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Availability and Accessibility of Mental Health Intervention Programs in Resource-Limited Settings: A Case Study of Western Ghana

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ABSTRACT

Despite global calls for equitable access to mental health care, service delivery in low-resource settings remains inconsistent and poorly integrated. This study explores the availability and accessibility of mental health intervention programs in Western Ghana, using a mixed-methods approach that combines structured surveys with in-depth interviews. Quantitative data from 200 respondents, including community members and health professionals, revealed that only 31% had access to mental health services, with less than 10% reporting the presence of trained personnel or regular psychotropic drug supply. Barriers such as distance to facilities, high treatment costs, stigma, and preference for traditional healing were widespread. Qualitative interviews confirmed these findings and highlighted systemic challenges including lack of infrastructure, minimal outreach programs, and weak implementation of national policy. The study concludes that despite Ghana's Mental Health Act 846 (2012), significant gaps persist in operational delivery. It recommends targeted investments in decentralization, professional training, culturally sensitive community engagement, and regulatory oversight to close the implementation gap and promote equitable mental health care access.

Keywords: Mental health services, Accessibility, Ghana, Community perceptions, Health system implementation

INTRODUCTION

Mental health remains one of the most neglected areas of public health in many low- and middle-income countries, despite growing evidence of its profound impact on individual well-being, economic productivity, and social cohesion. In Ghana, mental health disorders are estimated to affect over 21% of the population, yet access to quality mental health services remains

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highly restricted (Doku et al., 2012; WHO, 2017). Although the passage of the Mental Health Act 846 in 2012 was intended to improve service availability and promote community-based care, practical implementation across most regions, particularly in resource-limited areas such as Western Ghana, has been slow and fragmented (Osei, 2017).

Mental health services in Ghana have historically been centralized within three major psychiatric hospitals—Accra, Pantang, and Ankaful—leaving rural and peri-urban populations with limited access to care (Read & Doku, 2012). Moreover, the scarcity of trained mental health professionals, poor infrastructure, stigma, and weak referral systems have continued to hinder the expansion of services into primary healthcare settings (Adu-Gyamfi & Brenya, 2016). These limitations are exacerbated by minimal budgetary allocations and a lack of integrated policy implementation at the district and sub-district levels. Although community-based approaches have been advocated, the actual availability of programs and their accessibility by vulnerable populations remains underexplored.

The Western Region of Ghana, with its combination of urban centers and underserved rural communities, presents a unique case for examining the disparities in mental health service delivery. Given the region's resource constraints and reported mental health burden, this study seeks to assess the availability and accessibility of mental health intervention programs in the region. It also aims to explore the challenges faced by both providers and beneficiaries in accessing these services.

Understanding these dynamics is crucial not only for improving regional healthcare delivery but also for informing national-level reforms. By focusing on the Western Region, the study contributes empirical evidence to ongoing efforts to expand mental health care under the framework of Ghana's mental health legislation and primary healthcare policy.

METHODOLOGY

This study employed a descriptive cross-sectional design with both quantitative and qualitative approaches to assess the availability and accessibility of mental health intervention programs in the Western Region of Ghana. The mixed-methods approach enabled the collection of complementary data on the scope, structure, and perceived effectiveness of available mental health services.

Study Area

The research was conducted in selected districts within the Western Region of Ghana, a region that comprises both urban and rural populations and is

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characterized by limited mental health infrastructure. The region has no standalone psychiatric hospital and relies primarily on general hospitals and community-based health facilities for mental health service delivery.

Study Population and Sampling

The target population included mental health service providers, district health administrators, and adult community members who had either accessed or attempted to access mental health services. A multistage sampling technique was adopted. Five districts were purposively selected based on population size, location (urban/rural), and health infrastructure. Within each district, health professionals were sampled purposively while community respondents were selected through simple random sampling.

A total of 200 participants were involved in the study: 150 community members and 50 health workers (including nurses, prescribers, and mental health officers). Inclusion criteria required that respondents be at least 18 years of age and have either used mental health services or had roles in delivering them.

Data Collection

Data were collected using structured questionnaires, semi-structured interview guides, and institutional checklists. The questionnaires collected data on service availability, accessibility, affordability, awareness, and perceived quality of mental health programs. The semi-structured interviews provided deeper insight into institutional barriers, referral pathways, and community experiences. In addition, facility checklists were used to assess the presence of mental health units, trained staff, essential psychotropic medicines, and referral structures.

Data Analysis

Quantitative data were analyzed using SPSS version 23. Descriptive statistics were used to summarize the availability and usage rates of mental health services, while cross-tabulations explored relationships between sociodemographic variables and service accessibility. Qualitative data from interviews were transcribed and analyzed thematically, allowing for the identification of recurring patterns and explanatory narratives surrounding mental health program delivery.

Ethical Considerations

Ethical clearance was obtained from the appropriate institutional review board. Verbal and written informed consent was secured from all participants. Anonymity and confidentiality were assured throughout the data collection and reporting processe

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RESULTS

4.1 Quantitative Findings

A total of 200 respondents participated in the study, comprising 150 community members and 50 health professionals. Descriptive and thematic statistics from the structured questionnaires are presented below.

Table 1: Demographic Characteristics of Respondents (N = 200)

Variable	Category	Frequency (n)	Percentage (%)
Gender	Male	108	54.0
	Female	92	46.0
Age Group	18–29 years	42	21.0
	30–39 years	70	35.0
	40–49 years	54	27.0
	50 years and above	34	17.0
Occupation	Health professionals	50	25.0
	Farmers/Fisherfolk	48	24.0
	Traders	44	22.0
	Students/Unemployed	30	15.0
	Teachers/Professionals	28	14.0
Educational Level	No formal education	24	12.0
	Basic education	56	28.0
	Secondary education	68	34.0
	Tertiary education	52	26.0

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Table 2: Availability of Mental Health Services (N = 200)

Indicator	Yes (n)	%	No (n)	%
Mental health services available in facility	62	31.0	138	69.0
Trained mental health staff present	20	10.0	180	90.0
Regular psychotropic medication supply	16	8.0	184	92.0
Awareness programs in the community	54	27.0	146	73.0

Only 31% of respondents confirmed the presence of mental health services in their area. Availability of trained personnel and psychotropic medication was even lower, at 10% and 8% respectively. Just over a quarter reported exposure to mental health education or awareness programs.

Table 3: Barriers to Accessing Mental Health Services (Multiple Responses Allowed)

Barrier	Frequency (n)	Percentage (%)
Long distance to facility	110	55.0
High cost of treatment/transport	98	49.0
Fear of stigma	86	43.0
Lack of awareness of services	78	39.0
Preference for traditional healing	74	37.0
Long waiting time at facilities	40	20.0

Over half of respondents cited distance as a barrier, followed by cost (49%) and stigma (43%). The data reveal that even where services exist, systemic and personal barriers undermine utilization.

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Table 4: Beliefs About Causes of Mental Illness

Belief about Cause	Frequency (n)	Percentage (%)
Spiritual causes (witchcraft, curses)	96	48.0
Medical/biological causes	64	32.0
Substance abuse or stress	28	14.0
Uncertain / no idea	12	6.0

Nearly half of all respondents believed mental illness stems from supernatural causes, while only a third attributed it to medical or scientific explanations.

Table 5: First Line of Action When Faced with Mental Illness

Initial Response Option	Frequency (n)	Percentage (%)
Prayer camp / spiritual leader	78	39.0
Herbalist or traditional healer	47	23.5
Public hospital or clinic	61	30.5
Ignore / self-manage	14	7.0

A majority (62.5%) preferred spiritual or traditional interventions over biomedical services as the first point of contact, indicating strong cultural influence on mental health pathways.

4.2 Qualitative Findings

Thematic analysis of interviews with 20 health professionals and key informants revealed four main areas of concern:

Inadequate Service Infrastructure and Resources

Participants repeatedly described a lack of functional mental health units, equipment, or infrastructure. Most peripheral facilities lacked even basic resources for mental health screening or diagnosis.

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"We have no mental health officer and no separate consultation space. All we do is refer when cases get out of hand." — CHPS Supervisor

Workforce and Drug Shortages

Mental health human resources were critically lacking. In many cases, general nurses handled mental health cases without formal training.

"There is nobody trained here. I've had to manage patients based on personal experience, not formal education." — Community Health Nurse

Stigma and Cultural Beliefs

Participants echoed widespread beliefs about spiritual causation, often reinforced by community leaders and family members.

"They prefer spiritual deliverance. They don't see hospital treatment as relevant to mental problems." — District Psychiatric Coordinator

Barriers to Follow-up and Community Engagement

Outreach services, home visits, or referrals were often impractical due to logistics, poor communication systems, and lack of support from higher levels.

"We don't have any means to track patients after referral. Most get lost in the system." — Mental Health Officer

4.3 Integration of Quantitative and Qualitative Results

The integrated analysis of quantitative and qualitative findings reveals a consistent and troubling picture of mental health service delivery in the Western Region. Quantitative data shows that less than one-third of respondents had access to services, with overwhelming reports of shortages in drugs, staff, and infrastructure. These numbers are reinforced by qualitative accounts from health workers, who described operating in under-resourced environments without proper training or equipment.

Barriers to accessibility such as distance, cost, and stigma—statistically prominent—were vividly elaborated by community members and providers alike. Cultural beliefs regarding spiritual causation of mental illness, confirmed by 48% of survey respondents, were echoed in nearly every qualitative narrative. These beliefs directly influenced service-seeking behavior, with most individuals turning to faith-based or traditional healers as their first response.

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Furthermore, the near absence of mental health promotion and community education programs, as indicated in the survey (only 27% exposure), explains the poor awareness and utilization of formal services. Even where services exist, health providers described the lack of continuity, nonexistent follow-up systems, and administrative neglect, which aligns with survey reports of underutilization and dissatisfaction.

Taken together, the evidence paints a picture of a health system that, despite national legislation, is yet to translate policy into equitable service delivery. The disconnect between legislative intent and implementation realities is reflected in both numerical trends and lived experiences.

DISCUSSION

This study investigated the availability and accessibility of mental health intervention programs in Western Ghana, utilizing both quantitative and qualitative approaches to generate a comprehensive understanding of the challenges faced by communities and health providers. The findings indicate that despite the passage of Ghana's Mental Health Act (Act 846) over a decade ago, the delivery of mental health services remains fragmented, under-resourced, and largely inaccessible to populations in resource-limited settings.

The quantitative results revealed that only 31% of respondents reported the presence of mental health services in their locality, with significantly fewer indicating the presence of trained personnel or consistent medication supply. These statistics mirror earlier national-level studies which highlighted regional disparities and inadequate implementation of decentralized mental health care (Osei et al., 2015; Roberts et al., 2018). Health professionals interviewed in this study described operating within fragile systems lacking designated infrastructure, essential supplies, and basic human resources for mental health. The absence of trained personnel was not merely a statistical gap but a lived experience of professional frustration and service inadequacy. These findings affirm Doku et al.'s (2012) assertion that mental health delivery in Ghana is severely constrained by health system weaknesses and low policy prioritization.

Access to mental health services was further undermined by several interrelated barriers. Over half of the community respondents reported that distance to health facilities posed a major obstacle, while nearly half cited financial constraints and fear of stigma. These factors, which are well-documented in sub-Saharan African mental health literature (WHO, 2013; Semrau et al., 2015), interact in complex ways to limit

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service uptake even in areas where facilities technically exist. The preference for traditional and spiritual forms of healing reported by over 60% of respondents, supported by qualitative narratives, highlights the enduring influence of cultural belief systems on mental health-seeking behavior. As found in other Ghanaian studies (Read & Doku, 2012; Ae-Ngibise et al., 2010), this preference is not merely cultural but is reinforced by poor access, limited community awareness, and the historical absence of biomedical alternatives.

Furthermore, the findings expose the near-complete absence of community engagement and public education around mental health. Less than 30% of respondents had been exposed to any form of mental health education in their communities. Health professionals confirmed that mental health is rarely included in health outreach activities, with resources and training typically reserved for communicable diseases and maternal health. This invisibility of mental health within primary health systems contradicts the aspirations of Ghana's mental health policy and represents a missed opportunity for early identification and intervention (Eaton et al., 2011).

The implications of these findings are significant for mental health policy, planning, and implementation. First, the Ghana Health Service and Mental Health Authority must ensure that mental health is fully integrated into the district and sub-district health system. This includes the recruitment and placement of trained mental health professionals across all districts, as well as equipping facilities with essential medicines and referral systems. Second, intersectoral collaboration must be strengthened to regulate the practices of traditional and spiritual healers while promoting culturally sensitive, rights-based approaches to mental health care. Without genuine partnership and community-based frameworks, efforts to reform service delivery will face ongoing resistance and ineffectiveness. Third, sustained investment is required in public education campaigns, school-based awareness programs, and media advocacy to shift community attitudes and reduce stigma. These campaigns should be grounded in local languages and cultural idioms to foster community ownership.

This study has limitations that must be acknowledged. Although the mixed-methods design enhances the depth of findings, the study was limited to selected districts in the Western Region and may not capture the full diversity of mental health experiences across Ghana. The sample size, while adequate for descriptive analysis, may limit generalizability to larger populations.

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Furthermore, the reliance on self-reported data introduces the possibility of recall and social desirability biases. Nonetheless, the convergence of quantitative and qualitative findings enhances the validity and relevance of the conclusions drawn.

In sum, this study contributes critical evidence to the national discourse on mental health delivery in Ghana. It underscores the urgent need for systemic reforms that go beyond policy frameworks to focus on implementation, equity, and culturally appropriate engagement. Without such reforms, the right to mental health care enshrined in national legislation will remain unfulfilled for the majority of Ghanaians living in underserved communities.

CONCLUSION

This study has illuminated critical gaps in the availability and accessibility of mental health intervention programs in Western Ghana. Despite the progressive vision of the Mental Health Act 846 (2012), the translation of this legal framework into actual service delivery remains inadequate. Quantitative data revealed that most communities lack trained personnel, medications, or functioning mental health units. Qualitative narratives affirmed these findings and further exposed the systemic and sociocultural barriers that hinder access to mental health care.

Stigma, poor infrastructure, and deep-rooted beliefs in supernatural causation continue to push mental health clients toward traditional and spiritual healers, often as their first line of treatment. The study concludes that without sustained investments in decentralized services, public education, and intersectoral collaboration, the promise of equitable and community-based mental health care in Ghana will remain unrealized. It is essential for stakeholders to re-evaluate the implementation mechanisms of the national mental health policy and to prioritize both human resources and community engagement as pillars of sustainable mental health care reform.

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