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TECHNOLOGY, KUMASI, GHANA**

**Perceptions about mental disorders and help seeking behaviour of Akwatia
residents, Ghana.**

By

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MSc CLINICAL PHARMACY

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CERTIFICATION PAGE

I hereby declare that this submission is my own work towards the MSc and that, to the best of my knowledge , it contains no material previously published by another person, nor material which has been accepted for the award of any other degree of the University, except where due acknowledgement has been made in the text.

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ABSTRACT

One in four people in the world will be affected by mental or neurological disorders at some point in their lives and one in every four families have at least one member suffering from a mental or behavioural disorder. Mental disorders have an enormous burden on economies, families and individuals. Despite the prevalence and burden of mental disorders, many people suffering from these disorders do not receive professional treatment. In Ghana the treatment gap is 98%. This study is a cross sectional survey which seeks to assess the perceptions of non-carers and carers of the mentally ill in Akwatia about mental disorders as well as the perceptions of general practitioners about mental healthcare in the two main hospitals in Akwatia. A total of 351 non-carers, 75 carers and 14 general practitioners working in the two hospitals in the town responded to the survey. Information was obtained from both carers and non-carers through questionnaires. General practitioners provided information through self-administered questionnaires. Respondents generally believed that mental disorders referred to an abnormal change in the behaviour of an individual. They had knowledge about attention drawing signs of mental disorders. A small percentage of respondents had some misconceptions about mental disorders. The most common perceived cause of mental disorders was abuse of substances this was followed by spiritual causes. Both carers and non-carers frequently stated smoking of narcotics as a risk factor for the development of mental disorders. This was expressed as 26.7% and 30.9% of all responses for risk factors by carers and noncarers respectively. Carers of the mentally ill sought help for the mentally ill due to one or more of the

following reasons: when symptoms were difficult to handle; when their livelihoods had been negatively affected; fear of disgrace and fear of the person becoming a liability. Sixty percent (60%) of non-carers generally said they would prefer to seek help from the hospital should they become mentally ill. Carers of the mentally ill, sought help from other sources for their mentally ill relatives. 40.1% of carers sought help from prayer camps. About two thirds of respondents do not think that mental illness is a major health problem in Akwatia. Results show that people living in Akwatia need to be educated about mental disorders to address limitations and misconceptions in their knowledge about disorders and also to improve on help seeking behaviour. General practitioners also need to enhance their mental healthcare knowledge.



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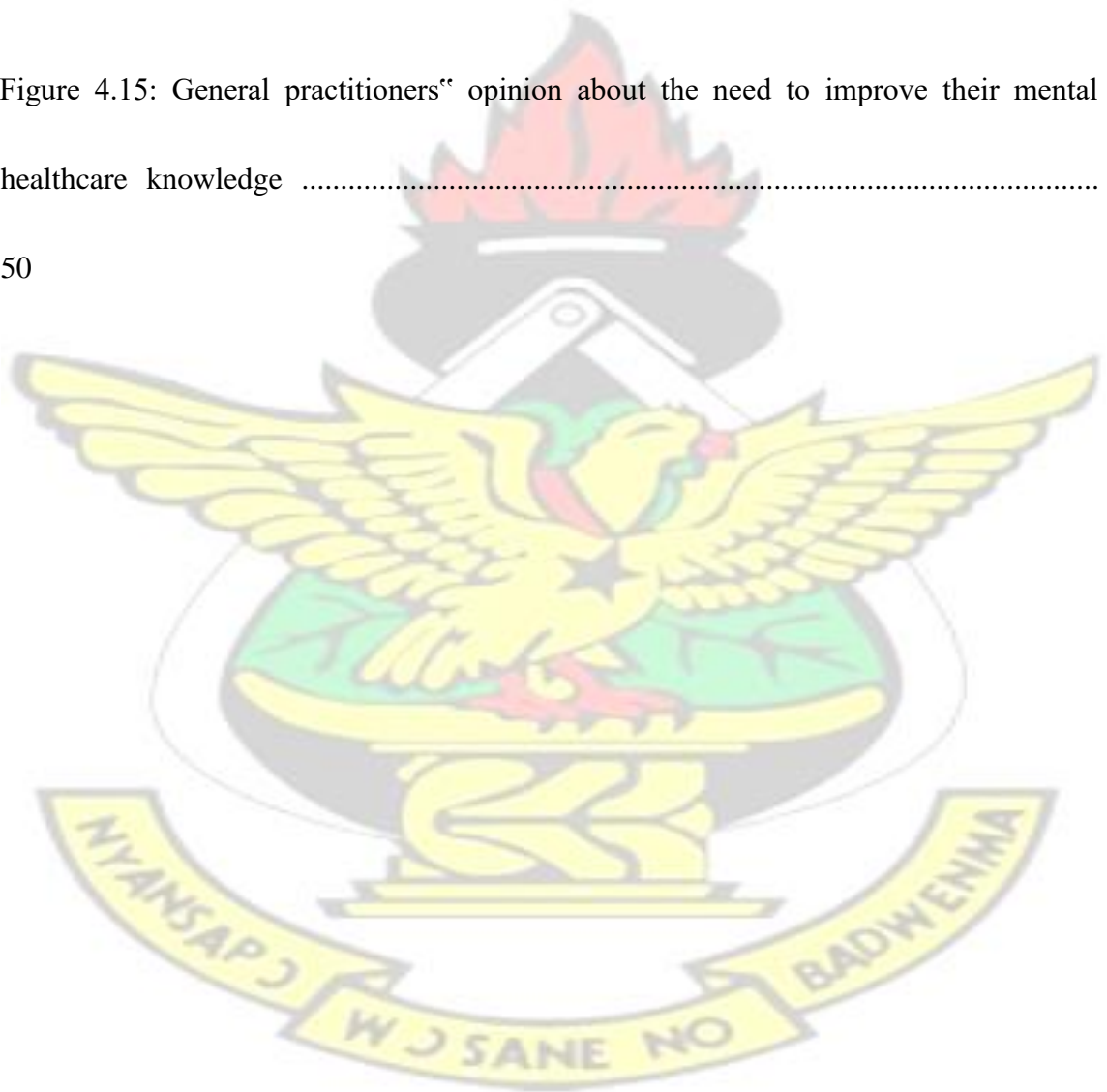
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CHAPTER 1: INTRODUCTION

1.1 OVERVIEW

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (World Health Organisation [WHO], 2014a).

According to the World Health Organisation, a mental disorder is a condition which is generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others which inflicts undue strain on the individual and reduces the person's ability to function (WHO, 2001; WHO, 2015a).

The impact of mental disorders on individuals and communities is enormous (WHO, 2003). Mentally ill people often suffer from stigmatisation, discrimination and human right abuses. They sometimes have educational difficulties, lower productivity, suffer from poverty (Unite for sight, 2015) and are sometimes deprived of good jobs, safe housing and opportunities to socialise with others (Corrigan and Watson, 2002). Their families are burdened by stress related to handling disturbing symptoms, the financial demands of the disease, social stigma, as well as psychological distress often associated with the fear of other members of the family inheriting a mental illness (Corrigan and Miller, 2009). Mental illness also imposes huge economic costs on nations. Loss of productivity and expenditure incurred as a result of mental disorders run into several billion dollars in developed countries (WHO, 2003).

As many as 450 million people suffer from a mental or behavioural disorder worldwide (WHO, 2003). Surveys conducted in developed as well as developing countries have shown that, more than twenty five percent (25%) of individuals develop one or more mental or behavioural disorder during their entire lifetime (Regier et al, 1988; Wells et al, 1989; Almeida-Filho et al, 1997 in WHO, 2001). According to the World Health Report in 2001, one in every four families has at least one member suffering from a mental or behavioural disorder (WHO, 2001).

In the year 2000, mental and neurological disorders accounted for twelve percent (12%) of years of life lost to disability due to all diseases and injuries; this is expected to increase to fifteen percent (15%) by the year 2020 (WHO, 2001). Four of the six leading causes of years lived with disability are due to neuropsychiatric disorders; the four disorders accounting for this are depression, alcohol use disorders, schizophrenia and bipolar disorder (WHO, 2003).

Mental health is so intricately linked with physical health that, Dr. Brock Chisholm, a psychiatrist and the first Director-General of the World Health Organization (WHO), famously stated that, “without mental health there can be no true physical health” (Kolappa et al, 2013). Many people suffering from chronic physical diseases such as diabetes and cancer also develop mental disorders as comorbidities (Academy of Royal Sciences & Royal College of Psychiatrists, 2009). People with severe mental illness often develop physical health conditions such as nutritional, metabolic, cardiovascular,

musculoskeletal diseases and infections more than people in the general population (Hert et al, 2011).

Despite the prevalence and debilitating impact of mental disorders on individuals, it is seldom treated with the necessary attention worldwide (Kolappa et al, 2013). In the developed world, between 44 – 70% of mentally ill people do not receive treatment for mental disorders and in developing countries the situation is even more alarming because the treatment gap is about 90% (WHO, 2003). In Ghana, it has been estimated that more than 650,000 people are suffering from severe mental disorders; and a further 2,166, 000 are suffering from a moderate to mild mental disorder yet the treatment gap is 98% (WHO, 2014b).

The mental health system in Ghana is plagued by a lack of adequate modern mental health facilities, inadequate number of mental health professionals, and underfunded mental health services (Roberts et al, 2014). These are health system factors which contribute to the treatment gap. However, patient related factors including the level of mental health literacy, as well as mental health seeking attitudes and behaviour of affected individuals can similarly affect the treatment gap.

In 2012, the government of Ghana adopted the WHO community based approach to mental healthcare and passed the mental health bill. This bill replaced the 1972 mental health decree which emphasized institutional care which is incongruous with national and international policy directives. The community based approach incorporates mental healthcare services into primary health care. The purpose of this is to make mental

healthcare services easily accessible, safeguard the continuity of care and build stronger collaborations with families or care givers of the mentally ill.

1.2 PROBLEM STATEMENT

The wide treatment gap of mental disorders in Ghana (98%) is an indication that there are barriers which prevent mentally ill people from receiving the professional treatment they need. In 2012 the mental health bill was passed. This bill was passed to provide legislature to make mental health services easily accessible by incorporating mental healthcare services into primary healthcare facilities which are nearer to the general public.

While this initiative solves the problem of accessibility, patient - dependent and general practitioner - dependent barriers can similarly contribute to the wide treatment gap by preventing people from seeking or receiving professional mental healthcare even when these services are within their reach.

Three important factors which are barriers to mental healthcare are:

1. Poor mental health literacy of the public;
2. Negative help seeking attitudes of the public and
3. Negative attitudes of general practitioners towards mental disorders.

Poor mental health literacy hinders recognition and detection of existing mental disorders while negative attitudes of the sufferer or his or her carers may prevent or delay help seeking actions. Negative attitudes of general practitioners in primary healthcare facilities towards mental disorders reduce their detection rates. Untreated mental disorders will

worsen with time and deepen the economic, emotional and social burden on the community, the sufferer and his carers respectively. If this happens it will defeat the government's initiative of bridging the treatment gap in Ghana.

This is a research that seeks to explore perceptions of the general public of Akwatia, those who are providing care for the mentally ill (carers) as well as the thoughts of general practitioners about mental healthcare in primary healthcare facilities in the town.

1.3 RESEARCH QUESTIONS

1. What does the general public in Akwatia think about mental disorders?
2. What are the perceptions of carers of the mentally ill about mental disorders?
3. What sources of help are being sought for the treatment of mental disorders?
4. What prompts help seeking activity for mental disorders?
5. Are there differences between the perception and attitudes of the general public and carers of the mentally ill?
6. What are the attitudes of general practitioners in primary healthcare facilities towards mental healthcare?

1.4 OBJECTIVES

1. To assess perceptions about mental disorders and help seeking behaviour of people living in Akwatia;
2. To investigate the attitudes of general practitioners about mental healthcare within primary healthcare facilities in Akwatia.

1.4.1 Specific Objectives

1. To assess the perception of carers and non-carers of the mentally ill about the meaning, signs, causes and risk factors of mental disorders;
2. To assess the preferred sources of treatment for mental disorders of people living in Akwatia;
3. To find out actions taken by carers to seek help for the mentally ill;
4. To assess the perception of general practitioners about their knowledge of mental health care.

1.5 RATIONALE FOR THE STUDY

Without mental health there can be no true physical health. Yet for many decades mental health has not received the attention it deserves. Mental disorders have a huge impact on economies of nations, communities and families. The 2012 Mental Health Bill of Ghana has adopted the principles of the mental health gap action plan drafted by the World Health Organisation. This bill focuses on the incorporation of mental health services into primary healthcare as an attempt to improve access to mental healthcare services within communities. In Ghana there is the need for more mental health research to help improve mental healthcare. In the absence of comprehensive research much will be assumed and practice would be based on inadequate evidence. This could eventually lead to an inefficient mental healthcare system in Ghana because there would not be information to inform practice based on research done in Ghana.

Information gathered from this research will provide insight into patient/carer dependent barriers in addition to general practitioner dependent barriers which need to be improved in order to optimise help seeking and the delivery of mental healthcare within the primary healthcare system in Akwatia. This study will add on to mental health research in Ghana. It will also serve as a baseline on which further studies could be done to explore mental healthcare of other communities in Ghana while providing relevant information to inform policy, practise and promotion.

CHAPTER 2: LITERATURE REVIEW

2.1 OVERVIEW

A good mental health status of an individual improves the person's capabilities and enables him or her to realise the goals that individual aspires to achieve (WHO, 2003).

When individuals achieve positive goals their collective efforts improve the general development of the community in which they interact. However people suffering from mental disorders may become less productive as a result of the incapacitating effects of the mental illness and discrimination (WHO, 2001). They are often agonized by the

distressing symptoms of the illness. They are sometimes confronted with the disdain associated with an inability to earn a livelihood to cater for themselves and their families. Families of mentally ill people also suffer because of the strain associated with coping with challenging symptoms which is compounded by economic difficulties, disruption of daily routines and restriction of societal engagements (WHO, 2001).

Mental disorders may exist alone or as comorbidities with physical illness. People suffering from chronic physical conditions may develop depression; similarly, people suffering from depression may also develop symptoms of chronic diseases (Chapman et al, 2005). Fortunately, mental disorders are treatable. Management of mental disorders with psychotropic medicines can improve the symptoms, reduce disability, shorten the course of the diseases and prevent relapse (WHO, 2001).

2.2 MENTAL HEALTH LITERACY

The World Health Organisation explains „health literacy“ as the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health (WHO 2015b).

The term „Mental health literacy“ is „health literacy relevant for mental health. It was coined by A.F. Jorm and some colleagues in the 1990“s when they realised that mental health was a deserted area of health in Australia (Jorm, 2011). They defined mental health literacy as knowledge and beliefs about mental disorders which aid their recognition, management and prevention (Jorm, 2011). Mental health literacy involves the ability to recognise specific disorders or different forms of psychological distress in addition to

knowledge and beliefs about causes, risk factors, self-help interventions and professional help available (Jorm, 2000). It also involves attitudes which facilitate recognition and appropriate help-seeking as well as knowledge of how to seek mental health information (Jorm, 2000).

Mental health literacy aids help seeking behaviour because it is information that is related to the possibility of taking action to improve a person's own mental health or that of another (Jorm, 2011). Low mental health literacy is associated with several adverse health outcomes and patients with low literacy are generally 1.5 to 3 times more likely to experience poor outcomes (DeWalt et al, 2004). A study carried out in the United States of America revealed that low health literacy was associated with a higher incidence of depressive symptoms among subjects. The researchers found that worse depressive symptoms were observed among subjects suffering from alcohol and substance dependence (Lincoln et al, 2006).

A review of literature by Ganasen and colleagues revealed that poor mental health literacy hinders effective treatment of those in need (Ganasen et al, 2008). Thus mental health literacy is of significant importance to the advancement of mental health within communities. Another group of researchers observed after an extensive literature review that factors such as educational level, age, employment status or ethnic group influence the health status of people. Nonetheless they also observed that possession of literacy skills is a stronger predictor of the health status of an individual (Rudd et al, 2005).

Low literacy among mentally ill people could affect communication between healthcare providers and patients as well as the patient's ability to comply with instructions for medication use (Ganasean et al, 2008). It can also influence the patient's ability to participate in written informed consent procedures, and patient's ability to maintain good health (Ganasean et al, 2008).

Mental health literacy can be improved through educational programmes. In Nigeria, a survey conducted among secondary school students revealed that there was a slight improvement in mean knowledge scores among students who participated in a teaching mental health programme as compared to those who did not receive such training (Bella-Awusah et al, 2014).

2.2.1 Recognition of Mental Disorders

Recognition of mental disorders is the most important step in mental health which influences help seeking (Reavley and Jorm 2012b).

The initial recognition and response to mental health problems generally takes place in the community (Horwitz, 1978). However, many members of the public cannot correctly recognise mental disorders and do not understand the meanings of psychiatric terms (Jorm et al, 1997). In 1995, Jorm and colleagues tested the ability of people to recognise mental disorders in Australia, by using vignettes for depression and schizophrenia. They found out that most of the participants recognised the presence of some sort of mental disorder but were not able to correctly label them by their specific names. Seventy two percent (72%) recognised that the person illustrated in the depression vignette had some sort of

mental disorder. Among these respondents only 39% correctly labelled the person as having depression. In the survey on schizophrenia for the same paper 84% of respondents also said there was some sort of a mental disorder, but it was correctly labelled by 27% (Jorm et al, 1997).

Lauber and a group of researchers did a similar study in Switzerland. In their study, only 39.8% of respondents correctly recognised the depression vignette, however, 60.2% of them considered the person depicted in the vignette as having a crisis instead of a mental disorder. The schizophrenia vignette was correctly identified by 73.6% of the interviewees (Lauber et al, 2003). In their study they realised that respondents' rigidity and interest in the media had a negative influence on the recognition of the schizophrenia vignette whereas in the depression vignette previous contact to someone suffering from a mental disorder had a positive influence on recognition.

Even though recognition of mental illnesses is low it has improved in some parts of the world over the years.

After 8 years Jorm repeated the 1995 survey using the same questionnaire and vignettes. He found out that recognition and labelling of mental disorders had improved (Jorm, 2006). After 16 years, apart from improved recognition of mental disorders, respondents gave more positive ratings for interventions provided by health professionals and antidepressants (Reavley and Jorm, 2012a).

Unrecognised mental disorders can lead to delays in treatment, worsening of the condition and resistance to future treatment.

2.3 MENTAL HEALTH HELP SEEKING BEHAVIOUR

Rickwood defined help seeking in four stages; awareness and appraisal of problems; expression of symptoms and need for support; availability of sources of help and willingness to seek out and disclose to sources (Rickwood et al, 2005). In many parts of the world people with mental disorders delay in seeking treatment but failure and delays in treatment are worse among older people, men, younger mentally ill subjects, and in developing countries (Wang et al, 2007). A survey involving 9282 people above 18years conducted in the USA by a group of researchers and the National Institute of Mental Health found that even though effective treatments were available, there were long delays between first onset of symptoms and when people sought and received treatment for mental illness. Some of the delays ranged between 20 and 23 years as in the case of social phobia and separation anxiety disorders respectively (National Institute of Mental Health, 2005). Wang and colleagues found similar results where median delays ranged between 1year and 30years before help seeking. Periods of delay span from three to thirty years for anxiety disorders, one to fourteen years for mood disorders, and from six to eighteen years for substance use disorders (Wang et al, 2007). Kohn et al also found complementary results buttressing the fact that the treatment gap for mental disorders is universally high but worst for alcohol related disorders (78.1%) and lowest for schizophrenia and other non-affective disorders(Kohn et al, 2004). Nonetheless, variations exist across different regions; while the treatment gap for schizophrenia among young Jewish adults living in Israel was 5.9%, it was 61.5% among 21-year olds in New Zealand (Kohn et al, 2004). In Italy the treatment gap was 15.9% for major depression but in the United Kingdom it was 83.9% (Kohn et al, 2004).

Apart from lack of available professional mental healthcare services in some parts of the world, several other factors are responsible for the failure and delay in accessing mental healthcare services. One of the reasons is higher costs of mental health care services and lack of health insurance coverage for the mentally ill (McLaughlin, 2004). Lack of knowledge about mental disorders and available mental healthcare services are also contributory factors to delay in seeking treatment (Thompson et al, 2004). In India, a study discovered that beliefs in religious and magical methods of therapy as well as ignorance of mental disorders were the commonest reasons for delay in biomedical therapy (Kumar et al, 2011).

2.3.1 Factors Influencing Help Seeking Behaviour

An attitude is “a settled way of thinking or feeling about something” (Oxford dictionary, 2015). Attitude towards seeking professional psychological help (ATSPPH) is defined as the tendency to either seek or resist professional psychological aid during crises or after prolonged psychological discomfort (Fischer and Turner, 1970). A positive mental health seeking attitude is an important determinant for seeking mental health services. Attitudes may vary from person to person but may be similar among people within a group of similar characteristics. Fischer and Turner developed the popular mental health help seeking attitude scale. They used the scale to analyse three 3 independent samples they found out that acknowledging the need for psychological help, stigma tolerance, interpersonal openness, and confidence in mental health professionals were related to help seeking (Fischer and Turner, 1970). Therefore, persons with all or a combination of these attributes were more likely to seek help.

A study conducted by Bayer and Peay discovered that a significant factor influencing people's decisions to utilise professional mental health services in Australia was the belief that mental health professionals were not really able to provide any substantial amount of help or support for difficulties faced by people (Bayer & Peay, 2007). This supports the work done by Fischer and Turner which states that confidence in mental health professionals influences help seeking behaviour.

Even though mental health literacy influences help seeking attitudes it may not necessarily predict help seeking behaviour. In her work about predicting the readiness of seeking mental health services among psychology students, it was revealed that though these students were literate in mental health there was no significant association between mental health literacy and readiness to seek help (Jones, 2014).

Causal attributions of mental disorders can influence the pathway to seeking help. There is a correlation between culturally determined causes of mental illness and help seeking attitudes. Drew Westen in his book (titled: Psychology Mind Brain and Body) explains that an individual's psychology is fundamentally shaped by cultural values, ideals and ways of thinking (Westen, 1996, p. 5-6). Therefore individuals usually accommodate to the patterns of standards and traditions handed down in the community (Western, 1996 p. 5-6). Even ways of thinking for example, using witch craft to explain disease or manipulating things that do not exist in reality such as negative numbers are shaped through interactions with others and become knitted into the individual's own psychological fabric (Western, 1996, p. 5-6). These cultural beliefs influence the individual's thoughts about the nature and causes of mental illnesses.

A cross-cultural study of mental health and attitudes towards seeking professional help conducted by Sheikh and Furnham indicated that although the three groups studied had similar positive attitudes towards seeking professional mental healthcare, there were significant differences in perceived causes of mental illness. They found out that perceived causal attributions were predictors of help seeking attitudes among British Asians, and Pakistani's but was not so for Westerners. They concluded that causal beliefs about mental distress contribute to attitudes towards seeking professional help for psychological problems for Asians (Sheikh and Furnham, 2000).

In Haiti, people often hold multiple or hybrid explanations to mental illnesses. As a result, the same person may seek help from multiple sources if they are available (WHO, 2010).

2.4 THE ROLE OF GENERAL PRACTITIONERS IN MENTAL HEALTHCARE

While prevalence of mental disorders is not commensurate with professional help seeking, detection of mental health problems among general practitioners is important for the initiation of therapy for the mentally ill. Failure of general practitioners in detecting mental disorders in patients is common.

In one study it was observed that family physicians detected only 34.9% of cases of major depression and 27.9% of cases of any depressive disorder (Coyne et al, 1995).

In another study carried out in Marshfield Wis., in the United States of America, 166 patients attending a primary care clinic were followed up between two interview appointments six months apart. They found out that primary care physicians were able to

diagnose below 10% of short-lived and episodic cases of mental disorders during the six month period (Kessler et al, 1985).

A study conducted in the Gaza strip revealed that general practitioners in primary care facilities were able to detect mental disorders at a rate of 11.6 % (Afana et al, 2002).

In Kenya researchers discovered that although 42% of 2770 subjects including inpatients and outpatients had symptoms of mild and severe depression only 114 (4.1%) had a working diagnosis of a mental disorder (Ndetei et al, 2009) .

These studies show that detection rates of mental disorders among clinicians are low; however this finding is attributable to certain factors. The nature of mental disorders makes detection difficult especially, when they are accompanied by other physical illnesses with overlapping symptoms (Academy of Royal Sciences & Royal College of Psychiatrists, 2009). Mental disorders may also be described by patients as physical symptoms. Practitioners might be carried away by these symptoms and may ignore the initiation of treatment for the underlying or comorbid mental disorder (Academy of Royal Sciences & Royal College of Psychiatrists, 2009).

Knowledge and experience of general practitioners about mental illness is also a key factor influencing detection. A group of researchers observed that General practitioners with post graduate psychiatric training and those over 40 years were better at detecting mental disorders than their other colleagues. This supports the fact that further training in psychiatry and longer years of experience for general practitioners are of substantial benefit in improving detection of mental illness (Afana et al, 2002).

These studies support the important role played by the primary care physician in the recognition and management of mental disorders and how deficiencies in their mental disorder detection abilities prevents mentally ill people from receiving treatment.

CHAPTER 3: MATERIALS AND METHOD

3.1 STUDY DESIGN

A cross-sectional study design was adopted in order to obtain the opinions of respondents about mental disorders during the research period. Questionnaires were designed with a blend of open ended and closed ended questions to allow respondents to express their own thoughts about the topic into more detail without influencing their personal opinions.

Three sets of questionnaires were designed for each group of respondents. They are listed below:

1. Questionnaire to assess the knowledge and help seeking behaviour for mental disorders of residents of Akwatia township;
2. Questionnaire for assessing the knowledge and help seeking behaviour for mental disorders of people who are caring for the mentally ill;
3. Questionnaire for assessing the opinions of prescribers about mental disorders.

A team of seven including the principal investigator were trained about how to collect data without bias prior to interviews. These included four community health nurses, one data analyst and one university undergraduate student. Trained data collectors pre-tested the

questionnaires. After that amendments were made to enhance clarity before they were used for their respective samples.

3.2 STUDY AREA

The study area is the town of Akwatia a mining town located in the Denkyembaour district in the Eastern Region of Ghana. It is the district capital of the Denkyembaour district a new district carved out of the larger Kwaebibirem district. The district was inaugurated on 28th June 2012. Akwatia is also a sub-district under the Denkyembaour district health directorate. It is situated at latitude 6, 0500 (62°60.000”N) and longitude 0, 8000 (048°0.000”W) at an altitude of 129M (TipTop Globe.com). The town of Akwatia is neighbour to Bawdua, and Kade townships.

Akwatia is the main center for diamond extraction in Ghana and used to be a booming diamond mining town up to the early 1990’s. Although there is a recession in diamond mining, some of the people still earn a living from small scale gold and diamond mining activities. In addition to mining the other two major sources of livelihood are trading and farming.

The estimated population for the Akwatia sub-district in 2014 was 29816 (Denkyembaour District Annual Report, 2014). It has four health facilities; two hospitals and two community based health planning services (CHPS). The two main hospitals are the Great Consolidated Diamond Company (GCD) hospital and the St. Dominic hospital. Both hospitals are primary healthcare facilities. They provide healthcare services under various disciplines such as surgery, medicine, paediatrics, gynaecology, public health &

community development. As at June, 2014 there was no mental healthcare unit in any of these two facilities.

CHPS compounds do not provide mental healthcare services. Patients with mental disorders are managed along with other patients during general consultation at the out-patient department. Difficult cases are referred to a psychiatric hospital. The nearest facility with a mental healthcare unit is the Kade Government hospital in the nearby Kwaebibirem hospital. Mentally ill people living in Akwatia who know about the mental healthcare unit in Kade often visit there for reviews and treatment.

3.3 STUDY POPULATION

Respondents were grouped into 3 categories namely, Non- carers, Carers and General practitioners.

Non- carers were residents of Akwatia who were not caring for the mentally ill at the time of data collection. These were people who had lived in the Akwatia township permanently for a year or more. This group were people who were likely to access healthcare from the health facilities available in the town. This group also represents the section of the population which had no close contact with mentally ill people as a common characteristic.

Carers were those who lived permanently within the Akwatia sub district and neighbouring villages or towns and who were taking care of mentally ill people at home and who visit the mental healthcare unit to obtain treatment for their mentally ill relative or relation.

General practitioners and prescribers were the qualified medical professionals including doctors and physician assistants who prescribed treatment for the sick at the outpatient departments of the two main hospitals in Akwatia. These professionals were permanent staff of their facilities and had practised in the area for more than a year and therefore were familiar with disease patterns of the area.

3.4 SAMPLING

3.4.1 Sample Size Calculation

The sample size determined for residents (non-carers) of Akwatia was 384 using the Cochran sample size determination model and taking into consideration the population size of 23766. The sample size was rounded up to 400.

$$SS = Z^2 * (p) * (1-p) / C^2$$

Ss = sample size

Z = z value at 95% confidence level = 1.96

P = p value = 0.5

C = confidence level = 0.05

$$SAMPLE\ SIZE = 1.96^2 * (0.5) * (1-0.5) / 0.05^2 = 384.16$$

This figure (384.16) was rounded up to 400. It was decided that a sample size of 100 will be used for the purposive sampling for carers. However due to the difficulty of obtaining responses from carers of the mentally ill and time constraints only 75 responses were

obtained. The population size for carers of the mentally ill who were accessing healthcare from the mental healthcare unit of the Kade hospital was 1008.

3.4.2 Sampling Technique

A stratified systematic sampling technique was used to collect data.

The town was divided into 6 zones with the suburbs as a guide. Respondents were selected from a group of selected housing units or residences of about 50 metres apart within each zone. The first house in each zone was conveniently chosen. Not more than two persons were interviewed from one housing unit.

Information was collected from all respondents using the questionnaires. Respondents who were caring for persons with mental disorders were purposely sampled. They were interviewed after they had visited the mental healthcare personnel at the mental healthcare unit of the Kade Government hospital. Two data collectors were assigned to this group of respondents.

Purposive sampling was also used for selection of general practitioners because the population size was small; therefore the sample size included all general practitioners at post at the two hospitals.

3.5 ELIGIBILITY CRITERIA

3.5.1 Community Survey for Residents of Akwatia (Non-Carers)

3.5.1.1 Inclusion criteria

Respondents who were 18 years old and above, who were fit and healthy who had lived in Akwatia for a year or more and were willing to participate were included in the study.

3.5.1.2 Exclusion criteria

All those who were 18 years old or more but were mentally or physically ill were not included in the study. Those who were less than 18 years old were excluded. Those who were unwilling to participate were also excluded.

3.5.2 Survey for Carers of Mentally Ill People

3.5.2.1 Inclusion criteria

People who were 18 years and above and who were caring for mentally ill persons receiving treatment from the mental care unit of the Kade government hospital for a year or more were included in the survey.

3.5.2.2 Exclusion criteria

All carers who were unwilling to share their experience were excluded.

3.5.3 Survey of Prescribers

3.5.3.1 Inclusion Criteria

All General medical practitioners who had worked in either of the two main hospitals in Akwatia for more than a year were included in the survey.

3.5.3.2 Exclusion Criteria

All medical practitioners who had worked for a year or more but were unwilling to partake in the survey were excluded.

3.6 DATA COLLECTION AND ANALYSIS

The Data collected was grouped according to the category they belonged to.

The categories were as follows:

- Residents of Akwatia – (Non-carers)
- Carers of mentally ill patients – (Carers)
- General practitioners

Data collected from residents of Akwatia were grouped and given code names according to the data collectors who collected them. This was done for easy referencing and clarification of responses when necessary.

All data collected was entered into the SPSS software and analysed.

3.6.1 Dissemination Plan

Information obtained from this study will be disseminated to the department of Clinical and Social pharmacy, KNUST. The Akwatia sub-district directorate will be given a copy of the findings of the study in order to influence promotion of mental healthcare in the district. A copy will also be given to the St. Dominic hospital in Akwatia which is the current place of work of the principal investigator and the largest hospital in the Denkyembour district.

This will be done to stimulate awareness and the importance of mental health in the delivery of healthcare in the area. Other healthcare institutions in the area will also be educated on the findings of this research as a way of building consensus for the improvement of mental healthcare in the area.

3.7 ETHICAL CONSIDERATIONS

It was anticipated that the privacy of people with mental disorders might raise a lot of concern among respondents. For this reason ethical clearance was obtained from the Committee for Human Research Publication and Ethics (CHRPE) of the Kwame Nkrumah University of Science and Technology before proceeding with the research. Permission was also obtained from the Denkyembour District Health Directorate and all the institutions where data was collected.

Written consent was obtained from each respondent. In addition to this respondents were assured of confidentiality of information. Information which had the potential of revealing the identity of respondents was not recorded. These included names of respondents and their residential addresses. No identification was used and hence respondents were completely anonymous. Effort was put in to ensure that respondents had enough privacy during interviews.

Each person approached for information was given the freewill to opt out of the study if they so desired.

KNUST



CHAPTER 4: RESULTS

4.1 DEMOGRAPHICS

4.1.1 Sex

A total of 426 respondents participated in the research. Seventy five (75) of them were people caring for the mentally ill. These are referred to as „carers“. The rest (351) were residents of Akwatia who were not caring for mentally ill patients at the time of the survey and are referred to as „non-carers“. Among the carers females constituted the modal sex group (60%) while males formed the modal sex group among the non-carers as shown in Figure 4.1.

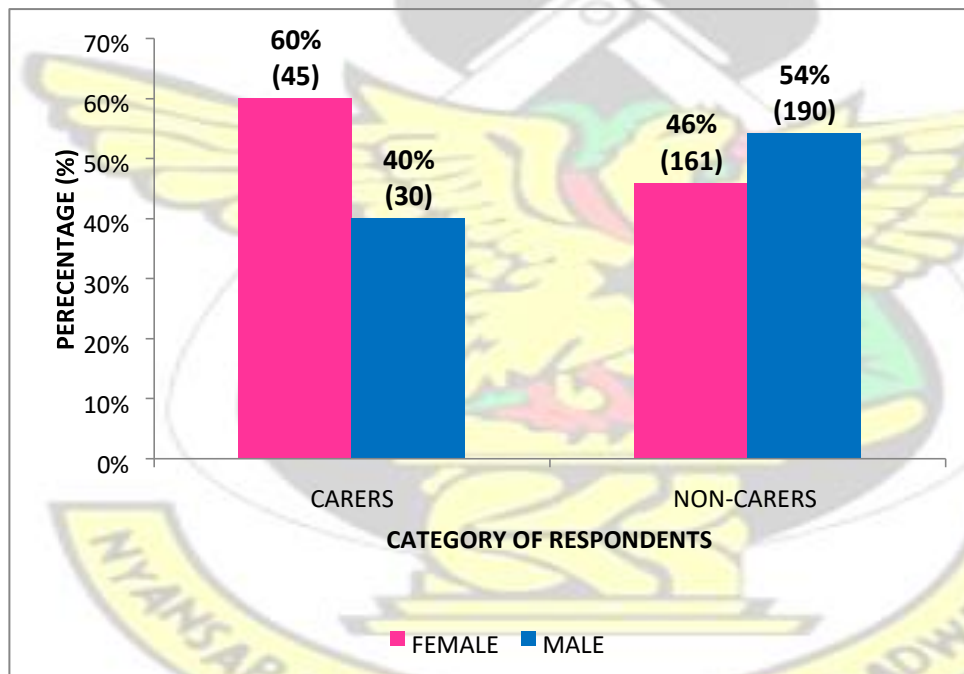


Figure 4.1: Female-male ratio of respondents

4.1.2 Age

The modal age group for carers was between thirty-six (36) and forty (40) years. This group summed up to 31%. In the case of non-carers the modal age group was between twenty-five (25) and thirty-six (36) years old which amounted to 37% as shown in figure 4.2.

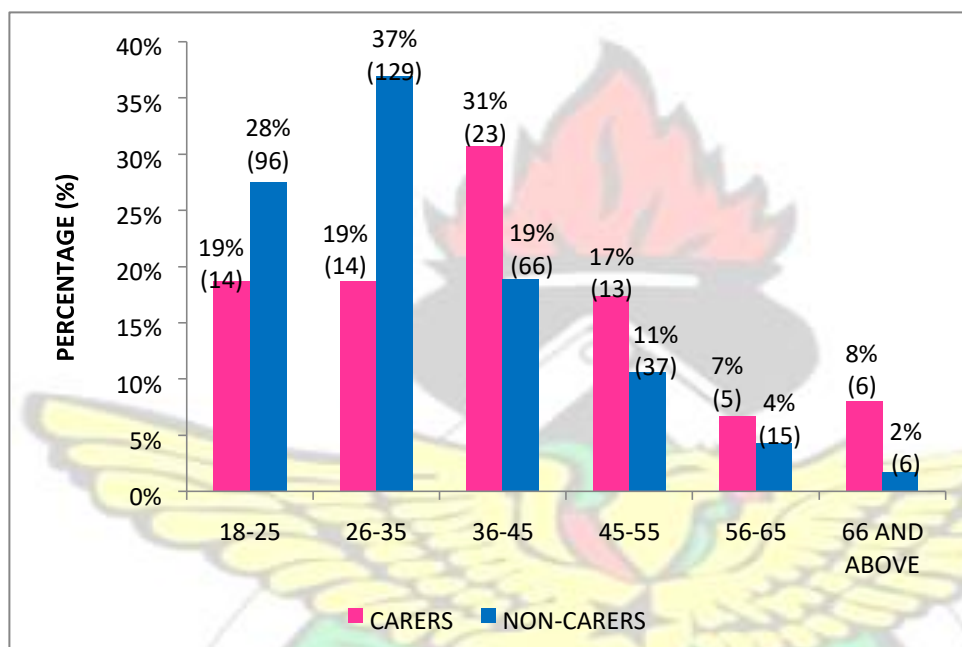


Figure 4.2: Age distribution of respondents

4.1.3 Educational Background

Respondents who had been educated up to the secondary school level represented the modal educational level for both carers and non-carers. There were more illiterates among the carers (21.3%) as compared to non-carers (6.3%); this is shown in Figure 4.3.

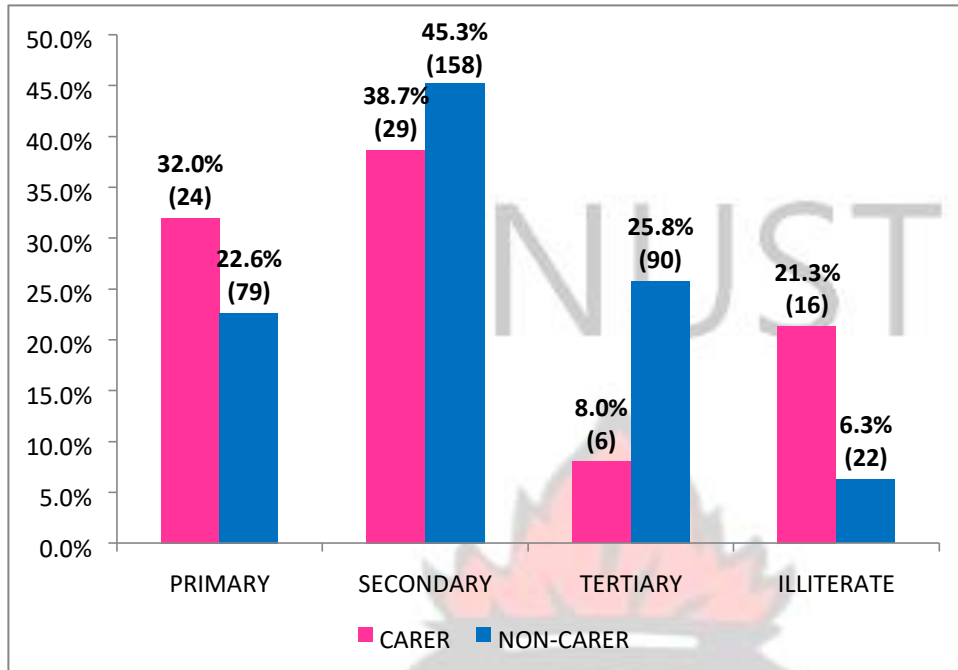


Figure 4.3: Educational background of respondents

4.1.4 Occupation

Among the carers the largest occupational group were engaged in farming as a source of livelihood. Most (27.1%) of the non-carers were traders as shown in Figure 4.4. The „other“ occupational group comprise of bakers, homemakers, drivers, photographers, corn millers and orderlies.

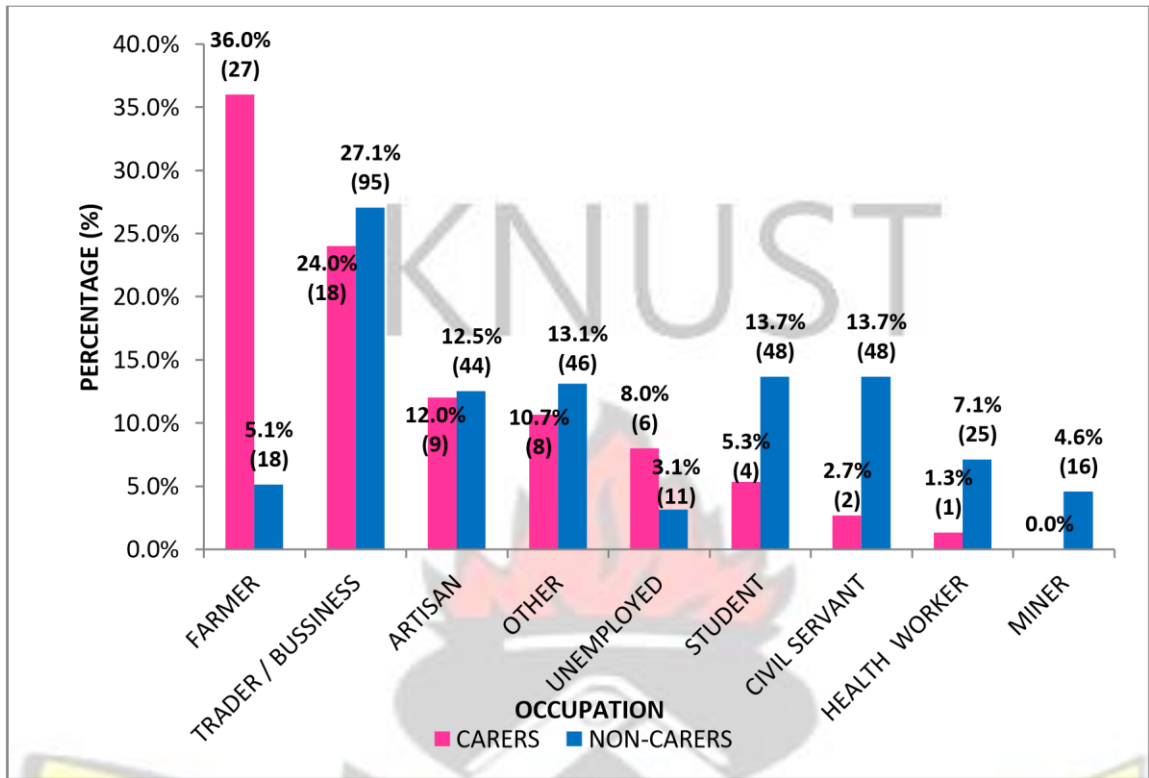


Figure 4.4: Occupation of respondents

4.1.5 Marital Status

The married group was the largest for both carers and non- carers. This represented 56.2% and 49.9% of both groups respectively. This was followed by those who were single who formed 34.2% and 44.2% of carers and non-carers respectively. This is shown in Figure 4.5.

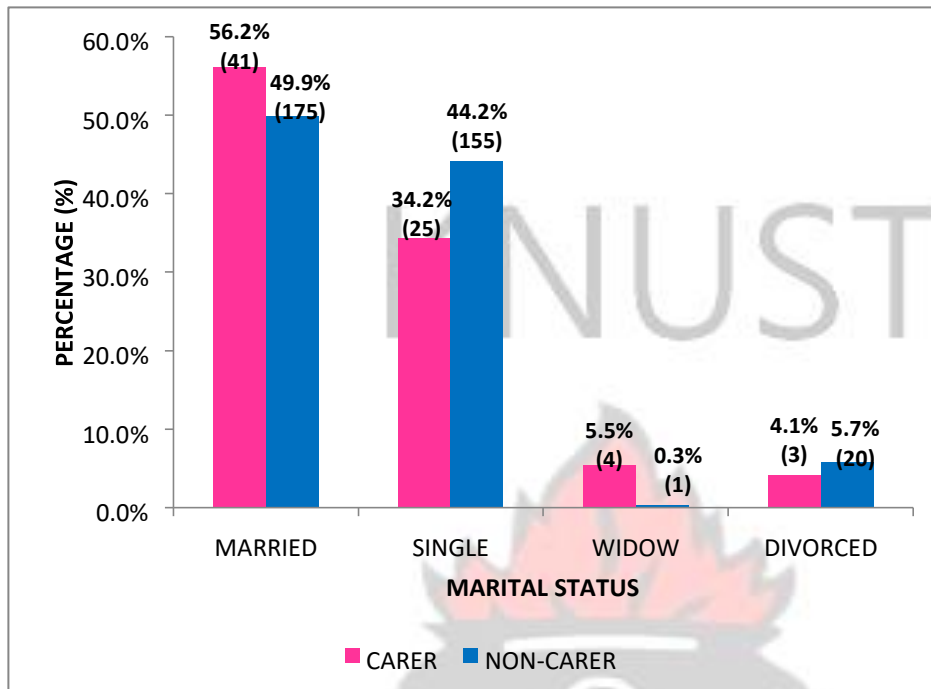


Figure 4.5: Marital status of respondents

4.1.6 Religious Affiliation

Among both carers and non-carers the largest religious affiliation of respondents was Christianity. This accounted for 88% among carers and 74.4% among non-carers as shown in Figure 4.6.

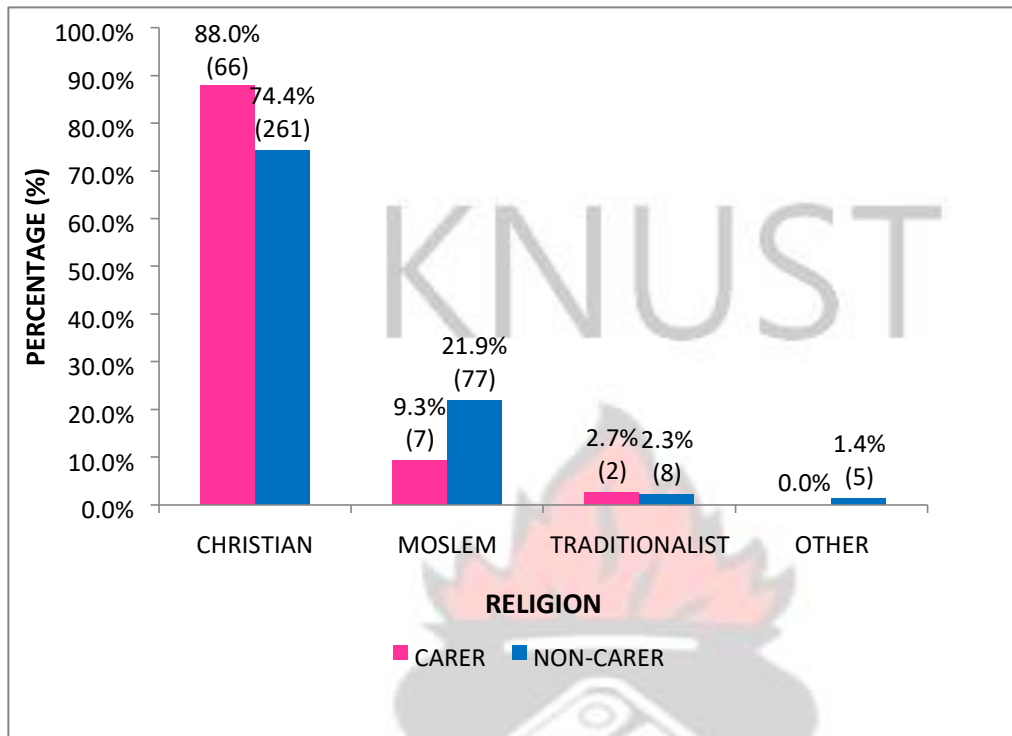


Figure 4.6: Religious affiliation of respondents

4.1.7 Number of Years Lived Within Community

55.6% of carers and 43.5% of non-carers had lived in their communities for more than 20 years. The rest had live there from a year to up to 20 years as shown in Figure 4.7.

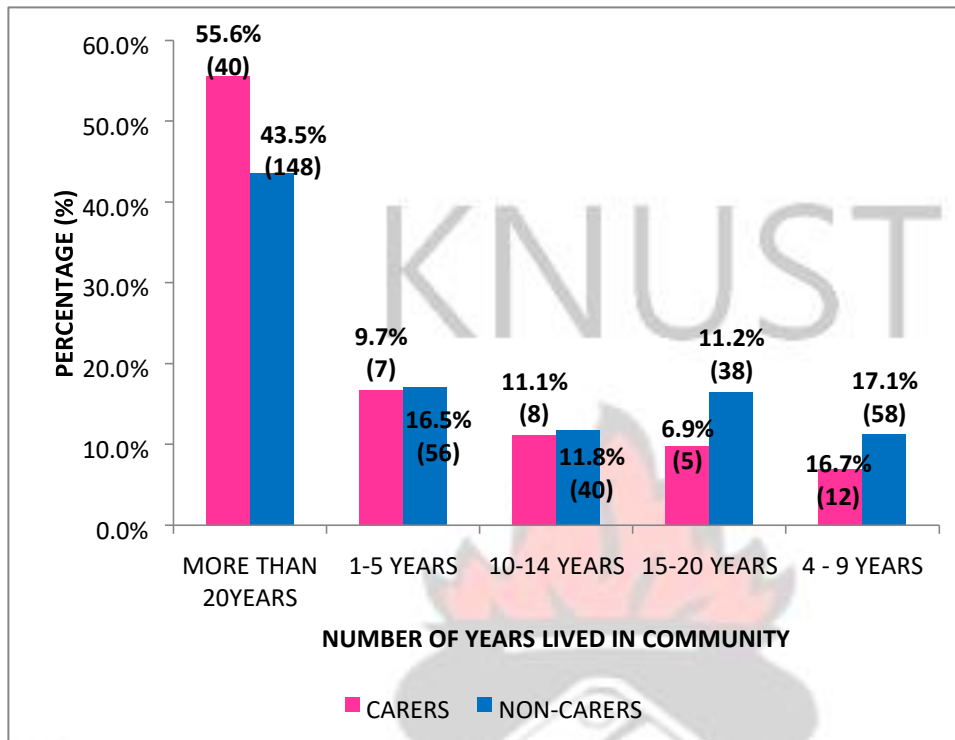


Figure 4.7: The number of years respondents have lived in the community

4.2 KNOWLEDGE ABOUT MENTAL DISORDERS

4.2.1 Explanation of Mental Disorder

Respondents expressed varied explanations to what they thought was a mental disorder. The most common opinion for both carers and non-carers was „abnormal, irrational or socially unacceptable behaviour“. This opinion represented 32.89% for carers and 29.39% for non-carers respectively as shown in Table 4.1 below. The second most frequently mentioned explanation for non-carers and the third for carers was „other“. This response represents beliefs which were diversely varied from each other and were also misrepresentations of mental disorders.

Table 4.1: Respondents explanation of a mental disorder

| RESPONSES | CARER | | NON-CARER | |
|--|--------|---------|-----------|--------|
| | NUMBER | (%) | NUMBER | (%) |
| Abnormal, Irrational or socially unacceptable behaviour | 25 | 32.89% | 102 | 29.39% |
| A disease, sickness, or problem of the brain or mind | 18 | 23.68% | 54 | 15.56% |
| Madness or insanity | 13 | 17.11% | 46 | 13.26% |
| Impairment of cognitive, reasoning or intellectual ability | 5 | 6.58% | 45 | 12.97% |
| A condition which affects a person's mood negatively and ability to relate to others | 0 | 0.00% | 12 | 3.46% |
| Other | 15 | 19.74% | | 25.36% |
| TOTAL OF RESPONSES | 76 | 100.00% | 34788 | TOTAL |

4.2.2 Signs of Mental Disorder

The most common sign of mental disorders stated by carers was exhibition of potentially harmful behaviour, violence or aggressiveness. However among the non-carers „neglect of personal hygiene was the most frequently mentioned response as shown in Table 4.2. Responses were rather low for mood changes, anxiety, suicidal thoughts and hallucinations for both categories of respondents.

Table 4.2: Signs of Mental Disorders As Reported By Respondents

| RESPONSES | CARERS | | NON-CARERS | |
|--|--------|---------------|------------|--------------|
| | NUMBER | (%) | NUMBER | (%) |
| EXHIBITING POTENTIALLY HARMFUL BEHAVIOUR, VIOLENCE , AGGRESSIVENESS | 26 | 18.30% | 67 | 11.40% |
| NEGLECT OF ONES PERSONAL HYGEINE | 25 | 17.60% | 99 | 16.8% |
| DEFICITS IN INTELLIGENCE, REASONING POWER, INABILITY TO CONCENTRATE, INABILITY TO FOLLOW CONVERSATIONS | 22 | 15.50% | 84 | 14.30% |
| TALKING TO ONESELF | 22 | 15.50% | 92 | 15.60% |
| GOING NAKED IN PUBLIC | 13 | 9.20% | 42 | 7.10% |
| AIMLESS ROAMING ABOUT / WANDERING | 10 | 7.00% | 27 | 4.6% |
| MOOD CHANGES | 10 | 7.00% | 39 | 6.60% |
| IMPROPER DRESSING OF ONESELF | 5 | 3.50% | 72 | 12.2% |
| ISOLATION FROM PEOPLE | 3 | 2.10% | 24 | 4.10% |
| ANXIETY, EXCESSIVE WORRYING | 2 | 1.40% | 23 | 3.90% |
| SUICIDAL THOUGHTS | 2 | 1.40% | 8 | 1.40% |
| UNCONTROLLED SEXUAL BEHAVIOUR | 1 | 0.70% | 1 | 0.2% |
| HALLUCINATIONS | 1 | 0.70% | 11 | 1.90% |
| TOTAL OF RESPONSES | 142 | 100.00% | 589 | 100% |

4.2.3 Causes of Mental Disorders

The most prominent cause of mental disorders stated by carers was „spiritual“ followed by head injury and then substance abuse as shown in Table 4.3. On the other hand the most common response among the non-carers was substance abuse, before spiritual causes. These accounted for 22.8% and 13.8% respectively.

Table 4.3 : Causes of Mental Disorders as reported by respondents.

| RESPONSES | CARERS | | NON-CARERS | |
|---------------------------------|--------|--------|------------|--------|
| | NUMBER | (%) | NUMBER | (%) |
| SPIRITUAL | 36 | 22.10% | 131 | 13.80% |
| HEAD INJURY/ TRAUMA / ACCIDENTS | 31 | 19.00% | 83 | 8.7% |
| SUBSTANCE ABUSE | 29 | 17.80% | 216 | 22.80% |
| ANXIETY | 23 | 14.10% | 93 | 9.80% |
| HEREDITARY | 15 | 9.20% | 94 | 9.90% |
| DISAPPOINTMENT IN RELATIONSHIPS | 7 | 4.30% | 86 | 9.10% |
| ABUSIVE RELATIONSHIPS | 4 | 2.50% | 24 | 2.5% |
| BROKEN HOMES | 3 | 1.80% | 49 | 5.20% |
| DEATH OF A RELATION | 2 | 1.20% | 20 | 2.10% |
| BRAIN DEFECT | 1 | 0.60% | 15 | 1.6% |
| DISCRIMINATION | 0 | 0.00% | 1 | 0.10% |
| ANTISOCIAL ACT | 0 | 0.00% | 3 | 0.30% |
| OTHER | 12 | 7.40% | 134 | 14.10% |

| | | | | |
|--------------------|-----|---------|-----|---------|
| TOTAL OF RESPONSES | 163 | 100.00% | 949 | 100.00% |
|--------------------|-----|---------|-----|---------|

24.07% of carers attributed the mental illness of their relatives whom they were currently managing to spiritual causes. The rest had other opinions as shown in Table 4.4.

Table 4.4: Carers views about the cause of mental disorder of their patients

| RESPONSES | NUMBER | PERCENTAGE (%) |
|---------------------------------------|--------|----------------|
| SPIRITUAL/CURSE / BEWITCHED | 13 | 24.07% |
| I CANNOT TELL WHAT CAUSED IT | 9 | 16.67% |
| CONVULSION | 6 | 11.11% |
| HEAD INJURY/ACCIDENT/PHYSICAL ASSAULT | 6 | 11.11% |
| ANXIETY | 4 | 7.41% |
| DIVORCE/BROKEN HOMES | 3 | 5.56% |
| ABUSE OF NARCOTICS OR ALCOHOL | 3 | 5.56% |
| DISAPPOINTMENT IN RELATIONSHIPS | 2 | 3.70% |
| FEVER | 2 | 3.70% |
| HEREDITARY | 2 | 3.70% |
| OTHER | 2 | 3.70% |
| RAPE | 1 | 1.85% |
| READING FOR LONG PERIODS IN SCHOOL | 1 | 1.85% |
| TOTAL OF RESPONSES | 54 | 100.00% |

4.2.4 Risk Factors for Mental Disorders

The use of narcotics was the most common risk factor indicated among both carers and non-carers. Among both groups elderliness was not commonly stated as a risk factor for mental disorders. This is shown in Figure 4.5 below.

Table 4.5: Risk factors for mental disorders as reported by respondents

| RESPONSES | CARERS | | NON-CARERS | |
|---------------------------------------|--------|--------|------------|--------|
| | NUMBER | (%) | NUMBER | (%) |
| THOSE WHO SMOKE OR USE NARCOTIC DRUGS | 71 | 26.7% | 277 | 30.9% |
| THOSE IN ABUSIVE MARRIAGES | 57 | 21.4% | 170 | 19.0% |
| THOSE WHO WORRY A LOT | 54 | 20.3% | 183 | 20.4% |
| THOSE WHO DRINK EXCESSIVELY | 49 | 18.4% | 159 | 17.7% |
| THE ELDERLY | 33 | 12.4% | 96 | 10.7% |
| OTHER | 2 | 0.8% | 11 | 1.2% |
| TOTAL OF RESPONSES | 266 | 100.0% | 896 | 100.0% |

4.3 ATTITUDES ABOUT MENTAL DISORDERS

4.3.1 Sex of People Likely To Suffer From Mental Disorder

A little over 50% of both carers and non-carers expressed that men were likely to suffer from mental disorders than women as shown in Table 4.6 below.

Table 4.6: Respondents opinion about sex susceptible to mental illness

| SEX | CARER | (%) | NON-CARER | (%) |
|------------|--------------|------------|------------------|------------|
| MEN | 35 | 50.7% | 173 | 51.0% |
| WOMEN | 34 | 49.3% | 166 | 49.0% |
| TOTAL | 69 | 100% | 339 | 100.00% |

4.3.2 Age Groups Which Can Suffer From Mental Illness

78.4% and 70% of carers and non-carers respectively were of the view that mental disorders could affect people of all age groups. However there were smaller percentages of respondents who thought that mental disorders could affect only specific age groups; 14.9% of carers and 20% of non-carers think that mental illness affects adults only. This is shown in Table 4.7.

Table 4.7: Respondents opinion about age group which can become mentally ill

| RESPONSES | CARER | | NON-CARER | |
|------------------|---------------|------------|------------------|------------|
| | NUMBER | (%) | NUMBER | (%) |
| ALL AGE GROUPS | 58 | 78.4% | 243 | 70% |
| ADULTS ONLY | 11 | 14.9% | 70 | 20% |
| TEENAGERS | 3 | 4.1% | 20 | 6% |
| CHILDREN ONLY | 1 | 1.4% | 0 | 0% |
| ELDERLY ONLY | 1 | 1.4% | 15 | 4% |
| TOTAL | 74 | 100.0% | 348 | 100% |

4.3.3 Economic Group Which Can Suffer From Mental Disorders

92.0% of carers and 81% of non-carers thought that both rich and poor people could suffer from mental disorders. However the rest among both groups thought that it could affect only the rich or only the poor as shown in Table 4.8.

Table 4.8: Respondents Opinion about Economic Group which can suffer from mental disorders

| RESPONSES | CARER | (%) | NON-CARER | (%) |
|----------------------|--------------|------------|------------------|------------|
| BOTH RICH AND POOR | 69 | 92.0% | 282 | 81.0% |
| THE POOR PEOPLE ONLY | 4 | 5.3% | 47 | 13.5% |
| THE RICH PEOPLE ONLY | 2 | 2.7% | 19 | 5.5% |
| TOTAL | 75 | 100.0% | 348 | 100.0% |

4.3.4 Possibility of Respondents Suffering From Mental Disorder

87% of carers and 72% of non-carers believed that it was possible for them to have a mental disorder. The percentage of non-carers who believed that they could not suffer from mental disorders was about twice more than those in the carer group as shown in Figure 4.8.

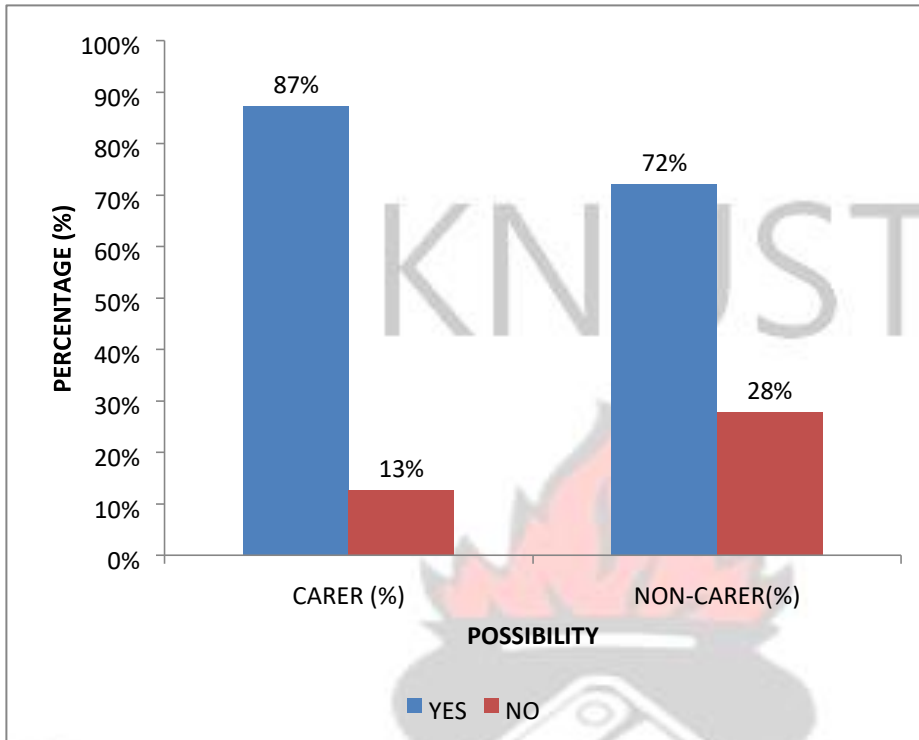


Figure 4.8: Respondents believe about the possibility of them suffering from a mental disorder

4.3.5 Curability of Mental Disorders

Even though more than two thirds of both carers and non-carers believe that mental illnesses are curable the percentage of respondents who believed otherwise was greater among non-carers than carers. This is shown in Figure 4.9.

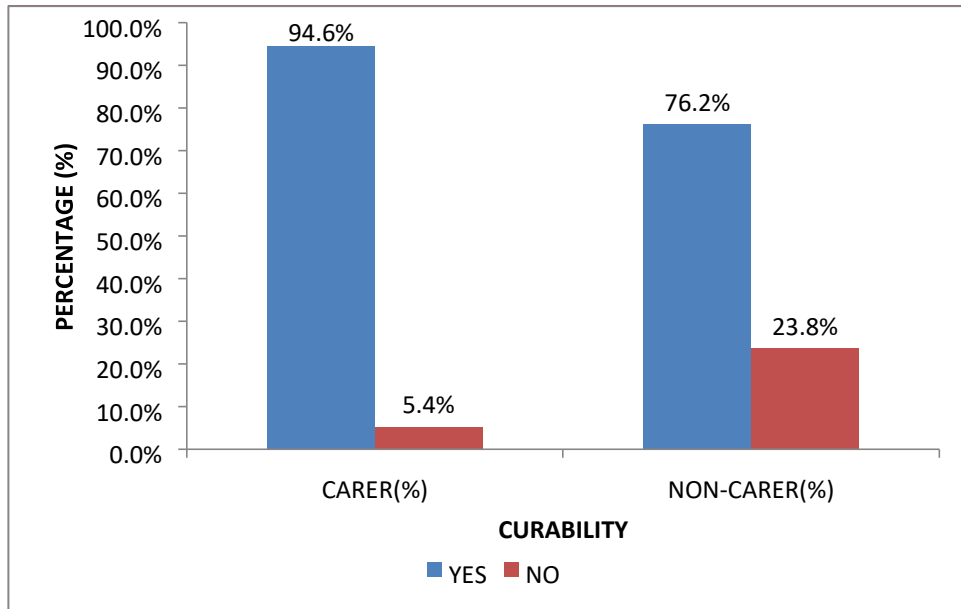


Figure 4.9: Respondents opinion about curability of mental illness.

4.3.6 PREFERRED SOURCES OF HELP

Among the carers, 73% said they would seek help from any hospital if they become mentally ill. Though most non-carers were of the same opinion the percentage of them who expressed this attitude were less than the carers. However a greater percentage of non-carers compared to carers preferred to seek help from a psychiatric hospital as shown in Figure 4.10. Among both groups of respondents the prayer camp was another preferred source of help even though it was in the minority it was the third most preferred source of help for both groups and respondents.

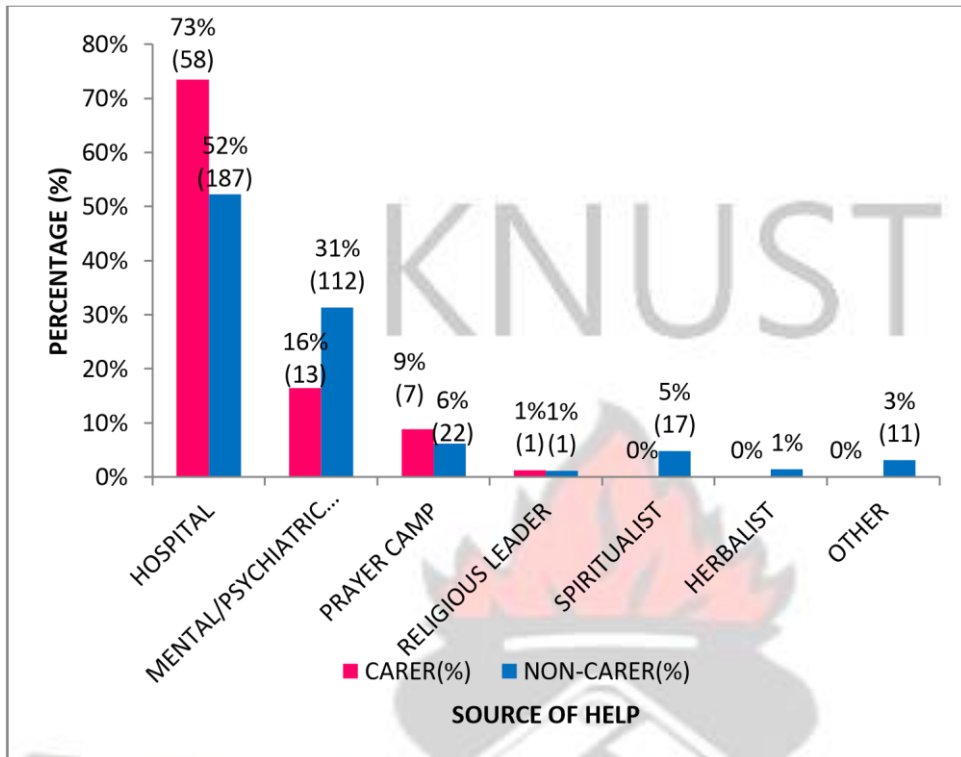


Figure 4.10: Respondents' preferential source of help if mentally ill

91% of both carers and 83% of non-carers said they were willing to patronise mental healthcare facilities within their communities if they were mentally ill. Contrarily, a smaller percentage from each group was not in favour of that opinion. This is shown in Figure 4.11.

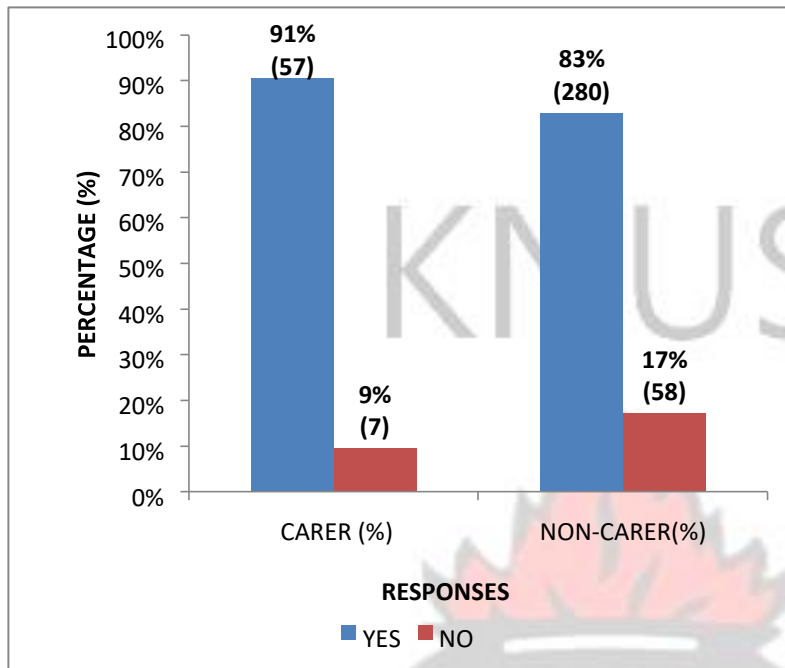


Figure 4.11: Respondents' willingness to seek help from community mental healthcare facilities

4.4 HELPSEEKING BEHAVIOUR

Those who were caring for mentally ill persons gave details of places they had patronised in an attempt to seek help for the mentally ill. They sought help for their relations from prayer camps, hospitals, spiritualists, herbalists and religious leaders.

Results reveal that carers of the mentally ill had sought help from a combination of sources during the help-seeking journey. Most responses indicated that help was often sought from the hospital. This represented a little over half (57.73%) of all responses. This was followed by prayer camps also representing 24.74% of responses as shown in

Table 4.9.

96.6% of carers mentioned that they had sought for help from either general or psychiatric hospitals while 41.4% of respondents had sought help from prayer camps. During interviews it was revealed that some patients had been taken to prayer camps by their care givers for months before visiting mental healthcare hospitals for help. Table 4.9: Places patronised by carers for help for the mentally ill

| PLACES PATRONISED FOR HELP | NUMBER | PERCENTAGE OF RESPONSES (%) |
|---|--------|-----------------------------|
| HOSPITAL OR MENTAL/PSYCHIATRIC HOSPITAL | 56 | 57.7 |
| PRAYER CAMP | 24 | 24.7 |
| SPIRITUALIST | 8 | 8.2 |
| HERBALIST | 7 | 7.2 |
| RELIGIOUS LEADER | 2 | 2.1 |
| TOTAL OF RESPONSES | 97 | 100 |



Even though carers had sought for help from one or more sources the most frequently mentioned source from which they had observed marked improvement in their patients was the hospital as shown in Figure 4.12.

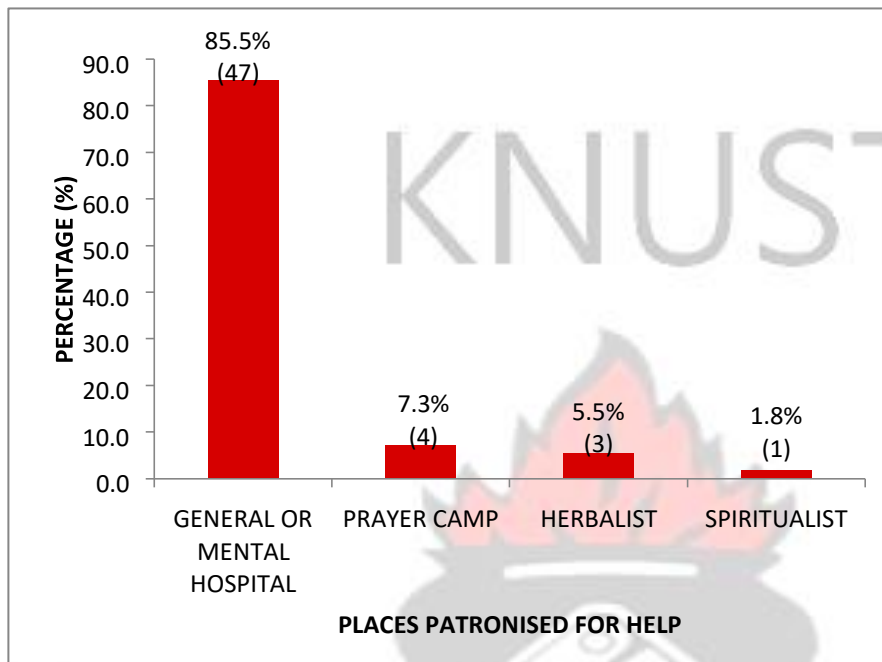


Figure 4.12: Source of help which produced improvement in mental condition of the mentally ill as reported by carers

Respondents who were caring for people with mental disorders indicated some factors which drove them to seek help for the mentally ill person. Among the factors mentioned, „the challenging nature of signs and symptoms or change in behaviour“ was the most common instigator for seeking help. This is shown in Figure 4.13. Some of the other reasons pertained to „affected livelihood“, „fear of disgrace“, and „anxiety over the condition of the affected person“.

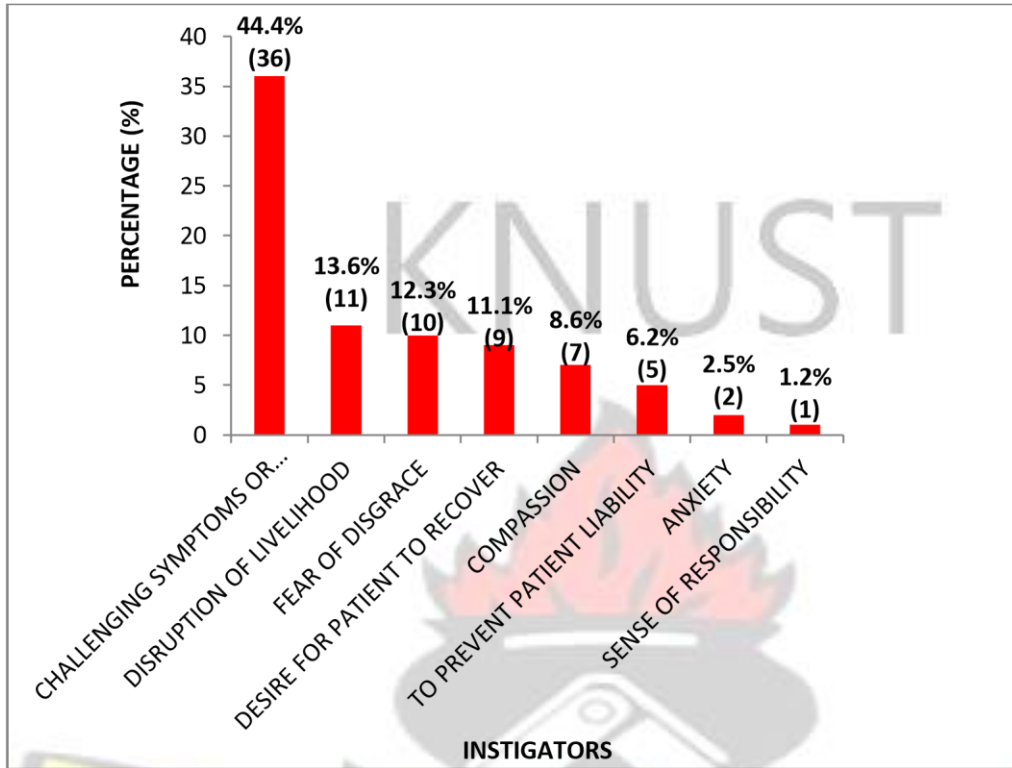


Figure 4.13: Factors which prompted help seeking among carers of the mentally ill

69% of non-carers and 19% of carers did not consider mental disorders as a major health problem in the community. 81% of carers and 31% of non-carers thought that it was a major problem as shown in Figure 4.14.

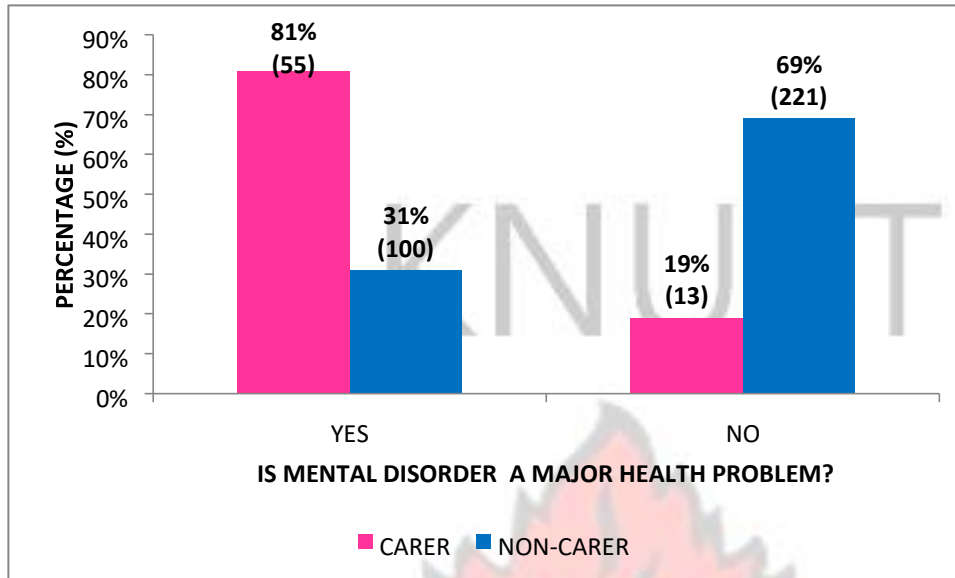


Figure 4.14: Respondent's opinion about whether mental disorders are a major health problem in the community

General practitioners including doctors and one physician assistant indicated their opinions about mental healthcare in their facilities by a Likert scale questionnaire. Generally, practitioners agreed that their knowledge of mental healthcare was sufficient. However 21.4% (3/14) indicated that their knowledge was not sufficient as shown in Table 4.10.

Table 4.10: General practitioners' opinion about the sufficiency of their knowledge of mental healthcare.

| RESPONSES | NUMBER OF RESPONDENTS | PERCENTAGE (%) | CUMMULATIVE PERCENTAGE (%) |
|----------------|-----------------------|----------------|----------------------------|
| STRONGLY AGREE | 3 | 21.4% | 21.4% |
| AGREE | 8 | 57.1% | 78.6% |
| DISAGREE | 3 | 21.4% | 100.0% |
| Total | 14 | 100% | |

A total of 71.4% (10/14) of respondents agreed that they were successful at diagnosing mental disorders while 28.6% indicated that they were not successful as shown in Table 4.11.

Table 4.11: General practitioners opinion about success of diagnosing mental disorders.

| RESPONSES | NUMBER OF RESPONDENTS | PERCENTAGE (%) |
|----------------|-----------------------|----------------|
| STRONGLY AGREE | 5 | 35.7% |
| AGREE | 5 | 35.7% |
| DISAGREE | 4 | 28.6% |
| Total | 14 | 100.0% |

Even though most prescribers indicated that they had sufficient knowledge about mental healthcare, a total of 85.7% agreed that they needed to improve upon it. Out of those who thought they needed improvement, 50% strongly agreed to that idea. None of the respondents said they did not need to improve on their knowledge as shown in Figure 4.15.

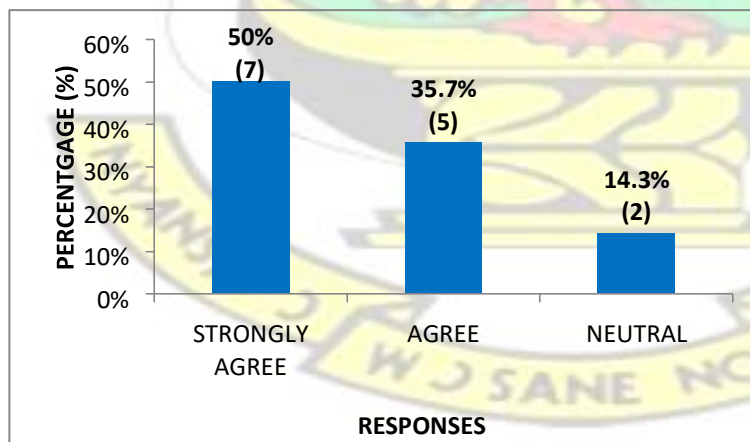


Figure 4.15: General practitioners' opinion about the need to improve their mental healthcare knowledge

Generally prescribers were of the opinion that their facilities were not effectively managing mental disorders. The number of those who agreed to this opinion amounted to 85.7%. Out of this percentage 78.6% strongly agreed to this assertion as shown in Table 4.12.

Table 4.12: General practitioners opinion about their facilities success at managing mental disorders

| RESPONSES | NUMBER OF RESPONDENTS | PERCENTAGE (%) |
|-------------------|------------------------------|-----------------------|
| STRONGLY AGREE | 1 | 7.1% |
| AGREE | 1 | 7.1% |
| DISAGREE | 11 | 78.6% |
| STRONGLY DISAGREE | 1 | 7.1% |
| TOTAL | 14 | 100.0% |

CHAPTER 5: DISCUSSIONS

The most common explanation among carers and non-carers about mental disorders suggest that they regard them as predominantly a change in the behaviour of an individual. This observation is similar to a survey conducted in Uganda where young people defined mental illness as relating to the behaviour of an individual (Okello et al, 2014). A complete description of a mental disorder according to literature is one which is characterised by the display of recurrent abnormal thoughts, alterations in emotions, behaviour and relationships with others which are associated with personal stress and impaired

functioning (WHO, 2001, WHO 2015a). However none of the two groups of respondents was able to provide a complete description of mental disorder. Only a small percentage 3.46% of non-carers explained it as affecting a person's relationship with others but carers failed to do so. Contrarily, migrant Asian Canadians defined mental illness predominantly as a feeling of lack of purpose in life, loneliness and anxiety which negatively affected their access to mainstream mental healthcare services (Li and Browne, 2000).

The pattern of responses stated for signs of mental disorders by both carer and noncarers were predominantly easily identifiable signs of mental disorders such as aggressive behaviour, neglect of personal hygiene, excessive talking to oneself, improper dressing and nakedness in public which are signs of worsening mental illness. However internalising signs which are experienced exclusively by the sufferer and could be elusive to others such as suicidal thoughts, hallucinations and anxiety were less frequently mentioned by both groups of respondents. Secondly symptoms mentioned were primarily behavioural, psychological or emotional in nature. Even though physical symptoms are associated with mental disorders (Kroenke et al, 1994, Simon et al, 1999, WHO, 2001) both carers and non-carers did not mention them as possible signs of mental disorders. These findings are indications that the knowledge of carers and noncarers about the signs of mental disorders is limited.

Recognition of mental disorders is the first indispensable step to seeking help (Reavley and Jorm 2012b). Limited knowledge of signs of mental disorders can affect the ability to recognise the presence of existing mental disorders and initiation of effective help seeking

actions. It can also lead to problems of articulation of symptoms to health practitioners (Jorm et al 1997).

Mental disorders are caused by a combination of biological, social and psychological factors (WHO, 2001). Respondents stated various causes of mental disorders which were either of biological e.g. hereditary, psychological e.g. anxiety, social or supernatural causes. Although both groups of respondents shared similar views about the causes of mental disorders, carers frequently stated that mental disorders had spiritual cause's while non- carers commonly said that they were due to substance abuse. Carers also stated spiritual causes as the main reason for the mental illnesses of the patients they were currently caring for. Both carers and non-carers stated smoking of narcotics as the most prominent risk factor for the development of mental disorders. This shows that they are aware of the psychotic effects associated with the abuse of narcotics. These findings are similar to a study conducted in India where majority of carers of the mentally ill stated genetic inheritance, substance abuse, and brain disease as the main causes of mental illness (Poreddi et al, 2015). It is also similar to other studies carried out in Malawi and Nigeria where illicit drug use and spiritual possession were frequently mentioned among respondents as causes of mental disorders (Crabb et al, 2012, Kabir M. et al, 2004).

However it is at variance with another study conducted in urban and rural communities in India where respondents said that mental disorders were caused by loss of semen or vaginal secretion, less sexual desire, excessive masturbation, God's punishment for the sufferers past sins, polluted air, sadness or unhappiness (Kishore et al, 2011).

Perceived causes of mental illness can influence patterns of help seeking and response to therapy (Jorm, 2000). A study comparing different aetiological paradigms for depression revealed that endorsement of the biological aetiological model was associated with increased preference for psychotherapy whereas endorsement of the psychological model was associated with an increased belief in self-help options (Goldstein and Rossellia, 2009).

Responses from both categories of respondents indicated that both groups thought that both men and women had equal chances of becoming mentally ill. Most respondents of both categories believed that mental disorders can affect people of any age group as well as the rich and poor. Both carers and non-carers believed that it was possible for them to be affected by a mental disorder in their lifetime. However there remained minorities who believed that mental disorders could affect only children, teenagers or only adults.

There were those who also believed that only poor people or rich people could suffer from such disorders. This is an indication that some respondents have misconceptions about mental illness which can negatively affect detection among specific groups of people whom they perceive as incapable of suffering from mental disorders such as children and teenagers. Kishore and his colleagues observed similar results in a study where 34.8% of rural subjects and 18% of urban subjects believed that children do not develop mental disorders (Kishore, 2011). This observation is disturbing because early detection and treatment seeking for mentally ill children and adolescents is determined by the perception and awareness of parents and providers about mental illness (Abera et al 2015).

Carers had a more positive attitude about the curability of mental disorders. This is expected because results show that they reported observing improvement in the condition of their mentally ill relatives after treatment had been sought for them at the hospital. . The outcomes observed show that carers as well as non-carers have knowledge about appropriate sources where they could get help and are likely to favour community based mental healthcare services when they are available. Even though respondents (carers and non-carers) mainly had preference for hospital mental health care services, 41.4% of carers had sought help from „prayer camps“ as part of the help seeking efforts. Prayer camps are popular sources of healing for mental illness in Ghana where healing is believed to be achieved through prayer, fasting and deliverance from evil spirits (Read et al, 2009). Carers also believed that the commonest cause of the illness of their mentally ill relatives was spiritual. This observation illustrates the assertion that the source of help chosen during help seeking can be influenced by perceived causes of mental illness (Jorm, 2000). Similarly, in Malaysia, a study revealed that mentally ill patients who believed that mental illness had supernatural causes mainly sought help from traditional healers and had poor compliance for drug therapy (Razali et al 1996).

This observation among carers is also evidence that shows that carers may seek help from different sources during the help seeking process. This bears resemblance of scenarios in Haitian culture where the same person may seek help from multiple sources when available because they often hold multiple or hybrid models of health and illness (WHO, 2010).

Factors which impelled carers to seek help for the mentally ill included the challenging nature of the signs, symptoms or behaviour of the mentally ill, disruption of livelihood, fear of disgrace, and fear of the ill person becoming a liability. This discovery is a clue that help seeking action may be delayed until the factors mentioned above set in, by which time the condition may have worsened. In an Australian study respondents mainly stated increasing illness severity or disability as the primary prompt to help seeking (Thompson et al, 2004). The behaviour of carers is a sign that help seeking may be delayed until the factors afore mentioned are experienced.

Although both carers and non-carers considered mental illnesses as a major health problem the percentage of carers who thought so was more than non-carers. On the other hand more non-carers than carers thought that mental disorders were not a major health problem. The emotional, economic and social burdens associated with mental disorders are often born by carers and families of the mentally ill. For this reason they are likely to perceive mental illness as a major problem than those without such experience.

The new mental health bill passed in 2012 by the government of Ghana stipulates a community based approach to mental health care. Primary health care settings provide a favourable opportunity for implementation of community based mental healthcare.

In Akwatia stable clients accessing healthcare are seen by general practitioners at the outpatient department. Acute episodes of mental illnesses may receive prompt attention at the emergency units.

Even though most prescribers (78.6%) said that they had sufficient knowledge about mental healthcare, 28.6% admitted that they were unsuccessful at diagnosing mental disorders and a large percentage, of 85.7% , agreed that they needed to improve upon their knowledge in mental healthcare. While the initial recognition of mental disorders takes place in the community (Horwitz, 1978), general practitioners play a vital role in detection, diagnosis and initiation of treatment for the mentally ill. However mental health problems are particularly hard to detect especially when there is an overlap of symptoms (Academy of Royal Sciences & Royal College of Psychiatrists, 2009) and therefore further training for general practitioners is essential. A study conducted in the Gaza strip revealed that general practitioners with post graduate psychiatric training, were better at detecting mental disorders than their counterparts who had not had such training (Afana et al, 2002). In another study in Gotland, Sweden, researchers found out that the rate of suicides due to depression reduced significantly over a period after a post graduate training on diagnosis and treatment of depression was introduced for general practitioners; however depressive suicides increased once the programme was discontinued (Rihmer et al 1995, WHO, 2001). This supports the idea that further training in psychiatry for general practitioners enables them to detect mental disorders more frequently and manage them adequately to the benefit of the patient and hence this observation reiterated by respondents is a positive assertion.

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CHAPTER 6: CONCLUSIONS AND RECOMMENDATION

6.1 CONCLUSION

Both carers and non-carers think that mental disorders refer to an abnormal change in the behaviour of a person. They also believe that people suffering from mental disorders usually display potentially harmful behaviour, neglect personal hygiene and show deficits in intelligence. In addition to that some carers as well as noncarers have misconceptions about mental disorders.

Both carers and non-carers prefer to seek help from the hospital or prayer camps for mental disorders. Nonetheless they are likely to seek multiple sources of help concurrently.

Carers sought help for the mentally ill when they found it difficult to handle the symptoms, when their livelihood was negatively affected, or as a result of fear of disgrace or fear of the person becoming a liability.

General practitioners believed that their knowledge about mental healthcare is sufficient but are sometimes not successful at diagnosing mental disorders and would like to improve on their knowledge.

6.2 RECOMMENDATION

- The public health unit of the Akwatia district health directorate is encouraged to educate residents about the complete definition, signs and causes of mental disorders as well as appropriate help seeking behaviour;
- General practitioners should be encouraged to get further training in mental healthcare to improve upon their services.
- Efforts to improve mental healthcare should also focus on targeting prayer camps as places to educate and provide professional mental healthcare services.

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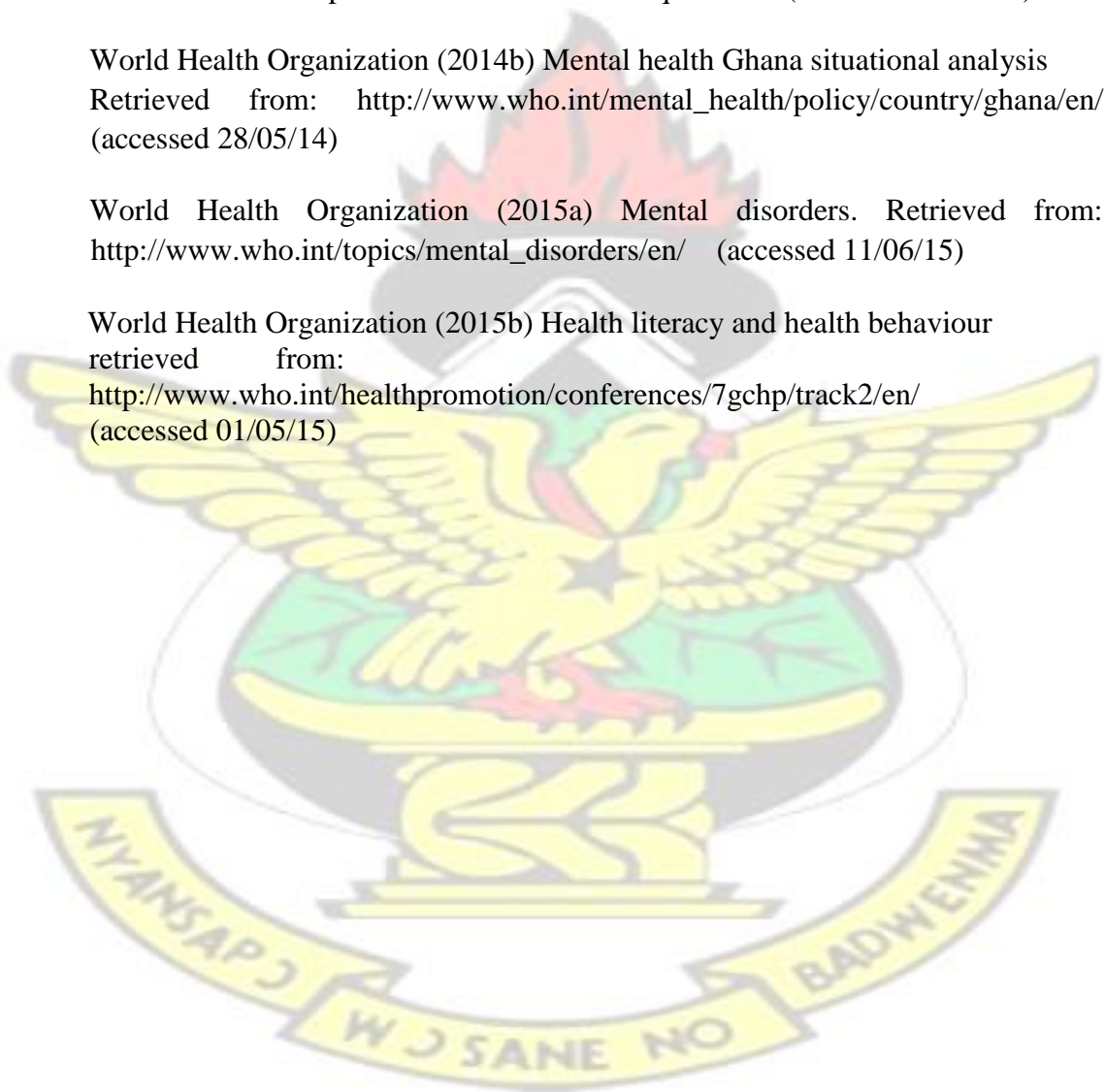
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APPENDIX I - Ethical Clearance Letters

 KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
COLLEGE OF HEALTH SCIENCES

 **SCHOOL OF MEDICAL SCIENCES / KOMFO ANOKYE TEACHING HOSPITAL**
COMMITTEE ON HUMAN RESEARCH, PUBLICATION AND ETHICS

Our Ref: CHRPE/AP/304/14 10th September, 2014.

Mrs. Geraldine Adwoa Okyere
St. Dominic Hospital
Post Office 59
AKWATIA.

Dear Madam,

LETTER OF APPROVAL

Protocol Title *“Assessment of the Mental Health Help Seeking Behaviour and Perceived Barriers to Hospital Mental Healthcare Services for Mental Disorders of People Living in Akwatia.”*

Proposed Site: *Akwatia, Denkyemba District, Ghana.*

Sponsor: *Principal Investigator*

Your submission to the Committee on Human Research, Publications and Ethics on the above named protocol refers.

The Committee reviewed the following documents:

- A notification letter of 16th June, 2014 from the Denkyemba District Health Directorate (study site) indicating approval for the conduct of the study in the District.
- A completed CHRPE Application Form.
- Participant Information Leaflet and Consent Form.
- Research Proposal.
- Questionnaire.

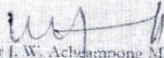
The Committee has considered the ethical merit of your submission and approved the protocol. The approval is for a fixed period of one year, renewable annually thereafter. The Committee may however, suspend or withdraw ethical approval at anytime if your study is found to contravene the approved protocol.

Data gathered for the study should be used for the approved purposes only. Permission should be sought from the Committee if any amendment to the protocol or use, other than submitted, is made of your research data.

The Committee should be notified of the actual start date of the project and would expect a report on your study, annually or at the close of the project, whichever one comes first. It should also be informed of any publication arising from the study.

Thank you Madam, for your application.

Yours faithfully,


Osomfuor Prof. Sir J. W. Acheampong MD, FWACP
Chairman

Room 7 Block J, School of Medical Sciences, KNUST, University Post Office, Kumasi, Ghana
Phone: +233 3220 63248 Mobile: +233 20 5453785 Email: chrpe.knust.kath@gmail.com / chrpe@knust.edu.gh

ST. DOMINIC HOSPITAL - AKWATIA

Email: sdhosp2001@yahoo.com

Akwatia



Box 59

23/6/2014

Mrs. Geraldine A. Okyere
C/O St. Dominic Hospital
Akwatia

Dear Mrs. Okyere,

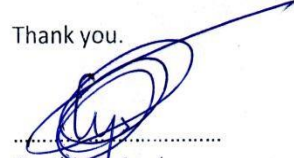
RE: PERMISSION TO CARRY OUT SURVEY

I write to acknowledge receipt of your letter concerning the above subject matter.

Permission has been granted from 23rd June, to 31st July, 2014 to enable you carry out your survey on "*the help seeking behaviour of mental disorders of people living in Akwatia*".

You are kindly expected to submit a brief report of your findings to the hospital to inform future decision.

Thank you.



.....
Cynthia L. Anaba
(Snr. Health Service Administrator)

For: Administrator

Cc: Head of Pharmacy
The Medical Superintendent

In case of reply the number and
The date of this letter should be
Quoted.
Our Ref: ER/KB/KGH/AD/vol.1/14



Government Hospital,
P.O. Box 114,
Kade.
+233 501334202

Your Ref.

9th July, 2014

Mrs. Geraldine A. Okyere,
St. Dominic Hospital,
Akwatia.

Dear Mrs. Okyere,

RE: PERMISSION TO CARRY OUT SURVEY

I refer to your letter dated 22nd June, 2014 on the above subject matter.

I wish to inform you that permission has been granted to you from the 23rd June to August 31st, 2014 to gather the necessary information about mental health in this hospital to enable you complete a survey you are undertaking.

We wish you all the best.

Thank you.

Yours faithfully,

A handwritten signature in blue ink that reads "Maxwell Larbi".

Maxwell Larbi
Snr. Health Service Administrator
For: Medical Superintendent

APPENDIX II-Sample of Questionnaires Distributed.

Questionnaire 1: For Assessing The Knowledge And Help-seeking Behaviour Of Mental Disorders Of Residents Of Akwatia.

QUESTIONNAIRE FOR ASSESSING THE KNOWLEDGE AND HELPSEEKING BEHAVIOUR OF MENTAL DISORDERS OF RESIDENTS IN AKWATIA

Questionnaire Number

Dear Sir/Madam,

I would be grateful if you could answer this questionnaire to express your individual opinion about mental disorders. The information you provide will be treated as confidential. This is purely for academic purposes. The information you provide would also provide a basis for the improvement of mental healthcare in the community. Please sign below to register your consent to take part in this survey. Thank you.

Signature of respondent.....

Please answer the following questions according to your own honest opinion.
Where applicable you may select appropriate option/options by ticking.
You may also provide your own answers in your own words where applicable.

Knowledge and attitudes about mental disorders/illness

1. In your own words explain what you understand by mental disorder.

.....
.....
.....
.....

2. What are the signs that show that someone is suffering from a mental disorder/illness?
Please list those you know

I.
II.
III.
IV.

1

3. What in your opinion do you think are the causes of mental disorders /illness?

Please list in order from the most common cause to the less common cause.

- I.
- II.
- III.
- IV.
- V.

4. List the mental disorders/illness you know of that can be treated or managed in the hospital.

- I.
- II.
- III.
- IV.
- V.

5. Do you think that it is possible for you to have a mental disorder in your lifetime?

- (a) Yes
- (b) No

7. Please give your reason for the answer

above.....
.....
.....

8. Which sex of people in your opinion is more likely to suffer from mental illness?

- (a) Men
- (b) Women

9. Which age group can become mentally ill?

- (a) Children only
- (b) Teenagers only
- (c) Adults only
- (d) Elderly only
- (e) All age groups

10. Which of the groups below do you think can suffer from mental illness

- (a) The rich people only
- (b) The poor people only
- (c) Both the rich and the poor

11. Which group or groups of people listed below do you think are at risk of developing a mental disorder?

- (a) Those who worry a lot
- (b) Those who smoke or sniff narcotic drugs
- (c) Those who drink excessively
- (d) Those who are in abusive marriages
- (e) The elderly
- (f) None of the above
- (g) Other please indicate

12. Do you think mental disorders can be cured?

- (a) Yes
- (b) No

13. Should it happen that in future you experience a mental illness where would you want to seek help from?.....

14. Please state your reason for your answer above?

.....
.....
.....

15. Have you suffered from a mental disorder before?

- (a) Yes
- (b) No

If your answer is 'no' for question (15) please skip to question (22)

16. What steps did you take to seek for help for your condition? Please list stepwise starting from the first action to the last action.

I.
II.
III.
IV.

17. Did you experience improvement in your condition after taking the steps you mentioned in **question 16**?

- (a) Yes
- (b) No

18. What motivated you to seek for help for your condition?

.....

19. If your answer in **(Question 17)** is 'Yes' would you take the same action if you had another mental disorder/illness in future?

- a) Yes
- b) No

20. If your answer in **question (19)** is 'No' where do you think you would receive the best treatment for the mental disorder/ illness?

21. Please state

.....

22. Apart from yourself do you know of anyone who has suffered from a mental illness before?

- (a) Yes
- (b) No

23. Describe or state the condition he or she suffered

from.....

.....

.....

24. How was the person related to you?

- (a) A friend
- (b) A relative
- (c) A spouse
- (d) Other please state.....

24. What will motivate you to seek for help for someone you consider to be mentally ill?

.....

.....

.....

.....

25. Name any health facilities within your area which treat mental illnesses and their location.

Name location.....
.....

26. Would you seek help from a hospital with a mental health department in your area if you were mentally ill?

- (a) Yes
- (b) No

27. If your answer for question (26) is "**Yes**" why would you seek help from a hospital with a mental health department

28. If your answer in question (26) is "**No**" why would you not seek help from a formal mental health facility in your community?

- a) The health facility cannot handle this type of case
- b) I do not want people to know that I have such an illness (there is no privacy)
- c) There is no such facility in my area that I can go for treatment
- d) There is a health facility but does not provide mental health services
- e) I do not have health insurance
- f) The facility charges high fees
- g) The facility is very far from my house
- h) Other please state.....

29. In your opinion, how can people with mental health disorders be helped?

State 3 points in order of importance.

- I.
- II.
- III.

Policy and regulations

Please tick appropriately

30. Do you know about the new mental health bill?

- (a) Yes
- (b) No.

If your answer in question 30 is 'NO' please skip to question 34

31. Does the new mental health bill encourage mental healthcare services to be available at the community level?

- (a) Yes
- (b) No
- (c) I do not know

32. Does the current mental health bill say that mental health services are to be covered by insurance?

- (a) Yes
- (b) No
- (c) I do not know

33. Does the current mental health bill prohibit people from discriminating against people suffering from mental illnesses?

- (a) Yes
- (b) No
- (c) I do not know

34. In your opinion, do you think mental disorders/illness constitute a major health problem in your community?

- (a) Yes
- (b) No

35. What do you think could be done to address mental health problems your community?

.....
.....
.....

Demographics

36. Age in years

37. Sex : please tick accordingly

- (a) Male
- (b) Female

38. Marital status

- (a) Married
- (b) Single
- (c) Divorced

39. Religion
(a) Christian
(b) Moslem
(c) traditionalist
(d) Other specify.....

40. Level of education
(a) Tertiary
(b) Secondary
(c) Primary
(d) None

42. What is your
occupation?.....

43. Which suburb of town do you live
.....

44. For how long have you lived in this community?.....

- (a) >20 years
(b) 15-20 years
(c) 10-15 years
(d) 5-10 years
(e) < 5 years

Date interviewed
.....

Name of interviewer.....

Questionnaire 2: To Assess The Opinions Of Prescribers On The Provision Of Mental Health Care Services In Akwatia.

QUESTIONNAIRE TO ASSESS THE OPINIONS OF PRESCRIBERS ON THE PROVISION OF MENTAL HEALTH CARE SERVICES IN AKWATIA

Dear prescriber this questionnaire is to help assess the opinions of prescribers about the provision of hospital mental health care services in Akwatia and surrounding towns. Your participation in this survey may help stakeholders to improve mental healthcare services for the benefit of patients in the area. For the purposes of confidentiality your identity is not required.

Please kindly confirm your willingness to participate by signing in the space provided.

Sign.....

Thank you for your willingness to participate.

1. My facility has mental health guidelines which are readily available for quick references when attending to a mentally ill patient.
 - a. Yes
 - b. Not sure
 - c. No

2. I have suitable diagnostic scales and other diagnostic tools for the assessment of mental health of my patients in my facility.
 - a. Yes
 - b. No

3. During consultation I ask my patients about their mental health problems
 - a. Yes I often do that
 - b. No I don't
 - c. I do it rarely

4. My knowledge of mental healthcare is sufficient.
 - a. Strongly agree
 - b. Agree
 - c. Disagree
 - d. Strongly disagree

5. I have sufficient communication skills to communicate with patients who have mental disorders.
 - a. Strongly agree
 - b. Agree
 - c. Disagree
 - d. Strongly disagree

6. I am successful at diagnosing the most common mental disorders in my health facility.
 - a. Strongly agree
 - b. Agree
 - c. Disagree
 - d. Strongly disagree

7. Which common disorders do you usually diagnose? Please list
 - I.
 - ii.
 - iii.
 - IV.

8. I think my facility has enough opportunities /variety of medicines to prescribe for mental disorders
 - a. Strongly agree
 - b. Agree
 - c. Disagree
 - d. Strongly disagree

9. My facility has a mental healthcare practitioner with whom I can collaborate with on mental disorder cases.
 - a. Yes
 - b. Not sure
 - c. No

10. I would like to improve my mental healthcare knowledge.
 - a. Strongly agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree

11. I immediately refer patients to a psychiatrist or the psychiatric hospital for care
- a. Strongly agree
 - b. Agree
 - c. Disagree
 - d. Disagree
 - e. Strongly disagree
12. If you have ever referred patients what was your reason for doing so?
- I. Uncertainty about diagnosis
 - II. Deterioration of the patient's health status
 - III. Limited possibilities/ options for prescribing medication
 - IV. Lack of confidence in diagnosing and managing mental conditions
 - V. Lack of guidelines of diagnosis and treatment of mental conditions
 - VI. Lack of support from a mental healthcare team
 - VII. Limited time for patient consultation
 - VIII. Lack of financial motivation
 - IX. Lack of explicitness in the roles of different healthcare professionals eg. General practitioners, psychiatrists, psychologists in managing mental conditions
13. I feel responsible for the management of my patients' mental health problems
- a) Strongly agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree
14. Is there a mental healthcare unit in your facility?
- a. Yes
 - b. No
15. Is there an active mental healthcare team in your facility?
- a. Yes
 - b. No
16. My healthcare facility is currently capable of effectively treating mental disorders in the community.
- I. Strongly disagree,
 - II. disagree,
 - III. agree ,
 - IV. strongly agree

PTO →

17. Specialty

18. Number of years of practice.....

I. 1month – 3years

II. 4- 10years

III. 11-15year

IV. 16-20 years

V. More than 20years

Questionnaire 3: For Assessing The Knowledge And Helpseeking Behaviour Of Mentally Ill Patients In Akwatia.

QUESTIONNAIRE FOR ASSESSING THE KNOWLEDGE AND HELPSEEKING BEHAVIOUR OF CARERS OF MENTALLY ILL PATIENTS IN AKWATIA

Questionnaire Number

Dear Sir/Madam,

I would be grateful if you could answer this questionnaire to express your individual opinion about mental disorders. The information you provide will be treated as confidential. This is purely for academic purposes. The information you provide would also provide a basis for the improvement of mental healthcare in the community. Please sign below to register your consent to take part in this survey. Thank you.

Signature of respondent.....

Please answer the following questions according to your own honest opinion.

Where applicable you may select appropriate option/options by ticking.

You may also provide your own answers in your own words where applicable.

Knowledge and attitudes about mental disorders/illness

1. In your own words explain what you understand by mental disorder.
.....
.....
.....
.....

2. What are the signs that show that someone is suffering from a mental disorder/illness?
Please list those you know
I.
II.
III.
IV.

3. What in your opinion do you think are the causes of mental disorders /illness?

Please list in order from the most common cause to the less common cause.

- I.
- II.
- III.
- IV.
- V.

4. List the mental disorders/illness you know of that can be treated or managed in the hospital.

- I.
- II.
- III.
- IV.
- V.

5. Do you think that it is possible for you to have a mental disorder in your lifetime?

- (a) Yes
- (b) No

7. Please give your reason for the answer

above.....
.....
.....

8. Which sex of people in your opinion is more likely to suffer from mental illness?

- (a) Men
- (b) Women

9. Which age group can become mentally ill?

- (a) Children only
- (b) Teenagers only
- (c) Adults only
- (d) Elderly only
- (e) All age groups

10. Which of the groups below do you think can suffer from mental illness

- (a) The rich people only
- (b) The poor people only
- (c) Both the rich and the poor

11. Which group or groups of people listed below do you think are at risk of developing a mental disorder?

- (a) Those who worry a lot
- (b) Those who smoke or sniff narcotic drugs
- (c) Those who drink excessively
- (d) Those who are in abusive marriages
- (e) The elderly
- (f) None of the above
- (g) Other please indicate

12. Do you think mental disorders can be cured?

- (a) Yes
- (b) No

13. Should it happen that in future you experience a mental illness where would you want to seek help from?.....

.....

14. Please state your reason for your answer above?

.....

.....

.....

15. Have you suffered from a mental disorder before?

- (a) Yes
- (b) No

If your answer is 'no' for question (15) please skip to question (22)

16. What steps did you take to seek for help for your condition? Please list stepwise starting from the first action to the last action.

- I.
- II.
- III.
- IV.

17. Did you experience improvement in your condition after taking the steps you mentioned in **question 16**?

- (a) Yes
- (b) No

18. What motivated you to seek for help for your condition?

.....

19. If your answer in **(Question 17) is 'Yes'** would you take the same action if you had another mental disorder/illness in future?

- a) Yes
- b) No

20. If your answer in **question (19) is 'No'** where do you think you would receive the best treatment for the mental disorder/ illness?

21. Please state

.....

22. Apart from yourself do you know of anyone who has suffered from a mental illness before?

- (a) Yes
- (b) No

23. Describe or state the condition he or she suffered from.....

.....
.....

24. What do you think was the cause of the mental illness?

25. What steps did you take to seek for help for him/her to get better

- I.
- II.
- III.
- IV.
- V.

26. Which of the steps produced improvement in the condition?

.....
.....

27. What motivated you to seek for help for him/her?

.....
.....
.....

28. How was the person related to you?.....

- (a) A friend
- (b) A relative
- (c) A spouse

Other please state:.....

29. Name any health facilities within your area which treat mental illnesses and their location.

Name location.....
.....

30. Would you seek help from a hospital with a mental health department in your area if you were mentally ill?

- (a) Yes
- (b) No

31. If your answer for question (30) is "yes" why would you seek help from a hospital with a mental health department in your community

32- If your answer in question(30) is "No" why would you not seek help from a formal mental health facility within your community?

- a) The health facility cannot handle this type of case
- b) I do not want people to know that I have such an illness (there is no privacy)
- c) There is no such facility in my area that I can go for treatment
- d) There is a health facility but does not provide mental health services
- e) I do not have health insurance
- f) The facility charges high fees
- g) The facility is very far from my house
- h) Other please
state.....

33. In your opinion, how can people with mental health disorders be helped?

State 3 points in order of importance.

- I.
- II.
- III.

Policy and regulations

Please tick appropriately

34. Do you know about the new mental health bill?

- (a) Yes
- (b) No.

35. Does the new mental health bill encourages mental health services to be available at the community level?

- (a) Yes
- (b) No
- (c) I do not know