ORIGINAL PAPER

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Previous help sought by patients presenting to mental health services in Kumasi, Ghana

Accepted: 12 September 2003

Abstract *Objective* There are four services providing mental health care to the people of Kumasi, Ghana. This study aimed to identify previous help sought by patients presenting to the services for an initial assessment. *Method* New patients presenting to each of the four services were asked about distance travelled, previous help sought and time since symptoms of illness started. Staff also recorded basic demographic details and clinical diagnoses. *Results* Of the 322 patients presenting to the four sites, only 6 % had seen a traditional healer whereas 14 % had seen a pastor before presentation. There was a greater delay in presenting to that service if the patient had seen a traditional healer or pastor. Many patients had previously used one of the other mental health units in Kumasi. *Conclusion* It is possible that fewer patients with mental health problems present to traditional healers in modern, urban Africa compared to rural areas. More patients consult with pastors than traditional healers and liaison with these groups may improve mental health care. It is important to maintain liaison between the four services as patients presenting to one clinic may have presented previously to another local clinic.

Key words mental health services – Ghana – Africa – traditional healers – pastors

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Introduction

Ghana is a country with very limited mental health care provision by European standards, but fairly similar to most sub-Saharan African countries (Laugharne and Burns 1999). There are three psychiatric hospitals and a few smaller inpatient units. There is approximately one fully qualified psychiatrist per million people in a country with a population of 18 million people. Understandably, patients with mental health problems may go to other helping agencies in the community before health services, such as traditional healers or pastors. Kumasi, the second largest city in Ghana and capital of the Ashanti region, has a population of 1.5 million people.

The services in Kumasi

The four sites that provided psychiatric services in the Kumasi metropolitan area were the psychiatric unit of the Komfe Anokye Teaching Hospital (KATH), the Community Psychiatric Nursing Unit (CPN clinic), the Pankronu Psychiatric Clinic and Santasi clinic. The former two services were state-funded and the latter two private services. The unit at KATH is a tertiary referral unit providing inpatient (12 beds) and outpatient care in a general hospital staffed by one consultant psychiatrist, two psychotherapists, four junior doctors and eight nurses. The CPN unit is staffed by a senior trained psychiatric nurse supported by four psychiatric nurses in a community outpatient unit. The Pankronu clinic provides inpatient and outpatient care in a 16–20 bed unit staffed by a psychiatric specialist and seven nurses. The Santasi clinic is staffed by a trained psychiatric nurse supported by two general nurses in a 16–20 bed unit and outpatient clinic.

It was evident from the clinical experience of staff working in Kumasi that patients might seek help from religious (mostly Christian) pastors and traditional healers before approaching health services. There was

no formal link between the health services and these other sources of help, although informal links were present through the informal social structures of Ghanaian society. Clinicians reported that many pastors were involved with prayer camps, and patients would often visit these for help with their problems. Several studies of pathways to care have suggested that traditional healers play a role in help-seeking behaviour for the mentally ill in sub-Saharan Africa, although consultation rates before presenting to services have varied considerably (Abiodun 1995; Alem et al. 1999; Patel et al. 1997). Few studies have highlighted the role of Christian pastors, but in Nigeria their involvement has been observed (Jegede et al. 1985).

Aims of the paper

This paper reports a survey of patients presenting to mental health services in Kumasi, Ghana. We aimed to ask the following research questions:

1. How many patients have sought help from pastors and traditional healers before attending the mental health service?
2. Do the four mental health services see patients already seen at one of the other services in Kumasi?
3. How large is the delay between onset of symptoms and presenting to mental health services, and is this delay affected by previous help sought?

Subjects and methods

The study sample comprised new attendants to the units over a period of 2 months. All patients who had a previous contact with that clinic and were attending for review were excluded from the study. We, therefore, aimed to interview patients presenting to that clinic for the first time.

A data form was devised to be used at all four sites to gather demographic data, information about source of referral, previous help sought, time since onset of illness to the time of presentation, area of residence, distance travelled and diagnosis. Each service continued to use their routine diagnostic procedures. The form was brief as staff completed it whilst doing their usual clinical work. When asking about previous help sought, the data form included the options of none, family doctor, pastor, traditional healer, other health clinic in Kumasi, and other (asking to specify).

Two meetings at each of the four clinics were held, led by the same researcher (JA-P). The first was with all members of the staff at each service to explain the study protocol and seek support for the study. The second meeting was conducted individually with each member of staff who was collecting data to train them on how to fill in the form. Each clinical encounter took up to 10 min to complete and it took place at the outpatients' department where first contact was usually made at each service. Data were analysed using SPSS.

Results

The questionnaire was completed at all four services in Kumasi by patients presenting for the first time to that service. Because of limitations on time and resources, the sample at each site was not consecutive.

Table 1 shows the clinical diagnoses given to the patients attending the four sites. As can be observed, there are differences between the sites, most notably KATH and the Santasi clinic diagnose a higher proportion of the patients as having a psychotic illness. The Pankrona clinic sees more people with neurotic illnesses and a high number of attenders at the CPN clinic are diagnosed with epilepsy.

Patients were asked if they had sought previous help for their problem. Of the 303 patients giving data, 160 (52.8%) had either come directly to that clinic or previously consulted a government hospital before being advised to go to a mental health clinic. Those people who had sought previous help may have been to more than one source of help. In all, 43 patients (14.2%) had seen a pastor and 18 (5.9%) had seen a traditional healer. Only 14 patients (4.7%) had seen a family doctor. Six patients had visited psychiatric hospitals in another part of Ghana.

Of the 39 patients with epilepsy, 12 (31%) had seen a pastor and 9 (23%) had seen a traditional healer, higher rates compared to other patients. The corresponding rates for patients with a neurosis were 4 (6%) seeing a pastor and 6 (8.5%) a traditional healer and, in psychosis, 22 (14%) seeing a pastor and 3 (2%) a traditional healer.

A total of 74 patients (24.4%) had previously been to one of the three other mental health centres in Kumasi. At the KATH clinic, data on the use of other services were available for 157 patients (90%). Thirty-seven patients (24%) had been previously seen at another Kumasi clinic. Data on all referrals to the CPN clinic revealed 26 (45%) had been seen at another Kumasi clinic, mostly at the private Pankrona clinic nearby, where 5 (20%) patients had previously been seen at the CPN clinic. At the Santasi clinic, only 6 (10%) patients had been seen elsewhere. In summary, the main overlap in services is between the geographically close CPN clinic and Pankronu private clinic. However, one in five of the patients coming to the hospital clinic at KATH had previously been to a private clinic.

Table 2 shows the findings at the four sites for duration of illness before first consultation. The data are not normally distributed and medians were used in analysis. The overall median time from onset of symptoms to presenting to that service was 6 months (interquartile range 35 months). Patients attended the Santasi clinic

Table 1 Diagnoses of new referrals to the four sites (percentages)

Diagnosis	KATH N = 175	CPN clinic N = 58	Pankrona clinic N = 25	Santasi clinic N = 63
Psychosis	86 (55.1)	17 (29.3)	8 (32)	39 (61.9)
Neurosis	32 (20.5)	15 (25.9)	13 (52)	11 (17.5)
Epilepsy	13 (8.3)	25 (43.1)	2 (8)	0
Other	25 (16.0)	1 (1.7)	2 (8)	13 (20.6)
Missing data	19	0	0	0

Table 2 Time between onset of symptoms to presentation at mental health service

Service	Number of patients	Missing data	Time since onset of symptoms: median number of months (inter-percentile range)
KATH	175	22	6 (35)
CPN clinic	58	7	24 (48)
Pankronu clinic	25	0	18 (35)
Santasi clinic	63	2	1 (4)

earlier in their illness, with the KATH clinic seeing patients earlier in the illness compared to the CPN clinic and Pankronu clinic (Kruskal Wallis test, $p = 0.001$). If patients had seen a pastor, the median time before presentation to services was 24 months (interquartile range 55 months) and, if patients had seen a traditional healer, it was 36 months (interquartile range 114 months). These were significantly longer times than from those not seeing these helpers (Mann Whitney tests, $p = 0.001$ for both groups). Of those patients with a psychotic illness, the median time before presenting to services was 4.5 months (interquartile range 23.5 months).

There were differences between patients presenting to the four clinics in Kumasi. Table 3 shows the basic demographics and distance travelled for those patients interviewed at each site. The distance travelled to each site is significantly different (ANOVA $P = 0.01$). Patients travelled further for the two private clinics (Pankronu and Santasi) than the state services (KATH and CPN). As the lower mean for KATH might reflect more people attending from Kumasi city, we also examined the urban/rural ratio of patients attending the four sites. At KATH, 69 % of patients were from an urban area, compared to 67 % at the CPN clinic, 56 % at Pankronu clinic and 64 % at Santasi clinic. These differences were not statistically significant.

Discussion

There are limitations of this study. Patients interviewed were not consecutive referrals due to the limited time clinicians had to fit the survey around their clinical duties. There was no evidence that the non-consecutive referral pattern might produce an identifiable source of bias. Clinicians in the four sites used the same data form and were instructed by the same researcher. However, we were unable to measure inter-rater reliability. We were dependent on the clinical diagnoses given by clinicians at the four sites and, therefore, the reliability and validity of these diagnoses is uncertain. We relied on self-report for previous consultation, and patients may have been reluctant to admit to consulting non-medical sources of help.

Table 3 Demographics of referrals to the four sites

	Number of patients	Mean age (SD)	Sex (% male)	Distance travelled mean km (SD)
KATH	175	32.6 (13.4)	55	15.4 (20)
CPN clinic	58	29.3 (16.3)	40	19.2 (27)
Pankrona clinic	25	37.2 (14.8)	56	29.0 (30)
Santasi clinic	63	30.8 (13.5)	49	24.7 (29)

The number of patients reporting having sought help from traditional healers was only 5.9 %. A study of inpatients with a psychotic illness in Accra in 1973 found that 92 % had consulted traditional healing centres before hospital consultation (Lamptey 1977). A study in Ilorin, Nigeria, in 1995 found a rate of 26 % using traditional healers before presenting to mental health services (Abiodun 1995), and in a rural area of Ethiopia, traditional treatments were preferred to modern medicine for mental disorders when key informants were surveyed (Alem et al. 1999). However, a study on pathways to care in urban Harare found patients with an acute illness first consulted biomedical care providers, often seeking traditional care if this treatment failed (Patel et al. 1997). It is possible that a lower use of traditional healers in Kumasi, as in Harare, may be a reflection of modern, urban Africans who are less likely to first consult traditional healers compared to their urban counterparts in the past or rural compatriots in the present. Factors may include easier accessibility of mental health services and an increased role of Christian pastors rather than traditional healers. Our finding that 14.2 % of patients had consulted a pastor compared to 5.9 % consulting traditional healers before presentation to services may reflect a cultural change in urban Africa that is significant for planning mental health care. Little research has been done on attitudes of church pastors in urban or rural Africa, although the growth of their involvement has been noted in Nigeria (Jegede et al. 1985). Acknowledging the possible role of churches in providing care together with educating and working with church pastors may be an important way forward in improving mental health care, especially when medical resources are scarce.

Our results show that patients seeking help from pastors of churches or traditional healers took longer to present to mental health services. This can be problematic as there is evidence that delays in treatment of psychotic illness leads to a worse prognosis (Black et al. 2001). The implication of this finding is that liaison between mental health services and traditional healers and pastors might benefit patients. If traditional healers and pastors can be educated about how to recognise severe mental illness and advise these sufferers to seek appropriate care, delay in treatment may be shortened. One study in Nigeria suggested traditional mental health practitioners are interested in attending seminars on orthodox mental health care (Makanjuola et al. 2000).

Patients presenting to each service had a differing diagnostic profile. This has to be interpreted in the light

that the diagnoses were made clinically, not operationally, and staff may have had differing skills and habits in making diagnoses. However, it seems likely that there were genuine differences in patients presenting to the four sites and this has implications on service provision and staff training at each site. Patients with epilepsy may be more likely to consult pastors and traditional healers.

Patients used different clinics. They may no longer be able to afford the private clinic and are turning to a state service, or are exercising the right to a second opinion. However, this finding emphasises the importance of appropriate communication with previous services with patient consent. If a treatment used elsewhere was effective or ineffective, this can inform future treatment.

Conclusion

It is possible that fewer patients with mental health problems present to traditional healers in modern, urban Africa compared to rural areas. More patients consult with pastors than traditional healers and good liaison and education with these groups may improve mental health care. It is important to maintain good liaison between the four services as patients presenting to one clinic may have presented previously to another local clinic.

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