The Sampling Method	53
3.4 The Tool for Data Collection	54
3.5 The Validity and Reliability of Study	57
3.6 Data Analysis	58

CHAPTER 4: RESULTS	60
4.1 Introduction to the Analysis	61
4.2 The Characteristics of the Sample	
4.3 The Clients' Perception of the Aetiology and Management of Mental Illness	65
4.4 The Clients' Knowledge on the Service Rendered by Clinical Psychologists, Psychiatric Social Workers and Community Psychiatric Nurses	70
4.5 The Clients' Expectation of the Quality of Service from Service Providers	75
CHAPTER 5: DISCUSSION OF THE RESULTS	83
5.1 The Characteristics of the Sample	83
5.2 The Clients' Perception of the Actiology and Management of Mental Illness	84
5.3 The Clients' Knowledge of the Services Rendered by Clinical Psychologists, Psychiatric Social Workers and Community Psychiatric Nurses	87
5.4 The Clients' Perception of the Quality of Services from the Service Providers	88
5.5 Limitations of the Study	95
CHAPTER 6: SUMMARY AND RECOMMENDATIONS	97
6.1 Introduction to the Summary and Recommendations	97
6.2 Summary	97
6.3 Recommendations	99

LIST OF TABLES

Table	Title	Page
1	Age Distribution of Respondents by Sex	61
2	Distribution of Respondents by Sex and Occupation	63
3	Distribution of Respondents by Religion	64
4	Comparison of Group Differences on Belief in Supernatural Causes Due to Education	66
5	Where Treatment was First Sought by Believers' of Supernatural Causes of Illness	68
6	Reasons for First Choice of Health Facility After the onset of the Illness	69
7	Comparison Between Education and Knowledge of the Clinical Psychologist	71
8	Comparison Between Education and Knowledge of Psychiatric Social Worker	72
9	Comparison Between Education and Knowledge of Community Psychiatric Nurse	73
10	The Knowledge and Utilization of the Clinical Psychologist	74
11	The Knowledge and Utilization of the Psychiatric Social Worker	74
12	The Knowledge and Utilization of the Community Psychiatric Nurse	75
13	Educational Level and the Satisfaction With the Overall Assessment	76
14	Clients' Satisfaction with Various Aspects of the Assessment	78
15	Clients' Response to the Satisfaction of Treatment	78
16	Cross Tabulation of Sex Perception of the Availability of Psychiatric Services	81
17	Clients' Satisfaction with the Availability of Psychiatric Services	82

LIST OF FIGURES AND APPENDICES

	Page
Figure 1: Bar Graph of Distribution of Sex According to Education	62
Figure 2: Histogram of the Duration of Mental Illness Among Respondents	65
Figure 3: A Bar Graph of Time Spent in the Hospital	79
Appendix 1: The References	106
Appendix 2: The Questionnaire	111

ABSTRACT

The study was aimed at gathering information on clients' perception of the quality of psychiatric services rendered to them at the outpatients department of the Accra psychiatric Hospital.

The data was collected with the aid of a structured interview schedule. The main findings were that clients are generally satisfied with the quality of services rendered to them at the Psychiatric Hospital on most of the indices used. However, they had dissatisfaction in the following areas: No investigations ordered for them, their diagnosis not explained to them and there were no home visits by the health professionals.

It was also realised that the clients did not have much knowledge regarding other important professionals in the Psychiatric Hospital like the clinical Psychologists, Psychiatric Social Workers and Community Psychiatric Nurses whose services they may need.

It also indicated areas of further study like finding out why almost all the clients complement the Hospital treatment with traditional medicine.

CHAPTER I

INTRODUCTION

1.1 BACKGROUND

According to Osei (1994), the nature and quality of psychiatric services available in Ghana have been summarised in the assertion of Matthew Rose (1964) as follows:

"The visitor to West Africa cannot fail to be impressed by the contrasts both between countries and within countries. Neighbouring Ghana, Liberia and Nigeria provide interesting examples. In Ghana, one sees evidence of much of what is most modern and progressive, yet, regretfully, activities in the psychiatric field are most primitive and unenlightened".

This statement and similar literature findings gave grounds for the study. Much literature on African beliefs regarding the etiology of mental illness has focused on belief in the supernatural and to popular belief that psychiatric patients prefer to seek treatment from traditional healers who can get into contact with the metaphysical world and thus unveil appropriate treatment (Senah, 1987; Danquah, 1979).

With the advent of modernization, this study seeks to verify if this mentality has changed or not and how it has affected the perception of the client with regards to his choice of treatment.

In reviewing literature on mental illness from WHO studies, Azinge (1983), a leading Psychiatrist, found that in the developing countries 25 percent of the clients at the

General OPD present psychiatric illness. These findings were supported by a collaborative study by WHO (Harding et al. 1980; Clement et al 1980; Wig et al. 1980) that more than 10 percent of General OPD Clients suffer from neurosis present with physical illness.

In the view of Azinge, the management of such patients in the General Hospital is difficult since they might need the involvement of non-medical and community resources. Due to the lack of these resources, they take up the primary health care staffs' time, they may be inappropriately and expensively investigated, they do not respond to various physical therapies and often become repeat attendants. He concluded that such patients form a dissatisfied and frustrated group of clients.

The studies also revealed that the community allocates the highest priority to acute and chronic psychosis, epilepsy and other crises. Even despite their susceptibility to modern psychiatric medications, these patients are rarely sent to the hospital. Referrals to the Psychiatric Hospitals are only the violent, unmanageable or intractable patients mostly because they could no longer be conceited or treated at home (Holmes and Splight 1975, Bankowshi, 1996)

According to Danquah (1982), Clinical Psychology was first introduced into Ghana in 1971. At present there are five practising clinical psychologists in the country. The services offered include psychotherapy, behaviour medicine, rehabilitation, psychiatry, cognitive assessments and palliative care (Danquah, 1996) The services are offered

from the Accra Psychiatric care, from which 4 of the psychologists work.

The question is are clients aware of these services in the Psychiatric Hospital?. If they are aware, why do more of them not seek care there. Do they patronize traditional healers? This leads to a further question as to whether those who come to the Psychiatric Hospital on OPD basis achieve satisfaction for the services rendered to them.

Otoo (1996), a one time Director of Health Service in Ghana, stated that the origins of the clients' expectations of the quality of services rendered to them by the Ministry of Health had it's antecedents in the 1980s. This was the time the Government introduced the 'cash and carry system' and when patients started paying for their services, they demanded better services from the service providers.

Since then, the need to meet the clients' expectations in the Hospitals had been gradually gaining recognition by prominent health policy makers in the country. The Regional Directors of Health Services in Ghana in one of their quarterly meetings in 1989, realised that although the coverage of services had increased, the quality of services was actually declining. The observation was supported by a little change in the health status indicators. The overall utilization of the OPD facilities had fallen and had been estimated at only 0.35 attendance per persons per year in 1987 which was less than one third of the rate in 1977 (Dovlo 1995).

In 1991, clients' expectation of the quality of care rendered to them began to rise as the user fees kept mounting especially in Government Health facilities, placing these in open competition with Mission Hospitals, private institutions, herbalists and chemical shops. Based on these, the Health Research Unit of the Ministry carried out studies in the Eastern Region of Ghana to find out what the public expects from Health Workers.

As a result of these studies, the following list of items were used to assess and meet the quality of care expected by the clients: Drugs, diagnosis, referral system, sanitation, laboratory, infection control, mortality and drug labeling.

Since these items above were established, health workers in the General Hospitals have been using them to assess the level of satisfaction of their clients. Unfortunately no such study has been carried out in any of the three Mental Hospitals or on the Psychiatric wings in the General Hospitals. In view of this, the researcher would like to use a modified scale and also find out the expectation of psychiatric clients.

1.2 STATEMENT OF THE PROBLEM

As can be seen from the background discussion, many factors gave rise to the study of the perception of clients regarding the quality of psychiatric services rendered to them on OPD basis.

As stated earlier, the causation of mental illness is linked to the supernatural powers. As a result help is sought

first from the traditional healer who has been endowed with special powers to communicate with the supernatural world and restore health to the individual (Twumasi, 1975; Danquah 1979 and 1982). These findings were made roughly 20 years ago so the study would like to find out if such beliefs still exist.

However, several authors, including Ofori-Atta & Linden (1995), have written that attributions of causes of mental illness among Africans also include natural causes (heredity, faulty diets, bad blood and use of cannabis) as well as the supernatural forces. Razali (1996) also outlined other attributions such as severe mental stress and immorality. This study would therefore find out patients' view with regards to the aetiology of their own condition which invariably will determine their choice of treatment.

Furthermore from the researcher's observation, it is clear that patients do not patronize the Clinical Psychology Unit at the Accra Psychiatric Hospital. Those who come there are mostly referred there by the Psychiatrists. Rarely does the clinic get referrals from the General Hospital since about 10 percent of the OPD clients have neurosis (Wig et al, 1981; Danquah, 1983).

This gives an indication that the clients might not be aware of the services of Clinical Psychologists. It is also doubtful if they have knowledge about other professionals like Psychiatric Social Workers and Community Psychiatric Nurses who are closely linked with their therapies. Could it also be that because of their insignificant numbers they are not making an impact? Or the Ministry of Health does not create

the conducive climate for the practices of such supportive staff to gain grounds in the country. This observation has support from a leading Ghanaian Psychiatrist Yaw Osei (1994) who said that

"Inspite of all rhetoric, our politicians and health planners are yet to recognize the importance of psychiatry in a society in a crisis of identity".

Offei (1995) the Eastern Regional Director of Health Services, in an address to his colleagues, made a public statement that Health professionals would argue that the quality of health care delivery had been at the heart of the profession since the days of Hippocrates and Florence Nightingale.

However, he said, they should be prepared to admit that all was not well with the care they render to their clients. He then called on all Health Workers to look at ways to satisfy their clients by identifying factors that clients perceive to be important for the quality of health care delivery in the health facilities. This, to him, was important because when their clients are satisfied with the care that they receive they are likely to utilize the facility better. Furthermore, it would provide the health workers their justification for continuing employment in the service with the proposed introduction of the Ghana Health Service and the Health Insurance Scheme.

In the following year, the former Minister for Health, Brookman-Amissah in a speech delivered at the conference on Medical Education held in South Africa (1996) noted that in

the future health care delivery systems would increasingly be judged by the extent to which they (health care system) respond among other things to 'the quality of care provided'.

According to Brown (1996) despite the awareness of the concept of client satisfaction as can be seen above, few efforts in research have been made to improve the quality of services except on measuring changes in mortality and morbidity or measuring coverage rates. The few studies in this regard have only been carried out in the General Hospitals in the Eastern Region of Ghana. None of such studies has been carried out in any of the three Mental Hospitals in Ghana.

This is sad because a large populace of the Ghanaian clients' views on the quality of health service rendered is ignored. This is so because Egdele (1983) reports that studies in the third World achieve remarkable consensus in the finding that 1 percent of the population suffer from a major mental illness at any one time (excluding alcohol-related problems). A further 10 percent are affected at some time during their lives.

Apart from the above reason, the level of satisfaction of psychiatric clients with regards to health care delivery should be given at least as much priority as those with physical ailments since the level of satisfaction with the health care delivery system determines their rate of recovery (Burnard, 1994).

This study seeks to address the lack of information concerning the level of satisfaction of psychiatric patients,

their knowledge of the varied services rendered by clinical psychologists, community psychiatric nurses and psychiatric services workers. In addition, it is aimed at finding out whether in the light of modernization, patients still attribute the cause of mental illness to supernatural forces or not, since this belief greatly dictates to them the choice of treatment.

1.3 RESEARCH QUESTIONS

The heart of the study is based on the following questions:

1. Why do clients with psychiatric conditions report to either the General Hospitals or Traditional Healers instead of Psychiatric Hospitals?
2. Do the clients have adequate knowledge on the availability of psychiatric services in the country?
3. Are the clients satisfied or not satisfied with the services given to them at the Psychiatric Hospital?

The implications from these questions raised include the following:

1. The need to find out the expectations of the psychiatric clients in order to satisfy them and increase the utilization of their services.
2. The need for the psychiatric health workers to increase the awareness of the morbidity of mental

illness and the availability of psychiatric services using the biopsychosocial model approach.

3. The need for health professionals to have in-service training in modern psychiatric principles.
4. The need to have greater co-operation between health professionals, community leaders, clients, and traditional healers.

These observations, implications and burning issues from the above studies, therefore contributed, in no small measure, in stimulating the researcher to find answers to them through a study.

1.4 THE SIGNIFICANCE OF THE STUDY

The study aims mainly to initiate new models of treatment for psychiatric patients at OPD.

In view of this, the study is focused on finding out:

- i) the areas of satisfaction as well as dissatisfaction from the patients' point of view on the quality of services given to them at OPD;
- ii) the areas of Psychiatric services that could be sold to the Public in order to increase their utilization;
- iii) where both medical and psychiatric staff need in-service training to improve their quality of psychiatric service;
- iv) the knowledge of the clients with regards to the aetiology and management of mental illness so that

appropriate health education programmes could be organized for them.

1.5 THE OBJECTIVES OF THE STUDY

General Objective

To evaluate factors that contribute to the clients' satisfaction at OPD level at the Accra Psychiatric Hospital.

Specific Objectives

1. To evaluate the psychiatric clients' knowledge on the aetiology and management of mental illness.
2. To determine the psychiatric clients' knowledge of the availability of psychiatric services in the Hospitals especially those rendered by the Clinical Psychologists, Psychiatric Social Workers and Community Psychiatric Nurses and
3. To evaluate the psychiatric clients' satisfaction or expectations of the services rendered to them in the Accra Psychiatric Hospital on OPD basis.

1.6 HYPOTHESES OF THE STUDY

Emanating from the research problem and the study objectives, the following hypotheses are to be verified:

1. There is a significant relationship between the educational level of patients and the perception that mental illness is caused by supernatural forces.

2. Patients who attribute the causes of their mental illness to sueprnatural forces are likely to consult the traditional healer/spiritualist first for management before orthodox medicine.
3. There is a significant relationship between the educational level of one and the knowledge of clinical Psychologists, Psychiatric Social Workers and Community Psychiatric Nurses.
4. There is a significant relationship between the educational level of the clients and the satisfaction accorded to clinical assessment by the service providers.
5. There is a significant relationship between the sex of the respondents and the perception of availability of Psychiatric services in the Hospital.

1.7 THE OPERATIONAL DEFINITIONS

The following operational definitions have been used for the key words in the study.

1) 'Clients'

'Clients' refer to adult patients between the ages of 16-64 years inclusive who report at the Accra Psychiatric Hospital for OPD services. They must also be in touch with reality.

2) Clients' Perception

This refers to the clients' opinions and attitudes with regards to the following:

- a) The causes and management of mental illness
- b) The awareness and availability of psychiatric services rendered by Clinical Psychologists, Psychiatric Social workers and Community Psychiatric Nurses
- c) The degree of satisfaction with the psychiatric services rendered to them at OPD level.

3) The Quality of Psychiatric Services

These refer to high standards of the following psychiatric services rendered to the clients:

- a) Thorough assessment of the clients
- b) Good outcomes of care
- c) Availability of competent psychiatric staff and drugs for the clients
- d) Less time spent in receiving the psychiatric services
- e) Clean hospital environment.

4) Accra Psychiatric Hospital

This is the oldest Psychiatric Hospital located in Accra which receives psychiatric clients from all parts of the country.

5) O.P.D. Clients

These are clients who come to the hospital and are treated and discharged on the same day instead of being admitted.

CHAPTER II

THE LITERATURE REVIEW

The literature review of this study will be discussed according to the objectives of the study as follows:-

- (1) Indigenous Ghanaian beliefs on the aetiology and management of mental illness.
- (2) Psychiatric Services in Ghana and
- (3) The clients' expectations of the quality of psychiatric services from the service -providers.

2.1 INDIGENOUS GHANAIAN BELIEFS ON THE AETIOLOGY AND MANAGEMENT OF MENTAL ILLNESS

- (a) The Aetiology of Mental illness as held by the Indigenous Ghanaian

Twumasi (1988) has asserted that before the advent of the whiteman to the Gold Coast in 1471, there were ethno-medical practitioners in Ghana to attend to common ailments. These practitioners were held in high esteem and regarded as opinion leaders when it came to health matters.

Many authorities have it that the traditional Ghanaian accepts from early childhood that the socio-physical environment is heavily impregnated with supernatural forces. Hence mental illness results from evil machinations of the enemy through witchcraft, ancestors, lesser gods and other cosmic forces (Field 1960, Lambo 1962, Erinoshio 1977, Danquah 1979, Twumasi 1988)

Senah (1987) explains this concept further by stating that the aetiology of mental illness is not readily known but it tends to have a sudden onset, weird, bizarre and chronic symptoms and has a highly incapacitating course. The traditional Ghanaian claims the condition is caused by infringement of the law of supernatural forces, the Supreme Being, Ancestors or lesser gods.

The social causative theory of mental illness as described above has also been espoused by subjects in most recent findings. Bankowski (1996) has demonstrated that in most traditional African societies, mental illness is thought to be induced by human beings by means of sorcery, witchcraft, magic or by divine agents like departed ancestors and angry gods. He concluded that in the traditional African concept, nothing seems to happen by itself.

Very current studies by Whyte & Ingstad (1998) also suggest that knowledge about mental illness in West Africa is coloured by perceptions of the body and how it functions, the place of the individual in the society and the cosmological forces that affect human beings.

One aspect of mental illness that has been empirically studied in Ghana is mental retardation by Danquah in 1976. In this study it was found that the condition was associated with a curse from supernatural beings. However, about 5% of the educated respondents attributed it to genetic factors.

In view of the belief that developmentally retarded children are a curse, methods suggested in handling such children include infanticide, abandoning them in the river banks, or hiding them from public view.

In the same way as Danquah (1976), and Razali (1996) revealed other causes of illness apart from supernatural forces, gave other causes such as severe mental stress and immorality. Ofori-Atta & Linden (1995) have also expressed the opinion that in addition to supernatural forces, there are also natural factors.

Ofori-Atta & Linden further asserted that beliefs depend also on acculturation, education and the socio-economic status of the people. In the face of the recent urbanization and education and its attendant consequences of fading traditional beliefs, the study would like to find out if the aetiology of mental illness expressed by Bankowski, Danquah and Twumasi still hold.

(a) Types of traditional Healers for Mental illness in Ghana

As can be seen from the above authorities, the beliefs regarding causation of mental illness are linked to religious beliefs and societies. Hence psychiatric help is usually sought first from the traditional healer who has been endowed with special powers to communicate with the supernatural world in order to restore health to the client.

Twumasi (1975) classified the traditional healers of mental illness into the following groups: Spiritualists/Diviners, Herbalists and Faith Healers

(i) Spiritualists/Diviners

According to Osei Field (1962) remarked that in the 1930s, the shrines were the first resort of people who were mentally ill, whether trivially or gravely, because the

illness is regarded as supernaturally determined and hence outside the province of hospitals.

The diviners at these shrines are priests or priestesses of cults of the Supreme Being, ancestors or lesser gods. They derive their powers from supernatural forces for diagnosing and treatment. They normally wear peculiar regalia that serve both for therapeutic and identification purposes for their clients.

(ii) Herbalists

Herbalists are the most numerous amongst the traditional healers and there were also patronized by the mental clients in the 1930s according to Field. They receive their training from their relatives through the oral tradition. They use mostly herbs from the environment for their healing. Some of these herbalists sell their preparations in open markets or travel from place to place to sell them.

iii) Faith Healers

According to Osei (1994) the trend above of Psychiatric clients patronizing both shrines and herbalists started declining in the late 1940s when the indigenous African churches started springing up. This resulted from the fact that Ghanaians who considered themselves too sophisticated to visit a shrine turned to the spiritual churches.

The Faith Healers blend the use of holy water, bibles, and elements in traditional Christian religion with traditional African rites of sacrifice, herbs, occult practices, traditional songs and dances in their healing sessions.

They also redramatize the events of Pentecost by the spirit of possession and speaking of tongues. Examples of such places where such healing practices take place are the churches of Mosama Disco, Aladura, Nakaba, and the Wandering Virtuosos.

According to Twumasi (1988), apart from church services, leaders of these churches operate healing sessions. Certain days of the week or occasions are set aside for healing purposes. Some also have clinics where both their church members and non-members go for healing.

(c) The diagnostics techniques of Traditional Healers for Psychiatric clients

An ardent scholar of Traditional Medicine, Senah (1996), indicated that the traditional healers use the following diagnostic tools in order to reach any meaningful diagnosis:- anamnesis, divination, the symptomatology presented by the client and examination of his specimens.

(i) The Symptomatology of the presenting condition

The traditional healers take a detailed history of the signs, duration, relieving agents and other related complaints. They also make use of information gathered from secondary sources like co-workers, relatives and friends on the nature of the condition.

(ii) Examination of the client's specimens

Urine, stools, sputum etc are examined to rule out certain medical conditions.

(iii) **Physical examination of the client**

Depending on the signs and symptoms accompanying the mental illness, the healer might ask for the client's specimens such as orthodox medical practitioners would request. They also inspect, and palpate clients to facilitate and validate their diagnoses. This physical examination is also considered highly therapeutic for the clients.

(iv) **Anamnesis**

This is the most important technique used by almost all traditional healers. The healer takes a very detailed psychosocial history of the client. According to Twumasi (1985), he would enquire whether there were any social disturbance, a disordered social relationship or an inability on the part of the client to communicate effectively with any household relative.

During the interview, he uses communication skills that facilitate therapeutic communication from the client. These include paraphrasing the sentences of the client, using open-ended questions, therapeutic touches etc. Through this method, the client indirectly gives out what he thinks is the cause of the condition for him.

This method is therapeutic since the clients are given the chance to share their feelings.

(v) **Divination**

This is yet one of the most powerful diagnostic tools. Through this method, the healer gets into contact with the metaphysical world to unveil the secrets responsible for the

clients ailment. It is thought to accurately direct him to the cause, prognosis and management of the condition.

Depending on the individual healer's training orientation, they use varied means like cowries, ordeals, soothsayers, dwarfs, trance and gazing of mirrors, reading signs on the palms or in water. This diagnostic technique places the traditional healer at a better advantage than the orthodox medical practitioners.

(d) The Traditional Treatment of Mental illness

Introduction

According to Danquah (1982) in view of the above, the choice of treatment is not associated with proximity nor with cost of treatment but rather with the type of belief concerning the etiology of the illness.

He said most patients with neurotic symptoms such as bodily pains, headache, insomnia, burning sensations in the head etc. first report to medical officers. In most cases, medication only gives temporary relief. They are then referred to the psychiatrists after several visits. The psychiatrists may continue with medication without success because they are pharmacologically oriented and sometimes have to cope with behavioural problems which they have not been trained to handle.

It should also be noticed that the undesirable effects of medication contribute to the non-compliance with the medication regime. Apart from that, although the somatic anxiety symptoms are often temporarily ameliorated by

medication, the psychosocial source of the anxiety and illness remains. Other serious effects are dependency to the drugs and the side effects.

The patients then lose confidence in the entire scientific approach. Both the patient and relatives then draw conclusions that the condition is beyond the understanding of modern medicine. The patient is then sent to the traditional healer who can unearth the supernatural powers.

A further study which supports Danquah's 1982 assertion is by Asenso-Okyere et al (1998). It was found that patients spend a lot of time seeking the cause of the disease and possible treatment before coming to Hospital. This was especially true of conditions considered to be spiritual in origin and which would therefore need spiritual treatment. According to Asenso-Okyere et al, the delays in reporting to Hospitals deals more with superstition than with the lack of money. The consequence of such beliefs is that diseases may be reported to Hospitals only when they can not be handled by those traditional practitioners and are in the advanced stages.

A similar study by Komla (1997) has it that clients believe that one can not treat any illness without adequately dealing with the spiritual factors which ultimately account for all illnesses and other human misfortunes. Other studies cited by Komla such as done by Geair (1991), Ngokwey (1994), and Bierlich (1995) support this. These studies found that there is always the tendency to look beyond the physical treatment of illness, to the spiritual. Thus treatment often

includes abstaining from particular types of food, alcohol, or sex during and or after treatment.

Senah (1997) classified the therapeutic approaches to mental illness by traditional healers under the categories of traditional pharmacopoeia, Occult, preventive and psychotherapy.

Traditional Pharmacopoeia

The use of parts of plants such as leaves, roots, seeds and bark of trees which can be processed into forms such as concoctions, ointments or powders. The routes of administration take several forms such as enema, oral inhalations, and instillation into the nostrils, eyes or ears.

Occult Therapy

Each healer in his training has been well equipped with varied forms of "weapons" to fight invisible force. These include sacrifices to pacify the magico-religious forces. The healer also utters prayers, gives off alms, utters incantations, and invocations to effect the therapy

According to Twumasi, (1985), before therapy is given to the client, a ritual ceremony is normally done to augment the potentiality of it. The clients are also given guidance on how to live with other members of the household, on how to take the drugs and the type of food to eat.

Preventive Measures

According to Danquah (1982), the client is made to believe that witchcraft practice is responsible for his condition and people who envy him are the cause of his

problems. These identifiable individuals or objects in the patient's immediate environment channel his anxiety into a phobic one.

He is then taught avoidance behaviour to reduce the anxiety. He can be instructed not to come face to face with the enemy or he can be given some charms, amulets, talismans to wear for protection against any further evil forces, enemies or bewitchment.

If the anxieties disappear temporarily, they are given discharge rituals to prevent a recurrence of the condition. When the patient breaks the instructions he returns to the healer for interventions.

Psychotherapy

The traditional healers use a lot of psychotherapy to effect a rapid recovery of the clients as discussed below:

Music and Dancing

Music as a form of therapy for emotional problems dates back to Biblical times when David used music for Saul when he was tormented mentally (I Sam 1:14-23).

In the same vein, the healers teach their clients therapeutic songs which portray the impression that the Supreme Being or the Ancestors or lesser gods can be depended upon. The clients also drum, dance and socialize during such occasions, which increases team spirit, thus cushioning their emotional problems.

According to Bruning and Frew (1987), the following factors account for the reduction of stress during singing of songs and dancing: Firstly, during these activities, morphine

University of Ghana <http://ugspace.ug.edu.gh>
- like substances called endorphins are released from the pituitary gland. They act as painkillers and also stimulate brain cells to produce dopamine which produce a feeling of euphoria and natural well being. These chemicals may remain elevated for as long as 30 - 60 minutes following the exercise.

Furthermore, music and dancing allow clients to clear their minds of troublesome worries because they decrease the time they have to spend attending to stressful things.

Lastly, it gives them the chance to socialize and release tension.

Bible Quotations

Clients are normally given quotations from the Bible, which are relevant to their respective problems. Favorite quotations like Ps.34:19, Mt. 6:25-31. Mt. 8:1-9 are normally cited in which Christ entreats his disciples to refrain from anxieties since He can heal all of them.

3. Confessions of the Clients

Clients are also asked to confess their sins and offer sacrifices to pacify the gods. In accordance with their beliefs, they often recover very fast after such confessions and rituals.

The Patronage and Efficacy of Treatment of Mental Illness

The popular belief that traditional healers are particularly well equipped to handle mental illness has been reflected in a study by Razali (1996). In this study, 73% of a sample of Malay Psychiatric clients in a general OPD had consulted a traditional healer first as compared with 25% who

had first seen the doctor.

In addition, most of the psychiatric clients who had not yet consulted a traditional healer said they would do so if the current treatment failed.

Another study by the same researcher in Burkina Faso in the same year also revealed that the West African has a strong belief that modern methods are good for physical illnesses but powerless against supernatural causes because they deal merely with symptoms to give temporary relief but the underlying social and moral problems still remain.

Furthermore, according to Osei (1994) out of 65 clients admitted to Komfo Anokye Psychiatric Unit between January and March 1993, 8 (14:3%) had come directly from healing churches where they had been in-patients for an average of five weeks.

Thirty-one of them (55:4%) had sought help as outpatients from a healing church at one time or the other before coming to the hospital. He added that his colleagues working elsewhere in Ghana reported similar observations. All these observations point to the fact that a respectable proportion of Psychiatric patients' first contact point is the traditional healer or the church.

This study is aimed at finding out the situation at the Accra Psychiatric Hospital.

On the efficacy of traditional medicine, Razali (1996) has stated that studies have shown that mild temporary relief is frequently obtained for neurotic disorders but much less often for psychotic disorders. This agrees with the findings of Osei (1994) that traditional healers offer useful service

to clients with predominantly psychoneurotic illnesses but are of little help (except in the provision of accommodation and a more tolerant environment) to those with psychoses and personality disorders.

2.2 PSYCHIATRIC SERVICES IN GHANA

According to Osei (1994) the history of modern psychiatry in Ghana is linked with colonial rule. Sir Griffith, a then Governor of Gold Coast introduced the Asylum System into Ghana in 1888.

E.B Forster, the first Africa psychiatrist South of the Sahara, took up appointment in 1951 at the lunatics Asylum and eventually turned it into the Accra Psychiatric Hospital. He encouraged the training of more psychiatric staff and introduced the teaching of psychiatry into the curriculum of medicine when the medical school was first opened in 1964.

With Independence of 1957, free medical and psychiatric services were provided. Different categories of personnel including psychiatric staff, were trained by the Ministry of Health. The Ankaful psychiatric Hospital was built in 1968 in the Central Region.

Around the 1970's, Col. I.K Acheampong, by his NRC Decree 30 of 1972 improved on the 1888 ordinance, and a third psychiatric hospital at Pantang in 1975 which was purported to be the largest in West Africa, had it been completed.

Osei then goes on further to say that these three hospitals are only called 'hospital' in name because Accra Psychiatric Hospital for example has not got its own laboratory, X-ray equipment or other diagnostic facilities.

Ankaful and Pantang are also sited well away from the people they are intended to serve and remain unattractive to staff and patients by their lack of general amenities.

Around the 1960's there was a worldwide increased emphasis on the need for modern psychiatric services. Balier (1964) gives a summary of a good service as follows:

"The essential foundation of a good psychiatric service is based on a continuing doctor-patient relationship. In other words, the patient is always under the care of the same consultant whether in the Hospital or in the community. This continuity is an essential condition to the maintenance of the doctor-patient relationship and should take priority in every form of treatment".

Kidd (1967), writing on the same topic, has it that unless a mental Hospital in its present position can cater adequately for the psychiatric needs of the population it serves, it must go. He therefore, recommended the open door system where treatment should be at the Hospital and/or at home. The essential aspect of such a system would include absolute continuity of care so that the patient relates not only to the same psychiatrist but also to the same clinical psychologist, psychiatric social worker, community psychiatric Nurse and other professionals who share his philosophy of treatment.

To this end, he recommended that such staff should have their own offices in the Hospital, attend Hospital team meetings, out-patients, ward rounds and keep in close touch

with their patients, both within and outside the Hospital.

According to Denham (1967) psychiatric patients in a Hospital, like any group of people who spend a long time in an institution, develop defects of personality, amongst which the loss of initiative appears to be the most noxious. He added that treatment of acute psychiatric patients is a professional process but rehabilitation is a social one. Social rehabilitation aims to reverse the process of social isolation and institutionalization. These roles are performed by Clinical Psychologists, Psychiatric Social Workers and Community Psychiatric Nurses.

In response to the need to adapt to the modern role of treating psychiatric patients, the Ministry of Health introduced a Community psychiatric Programme in 1990. This led to the rise of community psychiatric units in all the regions in the country to be run by Registered Mental Nurses (Osei 1994).

Clinical Psychology was introduced in 1971 as a Unit of the Department of Psychiatry in the Ghana Medical School (Danquah 1982). There are right now 6 of such professionals in the country and over 20 under training in the Psychology Department of Legon. It is interesting to note that out of these 6 Clinical Psychologists, only 3 work for the Medical School and one for the Ministry of Health. Two work at the University. The other 2 Psychiatric Hospitals have no clinical Psychologists.

Psychiatric social workers are attached to all the Psychiatric Hospitals. There are 2 Psychiatric social workers

in the Accra Psychiatric Hospital. The study would like to find out if patients are satisfied with the services rendered by these mental health professionals. It also aims at finding out if the Accra Psychiatric Hospital's policies have embraced this new concept of a multi-disciplinary approach to psychiatric services.

2.3 THE PSYCHIATRIC CLIENTS' EXPECTATIONS OF THE QUALITY OF SERVICES FROM THE SERVICE PROVIDERS

Introduction

Historically, according to Danko et al (1988), health professionals have been the gateways to treatment and decided when, and how to treat them best. However, two recent studies (Folse 1984, Kurz & Wollinsky 1985) question that assumption. Folse reported that 65% of all patients were actively involved in Hospital selection and 35% made that decision automatically.

Given that patients now play a more active role in Hospital selection, it is necessary to achieve a better understanding of their characteristics so that Hospital offerings can be developed to meet their needs effectively, rather than just the health person's needs.

It has been found that the clients' satisfaction with health care is important for several reasons. Kathryne and Miles (1992) cite the following studies to support the reasons. Firstly, satisfied patients are more likely to maintain a consistent relationship with a specific service provider (Marquis, Daviles & Wave 1983, Strasser & Schweikhart

1992). Secondly, by identifying sources of dissatisfaction, the Hospital can address system weakness thus improving its risk management (Strasser & Davies 1991) Thirdly, satisfied patients are more likely to follow medical regimens and treatment plans (Wartman 1983, Dovlo et al (1995).

Wollinsky & Kurz (1984) discussed factors that have much influence on a patient's choice of hospital as follows:-

- (i) Predisposing characteristics - These include the patient's age, sex or educational level. These factors precede the onset of the illness requiring hospitalization.
- (ii) Health status - People with chronic or serious or acute conditions are more likely to identify quality-related hospitals than those with mild ailments
- (iii) The clients' qualitative evaluation of prior contacts with health care especially the Hospital. For example, a client's satisfaction with previous medical treatment may influence his choice of that hospital again.

In view of this, a number of researchers have thrown more light on the client's expectation from the service providers as below:-

- (a) Thorough assessment of the client by the service providers
- (b) Availability of effective psychiatric services to clients
- (b) Human Relations of the service providers

(c) Time spent in the Hospital

The study has the following strengths and weakness:

The Study is recommendable because it has outlined the criteria by which research can be done to assess client satisfaction. However, the main weakness of this study is that it failed to give the nature of impact that these could have on the level of satisfaction. Furthermore, this study is foreign based. This present study seeks to correct these defects by finding out the effect patients' characteristics have on the criteria outlined.

(a) **Thorough Assessment of the clients by the service providers**

Most clinicians according to Nietzel et al (1994) believe that the first interview is most important because of the following reasons:

By the time the client arrives for the initial contact, he would have gone through several self-screenings.

Whether he comes alone or with relatives, as a rule, their support system and other problem solving resources have been exhausted. Hence the clients expect that their complaints be taken seriously.

It is also during this time that the most satisfactory history can be secured because both the client and the relatives are often eager to provide information in the first interview because of the increased levels of anxiety and the stranger-on-the train phenomenon. If there is any time lapse, resistance may develop and they may not give any more

information (Siasi 1984). Lastly, the clinician should also obtain enough information to enable him formulate a rational plan after the first interview.

According to Kaplan & Seccuzo (1993) although the length of interview depends on the co-operation of the client, clinician's experience, and the data collecting techniques a period of 45-60 minutes is enough to gather sufficient relevant data for tentative diagnosis, formulation and planning.

Boland (1995) has shed light on most of the expectations of clients with regards to assessment from the clinicians. They expect the clinicians to take into account their environment like family, work place and community when assessing their problems. Some also want them to go beyond the overt reason for the consultation and check for other illness, interpret future illness and give them medical advice about their lifestyles. Some of the clients even expect the clinician to explore the meaning of the illness in their life and help them understand the illness and how it might contribute to their growth.

On the other hand, some clients resent being taken beyond their agenda to issues which they consider to be their own business. Examples include their eating habits, smoking and sexual life etc.

Burnard (1994) also stated that there should be eye contact throughout the discussion. He warns clinicians that the client does not feel scared or intimidated by the clinicians' eye-contact. Eye contact according to him rather

ensures that the client feels listened to, understood and feels comfortable.

The study also pointed out that clients with problems of living (mental patients inclusive) always come to the clinic with their prescribed mode of therapy. These findings cannot pass without comment. In the first place, this study will find out the mode of therapy most patients present to therapists and why the clients need the therapist if they already have the therapy.

The patient's characteristics also account for the degree of assessment done by the service provider. According to Clark, Potter & McKinley (1991), patients who are older, female, have greater education and come from middle and upper classes, are given more time, ask more questions and get more explanations.

(b) The Availability of Effective Psychiatric Service To Clients

i. Proximity to Hospital

According to Carpentier, Prazuck, Bill (1995) proximity of psychiatric services is one of the expectations of clients. In their study, nearly all clients (89%) visited a dispensary, which was less than 5km from their homes. A majority of those who saw a traditional healer chose one who lived within 5kms of their homes.

However, the rest were willing to travel further, in some cases up to 500 km to see a healer or soothsayer of their choice. This reflects the importance to patients of finding the person with the right professional abilities.

Apart from the proximity of service, clients also insist on the availability of the health professionals at those places. (Geldenherys, 1997) According to his findings, although clients insist on seeing their own clinician on each visit and hope he/she will be present whenever needed, they usually recognize that the clinician needs time off and are willing to accept a deputy who can attend to them.

It has also been observed that sometimes they need the help of a team of people. However, what they don't like is having to consult a different clinician each time they need help in which case no one takes ultimate responsibility. They want their clinicians to be their advocate and to co-ordinate the care given by the other member of the Health Team. This will prevent them from getting discouraged and lost in the health care maze. Nobody wants to be cared for by a committee (Boland 1995).

A further study Boland (1995) has also revealed that clients demand a just distribution of services according to need. This need is not met because the demand for health care in most developing countries outstrips supply and this results in malpractice's like queuing, contentious criteria for determining urgency and the use of money and influence to jump queues.

Apart from this unfortunate situation, the primary concern of the client is to be able to reach any clinician which is contrary to his expectation as stated earlier whilst that of the clinician is to get through an overwhelming daily

University of Ghana <http://ugspace.ug.edu.gh>
overloaded with woefully inadequate ancillary and technical support.

Another expectation of clients in developing countries is that the clinician should be community based especially if the basic needs of living are unmet or neglected by the inhabitants. Hence attention to community issues by clinicians are more beneficial than attention to individuals needs.

iii Low Cost of Treatment

According to Fabb (1995) the public is now becoming unable to afford the cost of treatment in hospitals. Hence these matters should be discussed by the clinician and the client. The former can assist the client to choose more reasonable bills.

To this end, some clients decline the treatment offered, whilst others demand different medications and insist that if the clinician does not oblige, they will seek help somewhere else. Clients now expect to negotiate treatment with their clinicians rather than take their orders.

Carpentier, Parzuck et al (1995) in a study in Ethiopia also found that the clients prefer traditional treatment to the modern psychiatric care among other factors because of the cheaper costs. In this study, it was found that the cost of treatment by a traditional healer includes the services itself (paid for in kind) transport and any medicinal substances used. The cost of this was found averagely to be US\$5 per episode.

The cost to the user of treatment by a modern practitioner, on the other hand was about US\$10 per episode, which represents prescribed medication alone.

Asenso-Okyere and Dzator (1997) found that the average cost of treating malaria, for example, including direct costs and the opportunity costs of travel and waiting time amounted to 3.7 days of male output and 4.7 days of female output. They, therefore, resort to drug peddlers and traditional healers who are closer to them and provide cheaper services. In this study it was also found that some of the patients resort to traditional treatment because they can't just afford the drugs due to poverty.

Other reasons that were offered for the preference of traditional medicine apart from the low costs are that it could tell the social cause of the illness through sorcery and that it had satisfactory previous experience for clients.

Some of the patients in the study also complained of payment in the Government Hospital at every station instead of paying everything at one place to cover the cost of all the services.

In addition to the Hospital charges, patients referred to other direct costs like transportation for those far away from the clinics. In view of this, patients do self-medication and apply "wait and see" strategies where people expect their illnesses to be self-limiting.

Waddington and Enyimayew (1989), Asenso-Okyere et al (1996) found that despite the complaints of high costs of drugs, certain people still prefer the Hospital because of the presence of qualified personnel. Others were afraid of the risk of being sold expired drugs which was lower at the Hospital.

Other reasons advanced for the preference of modern medicine are that it is trustworthy because it is consistent and clearly defined. Furthermore, they said it worked more quickly and is not followed by relapses.

iii. **Favourable Terms of Payment**

The traditional healers also have more convenient terms of payments, varying from receiving payments in kind to payments in installments. In some cases the patients would be admitted and fed by the healer for the whole periods of treatment. The healer would only ask for a "thank you" after the patient is discharged (Asenso-Okyere 1998)

In this same study, some of the respondents reported that drug store operators even offered credit facilities to certain customers. When the patients didn't know the kind of drug to purchase, the store attendant would suggest the appropriate medication.

iv. **Availability of Drugs**

Asenso-Okyere et al (1998) found that the availability of drugs serves as a prime motivator for hospital attendance. Patients don't like the idea of buying drugs from the private pharmacy shops. In the study it was found that the patients preferred to go to nearby mission clinics where charges were relatively higher than the government facilities because they felt service was better and drugs were always available, and they were treated with more respect.

v. **High Expertise in Health Professionals**

The expectations of the urban populations is even higher according to Geldenhuys (1997). They have a fair knowledge of

some conditions and how they are managed through the mass media. Hence they don't have any blind trust in the clinician's ability but one has to earn it. He goes on further to state that when the clients expectations are not met, they need a forum in which their complaints can be heard.

(c) Good Human Relations of the Service Providers

(1) Unique Qualities of the Service Providers

According to Hall & Dornan (1988) humanness of the care providers is the factor with which patients are most satisfied. Similarly Abdulkadi (1995) makes the assertion that:-

'Clients may differ in culture, concepts, knowledge, attitude and personality but they are one in the expectation of the qualities of the clinician. They are looking for a person who differs from the rest of the species not only in his special knowledge and skills but also in in-depth and breath of understanding, tolerance and receptivity at all times of need'

To buttress this point, Burnard (1994) outlined six attributes of the clinician that clients expect in order to enhance their confidence as follows:

Firstly, the clinician must have an unconditioned positive regard for the client. This means the client should be viewed with dignity and should be thought of as having

inherent goodness in him. As such the clinician should start the therapy with the client with the hope that the person is likely to develop.

The second important quality of the health professional is empathic understanding. This is the ability to perceive the feelings of another accurately and to communicate this understanding to him.

Warmth is the third quality to be exhibited by health professionals. This refers to a certain degree of approachability and willingness to be open with the client.

Health professionals should also be genuine and committed to solving their clients' problems. The professionals should use all means to enhance and achieve this.

Carl Roger(1967) used the term transparency to describe yet another quality of health professionals of openness and clarity. He must be clear and explicit in his dealings with the client and should help the client to express his feelings clearly.

Lastly according to Burnard (1995) when people are distressed, there is the tendency to spend much time reminiscing about the past. This is because, it is safer to talk of the past rather than face feelings in the here-and-now. The Health professional has to help the thoughts and feelings through immediacy.

Boland (1993) says all the client needs is a clinician with these qualities to whom he can trust to help the client make his strategic life decisions like marriage, work, studies

etc. Are these qualities seen in the psychiatric health care providers?.

2. Information Sharing

One of the variables of humanness that predicts satisfaction is information sharing between the patient and the service provider (Hall, Roter & Katzi 1988).

Fabb (1995) has it that patients want one who will listen to them and sort out their problems. They may not like waiting for the clinician but once in the consulting room, they want as much time as it takes for the clinicians to understand their problem.

However, during a typical hospital visit, service providers and patients do not spend a great deal of time together, (an average of 16.5 minutes) according to a study by Howard (1984) in Canada. Of that time, 1 minute and 18 seconds, i.e. less than 10%, involves information giving by the service provider to the patient.

Temal (1995) gives evidence on this fact that in Ethiopia, on the average, the net patient-clinician contact time was a little over 8 minutes per client. In such situations, they concentrated on only the essentials whilst thinking about the crowd still waiting to be seen.

According to Roter (1984) patients typically ask roughly 3-4 questions per visit and the average questioning time averaging to 8 seconds. Patients are not always satisfied

with this limited time because they always would like more information about their diagnosis, prognosis for recovery, origins of condition (Kindelan& Kent 1987), as well as more complete disclosure about the risks of procedures and medications (Faden et al 1981, Keown, Slovic & Linhstenstein 1984).

To explain the lack of time allotted to information giving and questioning several researchers (Waitzkin 1985, Waitzkin & Stoeckle 1976, Friedson 1970) believe that service providers avoid giving information and leave patients in a state of uncertainty to preserve power. Hence they describe the service-providers-patient relationship as a 'micro-political situation' in which the former withholds information to maintain dominance and the patients seek it to challenge that dominance.

Despite this phenomenon it has also been noticed by other authorities that patients also hesitate to ask for information, clarification or additional information for fear of appearing ignorant, whilst others fear that they are taking time from more pressing requirements of the doctor or other more needy patients (Tuckett et al 1985).

This study would find out if the patients are given enough information concerning the diagnosis, prognosis, side effects of drugs and cause of illness.

3. The Quality of Service Providers-Patient Communications

The quality of service provider - patient communications are also very important. In a classic study, in Mexico, Korsch, Gozzi and Frances, (1968) tape recorded 800 pediatric visits in an OPD and then conducted follow-up interviews with the mothers. It was realised that the communication was very technical and narrowly focused (disease-centred).

The mothers reported that their emotional concerns were rarely addressed and one quarter did not have the opportunity to express the single most important problem on their minds.

Twenty percent felt they were not given a clear explanation of what was wrong with their children and almost half were not sure of what caused their children's illnesses. Similar findings were got in variety of settings and with different patient populations in different countries (Pendleton & Bochner 1980, Ben -Sira 1985, Clark, Potter & Mckinlay 1991)

It has been noticed that information conveyed from service providers to the patients is not always understood. A study by Svarstad (1976) in a reputable health institution also in Mexico, found out that 3 out of 4 times the service providers failed to give instructions on how prescribed drugs should be taken and when they did, the instructions were ambiguous. It also came to light that more than half of the patients interviewed misunderstood the reason for taking the drugs.

For instance, in the study, it was observed that some patients who received prescriptions to control their high blood pressure reported the drug was meant to treat symptoms like asthma, palpitations and lower back pain. Even the researcher who sat in during the consultation reported that many times, she herself could not understand the directions offered to the patients. Most of these failures according to the researcher are due to the use of medical jargon.

The service providers non-verbal communications also contribute to the patients' satisfaction. These include the messages that their gestures, tone of voice, posture and facial expressions convey

Service providers who express warm social climates like sitting close, maintaining eye contact, leaning forward and nodding in response to patient's, comments are associated with patients' satisfaction (Hall, Rotter, Katz 1988). If there are communication problems as brought to light in these studies in advanced countries, what is likely to be the case in Ghana, an under developed country?

Asenso-Okyere et al (1998) in their study observed that although most private hospitals in Ghana do not provide all the services available at the Government health centres, some patients still prefer treatment from them because of the perceived higher quality of services like promptness in their services and warm reception from those health workers. The traditional healers are also preferred because they have

patience with their client unlike the Government hospital staff.

4. Need For Psychotherapy

Burgest (1995) who did his study in Britain has observed that all clients who come to any Psychiatric Hospital are scared, have a sense of loneliness and nervousness. Hence they need a lot of psychotherapy. The main instrument in psychotherapy is communication between the clinician and the client with the aim of relieving symptoms and help with social adjustments.

According to Burnard (1994), although the mechanisms by which this method works are not well understood, the intervention takes place in three ways;-

(i) Catalytic interventions

There interviewers draw the client out and encourage him/her to discuss the issues further. They comprise questions well timed and sensitively phrased which discreetly and tactfully help the person to express his wants and needs. These techniques include funneling, reflection and checking for understanding.

(ii) Cathartic interventions

These enable the client to release tension through the expression of pent up emotions. An example is helping one to

express his feelings after an accident or divorce which is painful for him to relate.

(iii) **Emotional support**

In this way, the health professional acts as a sounding board for the ideas, plans and suggestions of the client. The primary skill needed here by the professional is listening. To achieve this, the professional must sit facing directly to the client to give him/her literal and metaphorical meaning. One should also lean towards the client and adopt an open position.

Are these needs in the clients met in the light of the numerous clients at the Accra Psychiatric Hospital? Are there improvised methods to cater for this deficiency in the Mental Hospitals? These are but a few questions, the researcher intends to find out.

5. Improving Service Provider-Patient Relations

For the above methods to take place effectively there is a need for good relationship between the Health professional and the client. According to Boland (1995) clients want health professionals to share information with them in humane ways. They should explain to them what is wrong in understanding terms, how serious their ailment is and what they should do about it.

He goes on to say that since about half of what the clinician says is soon forgotten, one needs to be careful

about the volume of information given, its complexity and timing. As the first pieces of information given are remembered best, what is important should be given first. If detailed information is needed, it should be checked to be sure it is understood.

Boland further found out that whilst clients expect clinicians to advise them about the treatment for the conditions, they are unlikely to take the advice if it does not coincide with their own views and beliefs.

The view point of Burnard (1994), is that advice should be restricted to concrete situations where expert information can make a direct contribution to the clients well being. Giving information about an illness is straightforward but with problems of living (in the case of psychiatric clients) the situation is different.

In these cases, one is tempted to give them suggestions as to what one would do given their situations. Such advice is not usually helpful and at times even dangerous. Sartre (1973) says clients with problems of living always go to the clinician already knowing the sort of advice that they will receive.

Burgest (1995) also discussed a number of pot holes when clinicians are communicating with their clients as below:-

The first one is that health professions depersonalize the clients and label them. Hence he encourages health

workers to always address the clients by their names or titles and conversations with them should be about their families, work or interests. They should also be involved in all decisions about their care.

Tryon and Leonard (1964) in a study found out that if a health worker attempts to find out how a client feels about a procedure and encourages him to participate in its administration, he appears to accept the treatment better and the outcome is more effective.

Burgess has also observed that health professionals avoid human contact which is therapeutic with the clients. Tactile contact is a non-verbal communicational tool, which is important for all those in the healing profession. It conveys to the client a sense of caring feelings by the professional. There are occasions that are indicated for a touch of the client on hand or shoulder.

To Kaplan and Saccuzzo (1993) human touch is a potential 'drug' but like any drug has side effects. Hence he cautions that if the Health Professional communicates by touch he should be guided by his answer to the question 'Am I doing this for my client?'

A phenomenon observed by Heron (1989) called social facilitation tends to characterize most health professionals in communicating with the clients. This means we tend to act like the models around us. Hence if a health professional is

tense, anxious, defensive etc during one's interaction with the client, the latter tends to respond in kind.

Apart from suggestions to improve the patients' satisfaction, several programmes have been initiated in advanced countries. One of such is highlighting the teaching of communication skills in medical schools and practicing physicians are required to spend time as hospital patients to truly appreciate the patients' perspective (Nooman, Schmidt & Ezzat 1990, Tosteson 1990)

At Johns Hopkin's Hospital, tutorial sessions are organized for service providers in interviewing. They are asked to enquire about the patients' attitudes, beliefs and perceptions concerning the condition rather than focusing on physical signs. The study has found that those taught this method had their patients satisfied and their patients could recall more than 20% of the information taught than those in the control group.

It was also realised that these professionals were found to spend more time in patient teaching and generated greater patient knowledge than those who didn't receive this training (Janis and Frshback (1953); Williamson (1976); Berkatis (1977). They further encouraged the practitioners to end their sessions by having their clients report information in their words and thus clarifying anything that was confusing or adding information that was omitted.

Other programmes focused on the patient rather than the service-provider. Rotter (1984) encouraged the patients to identify and write down the questions they would like to ask during visits to the Hospital. They should also be made to know that it's their right to have their questions answered to their satisfaction.

This study would like to find out in the face of shortage of staff, coupled with illiteracy, the state of the service provider - patient relations.

(d) Waiting Time

The few studies on waiting time and satisfaction in health care settings have mixed results. Maven, Licata & McPhail (1993) found that patients in emergency Departments who waited longer than their expected waiting times had significantly lower satisfaction levels than patients whose waiting time expectations were met. Bursch, Beezy & Show (1993) also found that the total time spent in Emergency Department was not as important as the amount of time it took before the patient received care.

By contrast, 2 recent studies conducted in O.P.D. by Krupat et al (1983), and Zapka et al (1995) found that long waiting time was not a significant predictor of patient satisfaction.

Maister (1988) also proposed that customers would be less anxious about waiting if they knew how long they were to wait. Miles & Strasser (1995) conducted test of this hypothesis in a sample of Emergency Department patients and found the patients who were updated about their waiting times had significantly higher satisfaction scores than those who were not updated.

The study aims at finding out what will be the findings in the Accra Psychiatric Hospital with respect to patients' satisfaction and waiting time.

SUMMARY

From the pertinent literature, it has come to light that the patients' characteristics like age, sex, religion, state of illness and level of education account a lot for their perception of the satisfaction of the quality of service given to them at the Hospital.

A number of indices used to assess clients' satisfaction have been outlined but the researcher will concentrate on the following:

1. The effect of religious beliefs on the cause and management of mental illness.

2. The effects of educational background of respondents on their knowledge those of the helping professions in the Psychiatric Hospital.
3. The number of visits of clients to the Hospital and their influence on their perception of the clinical assessment given to them by service providers.
4. The educational level of the clients and their perception of the human relations of the service providers.

CHAPTER III

RESEARCH METHODOLOGY

3.1 THE RESEARCH SETTING

The research was carried out at Accra Psychiatric Hospital. This hospital was built in 1906 to cater for the needs of those with psychiatric problems in the country.

It is situated at the heart of Osu-Clotey Constituency. It is been bounded to the North by the Asylum Down Residential Area and Adabraka Polyclinic to the South. On the East is the Young Men's Christian Association (YMCA) whilst the West is bounded by the Holy Spirit Catholic Church.

Being the premier Psychiatric Hospital in the country, its catchment area covers all the regions in the country. Although it was built to accommodate only 200 inmates, at the time of conducting the study it had 1,482 in-patients and roughly 15,000 clients annually on OPD basis. There are five consulting rooms at the O.P.D. and they get averagely 100 clients daily in total.

3.2 THE TYPE OF RESEARCH DESIGN

The type of research design used for this study is the evaluative cross-sectional survey.

According to Fraenkil J. & Wallen, (1993); and Philips (1994), the main characteristics of such a study include the following:

It is non-experimental, in that it does not attempt to provide cause-effect results but rather seeks to gather information from a group of people in order to describe some aspects or characteristics (such as perceptions, beliefs, opinions, attitudes and/or knowledge) of the population of which the group is a part.

The second characteristic is that the information is mainly collected through devices like interviews, questionnaires and observations from the predetermined population. The answers to the questions by the members of the group constitute the data of the study. The information is collected at just one point in time although the time it takes to collect the desired data may take anywhere from a day to a few weeks.

Lastly, the data is mostly collected from a sample rather than from every member of the population. This ensures relatively precise estimates of the population.

By this method, qualitative and quantitative data was assembled and comparisons were made between the psychiatric

clients expectation of their services and those actually received.

3.3 THE SAMPLING METHOD

According to C. Phillips (1994), the quality of the data generated by a descriptive design will depend largely on the quality of the sampling methodology with regards to the following:

- a) The type of sampling method to be used
- b) The type of sample to be used and
- c) The type of sample size required.

In view of these requirements, the researcher used the simple random sampling technique. The lottery method was used to select clients from the five consulting rooms on daily basis until the desired sample size of 100 was obtained.

This probability method was chosen because it ensured that the sample was a good representation of the clients from all the consulting rooms. Again, it helped to negate both the client and researcher biases.

The sample was drawn from adult clients who attended the Psychiatric Hospital for OPD services and who were aged between 16-64 years. They were also to be in touch with reality so that they could give this objective opinions. This

University of Ghana <http://ugspace.ug.edu.gh>
age group was chosen in order that varied views from both
adolescence and senior/older adults.

The sample size for the study was 100 because according to A. Donald, (1979), a descriptive research must have at least 10-20 percent of the accessible population for a sample since records at the hospital indicate that roughly 500 patients come to the hospital on OPD basis weekly.

3.4 THE TOOL FOR DATA COLLECTION

(a) Type and Reason for the Choice of Instrument

The data was collected with the aid of a structured interview schedule. It had both closed and open ended questions since the latter could reveal useful and relevant information that would be missed by the closed-ended type.

This type of instrument was used because it would give the researcher the chance to probe into answers given by the clients that might be vague and also qualitative data could be gathered.

Another reason for the choice of this instrument was because according to Burnard (1997), conversing with the client is in itself highly therapeutic. In view of this, the researcher interacted with them personally to offer this service.

Furthermore, the educational level in Ghana is generally low hence the responses might be inaccurate with other tools

used in collecting opinions from clients like questionnaires.

Lastly for the findings to be valid in descriptive study, the sample must produce a relatively high response rate and the interview schedules used ensured this by minimising the drop out rate characterised by questionnaires.

(b) The Development of the Instrument

The development of the interview schedule took many stages. The preliminary stage included the examination of related literature to the area of study. Discussions were then held with the following people to know the real nature of the problem:- Nurses, Psychiatrists, Clinical Psychologists, clients and departmental heads of the Psychiatric Hospital that render O.P.D. services to the clients.

Finally, the researcher had a one-day working experience in the areas that OPD patients normally pass through when they come to the Hospital.

On the basis of this information, variables associated with the objectives were identified. With the help of a research supervisor, the interview schedule was designed.

The test items on it included the following:

1. The demographic data on the clients chosen for the study.
2. The clients' knowledge about the aetiology and management of psychiatric conditions.

3. The client' knowledge of the services available in the Psychiatric Hospital especially those rendered by Clinical Psychologists and
4. The level of satisfaction of the services rendered by the service providers to psychiatric patients.

The length of these items was 35 to give the instrument both high reliability and validity values. It was pretested on clients at the OPD at the Mental Hospital and the necessary changes were made.

(c) The Administration of the Instrument

The interview took roughly 10 days to be completed. Five to ten clients (two from each consulting room) were interviewed daily. The time spent on each client ranged between 15-20 minutes. This means roughly 3 hours was spent daily on the interviews.

The clients were interviewed after they had collected their drugs. This had two advantages because by then the clients had gone through all the departments in the OPD and could then give better views on what they observed. Furthermore, after having collected their drugs, they were now more relaxed to express themselves.

The interview took place in a separate room in the Clinical Psychology Unit in the hospital where the respondent

could have enough privacy and also freedom from external stimuli to express himself. Only English and Twi were used during the interview to reduce biases and increase the validity and reliability of the results.

3.5 THE VALIDITY AND RELIABILITY OF THE STUDY

The validity of a study comprises the measures that a researcher takes to ensure that he/she is measuring the right variables spelled out in the research objectives. Reliability on the other hand is the measure taken to ensure that the same results can be consistently got any time the research is replicated.

To ensure high validity and reliability in the research, the following measures were employed:

1. An interview schedule was used to give the researcher the chance to clarify questions that might cause ambiguity or unfamiliarity to the respondents (clients).
2. Prior to the interview, every respondent was briefed on the purpose of the study and the time involved for each person willing to partake so that they could co-operate in their responses.

3. All the respondents were also told that information gained would be treated as confidential and this would also encourage them to co-operate.
4. The subjects were also chosen by simple randomization as discussed under the sample method. This is a probability method of sampling in which every client at the OPD was given an equal chance of being chosen thereby ruling out researcher biases.
5. The instrument (interview schedule) culminated into a blueprint through the information gathered from sources like health authorities, patients and departmental heads.
6. The interview schedule was pretested with two clients from each consulting room at the Psychiatric Hospital and the necessary corrections made.

All these measures were introduced into the study design to ensure that the results stand the test of time.

3.6 DATA ANALYSIS

This section presents how the data collected was organised and analysed. The type of data a researcher collects often influences the type of statistical analysis

required. This research was based on a cross-sectional survey of OPD patients at the Accra Psychiatric Hospital. (A cross-sectional survey collects information from a sample that has been drawn from a predetermined population).

In this study, since the type of data collected is primary, categorical and non-parametric, the commonly used statistical techniques both descriptive and inferential as used with categorical data was used to analyse the data.

Descriptive measures used included frequency tables, bar graphs, pie charts, cross-break (contingency) tables and percentages with respect to inferential statistics, chi-square and contingency coefficients were used to draw some conclusions from the results.

RESULTS

4.1 INTRODUCTION TO THE ANALYSIS

As stated earlier, this research is aimed at finding answers to the following questions:

- 1) What do psychiatric clients perceive to be the causes of mental illness?
- 2) Where do such clients first report for psychiatric help?
- 3) Do they have adequate knowledge of the services rendered by clinical Psychologists, Psychiatric Social Workers and Community Psychiatric Nurses?
- 4) Are they satisfied with the quality of services rendered to them at the OPD in the Psychiatric Hospital?

Five hypotheses arose from these research questions. Out of these three were confirmed and two rejected by statistical tests.

Since this research is based on a cross-sectional survey of OPD patients at the Accra Psychiatric Hospital, the type of data collected is primary, categorical and non-parametric. In view of this, the commonly used descriptive and inferential statistical techniques as pertaining to categorical data was used in analysing the data.

Chi-squares and contingency coefficients were also used to test for significance of differences observed.

The chi-square is a test of significance that assesses the probability of obtaining results that differ from what

might be expected by chance from a hypothesized population. The contingency coefficient on the other hand assesses the strength of the relationship between the two variables.

4.2 THE CHARACTERISTICS OF THE SAMPLE

1) Age Distribution of Respondents

The ages of the 100 respondents ranged from 16 to 65 years. As can be seen in Table 1, most of the subjects interviewed were between 16 and 35 years and constituted 64% of sample.

Table 1: Age Distribution of Respondents by Sex

Age Group (years)	Respondents					
	Female		Males		Total	
	No	%	No	%	No	%
16-25	17	32.12	13	27.65	30	30
26-35	19	35.8	15	31.94	34	34
36-45	9	17	10	21.27	19	19
46-55	7	13.2	6	12.76	13	13
56-65	1	1.88	3	6.38	4	4
Total	53	100	47	100	100	100

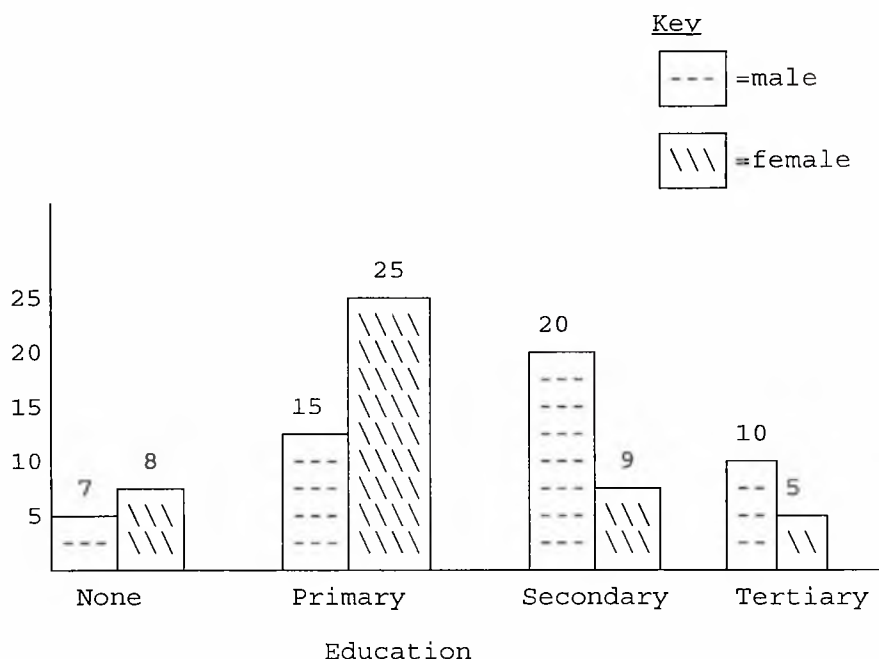
ii) Sex Distribution of Respondents by Education

The sex distribution of the respondents by education is illustrated in Fig.1 on the bar graph below. It shows that the sample comprised 47 (47%) male respondents and 53 (53%)

female respondents. The highest education obtained by most respondents was at the first and second cycle institutions.

As is true of the general population, more men had generally attained a higher level of education than women, with more women predominant at the level of primary education.

Figure I: Bar Graph of Distribution of Sex According to Education



iii) Occupation of Respondents by Sex

Table 2 below gives a representation of the distribution of the sample according to occupation and sex. It clearly shows that there were more respondents who were traders (25%),

students (19%) and unemployed (15%), than were in any other category.

Table 2: Distribution of Respondents According to Sex and Occupation

Occupation	Sex		Total (%)
	Male (%)	Female (%)	
Traders	19	6	25
Farmers	1	4	5
Craftsmen	7	4	11
Unemployed	9	6	15
Managers		5	5
Students	5	14	19
Teachers	3	3	6
Custom Officers	2	3	5
Labourers	1	8	8
	47	53	100

iv) The Religious Background of the Respondents

Of the 100 respondents, 86 were Christians, 11 Moslems, 3 did not belong to any religion and there were none of the traditional faith. This is shown in the Table 3 below:

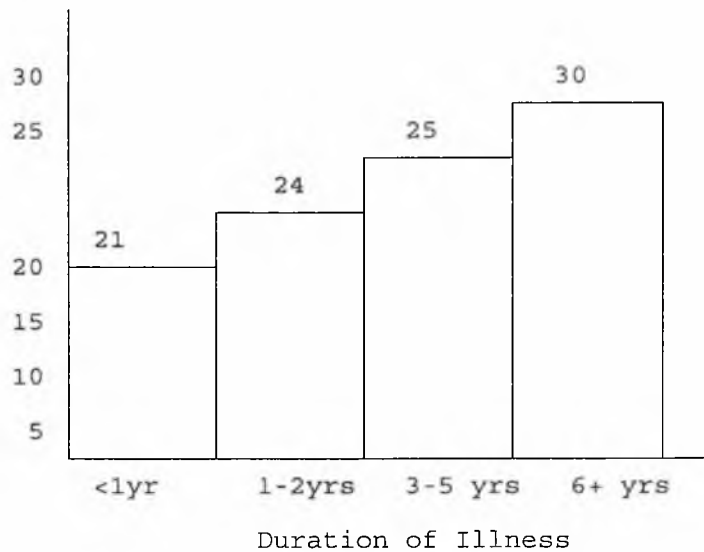
Table 3: Distribution of Respondents According to Religion

Religion	Number	%
Christians	86	86
Moslems	11	11
No Religion	3	3
Traditional Believers	0	0
	100	100

v) The Duration of the Illness

As can be seen in the histogram (Fig. 2) below, 21% of the respondents had had mental illness for less than 1 year whilst 24% had it for a duration between 1-2 years. The 25% of the respondents had suffered from the condition for 3-5 years and 30% of them had had it for more than 6 years.

Figure 2: Histogram of the Duration of Mental Illness Among Respondents



4.3 THE CLIENTS' PERCEPTION OF THE AETIOLOGY AND MANAGEMENT OF MENTAL ILLNESS

First Hypothesis

The first hypothesis sought to explore the relationship between the educational level of the clients and their perception that mental conditions are attributable to supernatural forces. That is, highly educated clients would be more likely to assign physical and emotional factors to mental illness than to supernatural factors.

The cross-tabulation is shown in the table below.

Table 4: Comparison of Group Differences on the Belief in Supernatural Causes of Mental Illness due to Educational Level

Educational Level	Supernatural Causes		
	Yes	No	N
None	9 (75%)	2 (25%)	12
1st Cycle	27 (67.5%)	13 (32.5%)	40
2nd Cycle	18 (60%)	12 (40%)	30
3rd Cycle	5 (27.8%)	13 (72.2%)	18
N	59	41	100

Chi-square = 9.731 df = 3 Sig = 0.02100

As can be seen in the (Table 4) above, 75% of the clients with no education attributed mental illness to supernatural factors and 25% attributed it to other causes. Among those with first cycle education, 67.5% attributed the cause to supernatural factors while 32.5% disapproved this cause. Also 60% of those in second cycle educational institutions attributed the cause of the condition to supernatural factors whilst only 27.8% of those in tertiary institutions traced it to supernatural forces.

A chi-square analysis to find out if there is any significant difference in the extent to which the clients attribute the condition to supernatural forces with regards to one's educational level yielded significant results $\chi^2 (3, N = 100) = 9.731$ $p < 0.05$. The strength of contingency coefficient is 0.70.

The above statistic shows that the higher one's educational status, the less one attributes the condition to supernatural forces. The results therefore, indicate that there is a moderate relationship between one's educational level and the supernatural causes attributed to mental illness. The first hypothesis is therefore confirmed.

A cross-tabulation of the educational level and the other causes attributed to mental illness showed that there was no significant relationship between these other factors and education except infection $\chi^2 (3, N = 100) = 10, p < 0.05$. This indicates that there is a strong relationship between education and believing that infection is a cause of mental illness ie. the more educated one is, the more prone one is to believe that infection can cause mental illness

Second Hypothesis

This hypothesis states that clients who believe that their condition is caused by supernatural forces are more likely to choose either a spiritualist or a traditional healer than clients who do not.

As shown in Table 5, this was not the case. This is because only 8 (13.6%) of the 59 who believe that supernatural forces cause mental illness went to the traditional healers/spiritualists first for treatment. On the other hand, (54%) of them reported first to the Psychiatric Hospital, (24%) General Hospitals and (9%) private hospitals for treatment.

Table 5: Where Treatment was first Sought by the Believers of Supernatural Causes of Illness

Type of Health Facility	No. of Clients
Psychiatric Hospital	21
General Hospital	23
Traditional Healers	8
Private Hospital	7
Total	59

The First Contact Treatment Centres

A majority of the clients interviewed, sought their first treatment at either a Psychiatric or a General Hospital. 42% of them first went to the former whilst 34% went to the General Hospital; 15% reported that they had sought their first treatment from either a traditional healer or spiritual churches whilst 9% also sought help from the Private Hospitals. They gave various reasons as shown in Table 6 below for their choice of first contact treatment. This also shows that beliefs of the relatives' of patients beliefs are perhaps even more important in the choice of treatment.

Table 6: Reason for the First Choice of Health Facility After Onset of Illness

Health Facility	Reason	Percentage
Psychiatric Hospital	Sent by relatives	24
	Specialist treatment	22
	Abnormal behaviour	7
	Head injury	1
General Hospital	Physical symptoms	22
	Nearest Health Facility	10
	Relations at Hospital	2
Spiritual/ Herbalists	Spiritual cause	12
	Church member	3
Private Hospital	Specialist treatment	3
	Physical symptoms	5
	Nearest health Facility	1
	—	100

Main Cause of mental Illness

The study also revealed that stress (79%) was given most frequently as a cause of mental illness irrespective of the educational level or the religious inclination of the respondents. Heredity (51%) was least as a cause. Stress was followed by head injury (68%) and infection (71%).

Complementary Treatment to Psychiatric Services

Respondents also revealed that patients complement the treatment they get from the Psychiatric Hospital with the following forms of treatment:

- 1) Spiritual churches 35%
- 2) Private Hospital - 31%

3)	Herbal treatment	23%
4)	Islamic Prayers	3%
5)	Deliverance services	4%
6)	General Hospital	7%
7)	NIL (only Psychiatric Hospital)	2%

This information is very important because it shows that apart from 2% of the patients interviewed, the rest complement their hospital treatment with spiritual healing and services of General hospitals and clinics.

4.4 THE CLIENTS' KNOWLEDGE OF THE SERVICES RENDERED BY CLINICAL PSYCHOLOGISTS, PSYCHIATRIC SOCIAL WORKERS AND COMMUNITY PSYCHIATRIC NURSES

Third Hypothesis

The hypothesis states that there is a significant relationship between the educational level of the client and the knowledge one has about Clinical Psychologists, Community Psychiatric Nurses and Psychiatric social workers. In other words, highly educated patients are more likely to have better knowledge of these professions than the less educated. The data for this comparison is presented in (Tables 7-9).

Table 7: Comparison Between Education and Knowledge of Clinical Psychologist

Educational Level	Heard of Clinical Psychologist		
	Yes	No	N
None	1	11	12
1st Cycle	3	27	40
2nd Cycle	10	20	30
3rd Cycle	10	8	18
N	24	76	100

$$X^2 = 18.844$$

$$df = 3$$

$$Sig. 0.00029$$

Table 8: Comparison of Education and Knowledge of Psychiatric Social Worker

Educational Level	Heard of Psychiatric Social Worker		
	Yes	No	N
None	0	12	12
1st Cycle	1	39	40
2nd Cycle	4	26	30
3rd Cycle	7	11	18
N	12	88	100

$$X^2 = 17.429$$

$$df = 3$$

$$Sig. 0.00058$$

Table 9: Comparison of Education and Knowledge of Community Psychiatric Nurse

Educational Level	Heard of Community Psychiatric Nurse		
	Yes	No	N
None	0	11	12
1st Cycle	2	40	40
2nd Cycle	5	25	30
3rd Cycle	11	7	18
N	17	83	100

$$\chi^2 = 33.656$$

$$df = 3$$

$$Sig. = 0.0000$$

The chi-square tests of differences above indicate significant differences amongst the various educational levels and the knowledge of all the helping professionals ($p > 0.001$).

The chi-square values for clinical psychologist was (3, $N = 100$) 18.844, $p < 0.001$. Those for the psychiatric social worker were (3, $N = 100$) 17.429, $p < 0.001$. Lastly the chi square value for the community Psychiatric Nurse was (3, $N = 100$) 33.656, $p < 0.0001$. The strength of contingency coefficient is 0.50.

In this regard, the hypothesis has been confirmed and it implies that education has a significant influence on the knowledge of the helping professionals. This impact is realised more for clinical psychologists and community psychiatric nurses than with the psychiatric social workers.

Furthermore the respondents had heard about Clinical Psychologists see Table 10 below. 14% of respondents were able to mention the services rendered by psychologists.

Twenty-four reported that they had heard of psychologists but did not know what services they render. Furthermore, of these only 10 had used their services before. This is shown in Table 10 below.

Table 10: The Knowledge and Utilization of Clinical Psychologists (CP) by Clients

Knowledge of Clinical Psychologist	Source of Information	Work of Clinical Psychologist	Utilization of Service
N	N	N	N
24	Mass Media 7 Health Talks 7 Patients/ Friends 6 Referrals 7	Solves problems 10 Counselling 1 Treat patients 1 Assess patients 2	10
24	27	14	10

Only 12% of the respondents had heard of a Psychiatric Social Worker. Out of this 9% had faint knowledge about their work as shown on the table and only 3 respondents (3%) had used their services before. This is illustrated below in (Tables 11-12).

Table 11: The Knowledge and Utilization of Psychiatric Social Workers (PSW) by Clients

Knowledge of PSW N	Source of Information N	Work of PSW N	Utilization N
12	Mass Media 4	Solve social problem 2	3
	Health Talks 4	Take history 2	
	Patients 1	Solve patients' problem 3	
	Referrals 4	Help patients to adjust 2	
12	13	9	3

As can be seen in Table 12 below, seventeen respondents had heard of a Community Psychiatric Nurse and 6 had used their services. Refer to the Table 12 below for the services mentioned and their sources of knowledge.

Table 12: The Knowledge and Utilization of the CPN by Clients

Knowledge of CPN (N)	Source of Information N	Work of CPN N	Utilization N
17	Mass Media 7	Diagnose patients 3	6
	Health Talks 6	Treat patients 2	
	Patients/Friends 3	Health education 4	
	Referrals 4	Home visits 3	
		Referrals 1	
17	15	20	6

4.5 CLIENTS' EXPECTATIONS OF THE QUALITY OF SERVICE FROM SERVICE PROVIDERS

The study aimed at finding out if clients were satisfied with the quality of services rendered to them by Psychiatric staff. The indices of quality of services considered included the following:

- 1) Thorough assessment of clients by service providers
- 2) The outcome of care to the clients
- 3) The time spent in the hospital
- 4) Environmental hygienic conditions of the Hospital and
- 5) Availability of psychiatric services

i) Thorough Assessment of Clients by Service Providers

The Forth Hypothesis

This aims at finding out the perception of respondents regarding whether they were given a thorough assessment by the service providers or not. A hypothesis was made to find if there is any relationship between this variable and education. This is shown in the (Table 13) below.

Table 13: Educational Level and Satisfaction with Overall Assessment

Educational Level	Satisfaction with Assessment		
	Yes	No	N
None	7	5	12
1st cycle	34	6	40
2nd cycle	25	5	30
3rd cycle	12	6	18
	78	22	100

$$X^2 = 3.986$$

$$df = 3 \quad sig. = 0.256$$

It can be observed from Table 13 that more than 50% of the respondents were satisfied with the overall assessment done by the service providers irrespective of their educational levels.

Subjecting these results to chi-square values to test the hypothesis that, there is a significant relationship between the level of education and the degree of satisfaction with regards to the overall assessment by the service providers, the analysis did not yield significant results $X^2 (3, N = 100) = 3.985, p > 0.05$.

The above results indicate that education has no effect on the level of satisfaction expressed by the clients with regards to the quality of assessment done by service providers. Other variables such as age and sex also revealed no significant results in relation to the assessment as can be seen with the following chi-square results:

- 1) Sex $X^2 (3, N = 100) = 0.838, p > 0.05$
- 2) Age $X^2 (4, N = 100) = 7.221, p > 0.05$

Table 14: Clients' Satisfaction With Various Aspects of Assessment

Responses	Variable of Assessment				
	Vital Signs	Enough Time	Investigation	Diagnosis	Overall Assessment
Yes	55	95	39	25	92
No	45	5	61	75	8
N	100	100	100	100	100

From Table 14, it can be seen that clients reported that they are satisfied with the amount of time spent on them. However, they were, for the most part, dissatisfied with what they perceived as inadequate investigations (61%) and the fact that the assigned diagnosis were not explained to them (75%).

Those who reported dissatisfaction with the various components of assessment gave the following reasons:

- 1) The service providers don't come on time
- 2) There are delays in the release of results
- 3) Service providers hurry patients
- 4) The diagnosis is not explained to them
- 5) The patients are not given physical examination by the service providers.

ii) The Outcome of Treatment to Clients

The study sought to determine client satisfaction with the degree to which they perceive that their symptoms improve with treatment.

As can be seen in Table 15, 85% of the respondents were satisfied that their condition had improved and 82% were satisfied with the treatment given to them by the service providers.

Table 15: Clients' Responses to the Satisfaction of Treatment

Outcome of Treatment	Responses of Satisfaction		Total
	Yes (%)	No (%)	
Improved Symptoms	85	15	100
Satisfied Treatment	82	18	100

Those who complained of dissatisfaction with treatment (18%) outlined the following reasons:

- i) Abnormal behaviour still persists 5%
- ii) Not fully treated 6%
- iii) The drugs have side effects 2%
- iv) Relapse in the face of problems 2%
- v) Relapse if drugs are stopped 1%
- vi) The same drugs being prescribed all the time 2%

Eight percent of patients reported that they experienced the following side effects even though the severity was low:

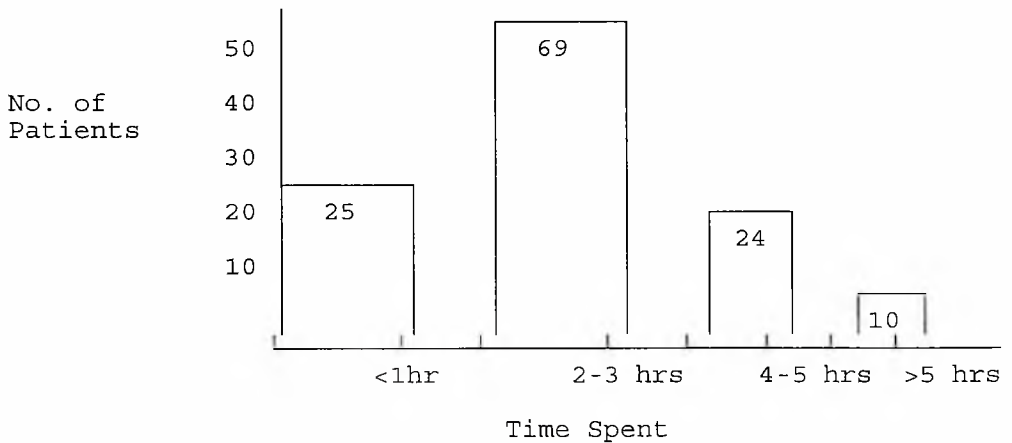
- i) Forgetfulness 2%
- ii) Drowsiness 2%

- iii) Obesity 1%
- iv) Fast speech 1%
- v) Sexual problems 1%
- vi) Difficulty in urinating 1%

The study also indicated that clients did not know most of the names of the drugs given to them. 51% of respondents could not mention what drugs they were on. 7% could mention only one drug, 6% mentioned 2 drugs. 8% could mention 3 or more drugs. The commonly mentioned drug was largactil. This implies that they are not given enough education on the drugs, side effects and how to take them.

iii) Time Spent in the Hospital

Fig. 4: A Bar Graph Showing the Time Spent by Respondents in the Hospital



As shown in the graph above Fig.4, 69% of the respondents spent 2-3 hours in the clinic whilst 25% used less than one hour. 24% spent 4-5 hours and 10% spent greater than 5 hours. Interviewing them on their perception of the time spent in the hospital, 69% of respondents said that the 2-3 hours spent was average whilst 6% mentioned that it was shorter than expected. However, 25% expressed dissatisfaction with the time spent in the hospital.

iv) The Environmental Hygiene of the Hospital

About half of the respondents (51%) expressed satisfaction with the hospital environmental hygiene.

The age groups between 16-35 years (40%) and those still in first cycle institution (44%) were not satisfied with the hygiene of the hospital.

The areas that were mentioned as being dirty included the following:

- i) Hospital compound
- ii) Hospital gutters
- iii) Hospital wards
- iv) Floor of OPD and Pharmacy
- v) Building needs renovation

vi) The Availability of Psychiatric ServicesFifth Hypothesis

The fifth hypothesis is that there is a significant relationship between sex of the respondents and their perception of the availability of psychiatric services.

As can be seen in Table 16 below, 85.1% of males and 89.8% of females expressed satisfaction.

Table 16: Cross Tabulation of Sex by Perception of Availability of Psychiatric Services

Sex of Client	Satisfaction			
	Low	Medium	High	Total
Female	4 (10.3%)	31 (79.5%)	4 (10.3%)	39
Male	7 (14.9%)	25 (53.2%)	15 (31.9%)	47
N	11	56	19	86

$$X^2 = 7.147 \quad df = 2 \quad \text{Sig. } 0.0280$$

Subjecting these figures to chi-square analysis the following was obtained ie. X^2 (2, N = 86) $p < 0.051$. The strength of contingency coefficient is 0.60. Based on this the hypothesis has been confirmed to imply that women appreciate the availability of psychiatric services more than men.

Examining patients' satisfaction of the various components of the availability of psychiatric services below,

it can be seen that besides home visits and proximity to the Hospital, the respondents were satisfied with the other components.

The area that accorded the highest perception of satisfaction is bureaucracy (83%) followed by the cost of drugs (76%) 74% of the respondents showed dissatisfaction with the home visits by health professional.

Table 17: Showing the Clients' Satisfaction of the Availability of Psychiatric Service

Variable	No. of Respondents		
	Dissatisfied	Moderately Satisfied	Very Satisfied
Proximity to Hospital	23	24	53
Continuity of care	6	16	65
Availability of Drugs	2	27	71
Cost of Drugs	9	15	76
Home visits	74	5	7
Bureaucracy	4	13	83

CHAPTER V

THE DISCUSSION ON THE RESULTS

INTRODUCTION

The discussion of the study is categorised according to the characteristics of the sample and the three main objectives of the study viz:

- 1) The characteristics of the sample
- 2) The perception of the clients regarding the aetiology and management of mental illness
- 3) The clients' knowledge of the services rendered by clinical psychologists, psychiatric social workers and community psychiatric nurses and
- 4) The clients' perception of satisfaction with the quality of services rendered to them.
- 5) Limitations of the study

5.1 THE CHARACTERISTICS OF THE SAMPLE

The statistics in table 1 above suggest that the highest proportion of respondents were found between 26-35 years (34%). It is around 26 years that individuals complete tertiary school and as such are exposed to emotional stressors like looking for employment, marriage and having to live independently.

It can also be seen that within this age group (26-35 years), there are slightly more males than females.

It was also observed that most of the respondents were Christians (86%) and there were no traditional believers. This might be due to the fact that modernization has promoted the Christian religion to the decline of the traditional religion. The other plausible reason might be that since the Hospital is located in the capital city and most of the traditional belief centres are in the hinterland, patients cannot patronize them.

With regards to the duration of the illness, it is clear from the study that almost equal proportions of the respondents have either acute or chronic mental illness ranging from 21-30 percent.

5.2 THE CLIENTS' PERCEPTION OF THE AETIOLOGY AND MANAGEMENT OF MENTAL ILLNESS

The study revealed that irrespective of respondents' religion and educational background, the cause of mental illness is perceived to be multifactorial. These include factors like stress, supernatural forces, heredity, drug abuse, brain damage and infections. This is in line with the findings of Danquah (1976), Ofori-Atta and Linden (1995) and Razali (1996).

However, the study brought to light that even though 59% believed supernatural forces much emphasis is now placed on emotional stress (79%) followed by physical factors like infections (71%), trauma to the brain 71% and drug abuse 68%. Hereditary factors (51%) are the least mentioned by the respondents.

University of Ghana <http://ugspace.ug.edu.gh>
There is currently a better understanding of the aetiology of mental illness as compared to 20 years ago in the results of Twumasi (1975) work. This might be partly due to the influence of education, urbanization, and proliferation of mass media of recent times as postulated by Ofori-Atta and Linden (1995).

It is, therefore, not surprising that 42% of the respondents in this study made their first contact point of treatment with either the Psychiatric or General Hospital instead of with a traditional healer. They mostly gave the reasons that they either came on their own accord or were brought by their relatives to the hospital on the grounds that there are qualified doctors to handle their conditions.

The first contact point for treatment of psychiatric problems as found in this study was hospital. This was contrary to the findings of Razali (1996) that 73% of West African Psychiatric patients normally consult a traditional healer first as opposed to 25%. It was also contrary to the findings of Osei (1994) that out of 65 clients admitted to Okomfo Anokye Psychiatric Unit, 14.3% had come from healing churches as in-patients and 55.4% as out-patients. The difference in results might be due to the fact that Osei's study centred mostly on the seriously ill psychiatric patients who needed hospitalization as compared to the out patient clients in this study. It could also be that Osei's study which is at Kumasi has a more rural catchment over the Hospital.

This study also showed that only 13.6% of those who attribute mental illness to supernatural forces reported first for treatment from the traditional healer but 35.6% and 39% of them reported first to the Psychiatric Hospital and General Hospitals respectively. The implication of this finding is that although the aetiology of the condition is held by some of the clients to be supernatural, they have the conviction that scientific medicine can ameliorate the symptoms. Or that their relatives decision/beliefs may be more important.

This supports a further finding of the study that a majority of the clients who reported first to the Psychiatric Hospital for treatment still patronise the spiritual churches (37%), followed by those who go to private hospital (31%), herbal treatment (23%) and only 2% stick solely to psychiatric treatment.

This shopping around for better treatment lends more support to the findings of Razali (1996) that most of the psychiatric patients who had not yet consulted a traditional healer said they would do so if their current treatment failed.

This attitude of clients suggests that there is an element in the orthodox psychiatric practice in Ghana which is inadequate or insufficient to the needs of patients. Perhaps part of the healing requires a combination of both spiritual and psychiatric practice. Further investigations would be needed in this direction.

5.3 THE CLIENTS' KNOWLEDGE OF THE CLINICAL PSYCHOLOGISTS, PSYCHIATRIC SOCIAL WORKERS AND COMMUNITY PSYCHIATRIC NURSES

This study supports the hypothesis that psychiatric patients do not have adequate knowledge about the availability of psychiatric services rendered by other professionals.

This is because on the average 24 of the respondents had knowledge about the clinical psychologists, 17 about community psychiatric nurses and 12 about the psychiatric social workers.

Statistical tests, however, show that the higher the educational level of an individual, the better informed he is about the other professionals.

Apart from that, only few have ever used the services before (clinical psychologists 10%, community psychiatric nurses 6% and psychiatric social workers 3%). The respondents' knowledge about the functions of these 3 professions is not different. Out of the 100 respondents, those who knew their functions ranged from 9 - 20 as shown on (Tables 9-11)

This is strange considering the fact that clinical psychologists have been in practice since 1971 (Danquah 1982), that community psychiatric nursing came into being in 1990 (Osei 1996), and most of the psychiatric hospitals have psychiatric social workers.

The most plausible explanation for this inadequate knowledge of these professions might be due to ignorance and high illiteracy rate in the country as well as lack of referral of patients from psychiatrists and physicians to

clinical psychologists. It is possible some of the clients could have used or heard of their services but might have attributed their functions to medical officers.

That notwithstanding, the findings clearly indicate that the modern concept to be operated in psychiatric hospitals as outlined by Balier (1964) and Kidel (1967) is not applicable to the Accra Psychiatric Hospital.

By this system, they recommended an open door policy where the patient should relate not only to the same psychiatrist but to other professionals such as clinical psychologist, psychiatric social worker and other professionals who share his philosophy of treatment.

They further suggested that this can be done by involving such professionals in hospital team meetings, out-patient consultation, ward rounds and keeping in contact with patients both within and outside the Hospital.

5.4 THE CLIENTS' PERCEPTION OF THE QUALITY OF SERVICE FROM THE SERVICE PROVIDERS

The discussion is based on the various indices used to measure the quality of service by the clients viz:

- a) Thorough assessment of the clients by the service providers.
- b) The outcome of the care of the patients
- c) The time spent in the hospital
- d) Environmental hygiene conditions of the hospital
- e) Availability of psychiatric services

a) Thorough Assessment of Clients by Service Providers

The study brought to light that respondents were satisfied with the assessment by service providers (92%), especially on their first visit. This is very significant because according to the findings of Kaplan and Scanzo (1993), the first interview should be impressive for the client.

The findings also expressed what Boland (1995) found that the clients want to be asked information concerning their environment, family and work place during assessment. However, 2% of clients resented questions which were considered to be personal like eating habits, smoking and sexual life. This is comparable to Boland's (1995) study.

The areas with which clients were not satisfied included their contention that their diagnosis was not explained to them (75%), investigations were not done (61%) and vital signs not taken (45%).

Kinderand and Kent (1987) explain that service providers fail to explain the diagnosis to patients partly because of the high illiteracy rate among patients, partly because patients do not ask questions or partly because of their fear of escalating the condition by disclosing the diagnosis to the client. This is because mental illness goes with much stigma.

Psychiatrists do not order a lot of investigations for the clients partly because with psychiatric diagnoses in general after a thorough intake interview, the diagnosis may become clear. This is in consonance with Barry (1974) that 50% of psychological conditions are psycho-social in aetiology

and can thus be diagnosed mostly by interviews and not through laboratory investigations. Nevertheless, patients coming into a hospital may expect medical procedures and do get disappointed. However, it is still imperative for psychiatrists to rule out physical conditions that mimic psychiatric conditions.

It is also imperative for vital signs to be taken on all patients to be able to establish the baseline information, monitor the progress of conditions and to detect the onset of side effects of the drugs. The present study has contrary facts to those of Clark, Potter and McKinley (1991) that patients who are older, female and have better education are given more attention. It was found that the respondents' characteristics, factors like age, sex or educational level had no influence on their level of satisfaction.

It was also found that those reported dissatisfaction with the assessment expected the psychiatrists to examine them physically or at least use the stethoscope on them to ascertain the real cause of their illness.

b) The Outcome of Treatment to the Patients

The study showed that most of the respondents reported that symptoms improved (85%) and 82% of them were satisfied with the treatment. The youth and those in first cycle institutions expressed the highest satisfaction levels.

Ten percent of those who expressed dissatisfaction, complained that they were not given enough psychotherapy but only drugs. This might be partly due to the fact that there

are only a few psychiatrists (Abdulkadir, 1995) and as such cannot give psychotherapy. According to Danquah (1982) they are not trained for such a service, and thus there is more need for referral to clinical psychologists or social workers.

Ironically, such clients are rarely referred to the other professions who are specialised in psychotherapy (Balier, 1964). This accounts for the length of recovery of clients since most psychiatric conditions improve better on a combination of psychopharmacological agents and psychotherapy (Gary and Kavanagh, 1991).

It was also noticed that over 50% of the respondents did not know the names of the drugs they were taking let alone their functions. This again confirms the findings of Potter, 1984; Kinderand and Kent, (1987) that due to illiteracy, lack of time or habit of not asking questions, patients play a passive role in the consulting room.

In view of this, there is non-compliance of drug taking. Some even refuse to take the cogention as prescribed thereby predisposing themselves to extra pyramidal side effects.

c) The Time Spent in the Hospital

The average time spent by each client in the hospital was 2-3 hours 69% expressed satisfaction with this time. Those who expressed satisfaction with this time said they were content considering the fact that the service providers are few and the clients are normally many. This agrees with the findings of Abdulkadir, (1995) and Haward (1984)

Those who spent less time in the hospital were mostly those who either came very early in the morning or only came to collect drugs for their relatives.

Those who showed dissatisfaction were either those who came from far away or their service providers did not report early for duty on that day.

d) Environmental Hygienic Conditions of the Hospital

Roughly half of the respondents (51%) expressed satisfaction with the hygienic conditions of the hospital environment.

Those who expressed satisfaction said the buildings were put up during the colonial days and as such the structures were not well planned. Apart from that, they were not meant to house the number of people now being attended to.

Those who were dissatisfied, were of the opinion that clients should be provided with places of convenience even if at a minimal fee, good canteen facilities for the clients and dustbins at vantage places for them to dispose off their waste materials. One of the clients remarked that 'the place should be clean enough to reflect the status of a hospital'

e) The Availability of Psychiatric Services

The study showed that 65-85% respondents showed satisfaction with the availability of psychiatric services. The study also brought to light the fact that the sex of the respondents had no influence on the perception of the availability of psychiatric services. Dissatisfaction was

expressed only with proximity to hospital (23%) and lack of follow-up home visits (74%).

The dissatisfaction with the proximity to the psychiatric services was not surprising because there are only 3 psychiatric hospitals in the country and the proposed psychiatric wings in the District Hospitals are really not functioning (Osei, 1975). Again, since the research setting is the oldest Psychiatric Hospital and also situated in the capital of Ghana, people from far and wide patronise it.

The study revealed that 74% of the respondents were dissatisfied with the home visits rendered to them by the service providers. They wished they would have had such personnel visiting them in their homes where they can feel free to ask more about their condition, prognosis and management. This however, is not possible because of constraints such as lack of staff and vehicles and other logistics.

On the continuity of care by the same clinician, it was realised from the interviews that the respondents were satisfied in this regard. It came to light that the reasons for seeing a different clinician was due to either a transfer of the primary clinician or he/she had gone on annual leave.

A good number of the clients did not see the change of clinicians as a problem except that it breaks the relationship and bond they normally form with their initial clinician.

With regards to the availability and cost of drugs in the hospital, over 70% of the respondents were very satisfied with

those services. However, those who were slightly dissatisfied had the following complaints:-

- 1) Even though they do not pay much for the drugs, they would prefer to pay for the cost of drugs at one place instead of at different places.
- 2) The psychotropic medications that are given to them in the consulting rooms which are expensive should be given receipts to cover them so that they can reclaim such monies from their employers.

Not all the essential drugs are available at the hospital pharmacy and those that are bought outside are always expensive.

f) The Human Relations of the Service Providers

The respondents were generally satisfied with almost all aspects of client care-giver relations.

The index that had the least satisfaction was instructions given to the clients especially at the pharmacy. This agrees with the findings of Korsch et al (1968), Potter and McKinlay (1991) that most of the instructions given to clients are very technical and ambiguous and more than half of the patients do not normally understand the instructions given by the service providers.

The few clients (6%) who complained of lack of privacy said the Nurses' table is very close to the consulting room and as such she can hear whatever conversation that is going on in the consulting room. This problem emerges as a result

of the architectural structure of the buildings in the hospital.

With regard to respect for the clients, they had a high positive opinion of the service providers. One respondent even remarked that their human relations are far better than their counterparts in the General Hospital. She was wondering if it is because they are specially trained to deal with mentally ill patients.

A few also complained that once in a while, the staff bring their relatives in and jump the queue. Others also complained that some of the nurses normally mix up their cards thereby not serving them according to 'first come, first serve' basis.

5.5 THE LIMITATIONS OF THE STUDY

This study like any other project work is not without limitations. In the first place, the study focused on only O.P.D. clients. This would not, therefore, give us the true picture of the clients' perception of the quality of inpatient psychiatric services rendered to them since the in-patients are left out.

Fatigue on the part of the respondents was also a very important setback on the study. This resulted from the fact that after they have gone through the bureaucratic procedures in the Hospital, they became wearied and did not co-operate well during the interview.

A further limiting factor was the fear of the clients in expressing their true feelings about their perception of the quality of psychiatric services rendered to them due to non-

assertiveness and fear of hurting the emotions of service providers and the consequent repercussions.

Ignorance of the general populace on their rights on what the service providers are expected to do for their clients due to lack of education also set a limit to the outcome of the results of the research.

Again the period was too brief for the clients to give a proper assessment of the quality of services rendered to them and in view of the stigma attached to the condition, some of the clients felt reluctant to have discussions concerning the condition.

This study has possibilities of Type 1 and 2 errors in the analysis because the sample size was not large enough and the true parameters of the population are not known. Furthermore, in some of the questions, the respondents were required to give more than one response. Lastly, no believers in traditional religion were represented in the sample hence their views could not be tapped.

CHAPTER VI

SUMMARY AND RECOMMENDATION OF THE STUDY

6.1 INTRODUCTION TO THE SUMMARY AND RECOMMENDATION

This is an evaluative cross-sectional survey research which is aimed at finding out the opinions of clients on the quality of psychiatrist services rendered to them on OPD basis.

This study was conducted at the Accra Psychiatric Hospital. One hundred subjects were selected at random from all the consulting rooms. An interview schedule was used to gather the data and analyses were made as per descriptive statistics, chi-squares and contingency co-efficients.

The study aims to answer the following questions:-

- 1) Where do clients with psychiatric conditions first report?
- 2) Do clients have adequate knowledge of the services rendered by clinical psychologists, psychiatric social workers and community psychiatric nurses?
- 3) Are clients satisfied with the services given them at the Psychiatric Hospital on an OPD basis?

6.2 SUMMARYi) The Characteristics of the Sample

With regards to the demographic data, the highest proportion of respondents were between 26-35 years. There were relatively equal numbers of male and female respondents.

ii) The Clients' Knowledge of the Aetiology and Management of Mental Illness

According to the results, the causes of mental illness are thought to be multifactorial and includes stress, supernatural forces, heredity, drug abuse, brain damage and infections, with heredity being the least mentioned.

The first contact place for treatment for most patients is the Psychiatric Hospital either on a voluntary basis or brought by their relatives.

It was also noticed that most of them still receive treatment from the spiritual churches, herbalist and private medical practitioners to complement the treatment being received from the psychiatric Hospital.

iii) The Clients' Knowledge Regarding Clinical Psychologists, Psychiatric Social Workers and Community Psychiatric Nurse

The study showed that 9-20% of respondents had knowledge about the above professionals and the work they do in the Psychiatric Hospital. Fewer still had used their services before.

iv) The Clients' Expectation of the Quality of Service from the Service Providers

The respondents were very satisfied with the overall assessment given to them. However, what dissatisfied them included the fact that few laboratory investigations were ordered for them and their diagnosis were not explained to them.

On the outcome of treatment, over 80% of the respondents reported improvement in their symptoms after coming to the hospital for treatment and they were also satisfied with the treatment given to them.

The respondents were satisfied with the amount of time spent in the hospital which is an average of 2-3 hours before collecting their drugs.

With regards to the respondents' satisfaction with the environmental hygiene of the Hospital, about half of the respondents showed satisfaction.

Besides home visits and proximity to the Psychiatric Hospital, the respondents were satisfied with the availability of Psychiatric services. Between 65-68% of the clients were satisfied with the quality of services rendered to them. However, 74% of the respondents were highly dissatisfied with the home visit services.

6.3 RECOMMENDATIONS

After analysing the data on the clients' perception of the quality of psychiatric services rendered to OPD patients at Accra psychiatric Hospital, the researcher wishes to make the following recommendations which fall under main categories:-

- 1) Psychiatric Health Education to the public
- 2) Instituting Government policies to promote modern psychiatric health services in the country and
- 3) Instituting hospital policies to promote modern psychiatric health services in the country.

4) Further Areas of Research.

1) Psychiatric Health Education to the Public

All Psychiatric health workers should mount serious psychiatric health education to prevent, minimize the occurrence of mental illness, and reduce the burden of distress.

The study indicated that health education on mental illness is done on a minimal level and it can be enhanced in the following ways:-

The target groups should be those who are very vulnerable. These include those aged between 26-35 years and those in second cycle institutions as indicated by the study. It should also be extended to those in stressful occupations such as traders and the unemployed.

The media of health education should include the following:-

Firstly, health talks should be given to clients on daily basis before they see their service providers and if possible whilst waiting to see the clinician they could be shown educative films on enhancement of their knowledge on better mental health.

Other avenues could include mass media, churches, schools, workplaces, organized groups on varied topics related to better mental health.

Open days could also be organised so that the public, government policy makers, parliamentarians and vulnerable

groups could come to acquaint themselves with the facilities that the hospital can offer to psychiatric patients.

National psychiatric weeks could also be organised so that there would be talks, symposia, seminars, mass media coverage and anything that can help promote mental health to be devoted for that week or even a month.

During the various discussions above, topics should include the following:

- a) Predisposing factors of mental illness
- b) The signs and symptoms
- c) The various members of the psychiatric health team and their roles
- d) Emphasis should be on services in the Psychiatric Hospital that are not known to the public especially those of the Helping Professions.

2) Instituting Government Policies that would Promote Modern Psychiatric Services in Ghana

The study also brought out the fact that the respondents perceive stress as the main cause of mental distress and that there is the lack of staff, infrastructure and logistics to carry out home visits to the expectation of the clients.

Hence Government of Ghana has to modify certain policies that will create an enabling environment for better mental health to flourish. This can be done in the following ways:-

- a) The educational sector should restructure their courses to be more employment oriented so that graduates from

such institutions can be gainfully employed after completing school. This would reduce mental stress.

- b) There should be attractive incentives for the training of Psychiatric staff so that health personnel can specialise in such areas. More emphasis should be placed in the training of those in the helping professions since they are few in the system. Apart from this their salary, fringe benefits and conditions of service should be attractive enough to motivate them to put up their best.
- c) The present policy of creating psychiatric wings in all Regional and District Hospitals should be reinforced and those in the helping professions should be posted to all these areas to offer their services. Apart from that, there should be Community Psychiatric Units where clients can be seen at first before referral to psychiatric wings.
- d) There should be adequate infrastructure in the form of buildings, offices, furniture, vehicles and other facilities that can facilitate the promotion of mental health to the public in the various psychiatric wings.
- e) There should be yearly mandatory refresher courses for both medical practitioners and medical assistants on the recent developments in mental health since some of the clients pass through their hands first before coming to the psychiatric hospital.

3) Hospital Policies

The Psychiatric Hospital must also adopt certain policies

in order to give wholistic psychiatric care to the clients as follows:-

- a) The open system policy as suggested by Bailer and Kidd (1964) which is a modern form of psychiatric care is not being practised in the Hospital. It is suggested this policy should be adopted so that those of the helping professions should be involved greatly in the management of all psychiatric patients who come to the hospital.

Such professionals should also be given enough infrastructure, means of transport, writing materials and anything that might be deemed necessary to facilitate the smooth running of the system.

This is more so with those suffering from depression and anxiety since it is a well known fact that such patients benefit maximally from both psychotherapy and medications (Burnard, 1997).

- b) A Hospital Chaplain should be inco-operated into the Health Team to meet the spiritual needs of the clients. This will prevent them from shopping around for charlatan spiritual centres where they advise them to stop the medication thereby making the condition worse.
- c) If possible, the renowned traditional healers who handle mental illness should be inco-operated into the Health Team and taught hygienic ways of preparing and administering their herbs. Their herbs can also be tested to ascertain their efficacy and toxicity level of them.

- d) The study also revealed that the clients are not well educated on the drugs they take hence they should be educated on the pharmacokinetics of the psychotropic drugs, side effects and what to do to abate them. This will help to promote drug compliance, speedy recovery and avert any possible extra-pyramidal side effects.
- e) The present system of writing the name and dosage of the drug on the envelope containing the drugs should be reinforced.
- f) The patience and respect accorded to patients as perceived by them in the study in Psychiatric Hospital should be intensified since it has numerous advantages for both the patient and the hospital. This can be reinforced and maintained by instituting the 'BEST WORKER AWARDS' to be appraised by both staff and patients.
- g) The Hospital should operate out-reach mental health services to the rural areas to ease the pressure in the hospital. Most of the patients who have stress related disorders should be referred to the helping professionals for psychotherapy and stress management.
- h) There should be a central cash point in the hospital in which all payments can be made for all expenditures in the hospital and the appropriate receipts issued.
- i) The hospital should fund studies related to mental health and make a collection of local studies on this subject. Findings of this thesis should also be made available to all psychiatric staff in mental health institutions, HRDD

(MOH), Institutional Care (MOH), Nurses and Midwives Council of Ghana and Ghana Medical and Dental Board.

4) Further Areas of Research

The following areas deserve further research in the Hospital:-

- 1) A study on why patients shop around for supplementary treatment.
- 2) A study into client satisfaction of the in-patients in the Psychiatric Hospital.
- 3) The impact of the helping professions on the health of the patients.

REFERENCES

- Ary, D. et al (1979): Introduction to Research in Education 2nd Edn. U.S.A., Holt, Reinehart & Winston Inc.
- Assenso-Okyere et al (1998). Cost Recovery in Ghana: Are There Any Changes in Health Care Seeking Behaviour? Health Policy and Planning, 2, 181-189.
- Azinge (1983): Mental Health Care in the Developing World Tropical Doctor 13, 149-152.
- Bamkowsiki et al (1996): Resonances Between Traditional Healer and Persons Seeking Help INITO Vol.17, No.2, pg.146-149.
- Barkarkis, K.D. (1977): The Communication of Information from Physician to Patient: A Method for Increasing Patient Retention and Satisfaction. Journal of Family Practice 5, 215-222.
- Boland, M. (1995): What Do People Expect from Their Doctors? World Health Forum, 16 No.3, 221-248.
- Brown, L.D. et al (1996): Quality Assurance of Health Care in Developing Countries. A paper presented at the Regional Directors of Health Service in Ghana.
- Bruning, N.S., Frew, D.R. (1987): Effects of Exercise, Relaxation and Management skills Training on Physiological Stress Indicators: A Field Experiment J. Appl Psychol 72(4):515.
- Burgest (1985): Social Exchange in Developing Relationships New York: Academic Press.
- Burnard, P. (1994) Counselling Skills for Health Professionals 2nd Edn. New York, Chapman & Hall.
- Burnard, L.C. & Kruppart, E. (1994) Health Psychology Biopsychosocial Factors in health and Illness, Harcourt, Brace College Pub.
- Carpentier, P. et al. (1995) Choice of Traditional or Modern Treatment on West Burkina Faso. World Health Forum, 2, 198-202.
- Clark, J.A.; Potter, D.A.; McKinlay, J.B. (1991): Bringing Social Structure Back into Clinical Decision-Making. Social Science and Medicine 32, 853-866.

- Danquah, S.A. (1976). A Preliminary Survey of Beliefs About Severe Mentally Retarded Children in Ghana, Psychopathologie Africaine XII, 2, 187-197.
- Danquah, S.A. (1982). The Practice of Behaviour Therapy in West Africa: A Case of Ghana. Behaviour Therapy and Experience Psychiatry, 13, 1, 5-13.
- Danquah, S.A. (1998). The Role of the Clinical Psychologist in Ghana. A paper presented at the Psychology Dept., University of Ghana, Legon.
- Darko, W. et. al (1988). Characterising Hospital Inpatients: The Importance of Demographics and Attitudes. Hospital and Health Services Administration 33, 3, 361-370.
- Dovlo, D. et al (1992). What Does the Public Want from Us? A Study of User Satisfaction with services in Government Health Facilities in the Eastern Region in Ghana.
- Dovlo, D. (1995) A speech on Quality Assurance Guidelines to Regional Directors of Health Services in Eastern Region.
- Egdell, H.G., (1983) Mental Health Care in the Developing World Tropical Doctor, 13, 149-152.
- Faden, R.R.; Becker, C.; Lewis, C. Freeman (1981): Disclosure of Information to Patients in Medical Care. Medical Care, 19, 718-733.
- Fraenkel, J.R. & Wallen, N.E. (1993) How to Design and Evaluate Research in Education, 2nd Edn. New York, McGraw-Hill.
- Hall, J.A. and Dornan, M.C. (1988): What Patients Like About their Medical Service and How Often They are Asked. A Meta-analysis of the Satisfaction Literature. Social Science and Medicine, 27, 935-939
- Harding, Clemant and Wig (1980): Preventive Care. WHO Vol.17, No.1, 227.
- Heron, J (1989): A Handbook of Facilitator Style. Kogan Page, London.
- Janis, I.L. and Freshback, S. (1953): Effects of Frear Arousing Communications. Journal of Abnormal and Social Psychology 48, 78-92.

- Kaplen & Saccuzzo, (1993) Psychological Testing: Principles Applications and Issues 3rd Edn, California, Colar Pub. Co.
- Kathryn, D. & Miles J. (1992) Patient Satisfaction with Ambulatory Health Care Service - Waiting Time and Filing Time. Hospital and Health Services Administration 42, 2, 165-176.
- Kelly, M. & May, D. (1982) Good and Bad Patients: A Review of the Literature and a Theoretical Critique Journal of Advance Nursing
- Kinderland, K., and Kent G (1987): Concordance Between Patients' Information Preferences and General Practitioners' Perceptions. Psychology and Health 1, 399-409.
- Komla, T. (1997) Traditional Medicine in Contemporary Ghana: A Public Policy Analysis. Social Science and Medicine, 45, 7, 1065-1094.
- Korsch, B.M.; Gozzi, E.K. and Francis, V. (1968) Gaps in Doctor-Patient Communication - Doctor-Patient Interaction and Patient Satisfaction Paediatrics 42, 855-871.
- Krupat, E. et al (1983); The Doctor-Patient Relationship: A Social Psychological Analysis. In R.F Kidd & J.M. Saks (edn) Advances in Applied Social Psychology (Vol.2) Hillsdale, N.J. Erlbaum.
- Marie, S. (1995). Young Patients Need Guidance. World Health Forum 16, 2, 221-248.
- Nietzel, M. et al (1994) Introduction to Clinical Psychology 4th Edn. New Jersey, Prentice Hall.
- Nkansa-Sarkordie (1992). The Quality of Care Assurance for Inpatients at the Akyem Oda Government Hospital. A dissertation to the West African College of Surgeons.
- Norman, Z.M.; Schmiadt, H.G and Ezzat, E.S. (1990) Innovation in Medical Education: An Evaluation of Its Present Status. New York, Springer-Verlag.
- Ofori-Atta, L.A. & Linden, W. (1995) The Effects of Social Change on Causal Beliefs of Mental Disorders and Treatment Preferences in Ghana. Social Science & Medicine 40, 9, 1231-1242.
- Osei Yaw (1994) Psychiatric Service in a Developing Country - The Case of Ghana Curare, 17, 39-43.

- Otoo, J.D., (1996) Talk on quality Assurance Guideline for a Regional Institutional Based Programme.
- Pendleton, D. and Bochner S. (1980): The Communication of Medical Information as a Function of Patients' Social Class. Social Science and Medicine, 14A, 669-873.
- Razali (1996) Psychiatric and Self-Healers in Malaysis World Health Forum, 15.
- Records from O.P.D. at Accra Psychiatric Hospital.
- Rogers, C.R. (1967): On Becoming a Person. Constable, London.
- Roter, D.L. (1984) Patient Question Asking in Physician-Patient Interaction. Health Psychology 3, 395-410
- Sartre, J.P. (1973): Humanism and Existentialism Methuen London.
- Senah (1987): The Role of Traditional Medicine in Ghana. A paper presented at the Nursing Dept., University of Ghana, Legon.
- Tenal Abdukardir (1995). Soaring Demand, Limping Supply. World Health Forum, 16, 3, 221-248.
- Tosteton, D.C. (1990): New Pathways in General Medical Education. Nw england Journal of Medicine, 322, 234-238.
- Tuckett, H.D.; Boulton, M. Olson, C. and Williams A. (1985) Meetings Between Experts: An Approach to Sharing Ideas in Medical Consultations. London: Tavistock.
- Twumasi, P.A. (1988) Social Foundations of the Interplay Between Traditional and Modern Medical System. An Inaugural lecture at the University of Ghana, Legon.
- Twumasi, P.A. (1975) Medical Systems in Ghana. Tema, Ghana Pub Co.
- Waitzkin, H. and Stoeckle, J.D. (1976): Information Control and the Micropolitics of Health Care: summary of An Ongoing Research project: social Science and Medicine, 10, 263-276.
- Waitzkin H. (1985). Information Giving in Medical Care. Journal of Health and Social Behaviour, 26, 81-101.
- Wesley Febb (1995). A Reliable Explainer World Health Forum 16, 3, 221-221-238.

INTERVIEW SCHEDULE

RESEARCH TOPIC: THE PERCEPTION OF O.P.D. CLIENTS ABOUT THE QUALITY OF PSYCHIATRIC SERVICES RENDERED TO THEM: A STUDY AT ACCRA PSYCHIATRIC HOSPITAL

INTRODUCTION

This interview schedule seeks to gather information concerning your opinion about the quality of psychiatric services rendered to you in the hospital on O.P.D. basis. Clients may refuse to participate but that is likely to affect the findings. All information gained in this interview is strictly confidential. This study is a partial fulfilment of the award of M.Phil in Clinical Psychology.

SECTION A: THE DEMOGRAPHIC DATA OF THE CLIENTS

- 1) Age:

16-28 years	[]
29-31 years	[]
32-45 years	[]
46-64 years	[]

- 2) Sex:

Female	[]
Male	[]

- 3) Occupation

Trader	[]
Farmer	[]
Craftsman	[]
Unemployed	[]
Others (specify)	

- 4) Education

None	[]
First Cycle (Primary, J.S.S., MSLC)	[]
2nd Cycle (Secondary, Vocational, Commercial)	[]
Tertiary (Post-Secondary, Polytech, University)	[]
Others (Specify)	

- 5) Religion

Christian	[]
Moslem	[]
Traditional Religion	[]
None	[]
Others (Specify)	

6) Type of Visit

1st visit	[]
Follow-up	[]

7) Duration of illness

Less than 1 year	[]
1-2 years	[]
3-5 years	[]
Above 6 years	[]

SECTION B: THE CLIENTS' KNOWLEDGE ON THE AETIOLOGY AND
MANAGEMENT OF MENTAL ILLNESS

Aetiology of Mental Illness

8) What do you consider to be the cause(s) of mental illness?

Supernatural forces	[]
Stress	[]
Heredity	[]
Drugs	[]
Head injuries	[]
Others	

Management of Mental Illness

9) (a) Where did you first seek treatment for your condition?

Psychiatric Hospital	[]
General Hospital	[]
Traditional Healer	[]
Spiritual Church	[]
Others (specify)	

(b) Give reasons for your choice

.....

SECTION C:THE CLIENTS' KNOWLEDGE OF THE SERVICES RENDERED BY
CLINICAL PSYCHOLOGISTS, SOCIAL WORKERS AND
COMMUNITY PSYCHIATRIC WORKERS

- 10) (a) Which of the Psychiatric Professionals listed below have you heard of?

Clinical Psychologist	[]
Psychiatric social worker	[]
Community Psychiatric Nurse	[]

- (b) What are the services rendered by those you ticked above?

.....

.....

.....

- 11) How did you hear of them?

Mass Media	[]
Talks from Health professionals	[]
Through other patients/friends	[]
Referral to them	[]
Others specify	

SECTION D: THE CLIENTS' EXPECTATIONS OF THE QUALITY OF SERVICE
FROM THE SERVICE PROVIDERS

- (i) Thorough Assessment of the Clients

- 12) Were your vital signs (BP, Pulse, Temperature) checked?

Yes	[]
No	[]

- 13) Did the clinician have enough time for you during the first interview?

Yes	[]
No	[]

- 14) a) Did you find some of the questions irrelevant?

Yes	[]
No	[]

- b) I f y e s s t a t e t h e m
-
-

- 15) Where other investigations done for you?

yes []
No []

16) Was your diagnosis explained to you?

Yes []
No []

17) a) Were you satisfied with your overall assessment by the Doctor?

Yes []
No []

b) If No, give reasons
.....

(ii) Outcome of Care

18) a) Did you have your symptoms improved?

Yes []
No []

b) If Yes, state them
.....

19) a) Are you satisfied with the treatment?

Yes []
No []

b) If No, state the reason
.....

iii) Time Spent in the Hospital

20) a) Which of the following ranges of time did you spend in the Hospital?

Less than 1 hour	[]
2-3 hours	[]
4-5 hours	[]
More than 5 hours	[]

b) Are you satisfied with the time spent in the Hospital?

Yes []

No []

iv) Environmental Hygiene of the Hospital

21) a) Are you satisfied with cleanliness of the Hospital environment?

Yes []

No []

b) If No, state the areas that are dirty

.....

v) Availability of Psychiatric Services

Rate your degree of satisfaction on the availability of psychiatric services on the variables listed below using the following grading system:-

- 1 = Very satisfied
2 = Slightly satisfied
3 = Dissatisfied

<u>Variable</u>	<u>Level of Satisfaction</u>		
a) Proximity to hospital	[1]	[2]	[3]
b) Continuity of care by the same Clinician	[1]	[2]	[3]
c) Availability of drugs	[1]	[2]	[3]
d) Cost of drugs	[1]	[2]	[3]
e) Home visits by service providers	[1]	[2]	[3]
f) Bureaucracy in the hospital	[1]	[2]	[3]

iv) Human Relations of the Service Providers

please tick the box that best describe your level of satisfaction of the OPD staff human relations to the clients. Use the following grading system:-

- | | | |
|---|---|----------------|
| 1 | = | Very satisfied |
| 2 | = | Moderately |
| 3 | = | Dissatisfied |

<u>Human Relation</u>	<u>Grading</u>		
a) Privacy during procedures	[1]	[2]	[3]
b) Respect for the clients	[1]	[2]	[3]
c) Instructions to the clients	[1]	[2]	[3]
d) Equal attention to the clients	[1]	[2]	[3]
e) Patience for the clients	[1]	[2]	[3]

Thank you.