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### Community Mental Health Workers And Capacity Building: A Qualitative Evaluation From Ghana

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**Community Mental Health Workers and Capacity Building: A Qualitative  
Evaluation from Ghana**

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## ABSTRACT

**Background:** Ghana is among countries facing human resource shortages for mental healthcare. Since 2011, the country has shifted to a community-based model of mental healthcare and has used task-shifting to fill the mental health professional gap.

**Methods and Results:** A qualitative study was conducted using in-depth interviews with 17 community mental health workers (16 psychology college graduates and 1 community psychiatric nurse) employed through the publically funded health system to explore their experiences in mental health promotion and service delivery on the ground. Several findings characterize the CMHWs experiences: limited mental health literacy, overwhelming stigma, performing duties outside of their job skill, lack of resources, and insufficient work space were all challenging factors to performing their work; unintended consequences arose from the possession of a psychology degree; a high degree of coping was exhibited by all participants their experiences generated significant future value.

**Conclusions:** CMHWs have important potential for building capacity in the mental health workforce and subsequent strengthening of the mental health system. Despite their much-needed work in changing mental health perceptions at the community level, they are still limited in their impact. The Ministry of Health must pay attention to engaging religious leaders to promote enhanced mental health literacy, fulfilling their commitment to provide free psychotropic medications, and leveraging future human capital to facilitate mental health program efficacy.

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## 1. BACKGROUND

Mental health disorders account for a significant and growing proportion of the global disease burden. In 2000, Mental illness accounted for approximately 12% of the global disease burden and is projected to increase to 15% by 2020<sup>1,2</sup>. Moreover, most of the global burden of mental, neurological, and substance abuse disorders occurs in low- and middle-income countries (LAMICs)<sup>3</sup>. This poses significant challenges for the already precarious health systems in these countries.

In LAMICs, between 76%-85% of people with severe mental disorders do not receive any treatment for their mental health. This gap is estimated to be even higher for those with mild to moderate severity<sup>4</sup>. The absence of care is largely due to a scarcity of mental health professionals in low- and middle-income countries<sup>5</sup>. Unlike most other medical treatment, mental healthcare relies on dialogical assessment and therapies issued by skilled workers, rather than technology or equipment<sup>6</sup>. Therefore, a dearth of trained mental health professionals results in a significant unmet mental healthcare needs. The World Health Organization estimates an additional 1.18 million mental health workers are needed in order to close the treatment gap in LAMICs<sup>7</sup>.

Ghana is a lower middle-income country that has taken initiatives to prioritize this need<sup>8</sup>. In 2007, the WHO estimated out of the 21.6 million people living in Ghana, 650,000 were suffering from a severe mental health disorder and 2,166,000 were suffering from mild to moderate disorders. That same year, only 32,283 people received treatment, or 1.15% of those estimated to have a mental disorder, rendering a treatment gap of nearly 99%<sup>9</sup>. In 2011, there were only 11 practicing psychiatrists, 19 clinical psychologists, 21 social workers, and 4 occupational therapists working within Ghana's mental health system. The passing of the Mental Health Act in 2012 was a large step towards restructuring how mental health services will be provided within the public healthcare system. The Act reflected a shift from an institutionalized model to a community-based approach and emphasized the protection of vulnerable groups. To remediate the lack of psychiatrists, the community focus relied on a task shifting of responsibilities- an approach that capacitates non-specialists to provide mental healthcare. These community mental health workers (CMHWs) are trained to identify and refer persons with mental disorders typically to one of three public psychiatric hospitals in the country for psychiatric diagnosis. Direct mental healthcare is then given by the nearly 900 psychiatric nurses at the institutional or more often community level<sup>10</sup>.

As the last decade has been focused on developing a structure of mental health delivery in LAMICs, very little is known about the challenges community mental health workers face on the ground. Given the relative novelty of mental healthcare provision in LAMICs, most papers in these countries are policy-focused, aimed to increase political will/prioritization and initial scale-up. One previous study examined the role and scope of CMHWs in Ghana from their own perspectives via survey and consisted of only community psychiatric nurses (CPNs), community psychiatric officers, and community mental health officers. While their range of duties vary with some overlap, their training was largely in psychiatric care<sup>2</sup>. Other studies focused on integration of mental health into primary care<sup>11,12</sup>. Therefore, the delivery of community mental health programs in resource-limited settings presents an area for further clarity.

In 2012, the Psych Corps program was launched to further mediate the shortage of mental health professionals. Psych Corps members (PCMs) are a team of psychology

graduates assigned to various health facilities, who reported directly to facility CPNs, and tasked with the slow but necessary work in increasing awareness and access to mental health services directly in the communities.

This research aims to elucidate the challenges and advantages CMHWs (CPNs and PSMs) on the frontlines face in their work and how an undergraduate degree in psychology might modify these experiences. Answering these questions in the early stages of implementation can quickly help identify inefficiencies or gaps that exist in the delivery of mental health services from the ground-up and permit recommendations in improving the practice of CMHWs and mental health system at large.

## 2. METHODS

### 2.1 Study Design

Qualitative interviews were conducted of 17 CMHWs affiliated with the Psych Corps, program in August 2015. A qualitative approach was chosen because individual experiences and perspectives are difficult to measure quantitatively<sup>13</sup>. Qualitative methods are increasingly recognized as providing valuable contributions to shaping health service delivery<sup>14</sup>. Community mental worker perceptions of impact and barriers are essential for future plans of scale-up and potential reproducibility in other resource-limited settings. A grounded theory approach guided this study, deriving theories and explanations inductively from the data<sup>15</sup>.

### 2.2 Sampling and Size

A sample size of 17 community mental health workers was achieved through a convenience sampling approach that included 16 Psych Corps members and 1 CPN. Psych Corps members are recent college graduates, many with a psychology degree. The government mandates all Ghanaian college graduates to complete a one-year national service in the country. Students that have completed coursework in clinical, community, and abnormal psychology may self-enroll or are assigned to the program by the government.

For the 2014-2015 cohort, an initial 128 Psych Corps were assigned by the government. The Psych Corps coordinator contacted 74 Psych Corps members out of 128 that were initially posted that were reachable by telephone for voluntary participation in this study. The remaining 54 non-active service personnel were initially assigned to Psych Corps, but were unreachable due to 1) their national service assignment being changed, 2) change in contact information, or 3) had later expressed that they did not want to enroll in the Psych Corps program. All members who enrolled over the phone were then approached at their mental health unit for an in-depth interview. The sample size was determined by theoretical saturation, or the point at which no new information arose from successive interviews<sup>16</sup>. Saturation was achieved once 16 Psych Corps participant interviews were completed as the last few interviews provided no new concepts. Only 1 CPN consented to be interviewed, therefore saturation for supervisors was not achieved.

### 2.3 Data Collection

In-depth semi-structured interviews were conducted at each respondent's health facility using an interview guide covering the following topic areas: participant description of job duties, degree of support in doing work, and perception of population need gaps (Appendix 1). The interviews also asked about the intersection of religion in their work, perceived impact, and challenges of the greater mental health system. Interviews ranged from 20 minutes to 90 minutes in length and were conducted by one interviewer. Participant experiences and perceptions were elicited through open, nondirective questions. Standard, open-ended probes were used to encourage participants to enhance depth of responses and to elucidate statements. Data collection and analysis were iterative in nature and the interview guide evolved as interviews progressed to ensure questions covered the breadth of emergent themes.



## **2.4 Data Analysis**

In order to assess variability and richness in the work of the CMHW, open-ended questions were employed as opposed to statistical representation. Analysis was performed by looking for content and themes using the constant comparative method. This process included open coding to identify key categories and concepts and axial coding to tie these categories to subcategories. NVivo software was used for data organization and retrieval.

### 3. RESULTS

**Table 1. Participant Characteristics (n=17)**

Sociodemographic, n (%)	
Age (years)*	24.9
Sex	
Male	5 (29.4)
Female	12 (70.6)
Fluent Languages	
Ashanti Twi*	13 (81.3)
Akan (unspecified)*	2 (12.5)
Ewe*	1 (6.3)
Ga*	6 (37.5)
English	17 (100)
Adan*	1 (6.3)
Nzema*	1 (6.3)
Fanti*	5 (31.3)
Guang*	1 (6.3)
Job Duties	
Health talks	15 (88.2)
Counseling	17 (100)
Prayer camps	4 (23.5)
Home visits/tracing	14 (82.4)
Tasks outside job duties*	10 (62.5)
Supervision*	
Work under psychologist	2 (18.8)
Work under psychiatrist	1 (6.3)
Work under CPN	13 (81.3)
Training*	
Attended Orientation	11 (68.8)

\*Excludes CPN Supervisor

❖Sociodemographic group may not add up to 17 or 100%

#### 3.1 Participant Characteristics

The study sample included 17 CMHWs with a mean age of 25 years (Table 1). The majority of participants were women. All participants were fluent in English with Ashanti Twi listed as the second most commonly spoken language. Moreover, all CMHWs participate in counseling patients while only four do outreach at prayer camps. Only three Psych Corps members work under a psychologist while the remaining work under community psychiatric nurses. The majority (~69%) of PSMs attended the two-day Psych Corps orientation and training prior to starting service, whereas the remaining PSMs did not attend any sort of training.

Four major domains were identified relating to the experiences of the CMHW: challenges of the work, the aid of the psychology degree, coping, and gains from the experiences.

### 3.2 Domain 1: Work Challenges

**3.2.1 Mental Health Literacy.** All respondents emphasized the lack of knowledge in mental illness and proper care within the population as a primary challenge. Interviewees described patients' lack of awareness regarding the presence of a mental health unit within their local health facility and belief that the only care available were the Ghana's three government psychiatric hospitals located in the country's lower regions. CMHWs stated patients believed mental healthcare to be only for those with severe psychiatric conditions and/or associated with having to take medication. Moreover, CMHWs stated irritation regarding epileptic patients being referred to their unit. One highlighted:

*They have to be educated. Because you know most people who hear about psychiatry, they think it's for those who are mentally unsound or something. But maybe you have marital issues and all those things and you can come here so we can come here so we can talk to you. But most of them don't see it that way. When they come here, they are mad. That's the perception that people have. And I learned epilepsy is not a mental condition. But this place, they treat it as one. So those epileptic patients they come to us here. And that's another problem. And also this place, they'll prescribe drugs to you but maybe you need therapy. So we need much time so we can talk to the person. But here when you come, no. They just give you drugs, and they talk to you for 30 minutes, then the drugs follow. The point is, the minute you come here you should not say 'I'm coming to take drugs.' So that's the major thing. (Participant 3)*

In addition, the vast majority of participants reported routing patients from traditional/religious healers for severe conditions such as epilepsy and psychosis as a key hurdle in their work. CMHWs perceive prayer camps and traditional healers to be culturally valuable, yet ineffective in the proper treatment of psychiatric conditions. These findings highlighted the lack of basic mental health education in the communities CMHWs serve and the importance given to routing patients to appropriate care. Participant 2 expresses the frustration associated with this area of work:

*I realized there is a lot of things that we need to do in this field. Especially awareness creation, it's a lot. Even people who are not mentally, who claim not to be mentally ill, I think they are mentally ill and I think we need to go out for all of them. Even the way they think, as Ghanaians, we meet psychologists and I don't want to blame them because of all these religious affiliations and all that. People want to talk to their pastors. I had a friend that was like "Ah, what is a clinical psychologist for and are they really needed in Ghana?" We have a lot of cases here. The first thing that they do when they have any medical illness is prayer camp, prayer camp, prayer camp. You know the prayer camps. They go there for a long time, no result. Even epileptic patients, sometimes they go off these medications and they resort to herbal medicines and sometimes it doesn't work. So they have to come back and a whole lot of issues within. (Participant 2)*

**3.2.2 Untrained in Tasks.** All participants reported having to do tasks outside of their job responsibilities or tasks they were not trained to do prior to starting their position. Half of PSMs stated they served medications to patients and two reported being asked to give Diazepam injections by their supervisors. Moreover, few respondents indicated learning how to restrain aggressive patients. Several of these issues are articulated by Participant 4:

*With the drugs, with the drugs we only heard of the drugs in class. If you're suffering from this, this is the treatment. Basically we've never seen the drugs before. So we came here and we had to help in serving the drugs. Aha. We're not experienced with that, we don't know anything about that, we have not been trained on drug anything. When we came here we had to help do that. And as he said- restraining. We also get very aggressive patients here and we have no experience in how to restrain. (Participant 4)*

In addition, one CMHW described doing untrained work in the HIV unit in which they were transferred to:

*The counseling. Usually those who do drug adherence counseling are trained counselors or even those who do the testing are supposed to be trained. (Participant 1)*

PSMs that worked directly under a psychiatrist or psychologist did not report performing untrained tasks.

**3.2.3 Access to Resources.** The two CMHWs who had a clinical psychologist working in their unit stressed the need for further assessment tools to perform necessary work. One Corps member highlighted:

*We feel like we can do more if we had those assessment tools because like she said there are some people that don't really have money but because we don't have the assessment tools we have to send them back without doing anything for them. Because until we assess them to really know what the problem is we can't move forward. But because we don't have them they have to just go back. It really affects us sometimes. (Participant 17)*

Participants expressed frustration at their lack of technology for enhanced efficiency and coordination. Reliable internet was indicated to be integral for better monitoring and feedback from the Psych Corps coordinator. At present, when identifying clients for home-tracing, several CMHWs must travel to the psychiatric hospitals and review the patients discharged in-person. Internet services needed to access training materials or for monitoring patients were seen to be of great benefit. CMHWs stated that all their documentation was done by paper, which was a source of frustration:

*We don't have modern technology- look at us! With this table and everything paper, paper, paper. (Participant 9)*

Moreover, some participants noted their mental health units don't have the requisite medications that their patients need and are forced to turn patients away.

*And if you go and the client is relapsing, that one is an issue. That's serious. And then continuity of taking medications, the costs involved. Sometimes it's just bad. Even if we try to get them free ones from Basic Needs- they have organization like that. If the person is epileptic they has to take medications every day. And if there's no money, then serious. (Participant 2)*

*I think with the drug issue, when we came we were told previously that the government was providing drugs for mental healthcare. It is a big challenge to the client. I don't know how the illness, but it seems to be affecting those who don't have money. I don't know how it is, but the ones who don't money are always the ones going through this, are suffering this illness. They come in, there's no drug. We have to prescribe drug for them. They go around and around to get the drug. And they are relapsing. They try getting drugs here too, maybe too expensive and they can't afford. Personally, I think the drugs should be brought in to help the whole situation. Because with the drug in and patient, we've seen the experience here. Those who come in and always taking their regimen, their drugs on all the time, coming in for review all the time; they are welcome. So I think the drug issue should be solved. (Participant 4)*

**3.2.4 Physical Space.** Approximately one-third of CMHWs stressed dissatisfaction in the mental health unit's size or location as a hindrance to their work. One PCM and one CPN highlighted, respectively:

*And I think we have a problem with, this is where we do the consultation. Yes. And as you see that is the washroom, so you'll be talking with clients and then you can see people walking in and out to the washroom. (Participant 12)*

*Presently I have four of them, and I cannot take more than four of them. Because of the size of our room, the confidentiality, privacy. Sometimes somebody comes in here and looking at the people in the room say, "Oh, I don't want to be here" or "I will not answer any question." So you may not get through them. They will be harboring, keeping things to themselves because they cannot trust us. They don't know who we are, there are too many people here. Sometimes we make an attempt to ask if they will need a privacy. If they do not feel comfortable to talk, we ask. So I cannot take more than four personnels. But then sometimes, pressure. We cannot avoid it. They are there; they've been assigned to the place already. So we rearrange and we plan and if we should be sending them out somewhere, bringing in other responsibilities then we do that. We shouldn't be more than the personnels that are there. Because we are three already in this small room. And then four people coming to join us. Seven? With one client? (Participant 9, CPN Supervisor)*

**3.2.5 Stigma.** Nearly all respondents reported identifying and handling stigma as a core job responsibility and challenge. Stigma influenced their unit location within the health facility subsequently affecting the patients they serve; this is best articulated by Participant 9:

*You see, formerly, you don't find us in an area like this. We'll always be in psychiatry hospital. Not in a general hospital like this, you will not even get a space. People discriminate against us, so you don't get it. Our clients, you will not stand our patients. You will not want to come into a hospital and have a psychiatric patient next to you. (Participant 9)*

Several respondents perceived stigma from other health professionals as a major surprise and ongoing challenge.

*The stigma we always have. And then within your own facility, your own people you are working with your own nurses. You see, that is one thing. Because if your own nurses are doing that, then those in the public I know when you mention Psychiatry or psychology you deal with mentally ill patients, people who are not normal, and so they see people as not being so important. (Participant 7)*

*There are other trauma nurses that don't even regard psychiatry nurses. That's another inner battle ongoing too. (Participant 11)*

*I think it was with the stigmatization. Stigmatizing not with the public, but with the health professionals. Yes. As I was telling you we didn't really have an office here. We were locked up in some nasty building, the place is dusty and all that. So they just moved us here. And when they are having workshops in the clinic, we are not aware. It's the unit, the stigmatization among health professionals. I'm really surprised because I expect them to understand the nature of our work. It's bad. They people say "Oh, where are the mad people, the mad people are here." They call us 'Second Office'. So it's bad. (Participant 2)*

Two Corps members described how caregivers can also act as barriers to seeing their clients and giving patients the proper care they need.

*Sometimes the question from the families. Sometimes they don't accept that the condition exist. (Participant 13)*

*Yeah the got lost in the camp, like their relatives couldn't find them. Then you come here and meet them sleeping on the benches, because they see the need for the drugs. But the relatives see the need for something spiritual. So they come here. The pastors and the relatives [have control over their care]. (Participant 3)*

**3.2.6 Challenges Affecting Operations.** All CMHWs that reported doing work directly in the communities (consisting of homes visits, health talks, case finding, home tracing) cited financial burden in trying to conduct their work. One CPN within the

sample stated the government travel allowance for her work was insufficient. Psych Corps members must use their own funds to transport themselves to their community site:

*Let's say if we have to go to home visits, you have to take care of your own transportation. They go like, if you're going to work then you pay for it yourself. You just take it like that. And sometimes it's really far. If I'm going to work I only take 1 care. But if I go for home visit then I have take two cars. There are times I have to go health talks maybe at a church. Maybe in the evening then that means that I would have closed from work. But then I would have to go in the evening and take care of my transportation once again. And then already NSA is not coming to us as it is supposed to, so it makes it a bit difficult. (Participant 17)*

Approximately 20% of members described how language barriers affected the impact of their work, and best articulated by Participant 16:

*The issue with language barrier. Before I started, I'm not very fluent in Ghanaian Twi, Akan Twi. I speak Fanti, it's very different. So sometimes when you deliver a health talk you are supposed to deliver in the local dialect- the Ashanti Twi, or the Akan Twi. It was challenging. But I had to pick up my vocabs and gradually I was given the opportunity to do more, more health talks, so I learned a lot. So I can say language barrier is a huge issue. You have clients you meet and some don't speak the same local dialect. So you have to get an interpreter, or somebody who understands the language too. So I think that has been a challenge too. I think that most clients want to find a common ground level with a health educator or person who is following up on them. So, um, if you are not able to communicate, and then for them to relate what you are saying, there's this, "ok I don't think they get me, so then I'm not ready to listen." But then once you start in the local dialect there's this, it's like there's a familiarity. They feel at ease and they are comfortable, and they are ready to open up, even to tell you their own personal issues. But when you start off with a foreign language, like English, you are distancing yourself from the reality and from the people. And I think when they realize that we speak in our local dialect, to them it is like, "Ok you are one of us, you are one of us." So it's a thing with talking the same language, finding a common ground that go with them, appreciating their culture, where they are coming from, their family backgrounds and putting it all together it makes the work a bit easier. Because your clients are ready to open up to you. (Participant 16)*

### **3.3 Domain 2: The Effects of the Psychology Degree**

**3.3.1 Perceived Value.** Most Psych Corps members viewed their psychology education and orientation training as valuable for its theoretical foundation. However, many felt that they were sufficient for practical applications in their daily work. Only one member reported neither helping at all. The majority of members state that additional practical training would have been preferential prior to starting their post. Of the four who stated feeling their education prepared them well for their work, two had done

previous internships, or attachment, and Psychiatric hospitals prior to joining Psych Corps.

*No. Very not prepared. For me I was not prepared at all. Cause from the orientation that we had, I thought we would be giving talking therapy. I didn't know that we'd be restraining, giving drugs, treatment too. So that's why I was saying I'm not prepared that much. (Participant 5)*

*Because looking at studies way back on campus, it was just theory, theory based. Our in charge Riley said she wished we had been [off letting/admitting] ourselves to hospitals while we were on campus, that was the best thing that we should have been doing. Maybe along the line we visit the psychiatric hospitals and attach ourselves to the psychologist or psychiatric nurses and then the practicality of what we are learning in school. So when we to this setting we just saw it clear "Filik adoji" - it's clear. Cause when I was in school I was being taught what is dementia, what is schizophrenia, and they'll give me features or characteristics ...a lot of stuffs. But we haven't had one-on-one experience with the clients with that condition. So we came here and the in-charge would say, "Oh, this is schizophrenia," and tying it with what we learn in school. So one, two, three, the fourth time there is that interaction we almost know that this one is schizophrenia because from the interaction that is going and the sentence they are giving, their hallucinations and delusions and their illusions, we know that this is a clear symptom of what schizophrenia. If it is epilepsy and they start giving the sentence, we are able to give that this is epilepsy. So we learned the practicality of what we are doing in school, and it has been very, very meaningful to us. (Participant 4)*

**3.3.2 Unintended Consequences.** Several members articulated that having a baccalaureate in Psychology led to an unintended consequence of being perceived as and assigned to the work of a clinical psychologist. Only two members worked directly with a clinical psychologist, both at the same facility.

*Like I said before my in charge came, because I said I was a psychology student, the notion was that I am a clinical psychology so I have to counsel, not counsel per se but we're supposed to do whatever a clinical psychologist is supposed to do. (Participant 11)*

*The problem is the health talks. Psychology, we majored in psychology. They didn't really talk to us extensively about these mental health issues. They tell you come and give a talk, I have to go online. I wasn't familiar with some of their topics like, do you know aneurosis? So they don't really give you training, when they tell me I just go online. I read and make my own notes. It's really my thing. I'm handling this.... We don't have a clinical psychologist here. And some of the cases that come, and they say "Oh, do this do this." But maybe that wouldn't be enough for that condition, you need like continuity of counseling." (Participant 2)*



*We had one main one [clinical psychologist], but she's no more here. So sometimes...There was one time there was a girl who, I think she was infected by the mother. So you could see that she was depressed, she was not taking the medication and all that. So I did a little bit of, I created the questionnaire for depression; asking um, what makes you happy what makes you sad. How many times do you get a? And I found out that she was depressed, it was having a toll on her. (Participant 1)*

### **3.4 Domain 3: Coping**

All PCMs indicated feeling overwhelmed by the nature of their work either infrequently or not at all. If the former, they employed techniques, turned to religion, or leaned on social support to manage their stress and situation. Participant 16 best articulated several coping techniques used for handling stress arising from her work:

*My therapy? I love writing. I love reading poetry too. And sometimes my stories can also come from some of the things that I have seen. Honestly speaking, this has reshaped my way of thinking. Because I realize that it is always good to share coming from that point I used to think that it is better to keep everything inside and then not voice out because people don't really get it, they don't understand. But I realize that sharing helps. Talking to my mom, talking to my new pad my notepad, pouring out my thoughts on paper. Also listening to music is also refreshing. It takes my mind outside a different environment. Something soothing, something nice. Yes, you listen to the words and then they encourage you. I am a Christian so I love to pray and I love to read my Bible when I can. It has helped me cope with all that. Because earlier on I said it was so difficult to adjust to the ward. I said "Okay, I can do the community, but I can't do this, I can't keep going back and forth and seeing clients at this place and all that." Or not exhibiting a normal behavior. I was torn. There were days I had to battle my emotions but then I understood emotional intelligence too, that you cannot mix my personal life with work. There are times when I got furious and upset on phone and then I have to go and give a health talk and pretend that everything is okay. Put on a smiley happy face and, you can't say to your in-charge I am upset, I'm angry I am not emotionally stable so I can't handle this health talk. Then you have to psych yourself. And thank God our classes taught us that coping strategies in community psychology. So that helped us a lot about stress management. Some of these health talks we give should be exemplified in our personal live too. It would be so wrong to say that, okay, I understand what is stress and stress management is but I won't practice stress management. So that is my own therapy. (Participant 16)*

### **3.5 Domain 4: Value Added**

When PSMs were asked whether they would consider doing this work for an additional year, all PSMs said yes. PSMs gave two main reasons for continuing in community mental health. The first was because the work provides a wealth of learning opportunities. Participant 3 describes this point:

*Because I learn a lot. You know like, there are certain situations, issues like going back in school you don't see the physical things. It's like abstract. And when you come you don't say oh people really have problems, like relationship issues- it's a normal thing. Maybe the person is depressed. So I really learned a lot from this thing. I like talking too...so far so good. I wish they would extend it. We do another year. (Participant 3)*

Secondly, PSMs believed they gained value from this experience as it increased their interest in mental health. Every PSM stated they would like to further their education in a master's in clinical psychology; 3 indicated they want to pursue a PhD in clinical psychology. Participant 3 furthermore indicated how seeing mental illness in-vivo and its impact in the community solidified the importance of recognizing mental disorders.

*It has increased it. A lot of people need help. The education aspect, most people don't know. So I think it's really increased it. I've been to places I never thought of going, because going to a prayer camp, there is nothing I was going to do at a prayer camp normally. So it's good. We hear cases, issues and you think "Wow, so this thing is real. (Participant 3)*

Participant 16 states how this work has bolstered her interest in working in the mental health field and how she would tailor interventions to promote awareness:

*But moving forward, I plan to do my masters, MPhil. And then continue to PhD and become a lecturer. And see if I can craft something very effective to raise mental health awareness. Creative ways. (Participant 16)*

Lastly, one PCM describes how the experience provided key insights for a future profession in the field:

*It did enhance, because then I get to know what I'm going in for. Maybe someone wants to be a banker but then you haven't really had the experience of how the job in a bank goes. But here the case if I want to be a psychologist, I've had an experience of how it goes cause I get to know when I come to work you're going to keep interacting with people over and over again. It's been fun. It's helped. It's helped. Because I know what I'm getting myself into. (Participant 14)*

#### 4. DISCUSSION/RECOMMENDATIONS

These results suggest the overwhelming challenge of CMHWs' work is the promotion of mental health literacy. CMHWs are faced with staggering stigma not only in the populations they serve but also within the health facilities they work. In Ghana, there is limited to no knowledge about mental well-being and conditions such as epilepsy are perceived as either an infectious disease and/or the result of demons. Such stigma permeates hospitals and health professionals resulting in the physical location of mental health units being placed in the fringes of facilities without signs, other nurses refusing to enter the unit or work with psychiatric nurses, and the constant referral of epileptic patients despite epilepsy being a medical condition.

Religion remains a potent social force in Ghanaian life, and in turn influences health-seeking behavior. Approximately 94% of the total population is religious (71.2% Christian, 17.6% Muslim, 5.2% Traditional)<sup>17</sup>. In the absence of education, those with mental disorders seek pastors or prayer camps for treatment of severe conditions like schizophrenia with little results. Many patients in prayer camps are subject to human rights violations and often held indefinitely against their will<sup>18</sup>. Therefore, a critical task for the CMHW becomes disrupting or modifying this system to educate a largely unknowledgeable population in order to permit appropriate care.

These interviews point to several factors that influence the performance of the CMHW. First is the absence of a clinical psychologist and psychiatrist to mitigate the burden of untrained tasks. In one hospital, two PSMs worked under one clinical psychologist that rotated about the district weekly. Through proper training and supervision, they were able to perform assessments in the clinical psychologists stead to maintain impact and continuity of care. In regions without a clinical psychologist or psychiatrist, CMHWs were more limited in their impact, having to refer clients to one of three psychiatric hospitals often too far for patients, or acting as a surrogate clinical psychologist. The degree in psychology allow for theoretical understanding of general conditions and approaches, but are insufficient for practical application in the field and does not replace a clinical psychologist nor skilled training. This introduces variability in the standards of care that would otherwise be unacceptable in other areas medical practice. In addition, patients unable to travel to psychiatric hospitals for proper care are more likely to turn to local faith-based solutions, undermining the CMHWs health promotional work. Second is the issue of language. A sizeable proportion of CMHWs stated they could not speak the local languages in which they work. Ghana has 81 dialects spoken within the country<sup>19</sup>. Despite English as the national language, it is not universally spoken (at most up to 36.1% of the population) especially in rural areas and among lower socioeconomic groups<sup>20</sup>. Speaking the common language found in the communities they serve is integral for CMHW's promotional work and increases the likelihood of altering a patient's understanding and health behaviors. Therefore inappropriately assigned CMHWs subsequently maintain the need gap in the communities in which they are supposed to serve.

Nevertheless, one key finding from this study is the potential reserve of human capital. Psych Corps members perceive the work as meaningful and gain insight from these experiences that will likely have downstream effects in their own communities and future work. Most remarkably, members do not report the burnout or negative

coping/resilience experienced by other mental health professionals<sup>21, 22</sup>. This may be due in part to religion, a protective factor, or arise from other endogenous or exogenous sources<sup>23</sup>. Despite reporting challenges in their role, each member affirmed they would do this work again. Nearly every Psych Corps member expressed wanting to continue their postgraduate studies in clinical psychology, indicating that the added benefit of enrolling those with a psychology degree permits members to leverage their knowledge and interest for further education. Lack of human resources for mental health remains a bottleneck towards achieving access to mental healthcare in Ghana. The emergence of such an enthusiastic and motivated pool could fill the severe resource needs gap the country faces.

Several limitations with this study exist. There was an insufficient number of interviews conducted on CPNs to obtain saturation in that group to glean total impact of each mental health unit and integration/interaction with Psych Corps members. Moreover, interviews were only conducted within four out of the ten regions in the country: Central, Greater Accra, Eastern, and Volta. While these regions are located in the lower part of the country which houses 70% of the total population, generalizability of experience is limited as more remote areas are expected to experience further restrictions in resources and perhaps other unknown challenges<sup>20</sup>.

As it stands, Ghana's Ministry of Health has prioritized a community-based model that aims to treat the most severe mental illnesses. The Psych Corps program is one step towards allocative efficiency by using existing human capital to further mental health goals. However, this comes at the expense of CMHWs being over task-shifted in their duties as they undertake responsibilities in patient care they are not entirely equipped to do. The Mental Health Act was a necessary move in recognizing the need for mental healthcare within the Ghanaian population, however further steps are needed so that care does not stagnate. Necessary action includes the free provision of epileptic and psychotic medications. The government states it provides free access to psychotropic medicines from hospitals and pharmacies when available, however this is not done in practice<sup>24</sup>. Most people seek care through prayer camps, or if more knowledgeable, through healthcare facilities. However, many cannot afford the cost of medication and therefore default, or return to faith-based alternatives. Covering medication costs for severe psychiatric conditions will be key to disrupting this cycle.

While CMHWs fulfill a necessary goal in educating the public, the end target for the Ministry of Health should be to employ a psychiatrist or psychologist at every major health facility. Patients enrolled in national health scheme must receive a diagnosis and prescription from a psychiatrist before receiving follow up care from the CPNs. Most psychiatrists are located in the southern part of the country at major general hospitals or one of the three psychiatric hospitals. The mental health hospitals are old, overcrowded and fail to provide adequate care for the nearly 2.8 million individuals that perhaps need treatment<sup>9</sup>. Having regional caregivers will significantly reduce barriers with access to care.

Finally, as stigma in the population is rooted enough to sustain affects in health professionals, promoting mental health literacy within healthcare facilities and medical training is integral to creating an environment wherein patients are more likely to report their condition and routed to the proper care. Religious leaders have perhaps the strongest influence on changing general understanding and health-seeking behavior. Therefore

educating religious leaders to see the merits of medical care as a supplement or alternative to faith-based treatments is critical for educating the population on awareness and proper treatment. These proposed initiatives require an increase national funding allocated towards mental health in an already limited health budget. Ghana's mental health sector is primarily funded by the government, therefore it should consider innovative financing measures to create new revenue streams for health. These funds should be diverted from solely psychiatric institutions to the regional and community health facility level. Lastly, the Ministry of Health should increase their mental health allocation of 1.4% of the total health budget to follow through on their legislative advancements<sup>8</sup>.

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## 6. APPENDIX

### **Appendix 1. Interview Guide**

Question 1: Why don't you tell me about the kind of work you've done here during your year of service?

Question 2: From your perspective, what kind of problems are people presenting the most with?

Question 3: Do you find your work to be meaningful? If so, in what way?

Question 4: How do you know you are doing a good job in your work?

Question 5: Do you face any challenges in doing your work? If so, what kinds?

Question 6: Tell me about any preparation you've had for this work.

Question 7: In what ways did you feel your education in psychology has aided or not aided in this work?

Question 8: Is there anything you feel would make your job more successful? If so, what?

Question 9: Who do you turn to with questions or problems in your daily work? How is it resolved?

Question 10: What kind of support do you receive during your time in Psych Corps?

Question 11: Does your work feel personally overwhelming at times? How often? And how do you handle them?

Question 12: Prior to joining Psych corps, what were your long-term plans?

Question 13: How has your interest in mental health change as a result of your involvement in this program?

Question 14: What are your future plans now?

Question 15: Given what you know now, would you do Psych Corps again/for another year?

Question 16: Is there anything you feel would make the overall mental health program more successful?

Question 17: What do you feel is the relationship between religion and mental health as it pertains to your work?