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"Improved access, delayed accreditation, low recognition": Perspectives of mental health educators, preceptors and students on the Kintampo Project in Ghana.

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Abstract

Purpose

The problem of mental health care neglect in Ghana is gradually improving. The Kintampo Project which trained mental health workers in Ghana has played a critical role through increasing access to mental health care.

Methodology

This qualitative study explored participants' perspectives on the Kintampo Project in three broad areas: perceived effectiveness, gains and challenges. Seventeen (17) interviews were conducted with former students, preceptors and educators from the project. The interviews were digitally audio-recorded, transcribed, coded and analysed using deductive and thematic methods.

Findings

The participants perceived the project to have been successful in increasing the number of mental health workers in Ghana. The project provided a route for career progression for those involved. However, the Kintampo Project faced accreditation issues, low recognition, improper integration and remuneration of trained staff in the Ghana Health Service. This study points to the fact that the sustainability of mental health training in Ghana can be obstructed, due to this career path being less attractive. Further research is needed to explore how best to achieve sustainability of similar mental health innovations.

Originality

This paper shares the views of participants in the Kintampo Project.

Keywords: Kintampo Project, Mental Health Education, Implementation, Sustainability, Clinical Psychiatry Officer, Community Mental Health Officer, Global Health Partnership, Ghana

Introduction

In the past few years, mental health care delivery and access have gradually been prioritised locally and globally (Alloh *et al.*, 2018). However, access to mental health care in low- and middle-income countries (LMICs) is still sub-optimal, with most people who need attention receiving no or inadequate care (Armstrong *et al.*, 2011; Gureje *et al*., 2019). Therefore, building a qualified mental health workforce is key to increasing access to and uptake of mental health services (World Health Organization (WHO), 2018).

In Ghana, the treatment gap for mental health disorders is enormous, nevertheless the narrative of many years of 'mental health care neglect' has shifted and efforts have been made by the government to improve mental healthcare services at all levels (Eaton and Ohene, 2016; WHO, 2022). A revived Mental Health Act was passed in 2012 and Clinical Psychiatry Officers ((CPOs), formerly called the Medical Assistant in Psychiatry (MAP)) and Community Mental Health Officers (CMHOs), were introduced as two new cadres of the mental health workforce. The CPOs is the equated to district-level psychiatrists and the CMHOs works with community psychiatric nurses (CPNs), and acts as a bridge between primary health care (Robert *et al,*. 2014). This new mental health workforce was intended to ease the pressure on mental health care in the large psychiatric hospitals by shifting the focus of mental health care to the community where it is most needed. Moreover, the two new cadres of mental health cost less to train than doctors and nurses; they provide specialist career opportunities; and improve workforce retention, as their knowledge and skills are specifically designed to fit the Ghanaian context (Roberts *et al.*, 2014). These new cadres combined with other changes to the national mental healthcare services have contributed to a greater awareness of mental health issues in the country (Eaton and Ohene, 2016).

There are three psychiatry hospitals in Ghana, all located in the South, namely: Ankaful Psychiatric Hospital, Pantang Hospital and Accra Psychiatric Hospital. Before introducing the two new cadres, the mental health workforce in Ghana was unevenly distributed between urban and rural areas, with the largest proportion found in the largest cities in Ghana (WHO, 2011). Moreover, there was also high attrition of mental health nurses and doctors, leading to a dwindling mental health workforce in Ghana's health system (Locke *et al.*, 2020; Roberts *et al.*, 2014).

The Kintampo Project was a part of the Country's health agenda and was set up to develop the mental health workforce and improve access to community mental health care in Ghana (Locke *et al.*, 2020; Roberts *et al.*, 2014). It was a global health partnership between the Kintampo College of Health and Wellbeing (formerly called the Kintampo Rural Health Training School in Ghana) and Southern Health NHS Foundation Trust (formerly Hampshire Partnership NHS Foundations Trust), UK. The project started in 2006 and ran until 2017 and in that period trained new mental health workers for Ghana (Robert *et al*. 2014). The initial stages of the Kintampo Project can be explored in greater details in Roberts *et al.*, (2014). There has been work that shares the UK narrative of this long-term education innovation done by Locke *et al.* (2020). The focus of this study will emphasize the importance of local knowledge and the views of the local communities whose lives the research aims to better (Lebel and McLean, 2018).

This current study set out to explore the perspectives of local participants, including educators, perceptors and former students of the Kintampo Project, led by the Dodowa Health Research Centre and supported by University of Winchester in the UK. To our knowledge this is the first study to explore the perspective of key informents (educators, preceptors and students) of the Kintampo Project, on the perceived effectiveness of the training course, and the gains and challenges in delivering this large-scale training innovation in Ghana. Other authors have explored the effectiveness of community mental health workers in Ghana and working in the community post-training (Agyapong et al., 2015; Agyapong et al., 2016). This study therefore compliments but differs from previous studies, and it is hoped that the knowledge generated from this study will improve the implementation and sustainability of mental health education to help achieve sustainable health and well-being (United Nations, 2020). Moreover, this study will contribute to a wider discussion with curriculum developers, educators, and other interested partners involved in current, and future projects of this nature. Finally, this knowledge would inform managers of health systems and policy makers with decisions related to mental health care providers and users.

Methodology

Study Design

This is a qualitative study which explored the lived experiences of study participants in the Kintampo Project (Patton and Cocharn, 2002). Key Informant Interviews (KIIs) were conducted with mental health educators, preceptors and students from the Kintampo Project. Educators were local tutors who taught on either of the two programnes. Preceptors were mental health nurses, already practicing mental health, who where trained throughout Ghana to mentor and supervise students on the Kintampo Project during their field practice, and after completion of training. 'Students' in this paper refers to those who were once trainees on the Kintampo Project and thereafter practitioners (CPO or CMHO).

The Ghana lead for the Kintampo Project, and the head of the host institution, acted as gatekeeper, who identified participants on the Kintampo Project. Participants were asked of their willingness to participate in the study and availability. A list of potential participants was compiled and followed up for interview. Nineteen participants, including six educators, seven preceptors and six students, shared their views about the Kintampo Project. Two participants at a later stage withdrew from the study and their interviews were not included in the study.

Data collection method

Data collection took place between August and September 2021. KIIs were conducted on the phone due to travel restrictions because of the COVID-19 pandemic. Each participant was called twice. The first call was to brief potential participants about the purpose of the study, then confirm their willingness to participate and agree on a date and time for the interview. The interviews were conducted in the second call, which lasted between 30 and 90 minutes.

Semi-structured interview guides were used for data collection. The interview guide was drafted by researchers at the University of Winchester, based on the literature and their knowledge of the Kintampo Project. It was then reviewed and developed by researchers in the Dodowa Health Research Centre. The interview guide explored issues on the project's implementation and sustainability in terms of effectiveness, gains and challenges. Debriefing sessions were held at the end of each week amongst the researchers to discuss the emerging findings and new probes for subsequent interviews. The interviews were all conducted in English and digitally recorded.

Data Management and Analysis

As the interviews progressed, saturation was reached after 19 KIIs when no new information emerged from the discussions with the participants. At this point, recruitment and data collection was stopped. Audio recordings were downloaded onto a laptop and transcribed verbatim by professional transcribers. The team reviewed the transcripts to ensure that there were no gaps or errors.

The analysis adopted the framework approach that embraces deductive and thematic methods (Gale *et al.*, 2013; Smith and Firth, 2011). This approach, widely used among health researchers working in teams, describes and interprets participants' views. It is an iterative data analysis process consisting of familiarisation with the data, generation of initial codes, continual searching for patterns and codes across interview transcripts, revision of codes, definition and naming of codes, production and interpretation of findings.

The verified transcripts were imported into MaxQDA Analytics Pro Software 2020 for coding. Before coding, the research team in Dodowa used the questions in the interview guide to develop a preliminary codebook that guided coding and analysis in the software (Saldaña, 2009). The preliminary codebook comprised broad codes (sub-topics in the guide), sub-codes (questions) and code definitions. The preliminary codebook was shared with the research team at the University of Winchester for their input and review. As coding progressed, emerging codes were inductively included. The codebook was finalised once the last transcript was coded. The transcripts were coded in a group comprising the Dodowa research team to reach intercoder agreement. Differences in coding were resolved during these group discussions. The iterative steps and teamwork thus incorporated transparency and reliability into the data analysis process.

Ethical Considerations

The participants received electronic copies of the Informed Consent Form (ICF) which consists of an information sheet about the study as well as a section for the participants to sign to indicate their consent via email. They were encouraged to read the information about the study, ask questions, and consent prior to interview. During the telephone interviews, the researchers reiterated information on the ICF. Each participant returned electronic copies of their signed copies of the ICF(s) to the team.

Participants were at liberty to refuse the interview if they wanted to. They were informed that any information shared with the study team would be used solely for research. Furthermore, data was anonymised by assigning numbers to participants where quotes are used in the findings.

The study was approved by the Ghana Health Service Ethical Review Committee (GHS-ERC:018/05/21) and the Dodowa Health Research Centre Institutional Review Board (DHRCIRB/054/05/21).

Findings

This section will present the background of the study participants and then the perspectives of participants in the Kintampo Project. The perspectives of local participants in the Kintampo Project are presented in three broad themes: effectiveness, gains and challenges.

Background of study participants

Of the seventeen participants, twelve were male. All joined as educators, preceptors and former students after the project started in 2010 and all had significant experience practising in mental health, an average of ten years.

Perspectives of the educators, preceptors and former students

Theme 1: Perceived effectiveness

This theme explores the participants' views on the effectiveness of the Kintampo Project, in terms of how the participants perceived the project's capacity to increase the mental workforce and the support provided to former students on the project.

Increase in mental workforce

The participants of the Kintampo Project described the project's goals as clear and decisive to drive mental health service delivery from an institutional base to a community base. Participants were ardent that training more mental health workers complemented the then mental health workforce, which was deficient prior to the Kintampo Project .

> *"I would say it's been very, very helpful with emphasis on very; places that wouldn't have had mental health practitioners, we now have them in the communities, in the district hospital, in the health centres almost a lot of places that wouldn't have originally had mental health people now had it, so I believe it was very, very successful". Educator*

> *"I think the Kintampo project or the Kintampo College of Health has trained more numbers in the community setting more than we can ever get. I don't think the Ministry of Health in Ghana would have had the CMHOs being trained because, in the past, it was only the psychiatric wings that were training nurses for an institutional basis". Preceptor*

> *"It was very effective, and it was our coming in as Community Mental Health Officers posted to the various districts in the region that led to the establishment of most mental health facilities in Ghana. So, based on that, I can say that the programme was very effective in accomplishing its goal". Student*

However, some students had negative views on the programme's effectiveness, mostly related to the CPO cadre. They mentioned that the project was ineffective, because it could not train the expected number of CPOs. They added that the first batch of CPOs faced challenges which affected subsequent enrolment in the CPO programme, and, as a result, the CPO programme was discontinued.

> *"I may say it was partially successful because those of us who have already been trained, most of us are in various psychiatric institutions providing the services as CMHOs, that is, Community Mental Health Officers. They are very resourceful and profitable throughout the country providing community mental health services. So, the clinical psychiatric programme was rather the problem, but generally, it was partially successful". Student*

> *"No, I think it has not been effective because most of us are not practicing psychiatrists. Most people finished, and they are still practicing the general outpatient department cases." Student*

Project support for former students

Many participants were of the view that the project was effective in terms of the support that former students received from the project. The participants mentioned that the curriculum used in training the students and the system of preceptorship, instituted by the project, enhanced their practice in mental health within the community and the health facility by increasing the former students' confidence and knowledge of mental health.

The participants added that the project initiated continuous professional development (CPD) workshops for students, preceptors and educators in the project. They described the CPD workshops as programmes intended to offer refresher training for attendees. In the beginning of the Kintampo Project, the CPD included annual conferences and travel by local participants to study mental health programmes in the UK. Most of the participants in the study were of the view that these CPD opportunities extended their knowledge in mental health, especially in new areas in their work and served as a refresher for certain procedures. They further mentioned that such meetings served as opportunities to meet and familiarise with other cadres (doctors, community health nurses and social workers) who practise mental health.

> *"There was an exchange programme that used to take some educators, preceptors and students to the UK to broaden their knowledge in mental health, and then they come back to use that knowledge to restructure the mental health systems". Preceptor*

> *"Apart from just training and placing them in the field by the Ghana Health Service, there had been CPD sessions held for them. Because mental health is a unique area and a continuing learning process, together with the team from the UK, we had annual conferences and annual CPD sessions to keep them in touch. Beyond that, they all had portfolios, and they had what we call preceptors and mentors who will continue nurturing them". Educator*

Contrary to this, some participants were unaware of any support apart from the in-school training.

> *"...I think that was probably not an area that the project sought to cover., from where I sit and with my experience and from what I know, the project was largely trying to send out graduates." Preceptor*

> *" After training we haven't had any in service training." Student*

Overall, study participants described their perceived effectiveness of the Kintampo project as: 'very effective', 'good', and 'helpful'. The project increased the mental health workforce by

training more individuals and the project support enhanced former students' skills which led to an improvement in awareness of mental health.

Theme 2: Gains

The project yielded gains to all the beneficiaries. These gains centred around three emerging sub themes; career progression, increased awareness of mental health care and access.

Career progression

The key achievement of the Kintampo Project was the introduction of the new cadres of mental health officers in Ghana. This provided an avenue for people who were interested in undertaking courses in mental health after obtaining certificates in senior high school education. From the students' perspective, their skills in managing mental health patients and their knowledge about psychiatric approaches improved because of the project. Examples of this included home visiting, an approach not previous used. It also provided a platform for career progression, which was a opportunity for students to become teaching assistants and educators. Moreover, it provided an opportunity for CHMOs to acquire a diploma to progress in their career. Subsequently, some of the students had the chance to travel to the UK, where they had the opportunity to study the UK programmes for mental health care.

> *"I happened to be in the first batch, and after the first batch, I was retained as a teaching assistant. Then I have become a tutor." Student*

> *"I would say it provided some bit of career progression for those who had certificates. It provided a level for them, a career progression for them to acquire a diploma." Educator*

Increased awareness and access

The main aim of the Kintampo project was to increase awareness of mental health and improve access to services. The participants' perception was that the increase in numbers of CMHOs, within five years had created high awareness of mental health care in the country and better access.

> *"I think it has improved accessibility to mental health care in the country as a whole. Created lots of mental health awareness because they are in the communities educating people in churches, radio and stuff." Educator*

> *"There was a time in this country, it was difficult to get onto psychiatry nursing, but today because of the project, there are personnel all over the country who are taking services through to the doorsteps of our service users." Preceptor*

The introduction of new cadres of community mental health officers in Ghana was a key achievement in mental health. The project also served as a platform to help trainees further their career in mental health.

Theme 3: Challenges

Participants in this study reported challenges related to programme structure and accreditation, recognition within the Ghana Health Service after training and training delivery by external tutors.

Programme structure and accreditation

For all the participants, it emerged that there were accreditation issues related to the Kintampo Project. According to the respondents, the CPO programme was initially structured as a degree programme. Therefore, most new entrants were qualified Physician Assistants (PAs) who held a diploma qualification. However, a few years after the Kintampo Project started, the Medical and Dental Council issued a directive that all PA programmes were to be offered at degree level. This posed a challenge, as because the CPO programme was already running as a degree programme, it now needed to be upgraded to either a postgraduate diploma or MSc. It emerged from the interviews that the students wanted an MSc, while the existing staff and some tutors felt threatened that their students would end up with a higher level qualification than their own. In addition, the CPO programme, although affiliated to the University of Cape Coast (Ghana), had not been accredited. Therefore, some former students mentioned that upon completion of the course, they had no certificates to practice as CPOs or practiced at their own peril.

> *"The main challenge that I can talk of which eventually led to the suspension of the CPO programme was the accreditation issue. The programme didn't actually have accreditation, although it was affiliated with the University of Cape Coast, because the accreditation board did not give it accreditation to run that programme they also could not issue the certificate on completion." Educator*

Similarly, the CMHO programme was structured to award its students with a diploma certificate in mental healthcare. However, when these health workers wanted to pursue higher education in mental health, their diploma certificates were refused in other institutions, because their certificates had very low credit hours of completion. The participants were therefore unhappy and disappointed that even though they were still practising as CMHOs, they had to pursue degrees in related health programmes, not mental health.

> *"... I'm aware some people are doing degrees in related programmes but are still practising as community mental health officers." Student*

Recognition within the Ghana Health Service

Tied to accreditation was recognition of the skills acquired within the Ghana Health Service. Our participants also agreed that it was difficult to use the skills they had acquired when entering the workforce or returning to previously held job roles after training. Directors or managers of the former students respective facilities were either not aware of these 'new roles' or, in some cases, did not support them to deliver the services the students were trained to give. Some participants blamed this on the project's failure to engage, sensitise, and involve the appropriate stakeholders when the project was set up.

> *"After completion we realised that most or some of the district directors of health services were not aware of community mental health officers. In other words, the level of recognition for the programme was quite low. You are posted to a place, and when you introduce yourself with your letter, the director asks you, 'so what work are you coming to do?' Which shouldn't be the case. So, the level of recognition, the sensitisation before the commencement of the programme wasn't much. And as a result of that, when we completed, the level of recognition for our role was quite limited." Student*

External Tutors

At the beginning of the project, the training content was delivered mostly by tutors who did not reside in Kintampo. Some tutors were from other parts of the Ghana, while others travelled in from the UK to teach the new curriculum. Contact hours with these tutors were limited and this affected the theoretical experience for students. In the initial stages of the project external tutors had to be used, because experienced tutors were not available locally although the intention was to grow local tutors as part of the project.

> *"As a student, our challenge that time was the fact that most of the people who were teaching us were external tutors…for external tutors when they come, they have what we called blocked lectures, and will teach you for three to four days and then they pile up the notes and leave. The person is not really available for you to have so many contact hours, so it was quite hectic… unlike the regular or the residential tutors that will be with you, teach you for a few hours and have time with you, and you meet again within the week." Student*

> *"We didn't have most tutors living in Kintampo, so we had to lean on external teachers coming in to do block lectures and stuff. Which kind of disrupts the calendar and makes it stressful for the students because the external lecturer may come in just for one week or two weeks in the whole semester and they have to write an exam on it." Educator*

The project had some challenges and the key among them was accreditation. Aside accreditation was recognition of the skills acquired from the project. It was challenging to use the skills

acquired when entering the mental health workforce within the Ghana Health Service or returning to job roles held prior to the training.

Discussion

This study presents the perspectives of educators, perceptors and former students of the Kintampo Project. It explores the perceived impact of the Kintampo Project in terms of effectiveness, the gain and challenges. Furthermore, it addresses whether the project has contributed to focus of the Mental Health Act (2012) to improve access to mental health services in Ghana by increasing the mental health workforce. Our study notes the challenges to the sustainability of mental health education in Ghana, such as certification, recognition and integration of the new cadres of mental health workers within the Ghana Health Service. On the other hand it also found that participants of the Kintampo Project have benefitted in terms of career progression.

Our findings showed that the participants believed that the project was effective, due to the increased number of students trained by the project. The first cohort of 72 trainees from the Kintampo Project graduated as CMHO and started working around the country to increase access to mental health care (WHO, 2011). Over the years the number of CMHOs has increased by almost 100% as documented by Roberts *et al* (2014).

The perception of participants in this study was that the increase in the number of CMHOs within five years has created high awareness of mental health care in the country. This can also be seen by CMHOs who are now distributed all over the country and are taking services to the doorsteps of their service users (WHO, 2022). The CMHOs conduct health education at various communities, including churches and mosques, as part of their roles. As a result, mental health services are now available at the community and district levels. With the involvement of the CMHOs in the health sector, some district directors of health services, together with other stakeholders, have established new mental health units. These units are attached to the various health facilities or the district health directorates to care for mental health disorders in the community (WHO, 2022). In the remote and rural areas, where there is no access to the main mental hospitals, the community mental health care bridged the gap and has improved accessibility to mental health care in the country as a whole.

Before 2011, a major human resource weakness was inadequate training amongst mental health workers and then subsequent lack of any refresher training (WHO, 2011). The introduction of preceptorship and CPD in the Kintampo Project were good innovations in expanding provider knowledge in mental health. Our findings suggest that these innovations where successfully implemented in the early phase of the project. Moreover, students from the first cohorts themselves became preceptors, who in turn then mentored or supervised subsequent students in their place of work. Nevertheless, the effort may have dwindled towards the end of the project and thereafter. Agyapong *et al* (2016) noted that 73% CMHOs reported rarely or never attending in-service training. Likewise, our study could not verify if any other form of CPD or refresher is in place for mental health workers. This is an area which could benefit from further research.

The lack of recognition and accreditation was a key finding in this study. CMHOs were trained to supplement the work of psychiatric nurses. However, in practice, due to the low numbers of psychiatrists, many CMHOs also take responsibility for diagnosis and treatment (Centre for Society and Mental Health, 2022). This confusion in the role or lack of recognition of the new professionals may be attributed to the existence of community psychiatric nurses (CPNs). These nurses have been trained to embark on mental health promotion, refer patients and care for community members discharged from mental health hospitals (Asare, 2010). In addition, CPNs and CMHOs have similar roles (Agyapong *et al.*, 2015). Therefore, the managers may truly be uncertain which duties to assign their 'new' staff. However, in institutions where the new cadres were known, integration into the system was almost effortless (Eaton and Ohene, 2016).

A challenge found in this study was the delivery of learning by external tutors. The Kintampo Project, like many other global health partnerships, was established through donor support to resolve a gap in mental health care (Caulfield *et al.*, 2019). Unlike in an Indian study by Armstrong *et al.* (2011) where the 4-day mental health training for health workers was taught by local trainers (Armstrong *et al.*, 2011), human resources had to be outsourced for training future educators and mental health care providers in Kintampo, Ghana. Hence, external tutors delivering block lectures may be classified as an unintended consequence of the project, especially in the initial phase of the project's inception. However, the teaching approach was probably the only option the project had at the time because of the country's persisting mental health human resource constraints (Atakora *et al.*, 2020).

The study highlights and reinforces the interconnectedness of education, workforce, and clinical service as playing a key role here. Altering one of these components would have affected the success of the others. To ensure the successful achievement of all three, education, clinical service and workforce, should be given equal attention and considered simultaneously, at every stage (Locke *et al.*, 2020; Tooke, 2008).

Policy implications

Findings suggest that there is the need to accurately define the roles of CMHO and CPOs to enable them deliver mental health services to the populace. These challenges identified through our interviews may have consequences for achievement of the aim of Mental Health Act, i.e. to strengthen community mental health services, by helping those who need mental health care to be easily identified and managed. However, the intention to produce one CPO to two or three CMHOs for all districts in Ghana by 2017 (Roberts *et al.*, 2014) may have not been achieved as our interviews suggest. The inadequate number of CPOs has created a gap in the referral and follow-up of patients with mental health problems by CMHOs who are to work closely with the CPOs (Agyapong *et al.*, 2015). This gap may have rendered CMHOs at the institutional level shifting focus from the community.

Study limitations

Our study is limited by recall bias because it is based on retrospective self-reported views of participants. This study only reports on the perspectives of participants from the Kintampo Project. It is possible that CPO, CHHOs and educators in other regions will have other perspectives. Also, managerial and administrative staff in the Kintampo College and other stakeholder institutions were not included. It would be valuable to understand their perspectives on the programme structure, set up, yearly student enrolment and sustainability of the Kintampo Project. In future research, the researchers would like to carry out a larger study to include additional data collection techniques e.g. Photovoice and a wider range of stakeholders to contribute further to understanding such innovations and their sustainability. In order to fully understand the effectiveness of the Kintampo Project the views of mental health service users should be sought.

Conclusion

The Kintampo Project was seen as a success in delivering training for the mental health care workforce. Future innovations in mental health will need to fully integrate new cadres in the Ghana health system to fill current gaps they intended to fill in the health care provision. Also, adequately promoting knowledge about the roles of new cadres will minimize the incidence of duplicatory and conflicting roles in the mental health care system of Ghana. We also posit that future studies can build on effective ways to strengthen stakeholder engagement and ownership of similar innovative projects, especially for mental health. This will serve to enhance sustainability.

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Conflict of Interest

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